

# Note to Reviewers

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Thank you for your time and input!

*-KDHE Title V Team*

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

**Kansas**

**FY 2017 Application/  
FY 2015 Annual Report**

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

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

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

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

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

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

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

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

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

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

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

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

### **Assessing State Needs**

With a goal to maximize the input of internal and external partners, the Kansas Title V Five Year Needs Assessment process utilized a mixed methods approach relying on continuous input from a diverse team of key informants, partners, and community members as well as broad public input. This comprehensive process and broad approach assisted with identifying key priorities to ensure an intended plan of action to effectively improve and address maternal and child health. The emerging needs stood out and are now the final priorities. Criteria used in final selection and categorization of priorities and elements of the state action plan follow.

- Determination of level of impact (priority, objective, strategy)
- Ability of KDHE and Title V to advance work and impact outcomes
- Existing infrastructure, capacity, sustainability
- Role of key partners in delivering outcomes

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

The Kansas Title V needs assessment resulted in eight state priorities, selected with the Title V mission, purpose, legislation, and measurement framework in mind.

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

7. Services are comprehensive and coordinated across systems and providers
8. Information is available to support informed health decisions and choices

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

#### Kansas Title V National Performance Measures (FFY 2017)

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

- NPM1: Well-woman visit (Percent of women with a past year preventive medical visit)
- NPM4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)
- NPM6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- NPM7: Child injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)
- NPM9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)
- NPM10: Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)
- NPM11: Medical home (Percent of children with and without special health care needs having a medical home)
- NPM14: Smoking during pregnancy and household smoking (A. Percent of women who smoke during pregnancy and B. Percent of children who live in households where someone smokes)

#### Kansas Title V State Performance Measures (FFY 2017)

Kansas selected five State Performance Measures to monitor progress with state priority needs that aren't addressed by NPMs.

- SPM1: Percent of preterm births (<37 weeks gestation)
- SPM2: Percent of children living with parents who have emotional help with parenthood
- SPM3: Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- SPM4: Number of Safe Sleep (SIDS/SUID) trainings provided to professionals
- SPM5: Percent of adults who report that it is somewhat difficult or very difficult to understand information from doctors, nurses, and other health professionals

#### **Kansas Title V Activities & Program Highlights**

Local MCH grantees across the state provide family centered, community based and culturally competent services and care to MCH populations throughout the life course.

1. Women/Maternal: prenatal care, breastfeeding, education, home visiting, depression/risk and smoking screening
2. Perinatal/Infant: perinatal/postnatal care, breastfeeding (duration & exclusivity), safe sleep, community outreach and public education (safe haven, text4baby)
3. Child: screenings (vision, hearing, developmental), health education (motor vehicle safety, nutrition), community outreach and public education (child abuse prevention, importance of immunizations)
4. Children & Youth with Special Health Care Needs: care coordination, family caregiver health needs, behavioral health, training and education, early screenings (vision, hearing, developmental), school readiness, collaboration and coordination with early intervention, social services and family support services
5. Adolescent: immunizations (HPV, flu), reproductive health, health education (motor vehicle safety, fitness),

community outreach/public education (teen pregnancy, injury, risky behaviors, suicide, abstinence)

6. Cross-cutting: comprehensive, coordinated care; Medicaid outreach and enrollment; preventive care such as well infant/child/adolescent/woman and immunizations; linking families with needed services through screening, referral, and follow up

The following MCH program highlights/updates reflect major accomplishments by MCH population health domains. Please review the full Title V MCH Block Grant Application to learn more: <http://www.kdheks.gov/c-f/mch.htm>.

### Women/Maternal & Perinatal/Infant Health

*Infant Mortality Collaborative Innovation and Improvement Network (CoIIN):* KDHE along with several partners and organizations including the March of Dimes and the Kansas Infant Death and SIDS Network is actively engaged in the Infant Mortality CoIIN, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. Each participating state selected two to three strategies to focus on as part of the national platform. Kansas' selections include: 1) Smoking cessation (before, during, after pregnancy) and 2) Early term and preterm birth. Change ideas implemented by pilot sites since 2015 focus on appropriate utilization of progesterone for previous preterm birth, elimination of Early Elective Deliveries, and improved screening/referral to evidence-based interventions for pregnant women who smoke.

*Perinatal Community Collaboratives/Birth Disparities Programs:* The Kansas MCH Program, in collaboration with local communities and the broader network of local health care and community service providers are involved in an on-going process of developing grassroots perinatal care collaboratives using the March of Dimes, "Becoming A Mom/Comenzando Bien" as a consistent and proven prenatal care education curriculum. Development of these began in 2010, bringing prenatal education and prenatal care together. There are currently nine established sites with plans to expand to five new communities each year. Birth outcome data reveals improvements in preterm delivery, low birth weight, and breastfeeding initiation rates. Most notable is the Infant Mortality Rate (IMR) from pre-program implementation to post-program implementation in the longest running programs (less than five years): Saline County 9.0 to 5.5 and Geary County 11.9 to 6.6 (deaths/1000 live births).\* \*Source: Kansas Vital Statistics 2005-2009 and 2010-2014

*Communities Supporting Breastfeeding:* The long-term goal of the Communities Supporting Breastfeeding (CSB) project is to improve exclusive breastfeeding rates for infants at three and six months of age by assisting communities with achieving the CSB designation by the Kansas Breastfeeding Coalition (KBC) as defined by the following six criteria: 1) A local breastfeeding coalition with a page on the KBC website listing local breastfeeding resources; 2) Peer breastfeeding support group(s) such as La Leche League or similar mother-to-mother group; 3) One or more community hospitals participating in High 5 for Mom & Baby or Baby Friendly® USA; 4) One business for every 1000 community citizens\* or 25 (whichever is less) participate in the "Breastfeeding Welcome Here" program; 5) One business for every 5000 community citizens or 10 (whichever is less) receive a Breastfeeding Employee Support Award from Kansas Business Case for Breastfeeding; and 6) A minimum of 20 child care providers completing *How to Support the Breastfeeding Mother and Family* course. Five communities achieved the designation of a CSB in 2015. Ten additional communities will work to be designated by the end of 2017 with continued funding from the Kansas Health Foundation. \*Number of community citizens defined by 2010 census.

### Child & Adolescent Health

In an effort to address the identified needs and priorities for children and adolescents, a number of initiatives involving state and local programs have been launched. The most recent Maternal and Child Health five-year needs assessment is complete and new priorities and objectives have been identified. The Title V program will remain focused on employing the strategies related to these objectives during the next year and beyond to advance efforts

related to the priorities for children and adolescents.

- Promote annual well visits through adolescence into adulthood
- Promote oral health and dental screening and care, with special emphasis on routines in out of home care settings (tooth brushing, increased access to water, reduced sweetened beverages)
- Promote incorporation of behavioral health into well visits
- Develop follow-up protocols for families to be referred for behavioral health services
- Partner with community providers to connect children and adolescents with supports that promote protective factors
- Implement evidence-based/informed practices to support healthy behaviors and choices and the development of positive coping mechanisms
- Promote accessible crisis services through school and out-of-school activities
- Provide services that support reducing the impact of Adverse Childhood Experiences
- Increase awareness of options for educating and reporting unsafe digital content Bullying and Cyberbullying intervention and prevention
- Make connections among schools, families, communities and health providers through programs such as school-based clinics

As part of the comprehensive statewide needs assessment, the MCH Program partnered with Kansas State University, Research and Extension to conduct an adolescent health assessment and a state adolescent health plan. The Adolescent Health Needs Assessment provided state-specific information regarding the adolescent population that was not previously available, including identification of issues of particular interest to adolescents themselves. The plan has been aligned with and integrated into the MCH State Action Plan Adolescent domain.

#### Children & Youth with Special Health Care Needs

A strategic planning process began mid-2013 in an effort to enhance and improve services provided to families through the KS-SHCN program. New priorities have been selected by families, providers, community partners, and other key stakeholders. These five priorities are: cross-system care coordination, behavioral health integration, addressing family caregiver health, direct health services and supports, and training and education. The new priorities align closely in many ways with the 2010-2015 objectives, however, have provided a new direction for the program. The KS-SHCN program was accepted into Cohort 2 of the Association of Maternal and Child Health Programs (AMCHP) Workforce Development Center (WDC) to address the needs of families of CYSHCN through collaboration, systems integration, and increased capacity for telemedicine/telehealth. The target population includes Kansas CYSHCN and their families in rural communities. The primary objective of this project is to increase capacity for utilization of telemedicine in rural communities. We will support health transformation through improved access to care and systems integration. Utilizing quality improvement and evaluation, we strive for sustainable and systemic changes for the CYSHCN population. To better meet the unique challenges of CYSHCN and their families, this project will build partnerships and engage key stakeholders to increase capacity for integration, collaboration, and systems change. The leadership team of this project consists of the state Title V CYSHCN Director and KS-SHCN Program Manager as co-leads and includes representation from Medicaid/Kancare, a community hospital partner, and coordinator for the HRSA Regional Telehealth Resource Center.

#### Cross-Cutting/Life Course

The most recent needs assessment revealed concerns that family functioning contributes to stressors across all population domains. Lack of services is an issue as well as lack of knowledge of services and stigma associated with accessing needed programs/services. Plans to address this involve focusing on family functioning in all MCH contacts; promoting the importance of partners (including men and fathers) as active participants in health matters; educating on the importance of future planning as it relates to building strong relationships and health and family considerations (spacing of children); utilizing the KS-SHCN "Family Caregiver Assessment" to identify needs and resources for family members; providing education for families of CYSHCN as to how their role as a caregiver impacts their own health and ability to care for their loved one; utilizing peer and social networks for women including to promote and support access to preventive health care; developing a progressive family leadership program to empower families and build strong MCH advocates; providing family and sibling peer supports for those interested in being connected to other families with similar experiences (Foster Care, SHCN, other); and using an evidence-based model, provide parenting resources and mentors for adolescent caregivers. The Infant Mortality CollN activities will also address cross-cutting issues including smoking during pregnancy and smoking in the household.

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

The Federal-State Title V partnership budget totals \$12,228,467 for FY2017 (federal funds \$4,689,065; state funds \$3,557,713; local funds \$3,981,689). Federal and State MCH funds totaling \$4,839,019 is allocated for local agencies providing community-based, family centered MCH services, including services for special health care needs.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

This section puts into context the Maternal and Child Health (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.

#### Overview & Authority

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

#### Geography/Demography

Kansas, spanning 81,759 sq. miles, is divided into 105 counties with 628 cities. The U.S. Census Bureau estimates there are approximately 2,904,021 residents living in the state of Kansas (2014). The state of Kansas has a unique geographic layout that ranges from urban to frontier counties. Within each of the regions throughout the state there are few populous cities intermixed with multiple rural areas. For example, within the South Central regions lays Wichita with a population of 388,413. Within that same region also lays Pratt with a population of 6,963. This is a good example of the diversity of the Kansas population where rural communities are influenced by mid-sized cities and mid-sized cities are therefore influenced by rural communities. This provides challenges to service delivery, but also an opportunity for sharing resources among the populations.<sup>1</sup>

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

The population density of Kansas was 35.5 inhabitants per square mile in 2014, a 13.1% increase from 31.4 persons per square mile in 1995. For comparison, the population density of the U.S. increased from 70.4 to 90.1 persons per square mile from 1995 to 2014, a 28.0% increase. In 2014, 36 of the state's 105 counties had population densities of less than 6.0 persons per square mile. The most sparsely populated county was Wallace, with a density of 1.6 persons per square mile. The most densely populated county was Johnson, with 1,213.1 persons per square mile. Several Kansas counties were re-categorized from one population-density peer group to another, to reflect population shifts indicated by the 2010 U.S. Census. During the 2010-2014 period, the population of the urban and semi-urban peer groups increased by 3.6% and 0.9%, respectively, while the frontier, rural, and densely-settled rural peer groups decreased by 2.5%, 1.3%, and 0.4%, respectively.<sup>1</sup>

## Population Growth/Change

The percent increase in the Kansas total population from 1992-2014 was 13.2%, including a 14.7% increase for Kansas males and an 11.7% increase for Kansas females. Kansas increased in population from 2,893,957 residents in 2013 to 2,904,021 residents in 2014, a 0.3% increase. Geary, Pottawatomie, and Riley Counties had the largest relative increases in population from 2010 to 2014 with percent changes of 7.4, 6.5, and 5.7 respectively. Elk, Stanton, and Greenwood Counties had the largest relative decreases in population, with changes of 6.3%, 5.9% and 5.4% respectively.<sup>1</sup> In 2014, there were an estimated 39,922 infants living in Kansas or about 1.4% of the total Kansas population (2,904,021). Women of reproductive age 15-44 accounted for 19.3% (558,538) of the Kansas population. The race and ethnicity composition for this group was estimated at 73.8% non-Hispanic white, 6.3% non-Hispanic black, 1.0% non-Hispanic Native American or Alaska Native, 3.7% non-Hispanic Asian and Pacific Islander, 2.4% non-Hispanic multiple race, and 12.8% Hispanic (any race). In 2014, there were 900,213 children and adolescents aged 1 to 22 years living in Kansas, which represents 31.0% of the Kansas population. The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. About three-in-ten (29.9%) Kansas children and adolescents belong to a racial or ethnic minority. Across the age groups, one-in-three (31.9%) young children (1 to 5 years) are part of a racial/ethnic minority versus about one-in-four (28.3%) young adults (20 to 22 years). About 14.7% of Kansans age 15 to 22 are Hispanic, compared to 19.0% of young children. Among families with children under 18, 30.2% are single-parent families versus married-couple families (69.8%). According to the 2011/12 National Survey of Children's Health, 19.4% of Kansas children aged 0 to 17 (est. 139,623 children) had special health care needs. These rates represent an increase from the percentage reported in 2009/10 (17.3%) for Kansas. The reasons for this increase are not fully understood. While it is possible that the number of children and youth with special health care needs (CYSHCN) is actually increasing, it is also possible that children's conditions are more likely to be diagnosed, due to increased access to medical care or growing awareness of these conditions on the part of parents and physicians.<sup>2</sup>

## Age

The median age of Kansans in 2014 was 36.1 years, a 5.2% increase from the median age of 34.3 in 1995. The median ages of Kansas males and females in 2014 were 34.8 and 37.5 respectively. Shifts in the Kansas population distribution by age from 1995 to 2014 included a decrease in the 35-44 age group of 16.1%. An increase of 27.7% in residents 45-54 years of age and 78.3% in residents 55-64 reflected the aging of the baby boomers. Furthermore, there were 9.8, 2.5, 16.3, 4.3, 23.5 and 13.1% increases in the 0-4, 5-14, 15-24, 25-34, 65-74, and 75 and over age-groups respectively.<sup>1</sup> The prevalence of special health care needs within the child population increases with age. Older children in Kansas were twice as likely as younger children to have a special health care need. In Kansas, preschool children (aged 0-5 years) have the lowest prevalence of special health care needs (10.2%), followed by children aged 6-11 years (23.9%). Adolescents (aged 12-17 years) have the highest prevalence of special health care needs (24.3%). The higher prevalence of special health care needs among older children is likely attributable to conditions that are not diagnosed or that do not develop until later in childhood.<sup>2</sup>

## Race/Ethnicity

According to the 2014 Census Bureau estimates, 76.8% of Kansans were non-Hispanic white and 5.9% were non-Hispanic black. Hispanics made up 11.4% of Kansas' population.<sup>1</sup> The prevalence of special health care needs varies by the child's race and ethnicity. Kansas Hispanic children (15.2%) were least likely to have a special health care need compared to non-Hispanic white children (19.6%) and non-Hispanic black children (22.3%).<sup>2</sup>

## Diversity/Languages

According to the 2010-2014 American Community Survey, in Kansas, 2.3% of the households met the definition of being limited English speaking compared to 4.5% of U.S. households. In Kansas, the prevalence of limited English speaking in households varies by language spoken at home. Limited English speaking among households speaking

Spanish was 23.0%, other Indo-European languages 8.7%, Asian and Pacific Island languages 27.2%, and other languages 15.0%.<sup>3</sup> Ninety-three percent (93.2%) of the people living in Kansas in 2010-2014 were native residents of the United States. About 58.9% of these residents were living in the state in which they were born. About 6.8% of the people living in Kansas in 2010-2014 were foreign born. Of the foreign born population, 34.9% were naturalized U.S. citizens, and 90.7% entered the country before the year 2010. About 9.3% of the foreign born entered the country in 2010 or later. Foreign born residents of Kansas come from different parts of the world.<sup>4</sup> Among people at least five years old living in Kansas in 2010-2014, 11.1% spoke a language other than English at home. Of those speaking a language other than English at home, 66.6% spoke Spanish and 33.4% spoke some other language; 40.5% reported that they did not speak English "very well." Notable is a change in Spanish speaking population in Kansas, which has been steadily increasing. The increase mirrors similar trends at the national level.<sup>4</sup>

## Education

Kansas compares favorably with the U.S. average in terms of educational attainment with a 90.0% high school graduation rate compared with 86.3% for the U.S. Thirty percent (30.7%) of Kansans have a bachelor's degree or higher compared with 29.3% for the U.S.<sup>4</sup>

## Income/Poverty

For 2014, the federal poverty level is \$24,230 for a family of four. Children living in families with incomes below the federal poverty level are referred to as poor.<sup>5</sup> Research suggests that, on average, families need an income of about twice the federal poverty level to meet their basic needs.<sup>6</sup> In 2014, based on the Small Area Income and Poverty Estimates (SAIPE), compared to the U.S. population, a lower percentage of Kansans lived in households with incomes below the federal poverty level (13.6% vs. 15.5% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (17.6% vs. 21.7% for the U.S.). During the past 10 years (2005-2014), Kansas experienced a significant increase in the poverty rate for children under age 18. Similar trends were seen in the United States.<sup>7</sup> In 2014, 125,562 Kansas children under 18 years of age were living in poverty. Most of these children live within four population centers: Sedgwick County (Wichita), Wyandotte and Johnson Counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). Five counties accounted for over half of all Kansas children (64,982 children; 51.8%) in poverty: Sedgwick (25,795), Wyandotte (15,554), Johnson (11,484), Shawnee (8,804), and Douglas (3,345). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty.<sup>7</sup> In 2014, the percent of Kansas' families living at or below the federal poverty level (9.2%) is lower than the U.S. (11.3%). Poverty is more common in Kansas families headed by single females and those with children in the household, regardless of race or ethnicity. In 2014, the Kansas percent of female headed households with related children under 18 years living below 100% federal poverty level (39.2%) was slightly below the U.S. percent (40.6%). The prevalence of special health care needs varies by income group in Kansas. CYSHCN prevalence among low income families, 0-99% of the federal poverty level (FPL), was the highest group (26.4%).<sup>2</sup>

## Health Insurance Coverage

Data from the show that the percentage of Kansas children under 18 years old without health insurance decreased from 7.6 in 2008 to 5.6 in 2014, a 35.1% decrease. Part of the reason for this finding is an increase in public coverage of Kansas children.<sup>8</sup> This increase suggests factors - such as the weakness in the economy and the state's active outreach efforts to enroll children who need coverage - may be responsible.<sup>9</sup> The U.S. percentage also decreased from 9.4 in 2011 to 8.9 in 2012. More than half (54.2%) of all uninsured Kansas children under age 19 live in the four largest population centers: Sedgwick County (Wichita), Johnson and Wyandotte counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). However, in the southwestern part of the state has many counties with high concentrations of uninsured children under age 19, a largely Hispanic

populated area and presumably many are not KanCare (Medicaid or CHIP) eligible. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with high concentrations of children in poverty, as stated above, but the children are less likely to be uninsured than those in the southwestern part of the state. In Kansas, 89.3% of CYSHCN were reported to have been insured for all of the previous 12 months, while the remaining 10.7% were uninsured for all or some part of the year. Overall, almost 96% of CYSHCN were reported to have some type of insurance at the time of the interview: about two-thirds (64.2%) had private coverage, 25.1% had public coverage, 6.2% had both, and 4.6% had no insurance.<sup>2</sup>

### **Primary Care Access/Workforce**

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

### **State Health Agency Current Priorities & Initiatives/Title V Program's Roles & Responsibilities**

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

Infant Mortality Collaborative Innovation and Improvement Network (CoIIN): KDHE along with several partners and organizations including the March of Dimes and the Kansas Infant Death and SIDS Network is actively engaged in the CoIIN initiative, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. Cross-state and region collaborative work involves learning networks/sessions for six identified CoIIN strategies. Each participating state selected two to three strategies to focus on as part of the national platform. Kansas' selections are Smoking cessation (before, during, after pregnancy) and Early/preterm birth. This work has resulted in implementation of the BABY & ME - Tobacco Free evidence-based program and screening for previous preterm birth resulting in utilization of progesterone. Sustainability is the key to improved outcomes and long-term success. From concept to reality, the state has worked to integrate CoIIN activities into existing systems (MCH, Tobacco, WIC) and programs (Becoming a Mom, Healthy Start, Safe Sleep, Communities Supporting Breastfeeding) to provide the mechanism to achieve current success and future expansion of successful programs. This integration extends to the inclusion of all CoIIN efforts in the Title V Needs Assessment. Due in part to the CoIIN exposure, Kansas is currently seen as a maternal and child health leader on the national stage recognized by NICHQ, AMCHP and the March of Dimes.

Community Supporting Breastfeeding: The Bureau of Family Health (BFH) and the Kansas Breastfeeding Coalition, Inc. (KBC) continue to work on several projects that support breastfeeding families and build community support. These organizations have partnered on the Communities Supporting Breastfeeding project with funding for continuation of this project into 2017 from the Kansas Health Foundation. Five communities were designated as a Community Supporting Breastfeeding (CSB) in 2015. Ten additional communities will be designated by the end of the project. The CSB project maximizes existing efforts, incorporating six separate breastfeeding support projects: 1) The Kansas High 5 for Mom and Babies project educates and works with hospitals to implement five evidence based practice steps from the Baby Friendly designation; 2) Supporting and Developing Local Breastfeeding Coalitions, a KBC project. The number of local breastfeeding coalitions has grown from 3 to 24 in the last 4 years with local coalitions implementing actions that assist their community; 3) Business Case for Breastfeeding, a KBC project – employers are educated about lactation support and can be recognized for their efforts; 4) Breastfeeding Welcome Here, a KBC program which encourages local businesses to welcome breastfeeding customers; 5) Kansas Child Care Training – child care providers enroll in a *How to Support the Breastfeeding Mother and Family* course, this is a joint project of the BFH Child Care Licensing Program, Child Care Aware © of Kansas and the KBC; and 6) Peer support – communities must have a peer support group such as a La Leche League, public health WIC/MCH support group or similar. The project has received state and national attention, selected for poster or session presentations at the following conferences: Association of Maternal & Child Health Programs (April 2016); U.S. Breastfeeding Coalition's National Breastfeeding Coalition (August 2016); Kansas Public Health Association (September 2016); American Public Health Association (October 2016); Quality Forum Kansas Foundation for Medical Care, Inc.

Perinatal Community Collaboratives/Birth Disparities Programs: The MCH Program and March of Dimes in collaboration with local communities and the broader network of health care and community service providers are involved in an on-going process of developing grassroots perinatal care collaboratives using the March of Dimes, "Becoming A Mom/Comenzando Bien" (BAM) as a consistent and proven prenatal care education curriculum. The March of Dimes Kansas Chapter began development of these community collaboratives in 2010, bringing prenatal education and clinical prenatal care together to create the comprehensive BAM program. The first program was launched and piloted in Salina (Saline County) in 2010. This innovative model was replicated in Junction City (Geary County) in 2012 with preliminary successes similar to that of the Saline pilot program. In 2014, the Kansas Department of Health and Environment (KDHE) Bureau of Family Health committed to partner with the March of Dimes for further expansion of the model across the state, as well as securing long-term sustainability of the program by integrating the model into MCH services at the local level. Three additional sites launched in 2014 (Crawford, Wyandotte, Riley counties). The continued success and expansion resulted in additional support from one of the three Kansas managed care organizations, Amerigroup (WellPoint). In 2015, five new sites launched (Clay, Dickinson, Lyon, Reno, Sedgwick counties) bringing the total active sites to ten. Nearly thirty additional communities have either attended training or indicated interest in launching the program with assistance from KDHE, primarily to convene key partners and build the collaborative. Interest is greatest in the southeast and western regions of the state where disparities persist and fewer resources exist (rural and frontier).

Healthy Start/Delivering Change: Healthy Moms, Healthy Babies: Delivering Change is a comprehensive approach to eliminating disparities in perinatal health in Geary County, Kansas, that focuses on individual/family level health, evidence-based practices, standardized approaches, and quality improvement. The Kansas Department of Health and Environment (KDHE) as the lead agency, is aligning Delivering Change with Title V and Kansas MCH programs and services to directly support individual participants. Delivering Change expands on existing work of the Geary County Perinatal Coalition to integrate a comprehensive array of services and maximizes the resources in Geary County through a system of mutually reinforcing activities that provide appropriate, high quality services to meet the needs of women, infants, and families. Key program models include: OB Navigator; Becoming a Mom/Comenzando bien©; Period of PURPLE Crying; Triple P – Positive Parenting Program; and Parents as Teachers. Key partners in

delivering these programs include the Geary Community Hospital, the Geary County Health Department and Flint Hills OB/GYN. Delivering Change uses a Collective Impact approach that will support achieving the three project goals: 1) Develop a comprehensive, coordinated perinatal system that leads to improved women's health; 2) Improve the quality of services available to pregnant women and new mothers; and 3) Develop a system of programs, services and partnerships that strengthen family resilience. A comprehensive process and outcome evaluation will ensure accountability through quality improvement and performance monitoring.

Early Childhood Comprehensive Systems: From August 2013-July 31, 2016, KDHE has administered the current 3-year Early Childhood Comprehensive Systems (ECCS) grant. Named the Kansas Initiative of Developmental Ongoing Screening (KIDOS), the project goal is to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers (birth to age three) across early childhood support systems at the state and local levels including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs and families. A pediatrician-chaired state work group has provided expertise and guidance for the KIDOS project. Using the Collective Impact framework, a comprehensive community toolkit has been developed to provide resources, tools, and guidance to communities coordinating comprehensive developmental screening systems. These tools and technical assistance has been provided to community implementation teams, including 5 regional summits conducted statewide in April and May 2016. Expansion of statewide capacity to provide quality training on the Ages and Stages Questionnaires (ASQ-3™ and ASQ: Social-Emotional) has occurred. New grant activities will build on the KIDOS project and continue a focus on developmental screening and referral processes as well as family well-being (i.e., maternal depression and trauma-informed care) utilizing CoIN and Collective Impact strategies.

Healthy Smiles: This collaboration involves MCH, Child Care, Oral Health, Oral Health Kansas, and other partners such as Child Care Aware of Kansas (CCA). The focus is on changing behavior and practices in child care settings to include providing nutritious meals and snacks, tooth brushing after meals, and toothbrush replacement to reduce untreated decay prior to school entry. In order to participate in the initiative, child care providers were required to complete a 2-hr oral health training on nutrition and tooth brushing. A pilot screening and kick off was held in May 2015, and free screenings were provided to children birth to 11 years. Providers received an Oral Health Kit containing educational materials, toothbrush and toothpaste for each child, digital timers, puppets, books, and more. A total of 105 children received education and screenings by a dental hygienist. Parents received results, referrals, and oral health literature. Results revealed 6 children had untreated decay and 60 had never been to the dentist (6 were less than 1 year of age). Free online trainings were offered to 200 providers. As a means to gather data on oral health practices in child care, a question regarding tooth brushing was added to the licensing inspection tool, and surveyors across the state now provide on-site consultation regarding oral health. Data obtained may guide future regulation changes and training.

Pregnancy Risk Assessment Monitoring System (PRAMS): Kansas is now one of 50 states participating in the PRAMS project. The project is new to Kansas (funded in 2016). Data collection will begin in 2017 and involve approximately 2,500 mothers providing information on their experiences and behaviors before, during and after pregnancy.

Promoting Safe Sleep and Reducing SIDS/SUID: Together with the Kansas Infant Death and SIDS (KIDS) Network, develop and deliver culturally tailored safe sleep resources, toolkits, educational materials, and trainings for home visitors, providers and child care providers with focus on a consistent message related to breastfeeding. Families benefit from community baby showers, Cribs for KIDS, and Sleepsack™ programs.

Adolescent Health Assessment and Plan: As part of KDHE's development of the Maternal and Child Health State

Plan for the period 2016-2020, Kansas State University Research and Extension conducted an assessment of adolescent health in Kansas. The priority health needs of adolescents, service gaps, access barriers and program recommendations were revealed through a comprehensive approach involving review of state-level population data, online surveys, and focus groups. The results informed the priorities, measures, and activities for the most current state action plan.

Special Health Care Needs Program (KS-SHCN): KS-SHCN completed a strategic plan in FY2015, developing a 5-Year Plan with 14 objectives and 31 total strategies. The KS-SHCN five year plan focuses on the five priorities as follows: (1) Care Coordination focuses on empowering families, improving communication among providers and systems, and stronger cross-system collaboration; (2) Family Caregiver Health focuses on promoting health and wellness among family caregivers, increasing awareness of and access to respite services, and family leadership and peer supports; (3) Behavioral Health focuses on collaboration to support integrated care, community education and referrals, and screening and assessments for KS-SHCN families; (4) Training and Education focuses on advocacy, youth leadership and self-determination, and training for professional in integrated care of people with disabilities; and (5) Direct Health Services is focused on gap-filling services such as oral health, access to adequate insurance coverage, and telehealth. These strategies are re-assessed each year by the SHS-FAC to monitor progress and make recommendation for changes, as needed.

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## II.B. Five Year Needs Assessment Summary

### 2016 Five-Year Needs Assessment Summary

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

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

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

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

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

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

#### State Performance Measures

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

SPM 2: Percent of children living with parents receiving emotional support (help with parenthood)

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

minutes/day

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

SPM 5: Percent of adults who report that it is somewhat difficult or very difficult to understand information from doctors, nurses and other health professionals

Evidence- Based or Informed Strategy Measures

ESM: Percent of women program participants that received education on the importance of a well-woman visit in the past year

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

ESM: Number of communities achieving the "Community Supporting Breastfeeding" designation

- NPM 4: Breastfeeding (Percent of infants ever breastfed; Percent of infants breastfed exclusively through 6 months)

ESM: Percent of parents of participants 10 to 71 months receiving education on developmental screening

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

ESM: Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit in the past year

- NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)

ESM: Number of school-age students that received information about bullying or social-emotional development.

- NPM 9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

ESM: Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year

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

ESM: Percent of families who experienced a decreased need of care coordination supports

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

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

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

KDHE continuously assesses the needs of Kansas MCH populations, so this is and will be an ongoing Needs Assessment that stretches beyond the 5-year vision. The new MCH State Plan truly reflects priorities and needs of MCH populations statewide and is a plan that demands commitment and "shared" responsibility among the state Title V program, partnering state agencies, and other valued state and local programs/partners. Success with advancing the plan during the next year and beyond lies in the strength of partnerships and willingness to align efforts and collectively impact outcomes, so branding for the plan and program was needed. The Title V team adopted the following image that represents the focus of our work which ties to the six MCH population domains.



## Needs Assessment Process Background

### Goals, Framework & Methodology

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

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

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

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

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

1. *While serving as the lead agency for Title V, KDHE is not alone in this work.* There are many complimentary and supporting efforts across state agencies that, in conjunction with Title V, can lead to improved MCH population outcomes. Partnerships will be key to achieving the goals of the Title V work over the next 5 years.
2. *Not all populations are addressed by other initiatives at the same level of intensity.* Significant attention has

been given to women, infants, and life course issues, likely as a result of infant mortality work that has been done. KDHE appears to lead in assuring that CYSHCN, child, and adolescent needs are identified and addressed.

3. *The cross-cutting/life course domain has particular significance in coordinating across initiatives and moving the needle on health across MCH domains.* Research indicates the importance of multi-generational approaches to individual and community well-being. The role of life course priorities and strategies has not fully been explored in Kansas; however, the Alignment of Key Frameworks indicated the importance of doing so through the Needs Assessment process.

### Stakeholder Involvement & Input

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

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

While the Kansas Title V Priorities reflect the overall needs of the state, the Needs Assessment process incorporated a regional approach, based on the Bureau's recognition of the unique needs of local communities. For nearly a year, the needs assessment team covered six regions of the state in person, conducting and facilitating MCH regional meetings, attended, facilitated, or presented at three MCH council meetings, the Blue Ribbon Panel on Infant Mortality (now part of the Kansas Maternal and Child Health Council, serving as the Perinatal/Infant Health Domain Committee), and various strategic planning meetings with MCH staff and stakeholders. The broad approach continued with three large scale surveys distributed over nine months. The Public Input Section provides a detailed breakdown of the data collection process, input methods and level of response.

### Process Strengths & Weaknesses

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

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

### Guiding Principles

This process highlighted the importance of recognizing and understanding the connections between priorities across MCH population domains. Four overarching themes were identified as guiding principles that impact Title V work in Kansas. It is important to note that these guiding principles do not stand alone yet build upon and complement each

other, further exemplifying the collaborative approach KDHE envisioned throughout the process. The guiding principles are:

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

# **Note to Reviewers**

Document pages  
22-46 contain  
duplicate information  
from the previous  
year's application  
(2015) and were  
intentionally left out.

*-KDHE Title V Team*

## II.C. State Selected Priorities

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

Central to the needs assessment planning and process to identify priorities was to work with the MCH Council to determine the status of Kansas MCH progress since MCH 2015 (2010 Needs Assessment) was implemented. This analysis assisted with identifying which priorities were still priorities five years later and therefore should be continued.

Following a review of priorities from the previous period (2010-2015), the Title V team (and partners) covered regions of the state conducting and facilitating meetings for more than 18 months: eight Public Health Regional Meetings (focused on improving birth outcomes using the AMCHP Compendium as a key resource for planning), three MCH Council meetings, 17 Communities for Kids meetings (focused on the health needs of children, adolescents including children and youth with special health care needs), focus groups centered on adolescent health with 350 participating adolescents, and strategic planning meetings with MCH staff and stakeholders. Additional, supporting processes and methods that resulted in rich input included online input surveys, presence at the Kansas Parent Leadership Conference, and a Child Care Licensing Program Tour to hear more about child care safety and issues related to availability, access, and quality. This comprehensive process and broad approach assisted with identifying priorities to ensure a plan of action to effectively improve and address MCH.

Over time, common issues across populations showed repeated connections that exemplified the interconnectedness of the priorities. This led to some original priorities not being a focus when it was realized that they were eventually naturally connected to other priorities, eventually becoming key goals or strategies in the action plan, assuring that a number of needs were actually covered within a priority and could be measured over time. Criteria used in final selection and categorization of priorities and elements of the plan included:

- Determination of level of impact (priority, objective, strategy)
- Ability of KDHE and Title V to advance work and impact outcomes
- Existing infrastructure, capacity, sustainability
- Role of key partners in delivering outcomes

The state priorities that emerged as well as the selection/decision-making process, are summarized below. A

crosswalk of the 2010 priorities and new priorities is also provided in this section. This crosswalk identifies how the previous priorities (focused and narrow) are still being addressed under new priorities as objectives or strategies.

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

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

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

From all sources of input throughout the needs assessment, promoting and providing services for optimal mental and behavioral health was a critical issue to a healthy family and overall community well-being. During data collection, follow up questions to determine 1) the nature of mental and behavioral health needs and 2) the role of MCH in mental and behavioral health helped to inform a broader priority that addressed mental and behavioral health as a component of family functioning. Parents and providers indicated that family functioning was contributing to stressors across all population domains. Lack of services were an issue, but the bigger issue was lack of knowledge of services and stigma. Teachers expressed feeling overwhelmed with young children's behavioral issues which then connected to a stressful home environment because of potential factors of overworked parents, poor nutrition due to lack of time and money, domestic violence, and unhealthy sleep habits. These factors were pointed out as interconnected and expressed in the child's behavior. This systemic issue suggests the need for resources to manage adult relationships in a healthy way to address the needs of women, and to interrupt the frequency of stressors to promote the child's health all the way from pre natal care into infancy and beyond. Parent education through home visiting, opportunities for community engagement, and life skills classes such as cooking, budgeting and job trainings could be addressed. Participants shared: *"If something could be written in the state plan around the research of ACES and trauma informed care and how these experiences are a health issue, behavioral and mental health will be in the priorities somehow. Social emotional health needs to be addressed."* *"We need to address stress."* *"[We need to] teach teens and families how to manage life skills and empower them."*

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

The priority of healthy development for children was a strong theme that addressed many needs in every community that could really stand on their own as priorities. These needs were connected to a common goal of the health of children on many levels and span into the adolescent years: injury prevention efforts, safety concerns in the home, and selection of safe childcare. What is unique is that these needs provide KDHE with the opportunity to focus on cross cutting goals in programs and practices. By strengthening existing successes of programs like Safe Kids Kansas as well as increase the number of MCH grantees that serve as a lead agency for local safe kids coalitions, KDHE can continue to strengthen the guiding principle of collaboration and creating community change. Additional needs that were absorbed into the priority of developmentally appropriate care focused on essential health, safety and education opportunities by providing prevention practices for parents and providers: safe sleep initiatives, access to childhood immunizations, oral health education and developmental screenings. Taken together, these

needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course. Participants and staff in the meetings provided useful and innovative ideas that KDHE will look forward to implementing and continue to improve upon while expanding current programs. Many of the suggestions and ideas are already in the scope of KDHE's work and will further promote collaboration at state and community levels.

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

Discussions during the needs assessment regularly focused on the need to address obesity across population domains. While there was targeted discussion about children, specifically related to school lunches, there was a shift to a broader view of a healthy start/beginning. Over the last year, the discussion shifted to Perinatal/Infant Health Domain National Performance Measures and breastfeeding. The areas of need/work began to emerge for the population, and the priority was reframed and revised. In addition to the need for improvement related to exclusive breastfeeding at least through 6 months, there is strong desire to expand existing work related to safe sleep and reducing SIDS/SUID, including the aspects related to breastfeeding/bed sharing/co sleeping. Plans include enhanced community baby showers which will incorporate cross-cutting issues including breastfeeding, safe sleep, and smoking in the home. In addition, training and messaging around these issues will be aligned among existing programs including MCH, home visiting, WIC, and chronic disease.

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

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

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

Seeking the appropriate care for the maternal and child health care population is critical to the continued support required to ensure that this population's needs are being met. For quality care to be delivered it's important that the professionals interfacing with this population are properly trained to provide this care. This is an area which impacts not only maternal and child health, but also children, perinatal/infant, adolescents and the children with special needs population. Ensuring professionals, serving MCH populations, have adequate training can impact individuals at birth and continues throughout adulthood. Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains. When asked what could improve services within the community, responses included "*having trained professionals who take the time and listen to our needs.*" Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and the health impact that it may have on this population. In particular children and youth with special needs was identified as a population that needed improved support from professionals. Strategies suggested included incorporating evidence-based trainings and mid-level trainings for home based practitioners. Additionally, it was reported that not only an increase in training occur amongst professionals, but

coordination of care also increase to enhance delivery of services. Through agencies collaborating with one another, resources are then shared within an interconnected environment that can help the MCH population be more aware of services and provide the appropriate linkage. This area has been recognized as one of importance. Objectives include: developing a trained, qualified workforce; providing training to providers to promote diversity, inclusion, and supports; and incorporating the support of early childhood service providers.

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

This priority is specific to the needs of children and youth with special health care needs though not exclusive as it addresses all children in the way that KDHE strives; comprehensively and inclusively. One of the main goals of the Special Health Care Needs program is care coordination, so that children and their families can navigate systems to gain optimal health in a consistent and comprehensive way. In the regional meetings and especially the Communities for Kids meetings, it became apparent that family support was emerging as a high need and that those supports include access to care (transportation, especially in rural communities, and providers who will treat CYSHCN especially oral health). As the assessment progressed family support also expanded into the need for social-emotional support and respite for caregivers. Providers were also a high need given many are not specialists and many do not practice near rural communities. Family-centered medical homes need support and partnerships can be explored based on the needs presented. This can include existing structures that KDHE can support as well as engaging MCO's and primary care providers, implementing tele-medicine, and professional development training. This priority exemplifies the collaboration and partnership building principles that KDHE promotes and is willing to sustain so that all children with health care needs are children first.

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

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

### Crosswalk of Kansas MCH Priorities

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

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

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

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

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

### **Corresponding NPMs:**

- 1. Well-woman visit (Percent of women with a past year preventive medical visit)
- 14(A). Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy)

NPM 1 was selected because of the discussion by stakeholders regarding the need for women's gynecological health to be improved. Service coordination among partners should help to ensure that the proportion of women receiving a well-woman visit is increased, as should the provision of consumer education regarding what services are available to them. State ESMs for this priority have a focus on promoting and collaborating with Title X to improve access to well-woman visits; they also include an overall focus on improved screening and care coordination related to physical and mental health issues.

NPM 14(A) was selected in part because more than 13% of Kansas women smoked during pregnancy as recently as 2011-2013 (Kansas Health Matters). Smoking in Kansas is higher than the national average, with 25.3% Kansas smokers, versus 24.1% of smokers throughout the nation (National Survey of Children's Health, 2011-2012). Smoking during pregnancy affects the mother, unborn child, and all members of the household. Increasing the utilization of the Kansas Quitline and other tobacco cessation programs by pregnant women should improve the health of entire households in Kansas.

**Priority Two:** Services and supports promote healthy family functioning.

There is no corresponding NPM for this priority. A State Performance Measure has been developed. This issue was identified as the continued success of maternal and child health services in Kansas. Participants throughout Kansas

voiced a need for trained, qualified professionals who could deliver services across domains. Strategies are focused on developing innovative methods for training the provider workforce.

**Priority Three:** Developmentally appropriate care and services are provided across the lifespan (Children)

**Corresponding NPMs:**

- 6. Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- 7. Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)

NPM 6 was selected because of the many discussions with stakeholders about current gaps in developmentally-appropriate care. Strategies focus on care coordination to ensure developmental screenings increase and are accessible through a number of approaches, including via tele-health.

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

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

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

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

**Priority Five:** Communities and (providers / systems of care) support physical, social and emotional health.

**Corresponding NPMs:**

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

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

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

**Priority Six:** Professionals have the knowledge and skills to address the needs of maternal and child health populations.

**Corresponding NPM:** 4(B). Smoking during Pregnancy and Household Smoking (B. Percent of children who live in households where someone smokes)

NPM 14(B) was selected for similar reasons as NPM 14(A). Providing opportunities for families to strengthen their relationships and be educated regarding healthy behaviors will empower households to make positive changes that should include a decrease in the proportion of adults who smoke. Therefore, a corresponding proportion of children living with smokers will also decrease. Reducing risk factors associated with smoking through education and related interventions is a focus of the strategies for this priority.

**Priority Seven:** Services are comprehensive and coordinated across systems and providers.

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

NPM 11 was selected because of the current lack of medical homes for children in Kansas. For those with special needs, only 43% reported having a medical home. And for those without special needs, only 59.1% reported having a medical home (BRFSS, 2013). Strategies target providers from a variety of service designations to engage them in supporting efforts to increase the number of children in Kansas with a medical home.

**Priority Eight:** Information is available to support informed health decisions and choices.

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

## **National Performance Measures (NPM) & Associated National Outcome Measures**

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

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

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

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

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

- Percent of children in excellent or very good health

- Percent of children meeting the criteria developed for school readiness

**NPM 7. Child Injury** (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9/adolescents age 10 through 19)

- Child mortality ages 1 through 9 per 100,000
- Adolescent mortality ages 10 through 19 per 100,000
- Adolescent motor vehicle mortality ages 15 through 19 per 100,000
- Adolescent suicide ages 15 through 19 per 100,000

**NPM 9. Bullying** (Percent of adolescents, 12 through 17, who are bullied or who bully others)

- Adolescent mortality ages 10 through 19 per 100,000
- Adolescent suicide ages 15 through 19 per 100,000

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

- Percent of children in excellent or very good health
- Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
- Adolescent mortality ages 10 through 19 per 100,000
- Adolescent motor vehicle mortality ages 15 through 19 per 100,000
- Adolescent suicide ages 15 through 19 per 100,000
- Percent of children with mental/behavioral health condition who receive treatment or counseling
- Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile)
- Severe maternal morbidity per 10,000 delivery hospitalizations
- Maternal mortality rate per 100,000 live births
- Low birth weight rate (%)
- Very low birth weight rate (%)
- Moderately low birth weight rate (%)
- Preterm birth rate (%)
- Early preterm birth rate (%)
- Late preterm birth rate (%)
- Early term birth rate (%)
- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths
- Neonatal mortality per 1,000 live births
- Postneonatal mortality rate per 1,000 live births
- Preterm-related mortality per 100,000 live births

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

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

conjugate vaccine

**NPM 14.** Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy and B.

Percent of children who live in households where someone smokes)

- Severe maternal morbidity per 10,000 delivery hospitalizations
- Maternal mortality rate per 100,000 live births
- Low birth weight rate (%)
- Very low birth weight rate (%)
- Moderately low birth weight rate (%)
- Preterm birth rate (%)
- Early preterm birth rate (%)
- Late preterm birth rate (%)
- Early term birth rate (%)
- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths
- Neonatal mortality per 1,000 live births
- Preterm-related mortality per 100,000 live births
- Post neonatal mortality per 1,000 live births
- Sleep-related SUID per 100,000 live births
- Percent of children in excellent or very good health

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

- SPM 1 - Percent of preterm births (<37 weeks gestation)
- SPM 2 - Percent of children living with parents receiving emotional support (help with parenthood)
- SPM 3 - Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day
- SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals
- SPM 5 - Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them

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

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

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

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

#### **Significance**

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

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

## Related Action Plan Objectives & Strategies

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

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

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

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

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

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

**OBJECTIVE 1.5:** Decrease non-medically indicated births between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5% by 2020.

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

**Priority 2:** Services and supports promote healthy family functioning.

**Corresponding SPM:** 2. Percent of children living with parents receiving emotional support (help with parenthood)

### Significance

The demands of parenting can cause considerable stress for families. Children and adolescents were less likely to engage in externalizing (acting out behavior) and display depression symptoms (sadness, feelings of worthlessness

or withdrawn behavior), or have to be retained in a previous grade, when their mothers reported having emotional support with child rearing. These children and adolescents were also likely to display social competence and school engagement than were their counterparts whose mothers did not report having emotional support.

#### Related Action Plan Objectives & Strategies

<b>OBJECTIVE 2.1:</b> Increase opportunities to empower families and build strong MCH advocates by 2020.
2.1.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others). 2.1.2 Conduct “ <i>Care Coordination: Empowering Families</i> ” trainings for parents of CYSHCN. 2.1.3 Increase the number of fathers and male support persons that are engaged in family health activities. 2.1.4 Identify options to provide supports (e.g., making healthy choices, positive coping mechanisms, violence, substance abuse, and mental health issues) to parents of adolescents, such as home visiting and peer-to-peer networks.
<b>OBJECTIVE 2.2:</b> Increase the number of providers with capacity to provide trauma-informed care by 2020.
2.2.1 Increase MCH state staff and partner capacity around trauma-informed care. 2.2.2 Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it. 2.2.3 Provide training for MCH grantees including home visitors on trauma-informed care.
<b>OBJECTIVE 2.3:</b> Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.
2.3.1 Develop and utilize strategies for MCH home visitors to improve effective outreach and engagement of families in universal home visiting services. 2.3.2 Enhance and expand coordinated intake and referral systems across the state to support appropriate referrals and levels of services for families. 2.3.3 Partner with Healthy Start; Maternal, Infant and Early Childhood Home Visiting (MIECHV); and Becoming a Mom (BAM) communities to ensure coordination and referral for home visiting services.

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

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

#### Significance

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

#### Related Action Plan Objectives & Strategies

<b>OBJECTIVE 3.5:</b> Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.
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- 3.5.1 Provide training and resources to child care providers related to healthy practices and regulatory requirements.
- 3.5.2 Provide training to child care surveyors regarding the regulatory requirements related to daily routine and physical activity, including protocol for assessing and determining compliance.
- 3.5.3 Provide resources for child care facilities and surveyors to encourage and support children's participation in activities that raise their heart rate for a minimum of 60 minutes a day.

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

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

**Priority 4:** Families are empowered to make educated choices about infant health and well-being

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

Significance

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

Related Action Plan Objectives & Strategies

**OBJECTIVE 4.4:** Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2018.

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

**Priority 8:** Information is available to support informed health decisions and choices.

**Corresponding SPM:** 5. Percent of adults who report that it is somewhat difficult or very difficult to understand information from doctors, nurses, and other health professionals

Significance

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

Related Action Plan Objectives & Strategies

**OBJECTIVE 8.1:** Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

8.1.1 Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education.

8.1.2 Provide resources to increase education and knowledge of healthy decision making.

8.1.3 Work with partners to ensure that well visits incorporate best practices.

**OBJECTIVE 8.2:** Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

8.2.1 Emphasize the importance of health insurance literacy with HLK.

8.2.2 Identify target populations and/or regions that require increased health literacy support.

8.2.3 Promote distribution and use of "*What to do when your child gets sick.*"

## II.F. Five Year State Action Plan

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

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

1. Women/Maternal: prenatal care, breastfeeding, education, home visiting, depression and tobacco/smoking screening
2. Perinatal/Infant: perinatal/postnatal care, breastfeeding (duration & exclusivity), safe sleep, community outreach and public education (safe haven, text4baby)
3. Child: screenings (vision, hearing, developmental), health education (motor vehicle safety, nutrition), community outreach and public education (child abuse prevention, importance of immunizations)
4. Children & Youth with Special Health Care Needs: care coordination, family caregiver health needs, behavioral health, training and education, early screenings (vision, hearing, developmental), school readiness, collaboration and coordination with early intervention, social services and family support services
5. Adolescent: immunizations (HPV, flu), reproductive health, health education (motor vehicle safety, fitness), community outreach/public education (teen pregnancy, injury, risky behaviors, suicide, abstinence)
6. Cross-cutting: comprehensive, coordinated care; Medicaid outreach and enrollment; preventive care such as well infant/child/adolescent/woman and immunizations; linking families with needed services through screening, referral, and follow up

### Women/Maternal Health

#### State Action Plan Table

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

##### Priority Need

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

##### NPM

Percent of women with a past year preventive medical visit

## Objectives

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

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

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

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

## Strategies

1.1.1 Increase the number of health departments and health centers with on-site assistance for accessing health care coverage (certified application counselors or Medicaid eligibility workers), especially to ensure coverage beyond the post-partum period. 1.1.2 Utilize peer and social networks for women, including group education models, to promote and support access to preventive care. 1.1.3 Increase the number of programs promoting individuals' responsibility through documented health plans. 1.1.4 Promote consumer awareness about the importance of preconception care. 1.1.5 Promote the development of personal health plans during well woman visits.

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

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

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

ESMs

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

NOMs

Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Maternal mortality rate per 100,000 live births

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

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

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

Percent of preterm births (<37 weeks)

Percent of early preterm births (<34 weeks)

Percent of late preterm births (34-36 weeks)

Percent of early term births (37, 38 weeks)

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

Infant mortality rate per 1,000 live births

Neonatal mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Preterm-related mortality rate per 100,000 live births

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

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

SPM

Percent of preterm births (<37 weeks gestation)

## Objectives

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

## Strategies

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

## Measures

### NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	73.7	75.7	77.7	79.8	81.9	84

### Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	63.7 %	1.2 %	309,668	486,081	
2013	68.2 %	0.9 %	332,196	487,313	
2012	66.4 %	1.4 %	322,447	485,511	
2011	66.7 %	1.0 %	323,032	484,259	
2010	71.6 %	1.6 %	340,609	475,647	
2009	71.7 %	1.1 %	346,490	483,018	

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

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

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

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

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

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

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

A yearly routine checkup is a great way to remain proactive about one’s health. The benefits of having an annual checkup include early diagnosis and treatment of existing conditions and prevention of future medical problems.<sup>1</sup> Data from the Kansas Behavioral Risk Factor Surveillance Survey indicated that, although not statistically significant, from 2011 (66.7%) to 2014 (63.7%), a declining trend was apparent in the overall prevalence of Kansas women aged 18-44 years reported having a routine medical checkup within the past year. In 2014, an estimated 63.7% of Kansas women aged 18-44 years reported having a routine medical checkup within the past year. The prevalence of having a routine checkup within the past year increased with age and household income poverty level. Non-Hispanic white (65.2%) and non-Hispanic black (65.8%) women were more likely than Hispanic (58.1%) women to have received a routine checkup within the past year. Married women (66.5%) were more likely to have had a routine medical check-up than unmarried women (61.3%). Insured women (68.7%) were significantly more likely to have had a routine checkup within the past year than uninsured women (43.3%). Significantly fewer women with less than high school (49.1%) reported having a routine checkup within the past year than did women who had some college (63.9%) or were college graduates (70.4%).

As part of Kansas Title V’s commitment to the continued development and expansion of the *Becoming a Mom* (BaM) collaborative prenatal education program in the state, there is also continued commitment to the development and implementation of additional “integration” components within the curriculum. These “integration” components allow for the strengthening of particular priority areas within the curriculum and program delivery model. One such priority area we plan to focus on during the 2017 grant year is women’s health in the interconception period. One area of focus will include the integration of personal health plans, including the development of a reproductive life plan, for each woman completing the BaM program. She will be encouraged to take her reproductive life plan to her provider for discussion during the remainder of her prenatal care and at her postpartum check-up. Additionally, as a part of this “integration” component during session six of the program, sites will be encouraged to invite a Health Care Exchange Navigator from their community to participate as a guest presenter on

the topic of accessing health care coverage following the loss of Medicaid coverage at 60 days postpartum. Ideally, this navigator will be available before and after the session to assist participants in navigating the federal insurance exchange and enrolling in an insurance plan that will increase the likelihood of the women receiving annual well-woman exams following her current pregnancy.

State Title V staff will continue to support the promotion of women receiving a well-woman visit annually, by messaging the importance of local Title V grantees partnering with other community agencies to provide on-site assistance for accessing health care coverage in the pre/interconception period. We will also continue to promote the development of personal health plans, including a reproductive life plan, for individuals receiving Title V services. In doing so, we will continue to highlight this topic, while sharing associated resources, during our annual Governor's Public Health Conference, Healthy Start Home Visiting Fall Regional Meeting, and other appropriate venues. As opportunity arises for building additional forms into our electronic data system, DAISEY, a "Reproductive Life Plan" form will be built and provided for all users of the system to access and incorporate as part of their service delivery plan.

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

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

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

We have developed and implemented a comprehensive "smoking cessation integration" toolkit as a part of our CollN work since July 2014. In 2017 we will continue our work on this initiative, with additional tests of change and PDSA cycles, in an effort to continually improve rates of screening, referral, and follow-up related to smoking in the perinatal period, and to improve the rate of engagement by women in the evidence-based smoking cessation programs we have made available in our state (which include the KS Quitline and *Baby and Me Tobacco Free (BMTF)* program). As successful tests of change are identified, we will work to implement these on a large scale across Title V programs and will develop an implementation plan for sustainability (including expansion/sustainability of the BMTF program, if determined to be a successful and cost-effective initiative). One test of change already in the development stage is a revised provider survey on smoking cessation support that is provided by the clinic/agency. This survey has been built in REDCap and is ready for distribution. In 2017, we look forward to using data received from the survey to help identify existing gaps and needs at the local level, which can be supported at the state level by provided education, training, and other identified resources. Another toolkit that has recently been developed, is the "mental health integration" toolkit. This toolkit is currently being reviewed by select members of our Kansas Maternal and Child Health Council, which serves as an advisory council for our state Title V program.

Once recommendations and endorsement is received from the council, the toolkit will be released for piloting in our *Becoming a Mom* program sites. Any need for adaptation will be identified and made during this pilot stage, before being implemented on a broader scale across other Title V programs. Currently, screening forms related to tobacco use in pregnancy and perinatal depression have been created and made available in our electronic data system, DAISEY, for use by all Title V grantees. The plan for 2017 is to build additional screening tools related to

alcohol and substance use (i.e. T-ACE screening tool) within DAISEY as well. Currently in DAISEY, the “KDHE Referral Form” is a required form for completion and submission anytime a referral for service is made by our Title V grantees. Within this form, there are particular referrals that require follow-up and documented “completion status” within the system. In 2017 we plan to continue to build features into this form that will allow grantees to capture limited notes related to the referrals and their follow-up efforts.

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

As mentioned in last year’s report, the AMCHP Compendium Regional Public Health Meetings provided an opportunity to engage interested communities in looking outside the box for opportunities to partner and collaborate with other community agencies in providing greater services to their MCH population. Among the models presented was the *Becoming a Mom* collaborative perinatal education program. At that time, as well as during several other opportunities this year, interested sites were encouraged to include their plans for program implementation in their 2017 MCH Aid-to-Local application. KDHE has also made other special efforts to engage the southeast and western parts of the state, where greater disparities and fewer resources exist in these largely rural areas. By increasing access to such comprehensive prenatal education and support services, where local MCH program staff serve as the lead or are at least a primary partner, and other Healthy Start Home Visiting and MCH case management services are intertwined, we look forward to an infrastructure that leads to a greater collective impact on the improvement of birth outcomes in Kansas. As of the April 2016 review of Aid-to-Local applications for Title V funding for the 2017 SFY, 16 communities included BaM program implementation in their application, in addition to the 10 currently existing programs. Plans are in place to engage these communities in training opportunities by fall, in hopes of beginning early phases of implementation by January to early spring 2017. Work is currently underway for the creation of an online training program for the Kansas program. This online course will consist of 10 training modules, covering the following content: introduction to the *Becoming a Mom* collaborative perinatal education model; program coordination; group facilitation; one module for each of the six program sessions; program evaluation. Program staff across sites will develop an individualized training plan with designated modules for required completion. Completion of the required components of the online training program will then certify the staff person for his/her role in program implementation. From early stages of program implementation in Kansas, the need for more comprehensive training related to the implementation of the program and group facilitation, has been apparent.

With KDHE Bureau of Family Health committing dedicated staff time and funding for the project, we are now in the early stages of making this a reality. This will ease the burden of implementation on new sites, as well as with existing sites that are facing staff turnover. It will also support the standardization of curriculum delivery across sites, leading to improved program outcomes. From here, we hope to start the process of establishing the Kansas model as an evidence-based program. Additionally, preliminary discussions have begun with our state’s Medicaid MCOs, regarding expanded partnership in supporting existing BaM programs, as well as expansion of the program in targeted areas of the state. These discussions have included: potential funding partnerships related to the development of a regional model approach to program delivery in small rural communities where birth numbers are too small to justify a full scale independent BaM program; program incentives; printing of standardized curriculum binders for consistency of curriculum delivery across all program sites; the idea of partnering in the implementation of telehealth for the delivery of specialized care and monitoring of high risk OB patients in rural/frontier communities across the state. Two BaM communities have already voiced interest in serving as a lead site in the piloting of a regional model, as well as interest in serving as a pilot site for the development of a telehealth initiative. In addition to the development of the “smoking cessation integration” toolkit that is described in other sections of this report/application, “integration” tool kits have also been built for the incorporation of evidence-based curriculum on safe sleep and breastfeeding. These toolkits are described under different sections of this report/application as well,

however we want to mention here that plans are certainly in place to continue to develop and update these components on an annual basis. Training on updates, as well as training for new sites, will be provided within the BaM program model, and toolkits will be made available for use by other MCH programs across the state.

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

Analysis of the data from the provider survey on screening for previous preterm birth and use of progesterone as a preventative measure will be very helpful with plan development particularly in the *Becoming a Mom* (BaM) perinatal collaborative communities. Once we have a gauge of where providers in these communities stand on this issue, work will be done to develop a toolkit that will have two components to be implemented in two phases. One toolkit and phase of implementation will be focused on OB providers and associated clinical staff, as well as administrative staff and policy makers. The toolkit will contain educational materials on the importance of screening for previous preterm birth and benefits to administering 17P, as well as protocols and associated resources for implementing such practice. The other toolkit and phase of implementation will be targeted at educating pregnant women as well as women in the interconception period (consumer focused). An “integration” component will be designed and implemented as part of the BaM curriculum that already has session content focused on risk factors for preterm delivery, signs and symptoms to watch for, and what to do if you experience signs and symptoms. The intention will be to first educate providers and then consumers, in an effort to not get the “cart before the horse” by educating consumers to advocate for care that providers may not be fully informed about or on board with such practice methods. As with other “integration” toolkits that have been developed and implemented in our state, once piloting of small tests of change are completed and adjustments are made, the toolkit will be made available and promoted for implementation across other communities.

An additional resource related to this work that has recently come to our attention is the Preterm Labor Assessment Toolkit (PLAT), developed by the March of Dimes and its co-authors. This toolkit is an evidence-based toolkit that helps medical providers establish a standardized clinical pathway for the assessment and disposition of women with suspected preterm labor. It can be implemented at all levels of maternity care, and incorporates best practices that outlines a step-by-step guide to standardized assessment and care. In the upcoming year, we plan to investigate this toolkit further, and determine our role in helping to support our partner, the March of Dimes, in piloting this toolkit in communities as a part of our above described work through the CoIIN Preterm/Early-Term Learning Network. One BaM community has already expressed interest in piloting this toolkit as early as January 2017, and has already done much of the background work required for implementation (Newman Regional Health Center in Lyon Co.).

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

As education on early elective delivery (EED) and preterm birth (risk factors, signs and symptoms, and what to do if experiencing signs and symptoms) is already a standardized component of BaM, we look to partner with March of Dimes in 2017 to target Healthy Babies are Worth the Wait (HBWW)/BaM communities for expansion of provider/hospital level policies and practices aimed at decreasing non-medically indicated births before 39 weeks gestation. One resource of continued interest related to this work is the March of Dimes 39 Week Toolkit. Although this toolkit has been available for implementation for several years, very few hospitals have utilized it. We hope that by developing greater partnership with the Kansas Healthcare Collaborative, together we can advance the work and goals in this targeted area at a much quicker rate than has been done alone.

## **Other Activities Impacting the Women/Maternal Population**

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

*Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program:* Beginning October 1, 2016, in accordance with redesigned federal MIECHV Program performance indicators, the MIECHV-funded evidence-based and promising approach home visiting programs will collect and report data on preterm births prior to 37 weeks for infants of mothers enrolled in home visiting services prior to 37 weeks of gestation. While the MIECHV Program will no longer collect and report data specifically on enrolled mothers' receipt of well-woman preventive care visits after September 30, 2016, data will instead be tracked on enrolled mothers who receive a postpartum visit with a healthcare provider within 8 weeks of delivery. The home visiting programs will continue to provide information, referrals, and support addressing multiple areas affecting maternal health and specifically preterm births and postpartum visits including prenatal care, inter-birth spacing, and maternal health insurance coverage. Screenings of alcohol, tobacco and drug use, maternal depression, and domestic violence using standardized tools will also be conducted and tracked to identify and address needs for additional information, support, and referrals as well as completed referrals. Further training and resource toolkits regarding these subjects and practices will be developed and provided throughout the coming year to MIECHV-funded home visiting program staff.

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

## **Women/Maternal Health - Annual Report**

The activities, programs, and services detailed below have impacted the following 2015 National and State performance measures.

- NPM 15: 3rd Trimester Smoking
- NPM 18: Prenatal Care in 1<sup>st</sup> Trimester
- SPM 02: Alcohol Consumption - Women in Reproductive Years
- SPM 03: Preterm births (<37 weeks gestation)
- SPM 08: Non-Medically Indicated early term deliveries (37 and 38 weeks gestation)

### **NPM 15: 3rd Trimester Smoking**

Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. In 2014, 9.9% (3,875) of women reported smoking during the last three months of pregnancy, a slight decrease from 2013 (10.5%). During 2005-2014, there was a statistically significant decreasing trend detected. The annual percent change was significant (APC=-3.88). Among women who reported smoking during the last three months of pregnancy, 73.0% reported Medicaid as principal source of payment for this delivery, a slight increase from 2013 (71.9%).

State data showing higher rates of smoking among young reproductive aged women and the Medicaid population led to Kansas selecting *smoking cessation* as one of the national learning strategies/networks to participate in as part of the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN), upon joining in July 2014. As Kansas is committed to advancing the national CoIIN agenda and Blueprint for Change to address state priorities,

this has been the driving force behind much of the work that has been done in Kansas related to smoking cessation before, during, and after pregnancy. Participation in the Smoking Cessation Learning Network has provided the platform, structure, support, and motivation to take smoking cessation efforts in the perinatal period to a new level in our state. A state “CollIN Smoking Cessation Workgroup” was formed with participating members from multiple agencies, including: the University of Kansas Medical Center, March of Dimes, KDHE Bureau of Family Health and Bureau of Health Promotion Tobacco Program, private providers, and local public health departments. This group has developed and prioritized an extensive action plan, measurement strategy, and change package, which outlines our state’s smoking cessation work plan, not only for the duration of the CollIN initiative, but for the entirety of the Title V state action plan. The plan is very extensive, covering several tiers of interventions that are categorized according to the Primary Drivers that have been designated by National CollIN. State selected strategic priorities around smoking cessation include *building community capacity to promote education, screening, referral, and treatment for women*. Throughout 2015 and into 2016, our state’s work has been focused on the following Primary Drivers: PD2: Providers and support personnel refer women to evidence-based programs like Quitline; PD4: Women in child bearing years avoid smoking or stop and stay quit; P5: Providers recognize role in coaching and supporting women to stop and stay quit.

The focus of strategies this past year has been on engaging women in smoking cessation services and increasing the number of referrals to evidence-based programs such as the Kansas Tobacco Quitline, improving quit rates before and during pregnancy and continued cessation in the postpartum period, as well as increasing the number of providers that are trained in the 5 A’s of tobacco cessation. Part of these efforts have included increased promotion of the online training course on *Brief Tobacco Interventions* that was developed and provided by the Bureau of Health Promotion, offering 1.0 CEU credit free of charge to providers completing the course. Promotion has occurred thru many venues, including multiple state level conferences such as the Governor’s Public Health Conference. This promotion has resulted in a private OB practice (from our *Delivering Change* Healthy Start project) and the *Becoming a Mom* perinatal education program requiring all staff to complete the training. Course participant numbers have steadily increased, from three per month in December of 2014 to 57 per month in January 2016. Reports show course participants from a variety of professional backgrounds, including: nurses, dietitians, administrators, physicians, social workers, care coordinators, educators and home visitors.

Throughout the year, state Title V staff have developed and coordinated tests of change that have been implemented through PDSA cycles at two local program level pilot sites. These pilot sites, in Saline and Crawford counties, are two of our *Becoming a Mom* Perinatal Collaboratives with the highest rates of smoking in pregnancy. The first PDSA cycle focused on developing and providing an inventory tool for use in assessing current screening and referral efforts for smoking cessation at their agency (which included assessing all MCH programs, WIC, and Family Planning). This test confirmed the following predictions: screening tools are not standardized and most often only verbal; resources are limited mostly to KS Quitline brochures with no other evidence-based program available; referrals are most often soft referrals, relying on client to contact KS Quitline on their own; no follow-up process is in place, nor is there any data tracking system in place to track efforts and outcomes. These findings clearly lead to our second PDSA cycle, which focused on the development of a smoking cessation integration plan and the training of the two pilot sites on the implementation of the “MCH Integration of Perinatal Smoking Cessation Services – BaM Program Model”. This plan included a process flow sheet and associated screening tool, targeted resources, referrals, follow-up, and data collection process. Data collection has included rates of: screening, fax referrals to KS Quitline, engagement in Quitline services, smoking cessation, and continuation of cessation in the postpartum period. Following a brief but successful pilot period, this package was replicated in the remaining eight *Becoming a Mom* programs in our state. In-person training was provided to all sites in November 2015. The training and smoking cessation integration package was well-received by all sites, as smoking in pregnancy has been a recognized priority issue in all ten communities, but sites did not feel they had the staffing resources available to develop such a plan. Following successful implementation in the *Becoming a Mom* programs in our state, the package has been made available for adaptation and use across other Bureau of Family Health programs delivered

by local Title V grantees. This was done so during a break-out session at our April 2015 Governor's Public Health Conference. During this session, our state lead for the CoIIN Smoking Cessation Learning Network co-presented with the Medical Director for our Geary County *Delivering Change* Healthy Start project. Together, presenters shared two toolkits for implementation across different perinatal care settings. The above mentioned package, or toolkit, was provided as a resource for public health program settings. In addition, session attendees were provided the "Delivering Change: Tobacco Cessation Toolkit", which was developed by the Medical Directory, and is targeted for delivery in a medical prenatal care setting. This toolkit includes: education resources for medical providers and support staff; implementation of 5As, including medical chart sticker reminders; tobacco treatment options chart; warm referral to the KS Quitline and follow-up at next appointment; patient educational materials, including multi-media messaging during prenatal visits along with pre and post-messaging testing.

Local MCH agencies continue to utilize the Kansas Tobacco Quitline as a referral resource for pregnant women to encourage them to quit smoking, as well as local tobacco cessation resources. MCH grantees are provided education on use of the Quitline and online resources to assist women to quit smoking. Training in the 5 A's method of tobacco cessation counseling is encouraged for grantee staff. Local grantee Healthy Start Home Visitors link pregnant women to smoking cessation resources as well and make referrals to the Quitline. Even though the MCH program continues to work with the Tobacco Program to promote the Quitline and expanded Pregnancy Program, preliminary data collection/analysis in this area has shown only a very small increase in engagement of and enrollment in Quitline services. Additional evidence-based smoking cessation program options were identified as a need. In an effort to fill this need, collaborative efforts between KDHE Title V, the March of Dimes Kansas Chapter, and Amerigroup (WellPoint/Medicaid MCO) brought the BABY & ME – Tobacco Free™ (BMTF) program to our state in August 2015. At this time, nine of the *Becoming a Mom* perinatal collaboratives were trained on program implementation. The BMTF program is one of the evidence-based smoking cessation programs highlighted through the CoIIN Smoking Cessation Learning Network, demonstrating smoking cessation rates of 60-70% in other states. Collaborative sites were given the opportunity to apply for Title V funding of start-up equipment required for program implementation. All nine sites applied and received funding, and began implementation of the program in January 2016, following contract signing with WELCO, Inc. (owner of the BMTF program). The March of Dimes Kansas Chapter secured funding from Amerigroup for the provision of diaper incentives across all nine participating sites. These diaper incentives are a required component of the BMTF program, creating a financial barrier to implementation of the program in many communities. This funding partnership was hence crucial in getting this program piloted in our state. Following a slow start, program enrollment numbers reached 34 by April 2016.

### **NPM 18: PNC in 1<sup>st</sup> Trimester**

Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes.

In 2014, 80% of infants were born to pregnant women receiving prenatal care in the first trimester, a slight increase from 2013 (79.4%). This exceeded the Healthy People 2020 goal of 77.9%. [During 2005-2014, Joinpoint regression analysis showed a decreasing trend over the interval 2005-2007 followed by a significantly increasing trend from 2007-2014.](#) Kansas 2014 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.

Local health departments, Federally Qualified Health Centers, hospitals, and local obstetrical and perinatal health care providers comprise our comprehensive prenatal care coordination system in Kansas. Local MCH agencies use care coordination and case management models to provide comprehensive prenatal services. Family Planning, WIC and MCH programs coordinate prenatal care outreach and assist clients in navigating the health care system

and KanCare (Medicaid/SCHIP). Kansas Title V funds and supports outreach and case management services such as Healthy Start Home Visitors (HSHVs), evidence-based models such as Nurse-Family Partnership®, Healthy Families America®, and *Maternal, Infant, and Early Childhood Home Visiting* (MIECHV), as well as many other programs aimed to improve engagement of women in early prenatal care. State supported efforts have been continued and ongoing throughout the past year to engage local grantees in improving coordination efforts among MCH, Family Planning, WIC, and KanCare, in order to better support pregnant women engaging in and continuing medical care throughout their pregnancy.

In 2012 when Family Medical (Medicaid and CHIP) programs separated from the State Welfare (TANF and SNAP) Agency, Kansas Department of Health and Environment (KDHE) developed efforts to expedite applications for assistance for children, families and pregnant women by centralizing eligibility determination. Recognizing many families need more one-on-one assistance with Medicaid applications, 12 Out Stationed Eligibility Worker positions were created, and have continued to this date. These workers are located across Kansas in Federally Qualified Health Care Centers and hospitals, where families without insurance may seek medical care. These eligibility workers determine eligibility for Medicaid and CHIP programs, as well as providing information and outreach to communities, local health departments, clinics and hospitals, explaining eligibility requirements, trouble-shooting payment problems, and encouraging families and pregnant women to apply. Local health department staff across MCH, WIC, and Family Planning programs continue their work to identify uninsured pregnant women and refer them to local Outstation Workers for expedited eligibility determination. Outstation Workers are also continuing their collaborative efforts within communities and with agency partners to make referrals for prenatal and parenting support and education programs, as well as medical prenatal care. As mentioned in last year's annual report, Outstation Workers participated alongside local health department MCH staff, mental health providers, birth centers, Early Head Start programs, and many other local agencies during the State hosted AMCHP Compendium Regional Public Health Meetings. These partnerships and referral practices continue to be the driving force behind getting pregnant women approved for Medicaid coverage and into care early. In July 2015, however, we once again began to see an emerging pattern with delayed processing of Medicaid applications, including those of pregnant women. This delay was due to the implementation of an entirely new Medicaid eligibility processing computer system, which unfortunately has created a backlog of individuals pending eligibility determination. Although these types of system changes are expected to create such processing delays for a temporary period of time, local program staff are continuing to report delayed access to care by pregnant women as a continued consequence of this transition, nearly a year following implementation. Established relationships between the above mentioned partners, has however, supported efforts to trouble-shoot eligibility processing problems and identify gap filling services that can be provided until applications are processed, hopefully decreasing the burden clients have felt by this transition.

Local efforts towards improving the health of women and infants include the Geary County *Delivering Change* project (Healthy Start community). *Delivering Change* is a non-profit project of the local Geary County Perinatal Coalition, made up of individuals and organizations that impact the health of mothers and their infants in Geary County, including the local Title V MCH program. This initiative was started in 2010 in response to a growing need for improved health of women of childbearing age, and improved outcomes for the infants born in the community. *Delivering Change* has created a community-wide collaborative that aims to increase or improve the tools necessary for improving maternal health and decreasing infant morbidity and mortality. Priority areas include **improved women's health**. In the approach, it is recognized that personal finances and lack of health insurance can be a barrier to getting early and consistent prenatal care, a vital step in having healthy babies. Outreach and enrollment in health coverage programs is a priority of the *Delivering Change* program. A scholarship fund has been established to cover prenatal care and delivery for residents of Geary County who are uninsured, or while awaiting approval for Medicaid coverage. Vital Statistics rates for the "Quality of Prenatal Care" as "Adequate/Adequate Plus" have steadily and significantly improved from 66% in 2010 to 73.5% in 2014. Additionally, rates of prenatal care beginning in the first trimester have improved from 68.9% in 2010 to 77.2% in

2014. In the Geary County community, on average 41-45 women each year enter prenatal care uninsured (FH OB/GYN statistic 2014/2015). Of those, an average 15 receive scholarship assistance at some level. Without this resource, most of these women likely would not seek early prenatal care. Well into the second year of Healthy Start funding, much progress has been made across many priority areas for the MCH populations in this community. State Title V staff have worked throughout the past year in the community, providing technical assistance to Title V supported staff at the Geary County Health Department and staff from the Geary Community HealthCare Foundation, in establishing a screening and referral process for getting pregnant and newly postpartum women enrolled in home visitation services provided by the health department. Multiple in-person meetings have occurred with facilitation by state Title V Director and staff. The goal of these meetings has been to establish a process that will connect women with the most appropriate level of care, based on her risk factors and individual needs.

Another Kansas initiative that is having great impact related to access to early and comprehensive prenatal care is the Perinatal Community Collaborative, known as Healthy Babies are Worth the Wait (HBWW)/Becoming a Mom (BaM). As a part of this initiative, community partners work together in a collaborative nature to engage and retain women in early and comprehensive prenatal care. No matter what the point of entry into the system of care might be, pregnant women are directly referred and enrolled in prenatal care that is inclusive of medical care, education, and support components. The 2015 annual aggregate report for the initiative shows that demographically, the project is hitting its targeted disparity population in the state. BaM data shows the ethnicity of its pregnant women participants to be 23% Hispanic (compared to 15% state level data), 7% Black, non-Hispanic (equal to 7% state level data), and 7% Other, non-Hispanic (compared to 6% state level data). 52% of BaM participants are enrolled in WIC, compared to 36% of women across the state as a whole (Kansas birth statistics). While 38% of pregnant women in the state are on Medicaid or uninsured, the BaM program is engaging 44% of this high risk population. Despite a higher percentage of the BaM population representing disparity groups than the state's pregnant population as a whole, 91% are starting prenatal care in their 1<sup>st</sup> trimester, vs. 80% according to state level data (Annual Summary of Vital Statistics, 2014).

### **SPM 2: Alcohol Consumption - Women in Reproductive Years**

According to the Kansas Behavioral Risk Factor Surveillance System (BRFSS), in 2014, 14.2% 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 (15.5%), compared to black women (6.5%) and Hispanic women of all races (11.1%). During 2011-2014, there was a decreasing trend.

Healthy People 2020 recommends that 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%.

In an effort to additionally support local Title V staff in bringing up the topic of alcohol consumption in the reproductive years, the question "Do you drink alcohol or use other substances?" was built into the "MCH Service Form". This form is part of our newly developed and implemented data collection system, DAISEY. Form completion such as this is a required part of data collection and submission by all Title V grantees in our state, and is intended to include some data points, such as this, that will trigger the provision of specific client education and referral services. It is planned to expand upon this question in the next revision, to include a screening form related to ETOH use, such as the T-ACE screening tool.

Related to the Becoming a Mom (BaM) prenatal curriculum, alcohol use in pregnancy and its associated risks is covered during two of the six sessions, as well as risks associated with alcohol use in the interconception period without the use of a family planning method.

### **SPM 3: Preterm births (<37 weeks of gestation)**

### **SPM 8: Non-Medically Indicated early term deliveries (37/38 wks)**

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 2014, according to the Centers for Medicare & Medicaid Services (CMS) Hospital Compare, the percent of Non-Medically Indicated (NMI) singleton live births of 37 and 38 weeks gestation was 4.0%, a decrease from 2013 (8.0%).

In 2014, the rate for preterm births, those occurring before 37 weeks gestational age, has been lower in Kansas (8.7%) than the U.S. (9.6%). The Kansas prematurity rate met the Healthy People 2020 goal of 11.4%. Among racial/ethnic groups, the black non-Hispanic prematurity rate (12.8%) was 52.4% higher than the white non-Hispanic rate (8.4%). Both non-Hispanic white and Hispanic premature births (8.2%) were lower than the State average. During 2005-2014, a statistically significant decreasing trend was observed (Annual Percent Change = -0.9).

As premature birth and low birth weight continue to be the primary cause for infant mortality, the Kansas Blue Ribbon Panel on Infant Mortality (est. 2009) recommendations included the March of Dimes Healthy Babies are Worth the Wait (HBWW)/Becoming a Mom (BaM) Birth Disparities Program\* as an initiative to address these issues. Implementation of the HBWW/BaM prenatal curriculum and community collaborative model is currently in place in ten locations in the state. By the nature of the community collaborative work around access to care and comprehensive prenatal education that is inclusive of social support services within the community during the perinatal period, it is a driving force behind improving birth outcomes in our state. The primary target of the curriculum is to address risk factors related to preterm births, improving knowledge and effectively influencing behaviors of the participants. In an attempt to reduce barriers and encourage program completion, partnerships at the local level leverage funds and other resources to support the inclusion of incentives, childcare, and transportation. Attendance by support people is also encouraged and incentivized. Topics included in the curriculum, spanning six two-hour sessions, include: importance of early, regular, and continued prenatal care; effects of harmful exposures (ranging from smoking and drugs, to diet, to stress and environmental exposures); risk factors, signs and symptoms of preterm labor, and what to do; delivery at appropriate level of NICU; labor and delivery, including risks related to early elective deliveries; infant feeding, with emphasis on breastfeeding; infant care, immunizations, safe infant care seat installation, "Period of Purple Crying", "Happiest Baby on the Block", safe sleep and SIDS risk reduction; postpartum care (physical and emotional), interconception health, ideal pregnancy spacing and family planning options. The curriculum includes an extensive support component that incorporates guest presenters from area agencies, as well as highlighting other applicable community resources. Most program coordinators and group facilitators are local health department MCH staff (supported by Title V funds), as the program is intertwined with other MCH services such as individual case management and healthy start home visitor services. 2015 program evaluation data included the seven existing project sites (three new sites were launched in November 2015 and not included in the 2015 report). All six questions related to preterm labor signs had statistically significant improvements from pre to post surveys. Participants reported greater knowledge of the importance of the last few weeks of pregnancy from week 36 to week 39 (72% to 95%), back to sleep (78% to 97%), and healthy pregnancy spacing (29% to 80%). The reported preterm birth rate (<37 weeks) was 7% for program participants compared to the state rate of 9% (source: Kansas Birth Certificates, 2014). Similarly, 4% of the births were considered low birth weight (less than 5lb. 8 oz.), also an improvement over the state rate of 7% (source: Kansas Birth Certificate, 2014). Sixty-five (65%) of participants reported some change in personal health habits (Figure 16). Out of the women who reported change in habits, the reported areas of behavioral change included improved eating habits (78%), back to sleep position (43%), increased exercise (40%), decreasing in second hand smoke exposure(17%), stopping or reduced smoking (10%) and stopped or reduced recreational drugs (1%).

The Kansas CoIIN preterm/early term pilot project was launched with Associates in Women's Health (AWH) (Wichita - Sedgwick County), in July 2015. The resulting practice now consists of 17 doctors and two Advanced Registered Nurse Practitioners. The practice provides obstetrics and gynecology services as well as maternal fetal medicine specialty care for high risk obstetrics patients. The AWH pilot focused on practice changes in three areas: provider recording of the expected delivery date, early identification of a previous preterm birth, and the initiation of progesterone treatment among high risk patients with specific gravida. System and process changes were implemented first. As advance preparation, patient data covering the period from April through June 2015 was established as the baseline for comparison. Practice changes were designed, implemented and evaluated using the Plan Do Study Act (PDSA) model developed by the W. Edwards Deming Institute and endorsed by the national Institute for Healthcare Improvement. This model is being utilized by CoIIN projects nationally. Each month, Kansas pilot site data was submitted to NICHQ in accordance with the CoIIN Measurement Guidance. Kansas was the first state to submit data to NICHQ and has been the most consistent data participant among the 31 states in this third phase of CoIIN. Summary results to date are detailed below.

- Record Expected Delivery Rate: Provider efforts to consistently record the expected delivery date on the Electronic Medical Record (EMR) are showing improvement from a low 75% in July 2015 to a median 86.7% for the period of April 2015 through April 2016. This standardization of processes through EMR modification, the implementation of an alert/reminder protocol and physician education has been adopted as a practice standard at AWH. It has served as a foundational first step towards improved patient tracking and a contributing factor in identification of preterm birth risk for subsequent pregnancies. It is important to note that one to three patients are "missed" monthly prompting questions about system and/or provider compliance issues. Further investigation that cross-references missed patients with provider names and systems fields is warranted.

- Prior Preterm Birth Identification: Provider identification of previous preterm births shows an improvement from a low of 95% in August 2015 to a consistent 100% from the period of October 2015 through April 2016. This speaks to the continued refinement of internal processes and procedures initiated at AWH and should be continued. Modifying the EMR system to alert providers to screen new patients has significantly improved compliance and been adopted by AWH as a standard of practice. This will be monitored by AWH will continue to monitor this to identify any emerging issues in the future. New opportunities to improve early initiation of prenatal care (and early risk identification) could include partnering with public health agencies and Becoming a Mom prenatal education programs.

- Prescription for Prophylactic Progesterone: The data on prescriptions for progesterone shows improvement from a low of 18.8% in June 2015 to a median 60% for the period from April 2015 through April 2016. While this is an improvement, much more can be done.

\*Additional background information on the Community Collaborative Prenatal Education Model, known as Healthy Babies are Worth the Wait (HBWW) / Becoming a Mom (BaM), and a current status update follows: In 2010, following the release of the Kansas Blue Ribbon Panel recommendations coupled with cuts in state and local funding, the March of Dimes Greater Kansas Chapter created an innovative concept of a community collaborative prenatal education model using the Becoming a Mom (BaM) / Comenzando Bien (Cb) curriculum to address birth disparities primarily among low-income, minority women who are eligible for Medicaid. Starting with a pilot program in Salina, Kansas (Saline County), the model has a two-fold focus of clinical services and prenatal education that is driven by private and public partnerships across the state and local level that includes: Title V, Medicaid, foundations, local health departments, federally qualified health centers, clinical providers, and local hospitals. The community collaborative model brings permanent Maternal and Child Health infrastructure, leveraged and shared resources, change in the prenatal care services delivery paradigm, a vehicle to identify community needs, a standardized evaluation system, and new funding opportunities for greater collective impact and improved birth outcomes. This

innovative model was replicated in Junction City (Geary County), Kansas in 2012 with similar successes as the pilot program. With two effective sites implementing the model, program evaluation tools were refined and standardized in 2013 in partnership with evaluators from the University of Kansas School of Medicine-Wichita and Wichita State University. Preliminary data reports showed improvements in participant's knowledge, behaviors, and growth of community partnerships and shared resources. Three additional sites, in Reno, Riley, and Wyandotte counties, were added. In 2014 KDHE committed to partner with the March of Dimes with a financial investment of \$277,034 over a three year period for further expansion of the model across the state. In the expansions' first year work plan, two additional sites, Crawford County and Lyon County, were added. The second year of the expansion plan, added three additional sites in November 2015. Two of these three were small scale project sites who actually came on board with their own locally raised funding to support initial implementation of the program. The third site in this phase of expansion involved a partnership between KDHE and the University of Kansas School of Medicine-Wichita, to launch our largest project site to date. This site includes five program locations across three major health systems (Wesley Medical Center, Via Christi Health Systems, and Health Core FQHC) in one of our greatest populated counties, encompassing multiple zip codes with some of the poorest birth outcomes. This investment has brought new challenges to the implementation of the program as well as greater development and refinement of the curriculum, implementation and referral process, and collaborative partnerships. Statewide expansion in the second year also included an additional investment of \$20,000 from KANCARE Amerigroup (WellPoint), one of Kansas' three managed care organizations (MCOs) that covers the state's Medicaid prenatal care expenses. Investments by these three organizations have provided the opportunity for site expansion, greater program development, and sophistication of the program's evaluation system. These initiatives are undoubtedly contributing to the steady decline in infant mortality rates (IMR) that have been observed in both Geary and Saline counties since the onset of such extensive community collaborative efforts in 2010. Saline County has witnessed a decline in IMR from 9.0/1000 (2005-2009) to 5.5/1000 (2010-2014) and Geary County from 11.9/1000 (2005-2009) to 6.6/1000 (2010-2014).

### **Other Activities Impacting the Women & Maternal Domain/Population**

*Pregnancy Maintenance Initiative (PMI) Program:* Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes. The Senator Stan Clark Pregnancy Maintenance Initiative (PMI) program (K.S.A. 65-1, 159a) was first established in the 1999 Kansas legislative session. The purpose of the program is to award grants to not-for-profit organizations for services to enable pregnant women to carry their pregnancies to term. PMI services are based on a case management model that incorporates an integrated, collaborative, and multi-disciplinary provider approach for the provision of a continuum of care during the pregnancy and for six months post-delivery. This approach minimizes duplication or fragmentation of services. The service model promotes public/private partnerships to facilitate the availability and ready access to affordable and appropriate care, thus improving the potential for a positive pregnancy outcome for the childbearing woman and infant. KDHE receives state general funds to support PMI programs at the local level. Grantees provide a dollar for dollar match of all funds awarded by KDHE. In SFY 2015 seven local programs received PMI funding and enrolled 388 new participants. This was an increase from SFY 2014 when five agencies received PMI funds and served 297 women. In SFY 2017 nine agencies will be funded and are projected to serve approximately 470 women. Two of the 9 funded agencies are local health departments that also provide MCH services.

*Pioneer Baby:* The Title V program partnered with University of Kansas School of Medicine (Wichita) and Kearny County Hospital (SW Kansas) in a collaborative quality improvement initiative titled "Pioneer Baby" to improve pregnancy and birth outcomes among reproductive-aged women in western Kansas. (Target population: Pregnant women who receive prenatal care and/or give birth at Kearny County Hospital, the local health clinic, or Scott County Hospital and who reside in one of the following 11 counties: Finney, Greeley, Grant, Gray, Hamilton, Haskell, Kearny,

Scott, Stanton, Wallace, and Wichita). As part of this larger project, Title V supported six focus group sessions held in 2015 (English and Spanish languages) to inform a health promotion program for pregnant women to increase healthy behaviors and improve birth outcomes. Sessions assessed women's perceived value of an intervention that addresses physical activity, nutrition, breastfeeding support and social support during and after pregnancy. Focus group data and survey data will be coded and analyzed and available in 2016. Findings from the focus groups will be applied to design an intervention that aims to reduce the likelihood of pregnancy complications including gestational diabetes among a vulnerable population in western Kansas thereby improving pregnancy and birth outcomes.

*Maternal, Infant & Early Childhood Home Visiting (MIECHV) Program:* Evidence-based and promising approach home visiting programs funded by the MIECHV Program served 577 enrolled pregnant women and families with children birth to five from October 2014-September 2015. These programs provided information, referrals, and support addressing multiple health areas including prenatal care (i.e., prenatal visits attended), preconception care (i.e., well-woman preventive care visits), inter-birth spacing, and maternal health insurance coverage. Screenings of alcohol, tobacco and drug use, maternal depression, and domestic violence using standardized tools were also conducted to identify needs for additional information, support, and referrals. Data is collected and reported on each of these MIECHV Benchmark indicators.

*Workforce Training & Development:* The Title V Program resources supported the following training, events, and other professional development opportunities for MCH grantees and staff.

- Fall 2014 Healthy Start Home Visitor Regional Trainings: Registration and tracking was conducted through KS-TRAIN. By using KS-TRAIN, the MCH staff provided a manageable registration venue for 85 learners and could offer a printable certificate for the 6 contact hours offered.
- 2016 Governor's Public Health Conference: Workforce development for state and local MCH staff included sessions on infant mental health, adverse childhood experiences, perinatal smoking cessation, and a pre-conference session focused on the MCH program updates and collaboration opportunities. The Local Public Health Program staff provide leadership and extensive logistical support for the conference.
- With Title V support, the Local Public Health Program participated in regional meetings designed to improve the health of Kansas families, with special emphasis on mothers and infants. LPH staff assisted with logistics and assisted with development of the inventory tool used to collect data about MCH programs from attendees in advance.
- With Title V support, Local Public Health staff collaborated with the Kansas Alliance for Drug Endangered Children to develop an online course for social workers, nurses, law enforcement and other professionals on identifying and responding to children impacted by parental/caregiver drug use. This project was also supported in part by the United Way of Greater Topeka. Extensive support was provided to the Kansas Alliance for Drug Endangered Children—Shawnee County, a coalition focused on addressing children impacted by parental/caregiver substance abuse.

*Epidemiology Resource:* Kari Teigen (MPH) began working for the Title V program since October 2015. She served as a KDHE intern/ GSEP fellow (HRSA-sponsored Graduate Student Epidemiology Program) from May to August 2015. During her time as a GSEP fellow, Kari created a profile of the selected life course indicators and preconception health indicators for the state of Kansas. She analyzed data from the 2011/2012 National Survey of Children Health (NSCH) and the 2013 Behavioral Risk Factor Surveillance Survey (BRFSS) to provide a profile of the select life course indicators and preconception health indicators. For all the indicators she made comparisons of the prevalence levels of Kansas and the United States, excluding territories, and she evaluated the prevalence of risk or protective factors, stratified by relevant demographics. The preconception health indicators were only evaluated for women between the ages of 18-44. The preconception health indicators evaluated are as follow: health status, educational status, current health-care coverage, routine check-up during the past year, current smoking status, fruit and vegetable intake, overweight/obesity, participation in recommended levels of physical activity, frequent mental

distress, diabetes and hypertension. The two reports were finalized and efforts has been made to disseminate the information written in the reports. Kari has made a presentation which includes an overview of life course theory and its relationship with preconception health, and the overall findings from the two reports. She presented on March 24, 2016 to KDHE staff members and plans to present at the MCH Council meeting on June 22, 2016. Furthermore, the full reports are available on the KDHE website ([www.kdheks.gov/bfh](http://www.kdheks.gov/bfh)) and Kansas Maternal and Child Health Council website ([www.kansasmch.org](http://www.kansasmch.org)). See the Cross-cutting/Life Course section for more information about the life course indicators.

## Perinatal/Infant Health

### State Action Plan Table

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

##### Priority Need

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

##### NPM

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

##### Objectives

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

2.2 Increase the proportion of births delivered at Baby Friendly hospitals by 2020.

2.3 Increase the proportion of women and pregnant women receiving education related to the impact of prenatal and postpartum nutrition and exercise on optimal infant feeding by 2020.

## Strategies

2.1.1 Expand the number of communities that achieve the criteria for the Community Supporting Breastfeeding designation. 2.1.2 Partner with the Kansas Breastfeeding Coalition (KBC) and WIC in their efforts to promote and support breastfeeding with businesses through the Breastfeeding Friendly Business and Business Case for Breastfeeding initiatives. 2.1.3 Develop standard curriculum for infant feeding for use by local communities across the state, integrating it into the Becoming a Mom prenatal education sessions. 2.1.4 Increase access to professional support through referrals and linkages between birthing facilities and community resources. 2.1.5 Partner with Medicaid and Managed Care Organizations to increase awareness of and access to breastfeeding supportive

2.2.1 Partner with WIC and KBC to expand the High 5 for Mom and Baby program by increasing the number of hospitals trained and number implementing the program. 2.2.2 Promote and support the Empower Initiative in partnership with United Methodist Health Ministries Fund (UMHMF), KBC and WIC. 2.2.3 Provide education to hospital and maternity care/OB staff to support implementation of baby friendly hospital policies

2.3.1 Develop prenatal education content to support an accurate, consistent message for women and families. 2.3.2 Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including Becoming a Mom, home visiting, and WIC. 2.3.3 Increase the number of referrals to WIC and breastfeeding peer counselors for breastfeeding support and education, including the expansion of breastfeeding peer counseling sites.

## ESMs

ESM 4.1 - Number of communities achieving the “Community Supporting Breastfeeding” designation

## NOMs

Post neonatal mortality rate per 1,000 live births

Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

### Priority Need

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

### SPM

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

### Objectives

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

### Strategies

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

## Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	87.2	88.6	90.0	91.5	92.9	94.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	84.4 %	3.1 %	32,770	38,808
2011	77.4 %	3.3 %		
2010	79.4 %	3.2 %		
2009	76.8 %	3.6 %		
2008	78.0 %	2.9 %		
2007	78.8 %	3.0 %		

**Legends:**

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.7	29.4	31.2	33.2	35.2	37.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2012	24.5 %	3.6 %	9,415	38,396	
2011	11.4 %	2.2 %			
2010	14.1 %	2.4 %			
2009	16.2 %	2.3 %			
2008	12.2 %	1.8 %			
2007	16.4 %	2.5 %			

**Legends:**

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 4.1 - Number of communities achieving the “Community Supporting Breastfeeding” designation**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	13.0	15.0	17.0	19.0	20.0

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

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

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

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

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

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

Objective: Increase the proportion of women and pregnant women receiving education related to the impact of prenatal and postpartum nutrition and exercise on optimal infant feeding by 2020.

In 2014, Kansas birth certificate data showed that mothers initiated breastfeeding in 86.1% of resident live births.

This was an increase from the 84.2% reported in 2013 and exceeded the Healthy People 2020 target of an 81.9% breastfeeding initiation rate. Non-Hispanic Asian mothers had the highest breastfeeding initiation rate (90.2%), followed by non-Hispanic white (87.6%) and Hispanic (84.8%) mothers. Non-Hispanic black mothers had the lowest breastfeeding initiation rate (72.4%). Over the past five years (2010-2014), a significantly increased breastfeeding initiation was observed.

Although breastfeeding initiation rates across the state have improved steadily in recent years, there is still continued work to be done to improve continuation and exclusivity rates at six months. HBWW/BaM sites and local MCH programs around the state have acknowledged a lack of a structured follow-up process for the offering of support at targeted points following the initial postpartum home visit as well as lack of a system for data collection related to tracking continuation rates. KDHE MCH staff have committed to assisting local health departments and HBWW/BaM sites with the development of a comprehensive follow-up process and data collection system. This will likely be in the form of an “integration toolkit”, much like those that have been produced for the smoking cessation and mental health integration components (as presented elsewhere in this report/application). A flow chart will be developed with follow-up calls, home visitation, and support/educational resources being offered at targeted points when mothers are most likely to stop breastfeeding (i.e. in the first week following birth and at six weeks upon return to work). Additionally, as capacity is available to build additional data collection fields and reports within our state data collection system (DAISEY), these will be built in an effort to support local Title V program staff in tracking breastfeeding status and follow-up efforts. Additionally, work will be done with HBWW/BaM sites to develop plans for targeted outreach to disparity populations. As experience with the new evaluation and data collection system (DAISEY) increases, sites will be encouraged to compare participant demographic data to identified high-need/risk groups in their individual counties to assess if the target market is being appropriately served. This in turn will hopefully have an improved effect on breastfeeding rates among the teen and non-hispanic black populations in our state. Coordinated efforts and collaboration across initiatives at the state level will coordinate a targeted outreach to all HBWW/BaM communities, to encourage each of them working to achieve designation as a *Community Supporting Breastfeeding\**.

Local MCH agencies provide education to prenatal and postpartum clients. Referrals for breastfeeding support are made by MCH staff and Healthy Start Home Visitors. Many HSHV and MCH staff are Certified Breastfeeding Educators and/or breastfeeding peer counselors. They participate in breastfeeding coalitions in their communities, and collaborations continue with WIC, hospitals, child care providers and local physicians in providing consistent messaging about breastfeeding. Breastfeeding is a “required” education type/referral for the home visiting program. It is also a referral type in DAISEY in addition to a general program referral to WIC.

\*Communities Supporting Breastfeeding aims to improve exclusive breastfeeding rates for infants at three and six months by assisting communities with achieving the designation by the Kansas Breastfeeding Coalition as defined by six criteria needed to provide multifaceted breastfeeding support across several sectors.

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

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

In alignment with the State Plan and Infant Mortality Collaborative Improvement and Innovation Network (ColIN) initiative, the Title V program will partner with the Kansas infant Death and SIDS (KIDS) Network to reduce infant mortality through expanded safe sleep efforts. The KIDS Network previously trained 24 Safe Sleep Instructors in the six public health regions (home visitors, nurses, health department staff). Increasing the number of instructors and expanding reach and scope of existing community models will build statewide infrastructure to promote consistent

infant safe sleep messages with consideration for cross-cutting issues that impact sudden infant death such as smoking and breastfeeding.

The collaborative project aims to enhance the Safe Sleep Instructor program by building capacity to roll out safe sleep promotion programs developed for specific venues, including the community, hospitals and outpatient maternal and infant clinics. In partnership with Title V, the KIDS Network will coordinate and oversee the following activities:

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

*Specific Aim 1: Enhance the Safe Sleep Instructors skill sets to include training Home Visitors and facilitating Community Baby Showers.*

This aim will be accomplished by bringing the Safe Sleep Instructors back to Wichita for a 2-day training where they will learn more advanced information to reduce the risk of sleep-related infant death and additional strategies to promote safe sleep. They will also build the skills necessary to begin to implement established, evidence-supported programs in their regions. Specific topics to be addressed include a) physiologic reasons believed to be risk factors for SIDS, b) how to further address issues related to breastfeeding-related promotion of bed sharing, c) local smoking cessation tools and resources, and d) how to facilitate brainstorming regarding strategies to reduce the barriers to following the safe sleep guidelines. In addition, they will engage in activities that will prepare them to successfully introduce regional Community Baby Showers to provide safe sleep education and tools for high risk mothers and their support persons. Activities will include asset mapping related to building community collaboratives, identifying funding opportunities and developing strategies for recruitment of target audiences.

*Specific Aim 2: Expand promotion of the AAP's Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention or the Safe Sleep Star program for outpatient clinic.*

This aim will be accomplished in year 2 by bringing the Safe Sleep Instructors back to Wichita for a third, 2-day training where they will build the skills necessary to begin to implement interventions with maternal and infant healthcare providers. Both the hospital program and the Safe Sleep Star program are relatively new initiatives and therefore are described in more detail below.

*Secondary Aim:*

Increase the number of Safe Sleep Instructors by approximately 5 per year to reach a total of 40 at the end of 3 years. This aim will be accomplished through targeted recruiting of additional Safe Sleep Instructors from areas in the state with no current Instructors, high rates of sleep-related infant mortality and/or low levels of related resources.

In addition, any attrition of current Instructors will be addressed through recruitment from the city or county where the attrition occurred. The new Instructors will attend an additional day of training before the full group training to receive the instruction and materials from the original Safe Sleep Instructor Training.

### **Other Activities Impacting the Perinatal/Infant Population**

*Safe Sleep Education & Services for Families/Professionals:* KDHE will continue to contract with the Kansas Infant Death and SIDS (KIDS) Network using Children's Initiative Fund dollars (Title V match source) to conduct safe sleep education and bereavement services statewide. The KIDS Network will ensure outreach, education and ongoing support for pregnant women (especially underserved populations) and promote public-private partnerships. Additionally, we will work with the KIDS Network to promote safe sleep and reduce SIDS/SUID by providing culturally tailored safe sleep resources, toolkits, educational materials, and trainings for home visitors, health care providers and child care providers with focus on a consistent message related to breastfeeding. Families benefit from community baby showers, Cribs for KIDS, and Sleepsack programs.

*Safe Sleep Education - Becoming a Mom:* The "SIDS / Safe Sleep Integration" component that all BaM program sites received in-person training on in February 2016, will continue to be supported and supplemented with ongoing annual updates provided via webinar by the KIDS Network. Additionally, as new program sites are implemented, this will be one curriculum component that training is provided in-person, so as to fully equip new group facilitators with the highest level of training prior to program implementation. New sites will also be required to provide pack-n-play cribs as one program incentive option, in an effort to ensure that expectant mothers with few resources are able to provide a safe sleep environment for their newborn infant. Programs will also continue to be encouraged to work collaboratively with Healthy Start Home Visitation programs in their community as a means to provision of a postpartum visit in connection with the BaM program. This collaboration between programs provides the opportunity for repeat messaging of the "alone, on her back, in a safety approved crib" message, as well as gives the family and home visitor an opportunity to work "hands on" with the baby's sleep environment in their home setting.

*Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program:* As of October 1, 2016, in accordance with redesigned federal MIECHV Program performance indicators, the MIECHV-funded evidence-based and promising approach home visiting programs will collect and report data on infants of enrolled mothers who were breastfed any amount at 6 months of age. Data on any breastfeeding at any point may also continue to be collected. The home visiting programs will continue providing pregnant and postpartum mothers with information, referrals and support to promote breastfeeding. Training opportunities and additional resource information for home visitors will be facilitated to encourage effective practices.

*Healthy Start Home Visitor (HSHV) Universal Home Visiting Program:* During SFY 2017, KDHE will complete review of the HSHV program. The goal of the review is to clearly define the HSHV program within the context of other state home visiting programs. As a universal home visiting program, one of the roles of HSHV is to ensure collaboration and partnership building with other home visiting programs as well as other health and educational programs for families statewide. Specific tasks will include updating the manual to be consistent with transformation and improvement of the program, developing initial and ongoing training and professional development criteria, and revising tools/assessments/forms utilized by home visitors to capture data to measure progress toward MCH outcomes.

HSHV Key Recommendations for Fiscal Year 2017: Along with a number of program design changes, KDHE will also be changing the name of the Healthy Start Home Visiting program. A KDHE sponsored contest including all local health departments with a HSHV program will be conducted to select the new name. Based upon a review of

home visiting best practices, recent input from HSHVs, and observations of three local Healthy Start Home Visiting programs, the following changes in program design will occur.

**HSHV Guidance/Training:** The Healthy Start Home Visitor will continue to be supervised by a licensed nurse or social worker. The supervisor will be responsible for the orientation and professional development plan for each HSHV supervised.

**Orientation:** Orientation of each new HSHV will be completed within a 3-6 month time period, dependent upon previous experience. This will be implemented by July 1, 2017. A formal, written orientation tool will be developed by KDHE to be used by all local HSHV programs. This tool will be approved by November 30, 2016, for distribution with implementation policy and procedures out to local programs. Local programs will implement the use of this tool by July 1, 2017. The written orientation tool will record new HV progress towards completion of orientation tasks and will be maintained as a part of the permanent personnel file beginning July 1, 2017. Items currently identified in the existing Kansas MCH Service Manual that align with the new program direction will continue to be part of the new HSHV orientation. This will be reviewed in program compliance monitoring effective July 1, 2017. Scheduled, formal, and documented supervision meetings with HSHVs will be completed at least monthly by the HV supervisor and be included in the orientation process. This will be monitored for compliance effective July 1, 2017.

**Initial Training:** An assessment of each newly hired home visitor for credentials, skills, and experience will be conducted by the HV supervisor. KDHE will provide guidance regarding this assessment. New HSHVs will shadow at least three home visits conducted by experienced HSHV, employed at least two years in the HSHV position, and who are in compliance with MCH guidance and requirements. New HSHV with home visiting experience may also shadow home visits to be determined in coordination with the KDHE MCH program contact. KDHE will provide a tool supporting follow-up questions and discussion to support these shadowing visits. A review of the shadowing visits process will be included in the new HV orientation effective July 1, 2017. These shadowing visits will be completed before the new HSHV conducts visits independently.

**Continuing Education:** Upon completion of the orientation period, a written, formal Professional Development Plan will be developed and implemented. A KDHE Performance Development Plan (PDP) template, will be used by all local programs. It will be developed for approval and introduction to local programs by November 30, 2016. Implementation by local programs will be July 1, 2017. The process for the development of the PDP will include a shared approach between supervisor and HV. Components to be included will be 1) Required Training; 2) Training recommended by the supervisor based upon performance evaluation; and 3) Training requested by the HV. The PDP will be formally reviewed at each monthly supervision meeting with written documentation of progress, dates, and signatures of both supervisor and HV. The PDP will be developed annually in conjunction with the formal, annual, written performance evaluation. All new policies, procedures, and required forms will be introduced to supervisors and HSHVs at a Fall 2016 HSHV training event. A planning committee is recommended with a Training Agenda and Training Objectives to be approved by September 30, 2016. The training event itself will occur in late Fall. A study of training topics most desired and needed by HSHVs will be conducted by September 30, 2016. A committee approach will be used in this study. Upon a completion of the study a continuing education priority plan will be developed to include sources of the topics included. The development of the 2017 continuing education plan requirements will be introduced to local programs by July 1, 2017. A KDHE tracking system will be used by all local programs. It will be developed for approval by September 30, 2016. Exploration of utilizing KS-Train will be conducted. This tracking system plan will be included with other policies and procedures reviewed at the Fall 2016 training.

A HSHV Core Competencies list will be under development for introduction to local programs by July 1, 2017. All HSHVs will be required to attend two regional HSHV professional development sessions (Fall and Spring) as well as

a pre-conference session at the Governor's Public Health Conference. Other professional development recommended session topics include:

- Local Health Department Policies and Procedures (new home visitors)
- Orientation to all the education topics the HSHV is expected to provide to mothers including resources to share based upon KDHE and/or LHD expectations (new home visitors).
- Orientation to community resources (new home visitors)
- Shadowing experienced home visitor (new home visitors)
- Basic Home Visitation
- Confidentiality/HIPAA
- Child Abuse/Neglect Identification and Reporting
- Ethics
- Bloodborne Pathogens/Universal Precautions
- Family-Centered Care
- Engaging/Involving Fathers in Care
- Trauma Informed Care
- Home Visitor Safety
- Home Visitor Self-Care
- Professional/Personal Boundaries
- Transition Planning from Prenatal to Post-Partum Home Visiting and from HSHV to Long Term Intensive Home Visitation Program (as appropriate)

Program Outreach/Recruitment: The HSHV program will develop a written outreach plan for submission in the annual MCH grant application. The outreach plan requirements will be included in the Fall 2016 HSHV training. Program monitoring visits will include a review of the written outreach plan and evidence it is being implemented. The HSHV program will conduct internal and external outreach and promotion of the home visiting services. Internal outreach will include each of the local health agency's programs delivering service to prenatal and post-natal women. External outreach will include physicians, hospitals, county social services programs, and early childhood education partners. In small counties without such local service providers, outreach will include these service providers in larger neighboring counties where prenatal and post-natal women receive such services. Outreach methods will go beyond brochures and flyers posted in the community and will include such approaches as letters, on-site visits, participation in coalitions of other service providers, media information, health fairs and other community events.

Initiation, Frequency, and Duration of Visits: When accepting a referral of a prenatal or postpartum mother, Healthy Start Home Visitors will attempt, whenever possible, to initiate an in-person meeting with the mother along with the referring partner (warm hand off). To dispel the belief system of some mothers, upon meeting a potential new prenatal or postpartum mother, the HSHV will explain the purpose of the program and what her role is. Whenever possible, Healthy Start Home Visitors will strive to initiate visits prenatally, as soon as possible. This shall not preclude, however, initiation of visits with post-natal mothers when that is the initial time of connection. KDHE will develop an assessment tool to be used by all HSHV during the first home visit. The use of this tool by local programs will be implemented by July 1, 2017. Home visits will be conducted prenatally with the frequency to be determined based upon the initial assessment of the mother's well-being. Home visits will continue as often as deemed appropriate by an ongoing assessment of the well-being of the mother and infant, following the birth, up until the baby's first birthday. Home visits will last approximately one hour per visit. The majority of the home visits will occur in the parent's home. As appropriate, the visit may occur in another location. For example, if the home visitor is referring the mother to another resource, the visit may occur in that location in order to support the follow-through with the agency or resource to which the mother is referred. When visiting the mother in the home, it is appropriate to engage other significant family members, such as the baby's father, grandparents, etc. In no instance will an official

visit take place by phone. MCH monitoring visits will include a review of the documentation verifying this approach to the delivery of services.

**Curriculum and Delivery of Home Visiting Services:** The Healthy Start home visitation program will continue to be universal in approach, available to all without additional eligibility requirements. KDHE will require that programs across the state provide a consistent approach to the program with a similar list of resources and education to be provided in each program. KDHE will develop a base curriculum home visit plan for each monthly prenatal and postpartum visit to provide consistency regarding education topics, resources provided, and anticipatory guidance. These base plans will then be individualized dependent upon parents' special health or life needs and any infant health or developmental issues. Local programs will implement this curriculum by July 1, 2017. Healthy Start Home Visitors will use KDHE provided forms to document services effective July 1, 2017. The Healthy Start home visitation program approach will be strength-based. The Fall HSHV training session may include strength-based service provision training. The Basic Home Visitor training will include this as well.

**Behavioral and Health Screening Assessments:** Healthy Start Home Visitors will make every effort to ensure that prenatal and post-natal mothers and their infants receive screening assessments with persons that are trained and qualified to conduct them. Based upon the results of these screening assessments, the Healthy Start Home Visitor, in conjunction with the assessor, will counsel the mother on resources to assist her. Written documentation including the completed screening forms and subsequent follow-up, if any, will be maintained in the parent file/chart. Records will be monitored for inclusion of this documentation. The screenings to seek will include:

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

**Parent Education Topics:** The Healthy Start Home Visitor will provide verbal and written education to the prenatal and postpartum mother. Education topics will include:

- Tobacco/smoking cessation
- Breastfeeding supports
- Safe sleep practices
- Other safety topics such as car seat safety, home safety, injury prevention, etc.
- Health literacy
- Health care insurance coverage
- Well woman and well child medical visit appointments
- Prenatal/postpartum women's health
- WIC and nutrition
- Infant care
- Oral health
- Child development
- Other resources offered by the local health agency, such as WIC
- Resources in the community for food, housing, utilities, etc.
- Transition to long-term intensive home visitation programs, as appropriate
- How to locate a high quality child care program, as appropriate

**Coordination of Services:** Referrals to other service providers that may meet a parent's needs will be made. When such referrals are made, there will be follow-up with the service provider to determine if the contact was achieved. When contact with the referral provider is achieved, the Healthy Start Home Visitor will further follow-up to determine

if the desired service was or is being delivered. The Home Visitor will seek signed consents for information sharing with other service providers, as appropriate. In the event the parent has multiple home visit service providers (such as Healthy Families America, Parents As Teachers, Early Head Start, Part C, etc.), the Healthy Start Home Visitor will make efforts to conduct conferences with those providers in order to coordinate service delivery. Referrals and subsequent contacts as well as signed consents will be documented and maintained in the parent file/chart. MCH monitoring visits will include a review of records to ensure compliance.

**Monitoring Visits:** Local HSHV programs will be monitored for compliance with KDHE requirements as part of the MCH ATL grant monitoring at least once every three years. A monitoring protocol within the existing MCH protocol, including all new KDHE requirements, will be developed for approval and introduction to local programs by November 30, 2016. Protocol implementation will be July 1, 2017. The current MCH ATL site visit tool will be revised to reflect new KDHE requirements with KDHE approval for distribution to local programs by November 30, 2016. Implementation of the new tool will be targeted by July 1, 2017. A KDHE developed tool for local agencies to conduct ongoing monitoring of their own programs will be developed. Tool approval for distribution to local programs is targeted for November 30, 2016. The implementation date targeted will be July 1, 2017. A TA Improvement Plan will be included as needed as a part of the monitoring visit conducted. This plan will document improvements needed and responsibilities of both KDHE and the local program. Documented regular follow-up on progress will be included for its duration in this Plan.

**Collecting and Analyzing Data:** Healthy Start Home Visitors will collect and track data regarding educational information provided to families and the referrals made to assist them in accessing other needed services. HSHVs will conduct follow up to determine the outcome of the referrals to ensure families accessed the needed services or to identify the reason services were not utilized. All HSHV information will be collected on the KDHE Program Visit form, the Maternal and Child Health Service form, and the KDHE Program Referral form. The information will be recorded in DAISEY, the KDHE data collection system developed for use by local HSHV provider agencies. DAISEY will yield client-specific as well as aggregate data that will be used by KDHE to measure outcome progress. Additional elements for inclusion in HSHV data collection processes include:

- The number of home visits provided
- The setting of the home visit
- The number of prenatal and post-natal visits provided
- The educational topics discussed during contacts
- Knowledge/usage of safe sleep practices, including written resources provided
- Knowledge/usage of safe car seat practices, including written resources provided
- Number of women smoking during pregnancy who are referred to a smoking cessation program
- Mothers who initiate breastfeeding based on self-report at post-natal visit
- Mothers who breastfeed their infants at 6 months of age, based on self-report at each post-natal visit.
- Women who start prenatal care in the first, second, or third trimester, based on self-report at first prenatal home visit
- Referrals made and referral completion

Information regarding HSHV services will be entered by local agencies as services are provided, providing KDHE access to real-time data. KDHE will analyze the data and information obtained through reporting to determine key findings and provide feedback to local programs. The data will be used in an ongoing manner for each subsequent FY 2017 outcomes report to the agency, federal government, and Kansas Children's Cabinet. The aggregate data will be analyzed quarterly locally as well as at KDHE for trends. A quarterly report, including some level of analysis of data, will be submitted by the local program to KDHE. A KDHE format for this report will be developed for KDHE approval and distribution to programs by July 1, 2017. This process will be included in a Spring 2017 HSHV training for implementation by July 1, 2017. The data analysis will be utilized to create local HSHV Quality Improvement

Plans. A KDHE process and format will be used in the formulation of these plans and will be developed for KDHE approval and distribution to programs by July 1, 2017. Training and implementation target dates will be determined. A review of the data collection, utilization, and analysis will be included in the annual local application for funding to KDHE as well as in the program monitoring visit.

### **Perinatal/Infant Health - Annual Report**

The activities, programs, and services detailed below have impacted the following FY 2015 National and State performance measures.

- NPM 01: Newborn Screening (timely diagnosis/clinical management)
- NPM 11: Breastfeeding at 6 Months
- NPM 12: Newborn Hearing Screening
- NPM 17: Percent VLBW at Level III hospitals
- SPM 01: Infants with Permanent Congenital Hearing Loss (intervention)
- SPM 09: Critical Congenital Heart Defect Screening

#### **NPM 1: Newborn Screening**

#### **SPM 09: Critical Congenital Heart Defect Screening**

During FY 15, the Kansas Newborn Screening Follow-Up (NBS-FU) program monitored the number of reported newborn metabolic screens and provided immediate and short-term follow-up on infants who screened positive for 28 metabolic conditions. A new, integrated data system was implemented for NBS-FU in March 2015, transitioning NBS-FU to the Newborn Hearing Screening (NBHS) program data system (AURIS). The data system consists of direct links with the vital statistics record and the Laboratory Information Management System (LIMS). This link has allowed NBS-FU to obtain accurate data on the number of infants with a reported screen and match those with the data shared from KHEL. This new match allows the one data system to identify infants who do not have a reported newborn screen, both metabolic and hearing, for whatever reason. Additionally, a new mechanism for reporting critical congenital heart defects (CCHD) was established through the Electronic Birth Certificate (EBC) and is captured within the AURIS data system. This alignment allows each newborn screening program to report data back to Vital Statistics if a baby has a screen but no entry into the vital database. Babies that are born out of state are also added to AURIS when a screening is completed after transfer to a Kansas facility. The NBS-FU Advisory Committee also recommended to begin implementation of severe combined immune deficiency (SCID) in the coming year.

The intensive Quality Initiative (QI) to increase rates of screening for Critical Congenital Heart Defects (CCHD) began in May 2014. Prior to the start of the QI, approximately 78% of babies were being screened in Kansas and 31% of birthing facilities in Kansas were screening for CCHD. To date 100.0% of birthing facilities are reporting completion of the CCHD screen prior to discharge. While Kansas chose to implement this critical point of care screening without a state mandate for screening, this did not deter facilities from participating in the QI, including the implementation of the CCHD reporting module on the EBC. Long-term success of this initiative rests on the ability of the NBS-FU program to assure screenings are provided and results are received. The next phase of this initiative will provide education and technical assistance to facilities that are not reporting CCHD results into EBC and tracking those infants who do not pass the CCHD screen.

The NBS Advisory Committee SCID subcommittee with specialists, providers, and interested stakeholders continues to meet on a regular basis and is working on protocols for infants who have abnormal lab results during the screening process. In 2014, NBS-FU and KHEL applied for, and received, a grant from the Association of Public Health Laboratories (APHL) to assist Kansas with the implementation of SCID. This grant assisted with the purchasing of necessary testing equipment and provides technical assistance on training, messaging and

communication efforts for consumers and providers, and other areas of need to fully implement this screening. Lab piloting of screening was anticipated to begin in 2015, however due to staffing and equipment needs pilot testing is anticipated to start during the summer of 2016, with full implementation of SCID screening soon after.

Due to significant shifts in available providers, services, and delivery systems a draft revision of the 2010 State Genetics Plan has been completed by NBS-FU with support from the NBS-FU Advisory Committee and the Special Health Care Needs (SHCN) program, who provides family supports and assistance around genetics services and medical needs. The final draft will be available in Summer 2016. The addition of a shared position between the NBS-FU and SHCN programs has allowed for opportunities to expand NBS-FU community supports around family and parent education initiatives and family-centered care coordination around needed resources and services. While the staff person is involved in short term FU related to NBS she is now the main contact for all families who have an infant diagnosed with a condition identified in the NBS process.

### **NPM 12: Newborn Hearing Screening**

#### **SPM 01: Hearing Loss Early Intervention**

In FY15, the NBHS program, SoundBeginnings (SB), continued to work to improve the health and quality of life of children with hearing loss and their families in Kansas and administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance.

Throughout FY15 collaboration with Birthing Hospitals, Midwives, WIC and Local Health Departments have contributed to success towards improvements in the NBHS program goals with 99% of Kansas babies receiving a hearing screen before one month of age. Of those infants that failed the hearing screen, 74% received a diagnosis before 3 months of age, which could include receiving a diagnosis of normal hearing or some level of hearing loss. Lastly, 86% of the infants who were identified with hearing loss, received infant toddler early intervention services before 6 months of age.

The NBHS and NBS-FU partnered to provide training, education, and resources to midwives in order to ensure all midwives are screening for all newborn screenings (hearing, CCHD, and metabolic). Only midwives associated with a licensed birthing center were part of the initial training efforts. NBHS worked with the Kansas School for the Deaf and Sound START on developing a Family Network Support system, and a Deaf/Hard of Hearing Liaison program to ensure that families receive unbiased comprehensive information and support to promote early access to language.

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. 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.

### **NPM 11: Breastfeeding at 6 months**

In 2014, Kansas birth certificate data showed that mothers initiated breastfeeding in 86.1% of resident live births. This was an increase from the 84.2% reported in 2013 and exceeded the Healthy People 2020 target of an 81.9% breastfeeding initiation rate. Non-Hispanic Asian mothers had the highest breastfeeding initiation rate (90.2%), followed by non-Hispanic white (87.6%) and Hispanic (84.8%) mothers. Non-Hispanic black mothers had the lowest breastfeeding initiation rate (72.4%). Over the past five years (2010-2014), a significantly increased breastfeeding initiation was observed.

According to the most recent National Immunization Survey (NIS), Kansas initiation rate was 84.4% (children born in 2012). This was an increase from 77.4% (children born in 2011). During the four birth year period (2009-2012), an upward trend was observed. While initiation rates made a good progress, more work is needed for breastfeeding at 6 months (51.7%) and exclusive breastfeeding at six months (24.5%) to meet the Health People 2020 goals. Healthy People 2020 aims to increase breastfeeding rate to 60.6% at 6 months and exclusive breastfeeding rate to 25.5% at 6 months. Babies who are breastfed exclusively for six months receive the most benefits from breastfeeding as do their mothers. Preventative health through exclusive breastfeeding can save health care dollars through reduction in acute illnesses and chronic disease.

Working together collaboratively across WIC, MCH, and HBWW/BaM, as well as with community partners such as local hospitals and birthing centers, breastfeeding coalitions, and La Leche League groups, much progress is being made to improve breastfeeding initiation and continuation rates in Kansas, as is evident by the above presented data. Healthy Start Home Visitors are working alongside WIC Breastfeeding Peer Counselors (BPC) to provide breastfeeding support to individuals in their homes and clinic settings in both the prenatal and postpartum periods.

Through the work of the HBWW/BaM *Integration* Pilot, Kansas Title V Director allocated funding to contract with the Kansas Breastfeeding Coalition (KBC) for the development of a two-hour evidence-based breastfeeding curriculum component. This evidence-based curriculum has replaced the existing two-hour session that was previously part of the HBWW/BaM program. Primary focus of the curriculum is on breastfeeding, however, it does also include information on safe/healthy bottle feeding practices in an effort to provide consistent messaging with other initiatives such as WIC's *Baby Behavior* training. Focus of this infant feeding session is on getting breastfeeding off to a solid start, partner support, and successful transition back to work, all of which have a great impact on rates of continuation. All 10 HBWW/BaM site staff were trained on the implementation of the curriculum in November 2015. The curriculum has also been made available to WIC/MCH programs in counties across the state where HBWW/BaM sites are not in place, through the work of the KBC. In isolated sites around the state, such as Saline County, initiation rates continue to be significantly higher among HBWW/BaM participants in comparison to county level data. This is likely related to the cohesive breastfeeding support system in the community that has been established through the efforts behind the *Community Supporting Breastfeeding* designations as well as the extensive support that is provided to HBWW/BaM participants by MCH staff who coordinate the program and facilitate the HBWW/BaM sessions.

According to the 2015 aggregate report for all Kansas sites, initiation rates rose to 91% (over the 86% state rate, according to Kansas Birth Certificate data, 2014). Actual rate of breastfeeding initiation among BaM program participants matched the number of participants who reported plans to breastfeed, following the BaM program, vs. the 89% who reported planning to breastfeed prior to the program (BaM Program pre and post-survey comparisons). Other program data shows that aggregately across BaM sites, 52% of BaM participants are enrolled in WIC, vs. 36% of all Kansas births (2014 Birth Certificate Data). Again, in some isolated sites around the state, WIC enrollment rates among BaM participants is higher. This may be due to the demographics or socioeconomic status of the community, but also may be affected by referral processes between the two programs. In an effort to dually target the high risk population that both programs are intended to serve, as well as to dually utilize the breastfeeding education and support components that are a focus of both programs, a "BaM/WIC Integration Plan" was created for implementation in both programs. Through this plan, enrollment processes from one program to another have been established, so that participants in one program are actively scheduled for services provided by the other program (i.e. certification appointment in WIC or prenatal group education session in BaM), vs. continuing to make passive referrals amongst programs as has historically been done. Additionally, incentives are earned in each program when dual participation is verified. This process is depicted in a flow chart that all sites were trained on during the February 2016 "BaM Integration Training, Part II" training day. During this training, staff across both BaM and WIC programs were invited to attend, while training content was dually presented by the Kansas BaM Coordinator and WIC Director.

Breastfeeding education is provided to pregnant and postpartum women seen by the local MCH agencies. Staff promote breastfeeding to pregnant and nursing mothers in any local agency programs they serve (WIC, Family Planning, and Immunizations). Follow-up is made at 3, 6 and 12 months to assist the nursing mother with any concerns as well as to document the duration rates.

Child Care Licensing collaborated with the Kansas Breastfeeding Coalition to make online training available and to offer Technical Assistance to child care providers as needed. The training “How to Support the Breastfeeding Mother & Family” averages 46 child care provider participants per month. The purpose of this focused training is to educate child care providers regarding the benefits of breastfeeding and increase the number of infants that are breastfeeding after the age of 6 months.

**NPM 17: Percent VLBW at Level III hospitals**

In 2014, the percent of very low birth weight infants delivered in subspecialty perinatal care facilities was 82.7%, a decrease from 2013 (86.6%). Over the ten year period (2005-2014), there was an increasing trend detected in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. Below is a table with the resident in-state VLBW live births born at the Level III hospitals by peer groups of residence. The less densely populated counties in Kansas, the smaller percentage of VLBW babies were born at the Level III hospitals. The Healthy People 2020 goal of VLBW infants born in level III hospitals or subspecialty perinatal centers is 90 percent.

Peer Groups	VLBW resident in-state born in level III hospitals	Total VLBW resident in-state	Percent
Frontier	5	11	45.5%
Rural	22	29	75.9%
Densely-Settled Rural	47	71	66.2%
Semi-Urban	48	68	70.6%
Urban	252	273	92.3%
Total	374	452	82.7%

Within the *Becoming a Mom* (BaM) collaborative prenatal education program curriculum, currently there is much inconsistency across sites as to what information is being presented on the importance of VLBW babies being born at appropriate level subspecialty perinatal care facilities. This inconsistency is due to the lack of this information in the original curriculum developed by the March of Dimes. Several individual BaM program sites have taken the initiative to incorporate information on the topic, but there is a lack of standardization across sites. Therefore it is in the 2017 “integration plan” to incorporate consistent messaging on the topic within the Kansas Model - BaM curriculum. Provision of such education is hoped to encourage expectant parents to communicate with their provider during prenatal care about a plan for delivery at an appropriate level NICU, if at risk for delivering a VLBW infant.

**NPMs 11, 13, 15: Healthy Start Home Visitor (HSHV) Universal Home Visiting Program**

Healthy Start Home Visitors conducted a total of 5,066 visits in 66 counties across Kansas in 2015. HSHVs work in

tandem with, and are supervised by, professional nursing and/or social work staff as part of the constellation of maternal and child health promotion and prevention services to improve birth outcomes and healthy infant development. Through home visits and other contacts, the HSHV provides outreach, support, and referrals to other community services to pregnant women and families with infants up to one year postpartum. The HSHV services are not independent of other MCH services, but are to complement and assist with MCH services to pregnant women and families with infants. The program is universal in approach, available to all without additional eligibility limitations. HSHV services are short-term, providing just one to a few visits, and are distinct from other longer-term, intensive home visiting programs.

The HSHV services are intended to increase knowledge, change beliefs and alter behaviors by increasing the number of women accessing early and comprehensive health care before, during and after pregnancy. A HSHV provides education on health and safety promotion, parenting, and preventive programs relevant to the prenatal and postnatal periods and infant development. They provide assistance to families in linking them to resources and in navigating access to systems of care. An important role of the HSHV is to have a broad knowledge of available community resources. HSHVs provide in-home interventions such as education and support. Home visitors have the potential to:

1. Increase the use of cost-effective preventive health care services such as prenatal care, family planning, immunizations, nutrition and well childcare.
2. Promote early entry into and compliance with prenatal care.
3. Discourage unhealthy maternal behaviors such as alcohol and tobacco use.
4. Identify families at risk and link them with services and supports.
5. Improve and enhance parenting and problem solving skills.
6. Reduce costs through use of paraprofessional visitors under nursing supervision.

A new position was created in 2014, *Maternal/Family and Early Childhood Health Consultant*, with primary responsibility for refining HSHV program criteria, expectations, outcomes, and processes. Initial changes included revising program guidelines to allow nurses and social workers who meet the minimum requirements for HSHV to conduct home visits in addition to the paraprofessionals who have traditionally delivered the services. This increased the number of personnel available to provide HSHV throughout the State. Program requirements for continuing education of HSHV were expanded to include attendance at any relevant conference that would meet their individual professional development needs. To improve data collection and reporting capabilities, a system was developed for use by all MCH grantees to capture information regarding the services provided, including HSHV. Data elements specific to HSHV were developed, such as the setting of visits, type of visits (prenatal or postnatal), education topics covered during visits, referrals made to connect families to needed resources, and the services families received as a result of the referrals. In addition, a section was added to the MCH application requiring those who planned to provide HSHV services to submit a work plan describing the home visiting services to be provided, when and where the services would occur, who would provide the service, the frequency and duration of visits, the period of time the family would be visited (prenatal and postnatal), and the topics to be addressed at each visit. And, a section was added to the quarterly progress report to gather information about the activities and reach of the HSHVs. This will enable KDHE to evaluate quantitative as well as qualitative data regarding HSHV services.

*Healthy Start Home Visitor (HSHV) Universal Home Visiting Program - Update on Program Review & Redesign:* In considering the program design update of the Healthy Start Home Visiting program, several activities were completed including: reviewing evidence-based and universal home visiting models; soliciting and reviewing input from Healthy Start Home Visitors; and conducting onsite visits to observe three local health department programs. More detail about each of these aspects follows.

The evidence based program models reviewed included home-based Early Head Start, Healthy Families America,

and Parents As Teachers. Multiple features from the models were adopted in crafting the evidence informed recommendations for the Healthy Start Home Visitation program redesign. Additional models reviewed included Every Child Succeeds, the Nurse-Family Partnership, The Incredible Year, Centering, and Becoming a Mom. Additionally research articles published related to parent engagement, family support and coaching programs, participant retention, and enhancing home visiting with mental health consultation were reviewed. Also studied was research related to brain architecture, the role of home visitation programs in improving health outcomes for children and families, using data to measure performance of home visiting, and facilitating cultural competence. Research groups included the Pew Charitable Trust, Harvard University, CLASP, FRIENDS National Resource Center for Community Based Child Abuse Prevention, Rockville Institute, The National Center for Children in Poverty and multiple others. Also included in this study was a review of tools to measure home visitation quality as well as tools that measure maternal depression, domestic violence, alcohol/substance abuse, and child development.

A review of a variety of local universal home visitation programs also occurred. Programs varied widely from state to state and were an additional resource for considering the redesign of the Health Start Home Visitor program. Those studied included Florida Healthy Start, the Milwaukee Health Department's Home Visiting Programs for Families, North Carolina's Durham Connects, Los Angeles' Welcome Baby, and Michigan's First Steps. Additional review included Massachusetts Department of Public Health's Welcome Family, Rhode Island's First Connections, Georgia's First Steps, and multiple others.

Surveys and focus groups were conducted with Healthy Start Home Visitors to learn more about current views and needs. Survey and focus group questions included how the HSHVs define the program within the community context, the view each holds of the role of the HSHV, tasks performed as a HSHV, topics currently covered in home visits as well as what HSHVs believe are essential topics to be covered and tasks to be performed. The focus groups explored identified barriers to providing HSHV services, inquired about how abilities may be supported, and requested input on ways the HSHV program could be improved. The input received was quite relevant to the program redesign. Almost universally, the desire to receive specific guidance and guidelines from KDHE was expressed by HSHVs. The guidance requested included specifics related to role, expectations, procedures, and documentation. It was also requested by at least some participants that the program become more evidence based or informed. Home Visitors also expressed interest in how to address recruitment barriers, engagement and retention challenges, local perceptions of the program and program promotion needs. Each of these areas has been addressed in the program redesign.

Onsite visits were conducted with three local health department Healthy Start Home Visiting programs. One visit was more urban, a second was more rural, and the third was in a health department in which Healthy Start Home Visiting was the only program funded with Maternal and Child Health funds. In each case, a number of topics were discussed with the Healthy Start Home Visitor, materials used in the program were reviewed, and in two programs a home visit was observed. The discussions with the local Healthy Start Home Visitors were enlightening. Topics included referral sources, participation in partnerships and coalitions, and program promotions. In all cases, WIC was the primary source of referrals though participation in partnerships and program promotions varied widely depending upon the locale. The pregnancy status of the mother visited (prenatal or postpartum) was 50%/50% in two programs though in one program 98% of mothers visited were postpartum. The difference appeared to be based upon other programs for prenatal mothers also offered in the third local program. The number of visits made and the location of the visits also varied among programs. In one instance, more than one visit was rare. In another case, the Healthy Start Home Visitor desired that visits could continue beyond the child's first birthday. Programs visited provided services both in the mother's home as well as at the local health department.

In all cases, the Healthy Start Home Visitor was a paraprofessional though education, background, and experience varied from high school graduate to registered nurse and licensed social worker. Each Home Visitor believed the

current Basic Home Visitor training required was only partially relevant to her work. A desire for additional resources and guidance from KDHE was expressed universally. Documentation, record keeping, and reporting standards were all included in what the local programs would like. They each also would like to be able to offer additional incentives for participation in the program to mothers they serve.

One on-site visit was conducted in a community that also implements the MIECHV program. The purpose of this visit was to discuss how these programs can coordinate and each find their own “niche” in the community. It was clear that in this community, as is suspected in others, the programs felt competitive for participants. With discussion, the programs appeared to better understand how to define the Healthy Start Home Visitation program within the context of other state home visiting programs, in this case MIECHV.

### **Other Activities Impacting Infant/Perinatal Population**

*The Kansas Infant Death & SIDS (KIDS) Network of Kansas, Inc.:* The Title V program partners with the KIDS Network to promote a statewide support system to help families, relatives, friends, caregivers and all others who are affected by the sudden death of an infant. In addition, the Network serves as the leading agency for safe sleep education and training for parents, professionals, and the public.

During 2015, the KIDS Network led the following:

**Community Baby Shower for Safe Sleep:**The central focus of the Community Baby Shower for Safe Sleep is to teach all participants about infant safe sleep. This includes educating parents and their support people on the ABCs of Safe Sleep, which is that all babies should sleep Alone, on their Backs, and in a safety approved Crib. Participants will know the ABCs of safe sleep and will intend to follow the AAP guidelines for safe sleep utilizing the tools received.

**Cribs for KIDS:** Pregnant women receive safe sleep education and a safety approved portable crib via hospital or home visit in a one hour, one class session due to being high risk for infant sleep-related death. Participants are expected to utilize the cribs to create a safe sleep environment for their infant.

**Dissemination of Safe Sleep Education:** Parents and caregivers receive safe sleep education via the birthing center, home visits or via community health fairs and conferences. Participants will know the ABCs of safe sleep and will intend to follow the AAP guidelines for safe sleep utilizing the tools received.

**Physician Safe Sleep Toolkit:** Designed to improve the consistency in safe-sleep communication between infant caregivers and providers. The focus is to provide a Safe Sleep Toolkit for providers to facilitate a consistent safe-sleep message (position, location, and environment) to caregivers of infants. The safe sleep toolkit is intended for use by pediatricians, family medicine physicians, and obstetricians. The focal point of the toolkit is a checklist for caregivers to complete regarding safe sleep.

**Sudden Unexplained Infant Death Investigation--Guidelines for the Scene Investigator:** A systematic training program for the Professional Infant Death Investigation Specialist. Developed by the Centers for Disease Control and Prevention as a guide to recommended practices to assist the investigation of infant deaths and the reporting of scene data to the pathologist for accurate diagnosis. Each participant is given information and materials to train fellow colleagues within their communities.

**Healthcare Provider Education:** Healthcare providers received safe sleep training via conferences and in-services in one-hour training increments. Safe sleep training is a high intensity service as it is a one-time event. Expected outcome: Knowledge of infant safe sleep will increase and providers will find the training useful. This information will be shared with patients/clients.

Child Care Provider Education: Child care providers receive safe sleep online training in a two-hour training session. Training is provided throughout the year in one time sessions. Participants knowledge of infant safe sleep will increase and safe sleep guidelines will be followed for infants in their care.

Statewide Safe Sleep Instructors: The Network had 24 instructors complete the Safe Sleep Instructor Training program. The time that they have been in their positions varied; most were in their current roles for less than 5 years (n=14), but one had just been hired and two had been in their roles for 24 years. Instructors worked in 14 cities across Kansas.

The total population served by the KIDS Network in 2015 was 6,785 detailed by population below.

Prenatal to 2 years: 293

2-5 years: 50

Parents: 3,854

Professionals: 2,588

*Becoming a Mom Program:* The SIDS/Safe Sleep component of the program underwent an update and standardization process, led by state MCH staff and the Kansas Infant Death and SIDS (KIDS) Network. This training occurred late 2015 and will be supplemented with ongoing annual updates provided via webinar by the KIDS Network. The KIDS Network also provided a state-wide Train-the Trainer program on SIDS/Safe Sleep, in an effort to provide more readily available local expertise equipped to provide local trainings on an on-going basis, creating a comprehensive safe-sleep network across public health, hospitals, private practitioners, and other community agencies. Integration of the evidence-based Period of PURPLE Crying program, modeled after Saline and Geary county programs in partnership with Kansas Children's Service League, became a standardized part of the HBWW/BAM program delivery. In addition to this, the integration plan included a Prezi slide presentation on safe infant car seat installation, developed by Kansas Highway Patrol in collaboration with the Saline County HBWW/BAM program. Participants were connected to safety car seat technicians in their community, whom may be Home Visitors, Safe Kids Coalition reps, or law enforcement personnel.

## Child Health

### State Action Plan Table

#### State Action Plan Table - Child Health - Entry 1

##### Priority Need

Developmentally appropriate care and services are provided across the lifespan.

##### NPM

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

##### Objectives

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

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

##### Strategies

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

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

## ESMs

ESM 7.1 - Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit

## NOMs

Child Mortality rate, ages 1 through 9 per 100,000

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Adolescent mortality rate ages 10 through 19 per 100,000

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

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Adolescent suicide rate, ages 15 through 19 per 100,000

## State Action Plan Table - Child Health - Entry 2

### Priority Need

Developmentally appropriate care and services are provided across the lifespan.

### NPM

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

### Objectives

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

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

## Strategies

3.1.1 Conduct an environmental scan to identify providers conducting developmental screening and determine the tools being utilized. 3.1.2 Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention. 3.1.3 Build MCH capacity for screening and follow-up through complete referrals to providers and community-based services. 3.1.4 Provide training to MCH grantees on developmental screening and use of Ages and Stages Questionnaires (e.g., ASQ-3; ASQ:SE2).

3.2.1 Develop a standard and consistent message to communicate importance of developmental screening among child care programs. 3.2.2 Make available and provide training to child care providers on social-emotional development, milestones, and age-appropriate activities using the Kansas Early Learning Standards. 3.2.3 Build child care provider capacity to support coordination and referrals with other providers and community-based services. 3.2.4 Partner with statewide networks such as Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs.

## ESMs

ESM 6.1 - Percent of parents of child program participants receiving education on child development and developmental screening

## NOMs

Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)  
Percent of children in excellent or very good health

## State Action Plan Table - Child Health - Entry 3

### Priority Need

Developmentally appropriate care and services are provided across the lifespan.

### SPM

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

## Objectives

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

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

## Strategies

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

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

## Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	40.7	44.8	49.3	54.2	59.6	65.5

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	37.0 %	3.2 %	70,393	190,075
2007	24.7 %	2.7 %	45,829	185,459

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 6.1 - Percent of parents of child program participants receiving education on child development and developmental screening**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	80.9	75.1	69.8	64.8	60.2	55.9

Data Source: State Inpatient Databases (SID) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	87.1	4.6 %	360	413,488
2012	92.6	4.7 %	381	411,684
2011	87.7	4.6 %	360	410,327
2010	101.3	5.0 %	406	400,844
2009	121.7	5.6 %	474	389,481
2008	129.7	5.8 %	498	384,092

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**ESM 7.1 - Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Child Health - Plan for the Application Year**

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

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

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

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

**NPM: Developmental screening**

According to the 2011/2012 National Survey of Children’s Health, 37.0% of Kansas parents reported they completed a standardized screening tool during a health care visit, compared to 30.8% nationally. CSHCN (44.3%) were more likely to receive a standardized developmental screening compared with children who did not have a special health care need (36.0%).

In fiscal year 2015 (10/01/2014-09/30/2015), according to the Kansas Medical Assistance program, Annual EPSDT Report, 80,400 (73.3%) of the 109,672 eligible children, under 1 through 5 years old, received at least one initial or periodic screen.

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

All children receive a developmental screening at least once a year from birth to age 6 at the local MCH agencies. Agencies use the Ages and Stages Questionnaire (ASQ-3; ASQ-SE) for developmental screenings for ages 2 to 60 months old and then for ages above 60 months, the Bright Futures Pediatric Symptoms Checklist (PSC). Local MCH agencies also provide the KanBeHealthy/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (well visits/screenings). Child Health programs use an outline and multiple screening assessment tools to determine the needs of each child. This guides the formulation of plans to meet the needs directly and indirectly through appropriate referrals.

The web-based shared measurement system (DAISEY) collects data related to education provided during MCH visits about child development as well as referrals for developmental screening and early childhood intervention services.

*Developmental Evaluation Clinics:* The KS Special Health Care Needs (KS-SHCN) program plans to expand the diagnostic clinics, which has been identified as a way to provide increased support for developmental evaluation, especially in rural Kansas. Plans for this year include expanding locations and services through telehealth. In the coming year, the clinic team will pilot telehealth services in these outreach clinics. These clinics are designed to follow the developmental screening and will focus on evaluating children of all ages from any referral source for a concern of a developmental delay or confirmatory evaluation of a diagnosis. This will support stronger partnerships with early intervention providers through the Part C/Infant-Toddler networks. Community education around these clinics will be enhanced in the coming year to support more community referrals including from the local health department, primary care providers, hospitals, and child care providers. Continued partnership building with the Native American population to hold additions diagnostic clinics within the reservation setting to assist with early diagnosis will be a focus. In addition, the clinic team desires to continue focusing on other at risk populations, such as rural residents and military families. Lastly, the clinics are designed to serve as a “training ground in developmental disabilities” for the LEND program. This partnership is valued and has been an area of improvement for Title V. This will continue to be a focus area for partnership building.

*Maternal, Infant, and Early Childhood Home Visiting (MIECHV):* As of October 1, 2016, in accordance with redesigned federal MIECHV Program performance indicators, the measure reported by the MIECHV-funded evidence-based and promising approach home visiting programs will change to enrolled children (birth to age 5) with a timely developmental screening using a validated parent-completed tool. The home visiting programs will continue to conduct developmental screenings with enrolled primary caregivers and their child using the Ages and Stages Questionnaires (ASQ-3; ASQ-SE). Of those with positive screens for developmental delays, data will also be tracked on children who a) received individualized developmental support from a home visitor, b) were referred to early intervention services and assessed within 45 days, or c) were referred to and received other community services. Additionally, home visitors will document routinely asking enrolled primary caregivers if they have any concerns regarding their child’s development, behavior, or learning. Curricula and practices for all the MIECHV-funded home visiting models intensively address child health and development.

*Early Childhood Comprehensive Systems (ECCS):* The Kansas Initiative for Ongoing Developmental Screenings (KIDOS), is the Early Childhood Comprehensive Systems (ECCS) grant project, funded from August 2013-July

2016. KIDOS focuses on state and local systems improvements to effectively coordinate, improve, and track developmental screenings and referrals for infants and toddlers across Kansas early childhood support systems, i.e., home visiting, early education, pediatricians and medical homes, intervention services, child care programs, and families. While the present ECCS grant will soon conclude, a FY'16 ECCS Impact grant application is presently under competitive review and, if awarded, will commence on August 1, 2016 for up to 5 years. New grant activities will build on the KIDOS project and continue a focus on developmental screening and referral processes as well as family well-being (i.e., maternal depression and trauma-informed care) utilizing CoIN and Collective Impact strategies.

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

The MCH program provides support to the Child Care Licensing (CCL) program. Future work related to developmental screening will involve regulated child care facilities. The state program will work with MCH and participate as a member on the KIDOS state work group to develop a standard and consistent message needed to communicate the importance of developmental screening among child care programs. In addition, the CCL program will continue to partner with the approved training organizations and statewide networks including Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs. Specifically, training specifically for child care providers focused on social-emotional development, milestones, and age-appropriate activities will be available for in-service hours.

The guiding document to be utilized for developmentally and age-appropriate activities is the Kansas Early Learning Standards (KELS)

(<http://www.ksde.org/Portals/0/Early%20Childhood/Early%20Learning%20Standards/KsEarlyLearningStandards.pdf>)

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

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

Many county health departments (local MCH agencies) partner with their local Safe Kids Coalition to provide training about child safety, injury prevention and car seat checks. In addition, communities utilizing the Becoming a Mom program curriculum provide information related to car seat education and installation during prenatal education sessions. MCH Healthy Start Home Visitors provide car seat safety/installation education, and many are Child Passenger Safety Technicians, qualified to conduct car seat checks.

The MCH program plans to work closely with the Bureau of Health Promotion, Injury Prevention Program and Safe Kids Kansas to implement the following strategies in partnership with MCH grantees across the state.

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

### **NPM: Child Injury (0-9 years)**

Between 2008 and 2013, rates of non-fatal injuries (a hospital admissions with a primary diagnosis of unintentional or intentional) have significantly decreased, from 129.7 to 87.1 injuries per 100,000 children ages 0 through 9. In 2013, rates of non-fatal injuries were highest among infants less than a year old (162.8 per 100,000), followed by children ages one to four (103.8 per 100,000), and children ages five to nine (57.1 per 100,000). Hispanic children were less likely than either non-Hispanic white and non-Hispanic black children to hospitalize with a non-fatal injury (52.7 per 100,000, versus 80.6 and 84.1 per 100,000, respectively). Males are more likely than females to sustain non-fatal injuries. The 2013 rate among males was 97.1 per 100,000, while the rate among females was 76.6 per 100,000.

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

Child injury education is provided as part of developmental screenings, immunizations, health assessments and Healthy Start Home Visiting (HSHV) services. Local agencies collaborate with Safe Kids Kansas for injury prevention and program guidance on topics including water safety, sun safety, poison control, car seat safety, choking and prevention falls.

The MCH program plans to implement the following strategies across programs (Becoming a Mom, home visiting, child care, injury prevention) to reduce the risk of child injury.

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

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

other educational resources provided by Safe Kids Coalitions. Such plans include the incorporation of education and resources from the “Poisons in the Purse/Diaperbag” campaign in session two of the curriculum. This will fit nicely with the information about risks to pregnancy from chemical/environmental exposures that is already part of the curriculum. Collaborative efforts to integrate resources from the “Charlie’s House” initiative (in connection with Safe Kids Coalition) are also planned for development and implementation in 2017. Again, Saline County BaM program has already taken the lead in integrating resources to assist parents with selecting a child care setting that meets health and safety requirements. Plans are to replicate Saline County’s *integration* efforts across other Kansas BaM sites, by providing training on the resources available through partnership with “Childcare Aware of Kansas”. This *integration* component is scheduled for the 2017 grant year.

Continuation of the Safe Kids Kansas and KS-SHCN smoke and carbon monoxide detectors project will continue in FY 17 until funding is no longer available. Both programs are committed to securing other funding sources to continue the program, however changes to the KS-SHCN program are being made to assure Care Coordinators continue to share safety tips with families per the Safe Kids Kansas recommendations. Both programs are committed to working together to keep all Kansas children safe and healthy and developing additional partnership projects in the future.

### **SPM: Physical activity 6-17 years**

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

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

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

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

1.1 Define different types of physical activity

1.2 State the recommended minimum amount of time for children to receive physical activity

- 1.3 List best practices for promoting physical activity both indoors and outdoors
- 1.4 Include physical activity guidelines in child care center or day care home policy
- 1.5 Talk to parents and caregivers about physical activity and screen time

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

The goal is to increase the minutes per day that children in out of home settings are involved in activity that raises the heart rate, with a goal of up to 60 minutes per day. In addition to training related to the CDC recommendations, child care surveyors will receive refresher training on the regulatory requirements related to daily routine and physical activity, including the protocol for assessing and determining compliance. This in turn will support the surveyors in their efforts to provide technical assistance and consultation during on-site visits for centers and homes.

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

The child care physical activity initiative is targeted to children who have not yet reached school age. In order to support school-age children, the MCH program intends to implement the following strategies.

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

In addition, to the specific strategies outlined above, information will be distributed to clients through MCH agencies regarding the American Academy of Pediatrics' Healthy Habits along with importance of daily physical activity. Local MCH agencies will encourage and promote physical activity among children and youth through counseling at developmental screenings, HSHV, WIC appointments and Family Planning. Families will be educated at each visit about physical activity the entire family can focus on. Grantees encourage at least 60 minutes of physical activity daily for children and adolescents in line with state and federal recommendations/requirements. Some local MCH agencies regularly provide presentations to students in elementary/middle schools regarding physical activity.

## **Other Activities Impacting the Child Population**

### **NPM: Medical Home**

Pioneer Care Advocacy Team (PCAT) Initiative: The Title V program is partnering with the University School of Medicine - Wichita and Kearny County Hospital as part of a collaborative quality improvement involving the Pioneer

Care Advocacy Team (PCAT) to reduce non-emergent Emergency Department (ED) use through coordination of regional health care and other health and social resources. The principal investigator (researcher) will oversee the following activities.

- Develop community survey to be administered by trained high school students and parent volunteers (anticipate 865 completed surveys). The survey will be developed in English and Kearny County Hospital will provide translation into Spanish to accommodate the approximately 29% of the Kearny County population who are Hispanic. Although we do not know exactly what percent of these individuals speak a language other than English, we do know that 66% of Hispanics in Kansas speak a language other than English in the home.
- Obtain IRB (Human Subjects) approval for this quality improvement project. IRB approval requires complete protocol and survey instrument, including translation, prior to approval. Because this is a quality improvement project with no individual identifiers or protected health information collected, we are requesting exempt status. The focus group script will be derived from survey data themes and it will also be translated prior to submission for IRB approval at a later date.
- Train students and parent volunteers on ethical conduct of data collection and data collection protocol. Multiple face-to-face training sessions will be scheduled for students and volunteers. The researcher will take each group through ethical considerations in data collection and participants will practice reading the survey questions aloud to one another until they are very familiar with the questions and comfortable with the language.
- Oversee students' data collection. Data collection will be scheduled on four evenings and two Saturdays in Summer 2016. Data collection dates and times will be widely publicized by the Kearny County Hospital and the two high schools. The survey will contain only closed-ended questions and students will be instructed to introduce themselves and ask if the person is willing to complete a short survey (or ask for an adult should anyone under 18 years of age answer the door), hand a clipboard with the survey and pen to the adult who opens the door, and wait at the door while they complete the survey. The student or volunteer will not handle the completed survey until it is sealed in an envelope by the person completing it.
- Enter and analyze data, including identification of themes to be used for focus group questions.
- Develop focus group script based on survey findings and additional open-ended questions developed by PCAT team members and other stakeholders. Kearny County Hospital will translate the focus group script into Spanish and also provide a bi-lingual facilitator to conduct at least one focus group in Spanish.
- Conduct 4 focus groups of 8-12 people each in Kearny County. Individuals completing the survey will be asked verbally by the survey volunteer if they would like to volunteer for focus group participation in fall 2016. If they respond affirmatively, they will be asked to provide their contact information and day of the week/time preference on a separate sheet. If we get an inadequate response to this request, we will also recruit for focus groups at local churches, civic organizations, and through local media. Kearny County Hospital will host the focus groups and provide food for participants. They will provide a co-facilitator for the English focus groups, as well as a bi-lingual facilitator to conduct at least one focus group in Spanish.
- Analyze qualitative data using open coding.
- Develop report to PCAT team and KDHE Bureau of Family Health from survey and focus group data that includes suggested evidence-based strategies to address issues raised by residents.

- Work with PCAT to develop plans to address health care, health information, and social services needs identified in the survey and focus groups. Facilitate planning with PCAT team, Kearny Hospital Board of Trustees, and other key decision-makers using the survey and focus group data to develop evidence-based plans to address the issues identified in the ED interviews, door-to-door survey and focus groups.

- Work with team to develop publishable manuscript regarding project and findings. There are a large number of rural communities with critical access hospitals that are struggling to meet the needs of rural and frontier communities. We believe the process, survey and focus groups tools, and evidence-based strategies will be of interest to these other communities.

### *Background*

PCAT previously conducted interviews with ED visitors, or their parents if children or adolescents, over a 45-day period in September and October 2015. Data indicates that 39% of the 136 patients interviewed during ED visits during the data period were children and adolescents 0-18 years of age (23% 0-6 YO; 16% 7-18 YO). Interview data also indicates that over 70% of those interviewed had primary care physicians (PCP), yet only about 19% had contacted their PCP or a clinic to request to be seen prior to coming to the ED. The frontier nature of Kearny County results in limited availability of healthcare for some residents, an issue that requires attention and creative strategies that will be of interest and use to other frontier counties with critical access hospitals in Kansas and the surrounding states. The purpose of this agreement is to identify: the knowledge and perceptions of health care resources among families; unmet health care, health information, and social services needs among families; strategies to address identified gaps through revisions or additions to the Kearny County healthcare system. The proposed project is a quality improvement project addendum to the Pioneer Care Advocacy Team (PCAT) initiative that adopts some of the methodology of the PFA initiative in Ghana applied to a rural county in southwest Kansas that will also use a combination of direct engagement (house-to-house survey) and group meetings of stakeholders (focus groups).

The PCAT Initiative started in August 2015 and is funded through July 2018. Multiple organizations contributed to fund the PCAT initiative:

- Kansas Department of Health and Environment
- Blue Cross and Blue Shield of Kansas Foundation
- Kansas Health Foundation
- Kansas Hospital Association
- Kansas Hospital Education and Research Foundation
- Sunflower Foundation
- United Methodist Health Ministry Fund
- US Department of Health and Human Services/HRSA

### **Child Health - Annual Report**

The activities, programs, and services detailed below have impacted the following FY 2015 National and State performance measures.

- NPM 07: Immunizations
- NPM 09: 3rd grade sealants
- NPM 10: 0-14 Motor Vehicle Crash Deaths
- NPM 13: Uninsured Children
- NPM 14: Child WIC Services & BMI
- SPM 04: Medical Home
- SPM 06: Childhood Obesity

## **NPM 7: Immunization full schedule 19-35 month olds**

Local MCH agency staff including Healthy Start Home Visitors encourage parents to keep children up-to-date on the immunization schedule. Many agencies offer open walk-in immunization clinics to not allow time and opportunity to become a barrier to their clients receiving their immunizations. Most agencies make reminder phone calls and send letters to remind parents to bring their children to receive their immunizations.

The proportion of Kansas children ages 19 through 35 months, who received all of the vaccinations in the combined 7-vaccine series (4:3:1:3\*:3:1:4) increased from 73.5% in 2011 to 76.5% in 2014. In 2014, non-Hispanic black children were less likely to be fully vaccinated than non-Hispanic white or Hispanic children (44.6% versus 73.1% and 68.2%, respectively). Similarly, the vaccination rate was lower for those with household incomes below 100% of poverty compared to their counterparts living at or above 400% of the poverty level (68.3% versus 79.6%, respectively). Compared to children with private health insurance coverage, lower rates of full series coverage were reported by low-income children with Medicaid (73.1% and 67.8%, respectively). WIC participants (68.6%) had lower vaccination coverage than more affluent children (72.4%). The vaccination rate among 19- to 35-month-olds living in non-metropolitan statistical area (MSA) (74.6%) was greater than for those living in MSA noncentral cities (70.6%) and MSA central cities (66.3%).

## **NPM 9: 3rd Grade Sealants**

Kansas law requires each child to have a yearly oral health screening. The Bureau of Oral Health (BOH) assists schools in complying with this statute. Bureau staff trains and calibrates all screeners—dentists and dental hygienists—and helps schools organize screening dates with school nurses. Screening data is collected and housed at the Bureau. In the 2014-15 school year, almost 160,000 children grades kindergarten through grade 12 received a dental screening. Delta Dental funding provide supplies to school screeners as well as a toothbrush for all school children receiving a dental screening. BOH partners with statewide safety net dental clinics and federally qualified health centers (many of which are also MCH grantees) to support outreach activities supporting the school sealant program. In 2017, BOH will conduct a “Smiles Across Kansas” third grade oral health assessment Basic Screening Survey (BSS) to update progress from the 2012 survey.

Oral health collaboration between the Bureau of Family Health and BOH resulted in projects addressing oral health care instruction and access in home-based child care facilities and special health care needs populations access to orthodontic and preventive dental services. Within the agency, collaboration has resulted in improved communication and policy development with the Division of Healthcare Finance (Medicaid). Title V continues to support the Healthy Smiles oral health initiative. Child Care Licensing purchased training spots for providers to complete, *Oral Health in the Child Care Setting - Toothbrushing: As Easy as 1-2-3*, an online training through Kansas Child Care Training Opportunities (KCCTO), and face to face training with Child Care Aware of Kansas. This course provides an overview of the importance of oral health in young children, the elements that cause tooth decay, and how to implement a tooth brushing routine into daily activities. Dental disease is a silent national epidemic in which nearly 1 in 3 preschoolers are already affected by tooth decay; therefore, promoting good oral health early assists with the overall health of a child.

Collaborations with external stakeholders include the Kansas Dental Association, the Kansas Dental Board, Kansas Association for the Medically Underserved (KAMU), Oral Health Kansas (OHK), Kansas Head Start Association, Kansas Action for Children, Association of State and Territorial Directors (ASTDD), Kansas University School of Medicine (KUMED) and statewide dental providers. During 2015, BOH successfully partnered with ASTDD, OHK, KAMU and Head Start to complete the state’s first Head Start Basic Screening Survey (BSS) (funded by the DentaQuest Foundation). The results will be analyzed by KU Medical Center and will be available to all partners. A pilot program with five safety net clinics was funded and implemented to allow enhancement of access and services

to our underserved populations through efforts by the Extended Care Permit dental hygienists. BOH will sponsor an all-day educational event in August to all state wide partners sharing the successes of these projects as well as the School Sealant Program.

### **NPM 10: 0-14 MV Crash Deaths**

According to the 2015 Annual Report (2013 Data) of the Kansas State Child Death Review Board (SCDRB): “In 2013, 38 children died in Kansas as a result of a Motor Vehicle Crash (MVC). There were five MVC deaths in the 0-4 age range; of those that were passengers in a car, none were restrained. Of the MVC deaths in the 5-9 age group, 67% were unrestrained, as well as 78% in the 10–14 age group. There were 18 deaths ages 15-17 and 50% of those were unrestrained. Driver inexperience and inattentive driving were noted as contributing factors in 42% of the total cases and excessive speed was noted in 45%. Drugs and/or alcohol use was noted to be a contributory factor in 29% of the cases, however in only one case was the decedent under the influence of drugs while driving. All-terrain vehicle use has become popular in both recreation and work. Their size, maneuverability, and durability make them extremely handy and fun to ride. Unfortunately, the thrills can quickly turn to tragedy. In Kansas, children ages 10 - 14 have comprised the highest number of ATV child-related fatalities since 1994. Young riders lack the size and strength to safely control an ATV. ATV drivers often travel on roadways that are not designed for ATV travel and drive at unsafe speeds.”

### **NPM 13: Uninsured Children**

Health insurance is critical for ensuring the health and well-being of children in the United States. Without health insurance coverage, children are less likely to receive medical care and more likely to have poor health status.<sup>1</sup> Data from the U.S. Census American Community Survey (ACS) showed that the percentage of Kansas children under 18 years old without health insurance decreased from 8.2% in 2009 to 6.2% in 2014.

Similar to all children in the United States, in Kansas, children's health insurance status varies by several factors, including race/ethnicity, household income, parents' educational attainment, parental nativity, among others.

In 2014, the highest proportions of uninsured children were among non-Hispanic American Indians/Alaska Natives (21.7%), followed by Hispanics (13.2%), non-Hispanic Asians (7.5%), non-Hispanic blacks (6.8%), and non-Hispanic whites (4.3%). Children living in low-income families were more likely to be uninsured than children living in higher-income families. The highest percent of children who were uninsured were children living in households with incomes below 100 percent of poverty (12.1%), followed by children from households with incomes of 100-199 percent of poverty (8.0%), children in households with incomes of 200-399 percent of poverty (5.0%), and children in households with incomes 400 percent or more of poverty (1.5%). Parental educational level is an important predictor of children's health insurance status. The percentage of children who were uninsured decreased as parents' education attainment (refers to highest education of a parent/guardian in the household) increased.

Compared with children whose parents had a college education, some college education or a high school education, children whose parents had less than a high school education were more likely to be uninsured (2.0%, 5.5%, 13.6% versus 16.7%, respectively). Children of immigrant parents (born outside the United States) were more likely to be uninsured than children of American-born parents (14.4% and 4.6%, respectively). Similarly, children living in non-English language households were more likely to be uninsured than living in English language households (12.3% and 4.6%, respectively). Children living in unmarried, separated, cohabiting households were more likely to be uninsured than children living in two-parent married households (9.5% and 4.6%, respectively). Children with no activity limitations/disabilities were more likely to be uninsured than children with activity limitations/disabilities

(having at least one of six types of difficulties: hearing, vision, cognitive, ambulatory, self-care, and independent living) (6.3% and 3.0%, respectively). Children living in non-Metropolitan Statistical Areas (MSAs) were more likely to be uninsured than children living in MSAs (7.9% and 6.0%, respectively).

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.

State MCH staff have continued to be instrumental in linking local grantees to health care navigators located across Kansas. As grantees become more aware of the resources that health care navigation staff provides, more grantees are referring their clients to them for assistance.

As reported under the Women/Maternal Health section, Kansas Department of Health and Environment (KDHE) created the positions of 12 Out Stationed Eligibility Workers, in recognition that many families need more one-on-one assistance with the completion of Medicaid applications. These workers are located across Kansas in Federally Qualified Health Care Centers and hospitals, where families without insurance may seek medical care. These eligibility workers determine eligibility for Medicaid and CHIP programs, as well as providing information and outreach to communities, local health departments, clinics and hospitals, explaining eligibility requirements, troubleshooting payment problems, and encouraging families to apply. While local health department staff across MCH, WIC, and Family Planning programs work to identify families with uninsured children and refer them to local Outstation Workers for expedited eligibility determination, Outstation Workers work collaboratively within communities and agency partners to make referrals for parenting support and education programs as well as medical care.

Local health department staff, alongside Outstation Workers, mental health providers, birth centers, Early Head Start programs, and many other local agencies work diligently to identify uninsured children, assisting parents with the state Medicaid eligibility and application process, as well as connecting them to a Medical Home in their community. This continues to be a priority of Healthy Start Home Visitors, to assist parents of uninsured newborn infants in applying for KanCare/Medicaid coverage. Most grantees provide a list of local health care providers from which clients may choose a provider. Some grantees with greater resources assist clients in making appointments and go so far as taking the clients to the provider. State MCH program generated Aid-to-Local grant application and reporting processes are inclusive of this priority, year to year. Local health departments continue to provide immunizations, well child checks, and MCH services on a sliding fee scale to families unable to afford care at full price.

*CYSHCN, Insurance Coverage, and EPSDT: [The Special Health Care Needs \(KS-SHCN\)](#)* program continued to work closely with families on the program to assist them in accessing insurance coverage. Care coordination staff explain the value of having insurance to clients/families and encourage them to apply for assistance through KanCare and/or marketplace exchange. The program has also worked closely with families to advocate with their insurance companies for needed services to be covered. A good example of this is formula coverage for those clients who have PKU. Many insurance companies do not cover formula, but since families have begun advocating to their personal insurance companies some of these companies have now begun covering formula cost.

The KS-SHCN program reminds families of the importance of their child's Kan-Be-Healthy (KBH), the Kansas Early Periodic Screening Diagnosis and Treatment (EPSDT) program. KS-SHCN partners with the Medicaid Managed Care Organizations (MCOs) to receive data of dually enrolled Medicaid/Title V CYSHCN program participants.

Monthly, a report is provided to the MCOs of enrolled Title V CYSHCN participants. The MCOs complete a report for KS-SHCN notifying of those under Medicaid case management and the status of the participants KBH. If a child on the KS-SHCN program is “not current” on their KBH checkups the care coordinator reminds them to get an appointment scheduled and will assist in that process if the family needs assistance. Local MCH agencies continue to provide immunizations, well child checks and MCH services on a sliding fee scale (that will go to zero) to families that are unable to pay for services. Services were provided regardless of insurance or ability to pay. Local MCH agencies including Healthy Start Home Visitors (HSHV) screen and assist families with enrollment for KanCare services. Local MCH Programs worked with state/local partners to assist families in accessing insurance coverage. HSHVs provided health education and made referrals as needed for pregnant women, postpartum women and their babies. Local MCH agencies serve as a gap-filling provider for families served through the Medicaid program. Local MCH agencies 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. MCH continues to work with KMAP and KanCare health plan providers to link them to potential clients. Local MCH agencies 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.

*Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs:* Evidence-based and promising approach programs provided enrolled families with information and referrals to support insurance coverage for their child. The MIECHV programs collected and reported data for this Benchmark indicator. During the period of October 2014-September 2015, 96% of children had insurance coverage.

#### **NPM 14: Child WIC Services & BMI**

#### **SPM 6: Children - Obesity**

According to the 2015 Kansas WIC provisional data, 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 (body mass index at or above 85<sup>th</sup> percentile) or obese (body mass index >95<sup>th</sup> percentile). Over the 10-year period (2006-2015), there was a significant decreasing trend observed. The annual percent change (APC) was significant (-0.75).

The 2011/12 National Survey of Children’s Health data showed that 30.2% of Kansas children aged 10-17 years were reported to be overweight or obese, which was less than but not significantly different from the national estimate of 31.3%. In 2011/12, 37.6% of boys and 22.7% of girls met the definition of overweight or obese. These proportions also varied by household income and race and ethnicity. Rates of being overweight/obese decreased with increasing FPL status. Those in the <100% FPL (42.9%) had significantly higher rates than that of children in the 400%+ (21.4%). The proportion of overweight/obese children was also significantly higher for children in the 100-199% FPL category compared to children in the 400% FPL group. Among racial and ethnic groups, non-Hispanic White children were the least likely to be overweight or obese (22.4%) and Hispanic children were the most likely (54.3%).

The Nutrition and WIC Services Section and local WIC Programs continue implementation of the Kansas Baby Behavior Campaign to WIC clients during 2015. This program discourages overfeeding and future overweight. All new employees receive Baby Behavior training through on-line training.

Changes in the Kansas WIC Program food package emphasize low fat milk and fresh fruits and vegetables. Evaluation of childhood overweight and obesity before and after implementation of the food package changes will

occur in 2016.

Several local WIC clinics organize physical fitness events annually to educate parents about the importance of activity for their children. The WIC Newsletter published six times per year provides staff articles about nutrition. WIC nutrition education materials are being evaluated and revised to include new nutrition information. The Kansas WIC Conference Spring 2016 provided education on nutrition and the feeding of children. 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. State nutritionists participate on the Association of State Public Health Nutritionists committees with an emphasis on healthy eating and physical activity. Some Kansas WIC clinics sponsor a Farmers Market in the health department parking lot or participate in nutrition booths at a Farmers Market and other community events.

Local MCH agencies are collaborating within the agency (WIC, Family Planning) to develop a consistent measure of overweight and obesity among children especially those with low income. Children who are high risk for obesity are referred to a dietician. Many local MCH agencies are working with their school nurses to screen children and have the school nurse contact the families to offer them follow-up options with a dietician or other community resources to assist their family.

*Child Care Licensing Program:* Child Care Licensing launched work with the Bureau of Health Promotion to develop a training to promote physical activity and educate licensed child care providers regarding the recommendations and health benefits of physical activity. Child Care program staff attended the fourth annual Governor's Council on Fitness Kansas Obesity Summit. The conference is sponsored by the Governor's Council on Fitness, and supported by the Kansas Department of Health and Environment (KDHE) and Kansas Alliance for Wellness. The keynote speaker was Terry O'Toole, PhD, MDiv, FASHA, who serves as Senior Advisor with the Division of Nutrition, Physical Activity and Obesity at the Centers for Disease Control and Prevention (CDC). Dr. O'Toole provides expertise and technical assistance to state and community-based programs, national partners and health organizations focused on promoting healthy eating, physical activity and obesity prevention. During the summit a GoNoodle interactive demonstration was presented with the aid of children from a local elementary classroom. GoNoodle is a free interactive, web-based program that encourages children to participate in brief bursts of physical exercise. GoNoodle is a great way to give kids a quick burst of physical activity on those days that weather does not permit going outside. The GoNoodle information was disseminated to child care providers through local child care surveyors and the information and link was added to the child care quarterly newsletters.

*Professional Development/Training Supported by Title V:* The Kansas Chapter of the American Academy of Pediatrics and the KS-TRAIN team (supported by Title V) updated the content of the four Healthy Habits modules that are posted to KS-TRAIN. The modules include: Healthy Habits, Module 1: Obesity in Kansas Children, A Growing Epidemic; Healthy Habits, Module 2: Negotiating Behavior - the Road to Long-Term Change, Healthy Habits, Module 3: Expert Committee Recommendations on the Assessment & Treatment of Child and Adolescent Overweight and Obesity; and Healthy Habits, Module 4: Preventing Childhood Obesity: Your Role as a Pediatric Provider.

The KS-TRAIN team also provided instructional design and course development services during the second quarter of 2015 through the first quarter of 2016 to the Kansas Department of Education and the Bureau of Health Promotion for a Kansas Fitness Information Tracking (K-FIT) Training for school physical education programs. The online course, KSDE: Feeding Infants in the Child and Adult Care Food Program, was developed in October 2014 for the Department of Education and Kansas child care providers.

During the third and fourth quarters of 2014, technical assistance and instruction was provided to the Bureau of

Family Health Child Care Trainer on the use of Go To Meeting and Go To Webinar. This tool was used to communicate with Kansas child care providers on the new online license renewal application process.

#### **SPM 4: Medical Home (per American Academy of Pediatrics (AAP) definition)**

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%).

Local MCH staff including Healthy Start Home Visitors screened, counseled and encouraged all children to obtain a medical home. Those who do not have an established medical home were referred to local providers to establish care and provide follow-up.

#### **Other Activities Impacting the Child Population**

*Developmental Evaluation Clinics:* The Kansas Special Health Care Needs program (KS-SHCN), in partnership with the Kansas State Department of Education (KSDE) and the University of Kansas Medical Center – Center for Child Health and Development (KU-CCHD), supports specialty clinics designed to assist in the assessment and diagnosis of development delay. These outreach clinics are held in multiple areas of the state where the child and family meets with a multi-disciplinary team of professionals, including (but not limited to) a developmental pediatrician, early intervention and childhood providers, speech/physical/occupational therapy, and others in the child's community who may support the child and family after diagnosis. Some of these clinics are held on military bases to identify and support those families who may find it difficult to get a diagnosis due to short term residency. For the first time, a clinic was organized for Native American children and held on the reservation in partnership with tribal leaders to identify children with developmental delays and to assist in connecting them to the appropriate services and supports. Leadership Education in Neurodevelopmental Disabilities (LEND) students participate in these diagnostic clinics to gain valuable insight into conducting evaluations and how to effectively communicate with the families who have children with special health care needs. In FY15, a total of 3,257 children and families were served through these clinics.

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

<sup>1</sup>U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2014. Rockville, Maryland: U.S. Department of Health and Human Services, 2015. Online at <http://mchb.hrsa.gov/chusa14/>

## Adolescent Health

### State Action Plan Table

#### State Action Plan Table - Adolescent Health - Entry 1

##### Priority Need

Communities and providers support physical, social, and emotional health.

##### NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

##### Objectives

4.1 Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

4.2 Increase the number of adolescents receiving immunizations according to the recommended schedule by 2020.

##### Strategies

4.1.1 Engage health care providers, Medicaid and Managed Care Organizations to promote annual well-child visits through adolescence into adulthood. 4.1.2 Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan (IHP) who have not had a well visit in the past year. 4.1.3 Partner with schools to evaluate the capacity and infrastructure to provide school-based services for physical, social, and emotional health needs.

4.2.1 Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program. 4.2.2 Provide parent education on immunizations, including schedules, and the importance to child and adolescent health. 4.2.3 Identify and promote existing vaccination programs and campaigns. 4.2.4 Work with Immunize Kansas Coalition (IKC) to increase HPV vaccination completion for youth ages 13-17 years.

##### ESMs

ESM 10.1 - Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year

## NOMs

Adolescent mortality rate ages 10 through 19 per 100,000

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

Adolescent suicide rate, ages 15 through 19 per 100,000

Percent of children with a mental/behavioral condition who receive treatment or counseling

Percent of children in excellent or very good health

Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

## State Action Plan Table - Adolescent Health - Entry 2

### Priority Need

Communities and providers support physical, social, and emotional health.

### NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

### Objectives

4.3 Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

4.4 Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

4.5 Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

## Strategies

4.3.1 Identify evidence-based programs in partnership with the Bureau of Health Promotion (BHP) that decrease risk factors associated with bullying through parental involvement, curriculum integration, and school staff-wide training. 4.3.2 Work with BHP to help schools improve school-based bullying policies to meet best practices. 4.3.3 Provide information to school nurses and counselors on how to respond to bullying. 4.3.4 Partner with school nurses and counselors to provide access to behavioral health services in schools. 4.3.5 Explore options for educating and reporting unsafe social media and digital content.

4.4.1 Provide annual training on Adverse Childhood Experiences (ACEs) and trauma-informed responses and approaches for MCH staff, grantees, and partners working with adolescents and their families. 4.4.2 Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments to reduce risky behaviors and promote healthy relationships including abstinence. 4.4.3 Partner with communities to connect adolescents with supports that promote protective factors (Faith-based, pediatricians, schools). 4.4.4 Support public awareness campaigns to prevent adolescent self-injury. 4.4.5 Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence and avoiding risky behaviors more easily available to youth and their families. 4.4.6 Identify methods to increase adolescent awareness of services and programs available to them in their community.

4.5.1 Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received. 4.5.2 Behavioral health awareness days with free screenings across the state. 4.5.3 Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment. 4.5.4 Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time. 4.5.5 Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

## ESMs

ESM 9.1 - Number of school-age students that received information on bullying or social-emotional development

## NOMs

Adolescent mortality rate ages 10 through 19 per 100,000

Adolescent suicide rate, ages 15 through 19 per 100,000

## State Action Plan Table - Adolescent Health - Entry 3

### Priority Need

Communities and providers support physical, social, and emotional health.

### NPM

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

### Objectives

NOTE: This NPM applies to Child and/or Adolescent Health Domain. It was selected as a Child Domain NPM.

### Strategies

NOTE: This NPM applies to Child and/or Adolescent Health Domain. It was selected as a Child Domain NPM.

### ESMs

ESM 7.1 - Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit

### NOMs

Child Mortality rate, ages 1 through 9 per 100,000

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Adolescent mortality rate ages 10 through 19 per 100,000

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

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Adolescent suicide rate, ages 15 through 19 per 100,000

**Measures**

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	184	172.7	162	152.1	142.7	133.9

**Data Source: State Inpatient Databases (SID) - ADOLESCENT**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	196.1	6.9 %	800	407,907
2012	226.1	7.5 %	911	403,006
2011	215.0	7.3 %	859	399,500
2010	231.4	7.7 %	910	393,330
2009	270.8	8.3 %	1,065	393,331
2008	277.8	8.4 %	1,101	396,356

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**ESM 7.1 - Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	9.9	8.9	8	7.2	6.5	5.9

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	11.0 %	1.8 %	25,495	231,663
2007	15.4 %	2.0 %	36,286	235,034

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	27.9 %	1.6 %	39,871	142,707
2011	26.4 %	1.3 %	36,724	138,964

**Legends:**  
 Indicator has an unweighted denominator <100 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 9.1 - Number of school-age students that received information on bullying or social-emotional development**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	15.0	20.0	25.0	30.0

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	85.5	87.6	89.8	92.1	94.4	96.7

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	83.4 %	2.2 %	191,615	229,749
2007	88.8 %	1.6 %	207,786	233,876
2003	78.2 %	1.8 %	185,944	237,889

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 10.1 - Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Adolescent Health - Plan for the Application Year**

**PRIORITY:** Communities and providers support physical, social and emotional health

**NPM:** Bullying (12 through 17, who are bullied or who bully others)

**NPM:** Adolescent well-visit (12 through 17)

**NPM: Bullying (12-17 years, who are bullied or who bully others)**

According to the 2011/12 National Survey of Children's Health (NSCH), reported by a parent/guardian, the prevalence of adolescents, 12-17 years of age, who always/usually/sometimes bullied or was cruel or mean to others in the past month was 11.0%. (The revised NSCH will also capture bullying victimization.) Adolescents with special health care needs were more likely to be a bully than adolescents without special health care needs (19.0% and 8.4%, respectively). Hispanic adolescents (16.8%) were more likely to be a bully compared to non-Hispanic white adolescents (10.7%). Compared with adolescents whose parents had a college education, some college education or a high school education, adolescents whose parents had less than a high school education were more likely to be a bully (7.9%, 10.0%, 11.6% versus 24.8%, respectively). Adolescents living in low-income families were more likely to be a bully than adolescents living in higher-income families. The highest percent of adolescents who were a bully were adolescents living in households with incomes below 100 percent of poverty (15.6%), followed by adolescents in households with incomes of 200-399 percent of poverty (13.5%), adolescents from households with incomes of

100-199 percent of poverty (12.3%), and adolescents in households with incomes 400 percent or more of poverty (4.2%). Adolescents without insurance coverage and with Medicaid/CHIP coverage were more likely to be a bully than adolescents with private health insurance (17.8%, 14.2% versus 8.5%, respectively). Adolescents of immigrant parents (born outside the United States) were more likely to be a bully than adolescents of American-born parents (24.2% and 8.6%, respectively). Similarly, adolescents living in non-English language households were more likely to be a bully than living in English language households (29.7% and 9.4%, respectively). Adolescents living in non-Metropolitan Statistical Areas (MSAs) and MSA, Central City were more likely to be a bully than adolescents living in MSA, Non-Central City (13.0%, 12.8% and 5.2%, respectively). There was no difference in the prevalence of being a bully between adolescents living in two-parent married households and those living in unmarried, separated, cohabiting households. There was no gender difference in the prevalence of being a bully.

The Kansas Youth Risk Behavior Surveillance System (YRBSS) data are self-reported by students in grades 9 through 12. In 2013, 27.9% of Kansas students had been electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting) or who were bullied on school property, during the 12 months before the survey. The prevalence of having been electronically bullied or bullied on school property was significantly higher among female (34.6%) than male (21.6%) students. The prevalence of having been electronically bullied or bullied on school property was significantly higher among 9th-grade (36.7%) than 11th-grade (24.3%), and 12th-grade (20.2%) students.

Objective: Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

The MCH program intends to gather information from the Kansas State Department of Education to learn more about the policies and approaches schools are implementing related to bullying. This will assist with identifying evidence-based programs currently in place. While focus will be on the adolescent population, launching programs in middle and high school settings, we are interested in continuing and expanding the existing program in elementary schools. There are at least twelve schools receiving funds and support from the KDHE Bureau of Health Promotion (BHP) to implement comprehensive bullying prevention programs. We hope to expand the reach of the program to more schools in targeted areas of the state.

Specifically, the program plans to begin implementation on one or more of the following strategies.

- Decrease risk factors associated with bullying through parental involvement, curriculum integration, and school staff-wide training.
- Work with BHP to help schools improve school-based bullying policies to meet best practices.
- Provide information to school nurses and counselors on how to respond to bullying.
- Partner with school nurses and counselors to provide access to behavioral health services in schools.
- Explore options for educating and reporting unsafe social media and digital content.

Local MCH agencies will continue to provide education and counseling on bullying during physicals and adolescent well visits in accordance with Bright Futures and CDC recommendations. Referrals are made to mental health, crisis centers and suicide hotlines for additional resources and to report bullying. Some local MCH agencies will work in collaboration with their local school districts and local law enforcement to educate students on bullying prevention throughout the school year. In addition, many local MCH agencies offer educational awareness about healthy relationships and defining what constitutes a healthy relationship, which is critical to understanding physical, social and emotional health.

A local MCH grantee (also a Federally Qualified Health Center), employs most of the school nurses in the local

school district and has implemented standardized policies related specifically to bullying and other social pressures. The grantee also employs full-time mental health professionals that share time between the middle school and high school. These mental health professionals work directly with students, faculty and administration to address social and emotional needs including intervention strategies to disrupt negative behaviors.

Objective 5.2: Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

The MCH Program plans to begin implementation of one or more of the following strategies.

- Provide annual training on Adverse Childhood Experiences (ACEs) and trauma-informed responses and approaches for MCH staff, grantees, and partners working with adolescents and their families.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments to reduce risky behaviors and promote healthy relationships including abstinence.
- Partner with communities to connect adolescents with supports that promote protective factors (Faith-based, pediatricians, schools).
- Support public awareness campaigns to prevent adolescent self-injury.
- Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence and avoiding risky behaviors more easily available to youth and their families.
- Identify methods to increase adolescent awareness of services and programs available to them in their community.

KS-SHCN, in partnership with the Kansas Youth Empowerment Academy (KYEA), has developed a youth leadership program called Faces of Change. Faces of Change is focused on leadership development through civic engagement for youth ages 16-22 with disabilities. The program is seven months long, with monthly sessions focusing on an area contributing to effective leadership, such as: what it means to be a true leader, authentic leadership, effective communication, and team motivation. Youth participants will be using the new leadership qualities that they are learning throughout the program through a Community Change Project, which will be created and led by the youth. This program was developed to address risk factors for youth with disabilities and special health care needs. It is believed that this program will decrease the following risk factors for youth with disabilities: low self-esteem and self-efficacy, high unemployment, and bullying. During the stage of young adulthood, youth need to find abilities within and connect with others. This program will have a strong emphasis on civic engagement, this provides participants the opportunity to explore abilities and realize their worth to society by giving back to others. The rate of unemployment for youth with disabilities ages 16-19 is more than twice the number of youth without disabilities. Youth participants will have enhanced employability skills such as communication, active listening, team work, time management and dress attire, and more. Lastly, youth with disabilities are more likely to be bullied compared with their nondisabled peers; contributing to secondary mental health conditions and increased risk for depression and suicide. These youth are not only victims of bullying by their peers, but also experience intimidation from medical professionals, family members and school faculty. Building communication and assertiveness skills, developing problem solving skills, and creating a network of peers and adults are intended outcomes of this program and will lead to positive outlets and create resiliency. Our belief is that by enhancing leadership skills, youth with disabilities and special healthcare needs will demonstrate increased self-efficacy, self-determination, and feel connected on a social and civic level to their community. Monthly weekend sessions began in April 2016 and continue through November 2016. Immediately following the completion of the first session series recruitment for the second session series will begin. The second series is slated to include youth with and without disabilities (based upon completion and evaluation findings from the first session series). Evaluations are being completed throughout and at the conclusion of the program, including a youth-completed pre/post self-efficacy and leadership assessment. Additionally, the evaluation plan includes long-term initiatives at one and three years after completion of the program. KS-SHCN is dedicated to offering an internship opportunity to at least one youth leader who successfully completes

the program in the future.

Youth with special health care needs will be encouraged to participate in the family/caregiver care coordination training held by KS-SHCN staff each quarter, so they may learn more about how to navigate the system. Topics covered in this are medical home, advocacy, partnering with providers, accessing insurance coverage, self-care and peer support. Youth participation will be monitored and evaluated to see if a training for youth needs to be conducted separately from parents/caregivers.

Objective 5.3: Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

The MCH Program plans to begin implementation of one or more of the following strategies.

- Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received.
- Behavioral health awareness days with free screenings across the state.
- Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.
- Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time.
- Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

**NPM: Adolescent well-visit (12-17 years)**

The 2011/2012 National Survey of Children's Health showed that 83.4% of Kansas adolescents, 12–17 years of age, had a preventive medical visit in the past year. Adolescents without health insurance coverage were significantly less likely than adolescents with coverage to have received a preventive medical visit in the past year (57.1% versus 85.4%, respectively). Of those who had health insurance, adolescents covered by public health insurance (Medicaid/CHIP) were less likely to have received a preventive medical visit than those with private insurance (78.4% and 88.7%, respectively). Hispanic and non-Hispanic black adolescents were less likely than non-Hispanic white adolescents to receive a preventive medical visit. About 68.3% non-Hispanic black and 77.3% of Hispanic children received a preventive medical visit, compared with 86.7% of non-Hispanic white adolescents. Girls were significantly more likely to have received a preventive medical visit than boys (90.1% versus 77.4%, respectively). Adolescents with special health care needs were more likely to have received a preventive medical visit than adolescents without special health care needs (88.7% and 81.7%, respectively). Adolescents with parents who had more education were more likely to receive a preventive medical visit. Adolescents whose parents had a bachelor's degree or more were most likely to have received a preventive medical visit (91.3%), followed by those whose parents had some college and adolescents whose parents had only a high school diploma (78.7% and 79.9%, respectively), and adolescents of parents with less than a high school degree (68.6%). Adolescents living in low-income families were less likely to receive a preventive medical visit than adolescents living in higher-income families. The lowest percent of adolescents who had received a preventive medical visit were adolescents living in households with incomes below 100 percent of poverty (74.3%), followed by adolescents from households with incomes of 100-199 percent of poverty (76.7%), adolescents in households with incomes of 200-399 percent of poverty (83.9%), and adolescents in households with incomes 400 percent or more of poverty (93.8%).

Objective 5.4: Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

The MCH Program plans to begin implementation of one of more of the following strategies.

- Engage health care providers, Medicaid and Managed Care Organizations to promote annual well-child visits through adolescence into adulthood.
- Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan (IHP) who have not had a well visit in the past year.
- Partner with schools to evaluate the capacity and infrastructure to provide school-based services for physical, social, and emotional health needs.

Local MCH agencies provide adolescent well-visits in conjunction with KanBeHealthy screenings and sports physicals. Information regarding adolescent well-visits are obtained from Bright Futures and provided as a resource to the program participants. Local MCH agencies that do not provide adolescent well-visit services collaborate with local physicians or Family Planning Programs in their communities to ensure that adolescent well-visits are being performed. Several local MCH agencies, including Harvey County Health Department, Haskell County Health Department and Riley County Health Department provide adolescent well-visit services annually; however, many local agencies refer adolescents to the Family Planning program at their agency or a local physician that provides adolescent well-visits. The majority of the local MCH agencies collaborate with the local school districts and/or school nurses to provide school-based services for physical, social and emotional health needs.

KS-SHCN will expand transition resources and services through care coordination, assuring youth understand the importance of and receive preventive care through the adolescent well visit, as well as develop skills to support effective transitions into the adult health care system. Youth of a certain developmental age will begin working with the care coordinator and identified community members to work towards an effective health care transition, utilizing tools and resources developed through a previous HRSA Integrated Community Systems grant. These tools include a youth self-assessment to determine where the youth feels most confident in their skills needed to accomplish their goals.

Objective 5.5: Increase the number of adolescents receiving immunizations according to the recommended schedule by 2020.

The MCH Program plans to begin implementation of one of more of the following strategies.

- Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program.
- Provide parent education on immunizations, including schedules, and the importance to child and adolescent health.
- Identify and promote existing vaccination programs and campaigns.
- Work with Immunize Kansas Coalition (IKC) to increase HPV vaccination completion for youth ages 13-17 years.

As part of the integration efforts within the Kansas model of the Becoming a Mom program, we would like to expand the educational handouts and resources available on the topic of immunizations within the curriculum. The Saline County project (original pilot site) has already developed handouts based on the March of Dimes' "14 Points to Preconception Health". These points have been adapted to fit the interconception health period and are incorporated as a part of the postpartum care session. Topics include information on HPV, Influenza, and Tdap vaccines. As a part of this component, the video of "Gavin's Story" from the Sounds of Pertussis campaign is shown. All sites will be trained on the integration of these resources. Additionally, we would like to integrate resources on infant and childhood vaccines and schedules from the VFC program and selected vaccination campaigns.

Local MCH agencies provide education about the importance of well visits and immunizations during all services,

including home visits. The Greeley County Health Department sends letters to parents of 11 year olds and high school seniors providing immunization education, schedules and encouraging parents to have their children vaccinated. The letters targeted to parents of 11 year olds focus on Tdap, MCV4, and HPV vaccinations; the letters sent to parents of high school seniors target MCV4 booster, MenB series, and catch-up of other vaccinations their children may need before heading to college. The Unified Government of Wyandotte County provides required adolescent immunizations to include HPV, TDAP and meningococcal as part of the assessment of a medical home and makes referrals if necessary.

During FY 2017, ten local agencies across the state, including nine agencies who also provide MCH services, will provide services to pregnant and parenting teens up to age 21 years through the Teen Pregnancy Targeted Case Management program. Based on applications received for FY 2017, the projected number of TPTCM participants to be served is 665. One of the objectives of the program is that all adolescents served, and their children, will access well child/adolescent programs such as EPSDT screenings and immunizations. In addition to ensuring adolescents receive prenatal medical care, TPTCM case managers educate adolescents on routine healthcare services, prevention of illness and injury, and available healthcare resources in the community. When an adolescent does not have an identified healthcare home the TPTCM case managers provide linkages to community healthcare providers. Other services participants receive through the program either directly or through referral to other providers, include behavioral health assessment and treatment, substance abuse assessment and treatment, and domestic abuse services. All adolescents served in TPTCM programs are Medicaid eligible. If an adolescent loses Medicaid eligibility when their pregnancy and post-partum period ends, TPTCM case managers assist them in identifying and accessing other healthcare coverage options. Helping ensure these adolescents have adequate healthcare coverage increases their ability to access needed health services, including adolescent well visits and behavioral health services on an ongoing basis.

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The MCH Program, in partnership with state and local partners, will remain focused on employing the objectives and strategies during the next year and beyond to advance efforts related to the priorities for adolescents. Efforts will also focus on the recommendations resulting from the most recent Adolescent Health Needs Assessment, outlined below. Note: The program will prioritize the recommendations and strategies that are now a part of the Title V State Action Plan under the Adolescent Health Domain.

RECOMMENDATION 1: Address the highest priority adolescent health issues.

*Mental Health:*

- Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

*Substance Abuse:*

- Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time.

- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

#### *Sexual and Reproductive Health:*

- Make accurate information on responsible sexual behavior, including the benefits of abstinence, more easily available to youth and their families.
- Support youth development behavioral interventions (i.e., social, emotional, or cognitive competence training that promotes pro-social norms, improved decision making, improved communication skills, positive bonding experiences between youth, their peers or non-parental role models) coordinated with community services to reduce sexual risk behaviors.
- Provide confidential, youth-friendly reproductive health services.
- Encourage communication between adolescents and their parents about reproductive health issues.
- Encourage all providers who serve adolescents to screen sexually active females for chlamydia.

#### *Nutrition and Physical Activity:*

- Increase the availability of healthy food and beverages in sufficient supply in schools.
- Increase opportunities for students to participate in regular physical activity both in and out of school (e.g., non-competitive sports leagues, intermural).
- Improve adolescents' awareness of good nutrition and physical fitness through relevant and technologically current education during the school day and out-of-school.
- Implement an awareness/information campaign to reduce sedentary recreational screen time among adolescents

#### *Injury Prevention:*

- Encourage the implementation of policies, procedures, and the evaluation of programs in health care settings to assess for and intervene with adolescents at risk for suicide.
- Support public awareness campaigns to prevent adolescent self-injury.
- Develop policies and establish prevention activities that work to reduce motor vehicle crash injuries and deaths to adolescents due to distracted driving and/or use of substances.
- Continue to enforce existing laws regarding adolescent drivers, such as mandatory seat belt use and zero tolerance for alcohol use.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

#### **RECOMMENDATION 2: Help families support the health and well-being of their adolescents.**

- Increase the availability of information to parents and family members about normative adolescent development, and risk and protective factors for youth.
- Provide support to parents who experience problems, such as relationship, violence, substance abuse and mental health issues, to enable enhanced relationships with their adolescents.
- Provide support to parents who experience problems, such as relationship, violence, substance abuse and mental health issues to enable enhanced relationships with their adolescents.
- Using the "Parents as Teachers" model, provide parenting resources and mentors for parents of adolescents.
- Encourage communication between adolescents and their parents about any health issue.
- Provide opportunities for parents to improve their skills in seeking out quality health-related information and

services.

**RECOMMENDATION 3:** Provide educational environments that prepare youth for healthy adulthood.

- Emphasize social emotional as well as academic competence in the school setting.
- Increase the availability of skill-based health information for youth.
- Support schools to establish and sustain health access points and health services on-site during the school day.
- Increase connections among schools, families, communities and health providers through programs such as Communities in Schools (CIS), and KU Medical Center's "Bull Dog" clinic at Wyandotte High School.
- Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

**RECOMMENDATION 4:** Encourage collaborations and increase community support for those working for and with youth.

- Co-locate services for youth to ease access and decrease embarrassment.
- Support effective afterschool and out-of-school programs.
- Provide assistance to help community programs integrate positive youth development approaches and principles into their service framework.
- Increase youth-related continuing education opportunities for professionals and para-professionals.
- Catalogue agencies, organizations, and programs serving youth, and identify their missions and goals.
- Encourage interdisciplinary teams to provide comprehensive and coordinated services for youth.
- Institute regular interdisciplinary conferences and workshops to encourage development of shared knowledge, language, and goals among networks and communities.
- Include youth in decisions about service integration.

**RECOMMENDATION 5:** Improve the responsiveness, availability and access of health care to youth.

- Use education and outreach to inform youth and parents about health care options and providers who specialize in serving adolescents.
- Increase training about adolescent health care for providers to ensure youth-friendly, culturally competent health services.
- Create avenues for youth to be involved in discovering and utilizing health care systems that meet their needs.
- Work with health insurers to widen the concept of well-child visits through adolescence (up to 24).
- Improve access to comprehensive care including dental, eye/vision and mental health services.

## **Adolescent Health - Annual Report**

The activities, programs, and services detailed below have impacted the following FY 2015 National and State MCH performance measures.

- NPM 08: Teen Birth Rate
- NPM 16: Youth Suicide 15-19
- SPM 05: Youth Alcohol

## **NPM 8: Teen Birth Rate (15-17 years)**

In 2014, the teen birth rate (aged 15-17 years) was 11.8 per 1,000 females. This was 5.6% lower than 2013 (12.5) and slightly higher than the 2014 national rate (10.9). Overall, there was an increasing trend over the interval 2005-2008, followed by a statistically significant decreasing trend from 2008 to 2014 with an annual percent change (APC) of -10.59. Teen birth rates declined significantly for all races and for Hispanics. Hispanic teens had the highest rate (25.8), followed by non-Hispanic black teens (14.2), and non-Hispanic white (8.0) in 2013.

*Kansas Abstinence Education Program:* KDHE continued the Kansas Abstinence Education Project funded by an Administration for Children & Families (ACF) Title V Abstinence Education grant. The KDHE contracted partner, Children's Alliance of Kansas, has coordinated abstinence education training to foster/adoptive/kinship parents and children/youth in foster care and out-of-home placement (residential care) as well as other at-risk youth. During October 2014 - September 2015, trained providers conducted All Stars, Choices, HEART (Healthy Empowering Adolescent Relationship Training) and Healthy Relationships trainings and programs reaching 792 youth ages 10-19 and 183 parents statewide.

*Teen Pregnancy Targeted Case Management:* The Bureau of Family Health's Teen Pregnancy Targeted Case Management (TPTCM) program provides comprehensive case management services to KanCare (Medicaid) eligible pregnant and/or parenting adolescents in Kansas communities, with priority given to communities with greater numbers of adolescent Medicaid recipients. The project's goals are: to reduce negative consequences of teenage pregnancy for KanCare-enrolled teens and their children; to increase levels of self-sufficiency and goal-directedness relating to their own futures and that of their children; and to delay subsequent childbearing until completion of goals related to basic education/training; or they reach 21 years of age. KDHE receives state general funds to support the TPTCM program.

Program funds are awarded annually to local health departments, FQHCs, and non-profit agencies through a competitive grant application process. In SFY 2014 and SFY 2015, ten local programs received TPTCM funding. In SFY 2014 TPTCM programs served 886 adolescents. In SFY 2015, the total number of adolescents served decreased to 788 adolescents, 426 of those served were new to the program. Of the ten local TPTCM programs, nine also provided Title V-funded MCH services. The co-location of both programs within an agency increased opportunities to collaborate to ensure adolescents received coordinated care and supports across programs. Local TPTCM programs provided individualized, intensive case management services to assist adolescents in the identification and attainment of goals in the areas of daily living, education or vocational training, employment, finances, health, interpersonal relationships, and parenting. In addition, they assisted clients in identifying and accessing other community resources such as healthcare services, child care assistance programs and providers, adoption counseling, and parenting education. Funded programs were encouraged to integrate services with other community providers serving the adolescent population such as local school systems, the Department for Children and Family Services, and YMCA and YWCA programs in order to develop community-wide systems of care.

In SFY 2015 and continuing into SFY 2016 changes were made to the TPTCM application and quarterly reporting forms to gather more specific information related to services provided, community collaboration and outreach efforts, referral processes, and progress towards attainment of program goals and objectives. These changes provided a more comprehensive picture of planned and provided program activities and enabled KDHE to better analyze program information to ensure services were addressing identified program goals and objectives.

## **NPM 16: Youth Suicide 15-19**

## **SPM 05: Youth Alcohol**

Suicide has been ranked as the second leading cause of death for youth (15 to 24 years old) in Kansas behind unintentional injuries (accidents/road traffic), consistently for the past decade. In 2012-2014, the suicide rate among Kansas youth ages 15-19 was 12.8 per 100,000. This was lower than 2011-2013 (13.2). However, for the period 2005-2014, using rolling 3 year averages, overall, there was a significant increasing trend observed in completed suicides by Kansas youth (15-19). The annual percent change (APC) was significant (5.11). Males, ages 15-19 were 3.5 times more likely than females to die from suicide (9.3 and 2.7 per 100,000, respectively, in 2012-2014).

According to the 2011/12 National Survey of Children's Health, 66.9 % of Kansas children age 12-17 with emotional, developmental, or behavioral problems requiring counseling who received mental health care (64.1 % for the U.S.). Mental and behavioral disorders and serious emotional disturbances in adolescents can lead to school failure, alcohol or illicit drug use, violence, or suicide.

The 2013 Kansas Youth Risk Behavior Survey showed that compared to 2011, fewer students reported smoking cigarettes (10.2% vs. 14.4%), having at least one drink of alcohol on at least 1 day during the 30 days before the survey (27.6% vs. 32.6%), using marijuana at least once during the 30 days before the survey (14.3% vs. 16.8%), and using ecstasy at least once in their lifetime (5.2% vs. 6.0%). More students reported feeling sad or hopeless (24.0% vs. 21.9%) and making a plan about how they would attempt suicide (12.5% vs. 9.9%) during the 12 months before the survey. Significantly more students reported seriously considering attempting suicide (16.4% vs. 11.8%) and actually attempting suicide (8.4% vs. 5.9%) during the 12 months before the survey. The percentage of students that attempted suicide results in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the 12 months before the survey was 3.1% in 2013, an increase from 2.5% in 2011. Often the youth who attempt suicide have associated mental health or behavioral concerns such as depression, substance abuse, and a sense of hopelessness, increased stress and a lack of family support.

The Bureau of Family Health and Title V program plan to implement strategies in the coming year targeted to prevent and reduce bullying, suicide, and other adolescent risky behaviors. More support will be given to projects similar to the Kearny County Hospital Bullying Prevention Project. The MCH program partnered with Kearny County hospital and the City of Garden City to host community events related to bullying prevention. *Time for Three*, a group nationally known for bullying prevention efforts, musical performances, and speaking engagements, performs for schools and tells their personal stories of being bullied as youngsters. The group appeared in both Lakin and Garden City high schools in October 2015. The cause directly aligned with the Kansas MCH priorities and measures.

#### Related State MCH Priorities

1. Communities and providers support physical, social, and emotional health.
2. Professionals have the knowledge and skills to address the needs of maternal and child health populations.
3. Services and supports promote healthy family functioning.

#### Related National Performance Measures

NPM 9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)

The events were an overwhelming success. The students raved about the school assemblies, cheering loudly throughout the programs. School leadership from Lakin and Garden City have committed to meet together in the near future to consider collaborative initiatives to reduce the frequency of bullying behavior among their students. The schools and hospital (common partner) are eager to meet with the state Title V staff to talk more about tools and/or

programs for the schools to consider.

After the event at Garden City High School, a young student was moved by what she had seen and heard. She shared her vision for using her personal story to impact her classmates, displaying maturity that is way beyond her age. She wrote the following letter, thanking the program for making the event possible.

*Dear Secretary Mosier,*

*A year ago this month I was bullied. For no reason at all I was taunted, I was verbally and emotionally bullied. I like to think of myself as a selfless, kind, and friendly person but I wasn't that confident in myself so when those 5 people victimized me I broke down completely. At the time I didn't know that I was being bullied, but 5 months later after crying three nights in a row and getting some help and information from my counselor, I found out that I was being bullied. I accepted it, like to think I got over it, and decided to take a stand for it. I realized I wanted to do something for teens my age that would prevent them from crying themselves to sleep as I did. I didn't want people to suffer from bullying and decided to defend the victims of bullying.*

*The weekend of the 4th of July of 2015 I flew to Washington D. C. With my fellow FCCLA members to compete nationally in a star event that I did over texting and driving. While there I came in contact with a company named "DUDE. be nice" they were a company in L.A. that wants to create apparel that means something. Their mission is to help spread kindness in the world and reduce the rate of bullying. After meeting them my sadness and self-consciousness turned into motivation, I wanted to do a DUDE. be nice project at my school. After much support from my family, FCCLA advisers, and school administrators, I set on the path to create a project that could help reduce the act of bullying in my school.*

*My project will be occurring the month of November of this year, and it will consist of my school being covered with posters and signs of compliments to remind every person in the building their importance, and that we are grateful for them being there and being themselves. I will also be giving "compliment cards" randomly throughout the month, gifts during our lunch shifts for those caught doing acts of kindness, I will be having self-esteem boosting activities every Wednesday of the month, be showing the cyber bully movie in our school auditorium, and setting up a live video chat with the the CEO of the DUDE. be nice company. I've organized a t-shirt sell from the company and will be tie-dyeing the shirts as one of my events in the month of November. These shirts will be worn in the biggest part of the event, a school wide assembly where a speaker will talk about his bullying experience and how one act of kindness changed his life. All of which I am self-funding. Money definitely falls short, but my parents are very supportive and passionate about this topic as I am that they help me when I have to put money out of my own pocket to pay for these activities.*

*Although it seems as if my plans are set in stone, I've caught myself lose hope and motivation every now and then. Throughout this experience I've grown as a person and learned to accept myself for who I am. However when you have been bullied severely, it scars you, and random things trigger that memory or moment. There's been time when I want to end my project, because I feel it won't be successful. When I watched Time for Three, perform at my school I was reminded of my purpose to have this project. I was inspired to make it bigger and was reminded of why I set my mind on doing this in the first place. I remembered that if I can simply get one person to do acts of kindness to others, and be nice than that's one bully less. Time for Three, has put a new modern perspective on such an important and sensitive topic. Their music was powerful and they were extremely fun and entertaining. I feel like more students and schools would be impacted by them as I have been. They told a strong story in their music, they sent me hope that even when times are dark there will be light in the end of the tunnel. I feel like they would be a great project to take around to schools in our state.*

*Thank you, for your time in reading this, and for all you do.*

*--Junior at Garden City High School, Garden City, KS*

The Kearny County Hospital CEO reflected on the event and partnership, "Perhaps the most effective changes with

regard to this critical and time-sensitive issue will happen through grassroots efforts, led by motivated students who are old enough and capable of leading change, but young enough to believe anything is possible. They have a unique ability to influence their own peers to make better choices. Replicating such programs in other Kansas schools would be a good use of state resources."

### **Adolescent Health Needs Assessment**

In Spring of 2014 KDHE contracted with Kansas State University Research and Extension to conduct a statewide assessment of adolescent health needs and develop a state adolescent health plan. The assessment process consisted of a review of existing health data, an online community input survey, community focus groups, and gathering of input from key stakeholders. Following completion of the assessment processes in 2014 the preliminary results were shared with program representatives from the KDHE Bureaus of Oral Health, Health Promotion, Community Health Systems, and Disease Control and Prevention in October 2014 and with the Kansas Maternal and Child Health Council in December 2014. During both meetings participants provided additional perspectives on adolescent health issues in Kansas and made recommendations for prioritization of the needs identified in the statewide assessment and strategies to address the needs. The adolescent health needs assessment process was completed in early 2015 and the final Adolescent Health Report resulting from the assessment was received from Kansas State University in December 2015.

The Adolescent Health Report included specific recommendations and strategies to address the needs of adolescents in Kansas. Recommendations were grouped in 5 categories: 1) Address the highest priority health issues (mental health, substance abuse, reproductive/sexual health, nutrition and physical activity, and injury prevention), 2) Help families support the health and well-being of their adolescents, 3) Provide educational environments that prepare youth for healthy adulthood, 4) Encourage collaborations and increase community support for those working for and with youth, 5) Improve the responsiveness, availability, and access of health care to youth. Specific strategies recommended to address high priority health issues include school-based access to screening, referral, and treatment; establishment of networks of skilled, supportive adult mentors in safe, accessible environments; provision of confidential, youth-friendly reproductive health services; increased availability of healthy foods and beverages in schools; implementation of an awareness campaign to reduce sedentary time and increase physical activity; development of policies and prevention activities to reduce motor vehicle crash injuries and deaths. To help families support the health of children, identified strategies target increased availability of information and supports to parents and family members about normative adolescent development and risk and protective factors for youth and increased opportunities for parents to improve their skills in seeking quality health-related information and services. Strategies for providing educational environments that prepare youth for healthy adulthood include establishment of health access points and services on-site during the school day and increased availability of skill-based health information for youth. To encourage collaborations and increase community support for adolescents, strategies such as effective after school and out-of-school programs, increased youth-related continuing education opportunities for professionals and paraprofessionals, and interdisciplinary conferences and workshops were recommended. To address the need for improved responsiveness, availability, and access to health care identified strategies include education and outreach to inform youth and parents about healthcare options and providers who specialize in serving adolescents, work with health insurers to widen the concept of well-child visits through adolescence (up to age 24), and create avenues for youth to be involved in discovering and utilizing healthcare systems that meet their needs. Results and recommendations included in the report were used to help guide decisions about current and future MCH programming and services for youth in Kansas.

Since its completion, information regarding the Adolescent Health Report has been shared by KDHE and Kansas State University Research and Extension staff in multiple community meetings and conferences. A list of conference presentations is included below.

- 1) Johannes, E., (2015). *Extension's Role in State Adolescent Health Planning*. National Health Outreach Conference (NHOC/ECOP), Atlanta, GA. (April, 2015)
- 2) Johannes, E., & Miller, B., (2015). *What Can We Learn About Health from Kansas Teens: Results of the Kansas Adolescent Health Needs Assessment*, Kansas Health Home state conference, Kansas Department of Health and Environment, Wichita, KS (August, 2015).
- 3) Johannes, E., (2015). *Kansas Adolescent Health Needs Assessment: What Can We Learn From Teens About Their Health Needs?* Safe, Healthy and Prepared School conference, Kansas Department of Education, Manhattan, KS. (Sept. 2015)
- 4) Johannes, E., (2015). *What Can We Learn About Health from Kansas Teens: Results of the Kansas Adolescent Health Needs Assessment*. K-State Research and Extension Annual Conference, Manhattan, KS (October, 2015).
- 5) Miller, B., & Washburn Buck, M. (2015) *Results of the Kansas Adolescent Health Needs Assessment: Opportunities for community-based partnerships*. Frontiers Community Partners for Health and Heartland Institute for Clinical and Translational Research conference, University of Kansas Medical Center, Kansas City, MO (October, 2015).
- 6) Johannes, E., Miller, B., & Washburn Busk, M., (2015). *The Kansas Adolescent Health Needs Assessment and Plan: What have we learned from Kansas teens?* Semi-annual Family and Consumer Sciences Extension conference, Manhattan, KS (February, 2016)
- 7) Miller, B., Johannes, E., & Washburn Busk, M. (2015). *Kansas Adolescent Health Needs Assessment*. K-State Grad Research Forum (KRF). Poster selected for presentation at the state capital (Feb. 2016).
- 8) Johannes, E., (2016). *Learning about Health from Kansas Teens: Results of the Kansas adolescent health needs assessment (2015, 2016)*. Invited presentation at the Kansas Governor's Public Health conference, (April 28, 2016); Wichita, KS
- 9) (planned) Sisson, R., & Johannes, E., (2016). *Better Together: Collaborating to improve the health of children and adolescents*. Kansas School Nurse conference, July 21, 2016; Wichita, KS.

Three radio interviews and accompanying articles featuring the needs assessment process and results were also completed. Kansas State University Extension Communications produces the radio programs and articles and distributes them electronically throughout a national network of media sources. The processes and results of the Kansas adolescent health needs assessment also serve as a template for the national Extension Committee on Planning's "Positive Youth Development for Health" task force which represents Extension's national health outcome initiative.

### **Child/Adolescent Health Consultant Position**

Following the retirement of the MCH Child and Adolescent Health Consultant in December 2014, the position description was revised to include additional responsibilities related to implementation of the child and adolescent health action plans. The position has responsibility for conducting analyses of child and adolescent health data to identify trends and needs, developing strategies to address issues, and ensuring statewide coordination of child and adolescent health services. In addition, the position has responsibility for strengthening partnerships with public and private agency and advocacy groups with focused interest in child and adolescent health issues, including schools. The MCH Child and Adolescent Health Consultant will be responsible for ensuring the recommendations from the Adolescent Health Report are included in state adolescent health efforts as well as focusing on achievement of the adolescent health strategies in the MCH State Action Plan. Although the vacant position has been posted almost

continuously since early 2015, it has not yet been filled. Recruitment efforts include advertising in local newspapers; posting on electronic job sites; and disseminating information about the position to MCH grantees, the Kansas School Nurse Association, the Kansas Public Health Association, and participants in the adolescent health needs assessment. Two viable candidates for the position were identified within the past year but both applicants declined the position, in part due to the salary range, although approval was obtained to offer the position at a higher salary based on the qualification and experience of the candidates. Recruitment for the position is ongoing. In the absence of the consultant, the Local Public Health Program provides MCH related articles, news, resources and training opportunities through the Public Health newsletter, Public Health Connections. The Bureau of Health Promotion, the Midwest Dairy Council and KS-TRAIN are frequent contributors with information about adolescent health for the public health workforce [http://www.kdheks.gov/olrh/public\\_health\\_connections.htm](http://www.kdheks.gov/olrh/public_health_connections.htm).

## Children with Special Health Care Needs

### State Action Plan Table

#### State Action Plan Table - Children with Special Health Care Needs - Entry 1

##### Priority Need

Services are comprehensive and coordinated across systems and providers.

##### NPM

Percent of children with and without special health care needs having a medical home

##### Objectives

5.1 Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.

5.2 Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.

5.3 Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

## Strategies

5.1.1 Support family-centered medical homes through increased awareness among families, including communicating with their doctors and building effective health advocacy skills. 5.1.2 Provide professional development opportunities to health care providers to increase family-centered medical home supports. 5.1.3 Implement communication and referral protocols for SHCN Care Coordinators and providers.

5.2.1 Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers. 5.2.2 Expand KS-SHCN to have care coordinators located in all six Kansas public health regions. 5.2.3 Engage Managed Care Organizations and primary care providers in collaborative coordination for SHCN clients. 5.2.4 Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care. 5.2.5 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients and BAM participants.

5.3.1 Complete the online navigational toolkit to provide resources and services, including expansion to Help Me Grow. 5.3.2 Increase access to primary and specialty care in underserved areas. 5.3.3 Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals. 5.3.4 Connect SHCN care coordinators with foster care and Managed Care Organization case managers to provide technical assistance and support for SHCN clients. 5.3.5 SHCN providers will have access to care coordinators for support and assistance in their community (in-person or remote access).

## ESMs

ESM 11.1 - Percent of families who experienced a decreased need of care coordination supports

## NOMs

Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Percent of children in excellent or very good health

Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)

Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

**Measures**

**NPM 11 - Percent of children with and without special health care needs having a medical home**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62.1	65.2	68.4	71.8	75.4	79.2

**Data Source: National Survey of Children's Health (NSCH) - CSHCN**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	53.8 %	3.6 %	74,319	138,094
2007	49.3 %	3.5 %	68,915	139,663

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: National Survey of Children's Health (NSCH) - NONCSHCN**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	60.4 %	1.8 %	343,986	569,398
2007	64.4 %	1.7 %	346,478	538,116

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 11.1 - Percent of families who experienced a decreased need of care coordination supports**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	10.0	15.0	20.0	25.0

**Children with Special Health Care Needs - Plan for the Application Year**

**PRIORITY:** Services are comprehensive and coordinated across systems and providers

**NPM:** Medical home (Percent of children with and without special health care needs having a medical home)

Objective: Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.

- Support family-centered medical homes through increased awareness among families, including communicating with their doctors and building effective health advocacy skills.
- Provide professional development opportunities to health care providers to increase family-centered medical home supports.
- Implement communication and referral protocols for SHCN Care Coordinators and providers.

### **Care Coordination Training**

In FY16, KS-SHCN implemented one-day parent/caregiver care coordination trainings to assist parents/caregivers and increase their knowledge of medical homes, health homes, community services and supports, obtaining insurance coverage, advocacy and to develop skills to better partner with their child's providers. The response to this program by participants has been very favorable.

KS-SHCN conducted two of these trainings. The trainings are facilitated by KS-SHCN staff who also are parents of children who have special health care needs. Trainings begin with the staff sharing their personal story to help families feel comfortable in knowing that they are in a non-judgmental environment where they are free to openly share their hopes, dreams and daily struggles of being a parent of a child with special health care needs. The response to this program by participants has been very favorable. Participants complete a pre-, post-, and one-year evaluation, providing information that can then be used to improve the training. For FY17, KS-SHCN will conduct 4 (one per quarter) parent/caregiver care coordination trainings across the state.

Objective: Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.

- Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers.
- Expand KS-SHCN to have care coordinators located in all six Kansas public health regions.
- Engage Managed Care Organizations and primary care providers in collaborative coordination for SHCN clients.
- Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care.
- Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients and BAM participants

### **Transformation of the Title V CYSHCN Program**

KS-SHCN will continue to seek opportunities to align with the MCH programs and services across the state. A huge part of this includes a shared message that CYSHCN are children first and that infants, children, and adolescents served through MCH services may also have a special health care need, even if not connected to the KS-SHCN program or served by a specialty clinic. Therefore, efforts to educate MCH staff and grantees and align KS-SHCN and MCH services will be a focus of the coming year. This began in January 2016, when the KS-

SHCN Satellite Offices (SO) were integrated as part of the MCH ATL process. Through this integration, the KS-SHCN will expand from 6 offices to 11 in FY17.

Of the previous six SO's, three were located in local health departments (Crawford, Ellis, and Saline counties), two in hospital systems (Wyandotte and Sedgwick counties), and the administrative office served the North Central and Southwest regions (Shawnee county). The SO's serve as the entry-point into KS-SHCN, working directly with families throughout the application process, and assisting them with their application, and answering questions. The SO's are being assessed for capacity and staffing needs to expand their role to include care coordination services in the coming year. With the integration into the MCH ATL application, 11 SO's will be in place across the state starting in July 2016. This includes a total of 7 new local health department partners, covering a range from 4 to 22 counties, depending on the geographic area. This will support future plans for expansion of the KS-SHCN Care Coordination program into the local communities, to be done at the SO and the Administrative Office serving as the training and technical assistance to the statewide KS-SHCN Care Coordination system. This expansion is planned for FY18.

The program continues to build infrastructure and capacity for increased services for all CYSHCN in Kansas. KS-SHCN has been aligning program services and contractual supports with the "Standards for System of Care for Children and Youth with Special Health Care Needs." This began with the strategic planning, however has been enhanced with the KS-SHCN 5-Year Plan and the recently awarded D-70 Systems Integration Grant. As a requirement of the grant, a "state plan" must be developed. Rather than developing a plan specific to the grant, the team decided it would be most worthwhile to develop a plan around the overall system of care in place for CYSHCN. The "Kansas State Plan for Systems of Care for CYSHCN" is being submitted as part of the 2016 Grant Progress Report.

Since this plan encompasses much more than the KS-SHCN or Title V systems, and it is desired will create a plan for the 10 system standard domains, the plan is being developed in 4 stages over the course of two years. This will allow for sufficient review and assessment of each domain and related standards, utilizing a community engagement process and engaging the most appropriate partners for each domain. The process includes six regional meetings (one in each public health region of the state), a statewide survey, and a full-day planning meeting with key stakeholders. Through the qualitative data received through the regional meetings, the quantitative data received through the survey, and the strategies presented at the planning meeting, a shared vision was achieved for the domains discussed.

This first stage began in February and concluded in May 2016 and focused on the Medical Home and Community-Based Services and Supports domains. The second stage will begin in August and conclude in October 2016 and focus on the Screening, Assessment, and Referral and Eligibility and Enrollment domains. The third stage will take place February through May 2017, focusing on Family Professional Partnerships, Transition to Adulthood, and XXX. The final stage will occur August through October 2017 focusing on the final three domains: Health Information Technology, Quality Improvement, and Financing. Each stage will utilize the same process with the ultimate objective being a plan that includes shared vision and ownership among all systems that make up the overall System of Care for CYSHCN.

Now that the KS-SHCN program has begun implementing strategic plan activities, it is expected that the program will grow and provide improved services to individuals served by KS-SHCN. Many of these goals and strategies will take a few years to develop, but provide opportunities for steady improvements in services and supports for CYSHCN and their families.

Through the KS-SHCN ATL Process, new partnerships are expected in FY17. Ultimately, potential applicants were

provided access to the online application and reporting system, Catalyst, for ATL grant. The applicants were provided the KS-SHCN Priorities and Objectives, and asked to share the “problem” or “community need” as related to the Objective. For each objective the applicant was interested in addressing, they were then asked to share strategies or activities to implement, anticipated health outcomes, and long-term sustainability needs. KS-SHCN received 20 separate projects from a total of 12 partnering entities.

A review team consisting of the following was developed to review all applications: Special Health Services/Title V CYSHCN Director; KS-SHCN Program Manager; KS-SHCN Care Coordinators; and SHS-FAC Members. This resulted in at least 3 or 4 separate reviewers for each project proposal. A scoring rubric was provided and the responses were compiled and calculated. Internal (KDHE) reviewers met to discuss each proposal and make one of the following recommendations: Do Not Fund; Fund with Conditions; or Fund as Written. Of the 20 proposed initiatives, 5 were funded “as written,” 3 were not recommended for funding, and the remaining 12 were recommended to “Fund with Conditions.”

Of the 20 applicant proposals, 50% were entirely new project initiatives, which were not solicited by the KS-SHCN program. Of the 17 funding recommended proposals: 7 were from entirely new partners; 4 were from existing partners, but new initiatives; and 6 were continuation funding requests from existing partners.

Accepted proposals included specialty and outreach clinical services, parent trainings and supports, care coordination, community services, and youth leadership and development.

#### Specialty and Outreach Clinical Services

*Kansas City clinics:* PKU (only for established patients), Cystic Fibrosis, and Cleft/Lip Cleft Palate

*Wichita clinics:* PKU\*, Cystic Fibrosis, Cleft/Lip Cleft Palate, Orthopedic, Specialty Team, and Wheelchair Seating  
\* Kansas has not had a Pediatric Geneticist until recently. Therefore, the majority of newly diagnosed patients are seen out of state. Partners at the Wesley Medical Center invited KS-SHCN to take part in the development of a broader genetics program, supporting a shift in the PKU clinic to a broader metabolic clinic in FY 2017. This includes the development of treatment protocols, technical assistance and consultation from out-of-state Geneticists, and physician training/capacity building.

*Outreach clinics:* Wheelchair Seating (four communities in Western Kansas, with expansion planned for FY17), Cardiology, Rheumatology, and Special Child Clinics\*\*

\*\*Special Child clinics are diagnostic evaluation clinics for those suspected to have developmental delays. Currently, referrals are primarily received by local school district early childhood and elementary education programs. Throughout the coming year, some of these clinics will be done via telehealth in an effort to expand access to these services, including an expansion of referral networks.

*Dental Hygienist Services:* Oral Health Kansas will provide support for a dental hygienist as part of the multi-disciplinary team in select clinics, providing oral health education, oral screenings, and fluoride varnishes to patients seen in clinic.

#### Parent Training and Support

*Project to Educate and Empower Parents of CYSHCN:* Support for a Parent Health Information Specialist (PHIS) to consult directly with parents of children or youth with special health care needs to provide support to address social,

behavioral and community needs. This also includes training for parents and providers.

*Barton County Family Empowerment:* Provide families support through case management and assistance with navigating services. Will also develop a mechanism for families to communicate with one another for peer supports, including parent/caregiver education. Will research and assess capacity of the system for respite care services.

*Wheelchair Specialty Clinic Care Coordination:* In addition to the wheelchair seating services, the applicant plans to hire a patient navigator to provide additional education and support services to those served through clinic.

### Care Coordination Activities

*Hospital-to-Home Transition Program:* A community-based transition to home program, following a hospitalization for medically fragile patients. Includes the provision of increased education and coordination (both initially and ongoing) to caregivers and families, increased surveillance and support in the home following discharge, and increased coordination and partnership with the discharging institution and insurers.

*Connecting the Docs:* Support for a full-time Care Coordinator in the FQHC in Southeast Kansas to provide serves to low-income special needs children. Ultimately, this will lead to the development of a replicable model to implement Phase 3 of the KS-SHCN Care Coordination program.

### Community Services

*University of Kansas Behavioral Health Integration:* A behavioral health assessment will be developed and shared with those who attend clinics in Kansas City. Referrals, resources and services will be provided to those identified with a need.

*University of Kansas Native American Needs Assessment:* A survey will be developed and an analysis conducted to identify gaps and barriers to meeting the health care needs of the Native American children.

*Health in the Classroom: Working alongside Special Ed Co-Ops, Teachers and Parents to Promote Coordinated Care:* Nurses will make monthly visits to local area schools with special education cooperatives to go into the classroom setting and provide health, nutrition and wellness education to students with special healthcare needs.

*Telehealth and Telegenetics:* The Saline County health department will be using telehealth to improve patient appointment services and partnering with other providers in the community to offer telehealth as a way to reach those in rural areas. Wesley Medical Center's Children's Hospital, in partnership with the KU School of Medicine, has recruited a pediatric geneticist and will be expanding telegenetics services to the Southwest region of the state.

### Youth Leadership Development

*FACES of Change:* A seven-month leadership program for youth with disabilities that will foster attitudes of civic engagement and services through the development of leadership skills. Implementation began in April of 2016 and will conclude the first session series in November 2016. The second series will begin in 2017.

The majority of these programs are pilot programs, intended to provide the most financial support during the initial development and first year of implementation, with a gradual reduction in funding until the initiative is self-sustaining or other funding has been secured. Evaluation and sustainability plans were integrated into the proposal process to support effective data collection and long-term sustainability of the initiative.

## **KS-SHCN Care Coordination Program**

KS-SHCN has made strides to integrate with other Title V programs in an effort to show that children with special health care needs are children first and what affects all children affect them too. This is the program staff's effort to reduce silos and work cohesively as a unified group to improve services for all children including those with special health care needs. This will continue as part of the FY17 plan to address the cross-system collaboration objective.

Staff training has begun with curriculum adapted from the Boston's Children's Hospital Care Coordination model. The new KS-SHCN Care Coordination Program began training and the official pilot to begin June 2016 with the Topeka Administrative SO. Once the pilot is completed, a robust training will begin with the external SO staff. Each SO will assign a participant to be part of the core team, who will participate in monthly conference calls and bi-monthly in-person meetings to evaluate and revise the project as needed throughout the first year of implementation. Care coordinators will partner with families to assist them in understanding various state and community systems, and how to effectively (and independently) navigate these systems. As partners, Care Coordinators will work with families to identify needs and wants for the development of an Action Plan. This will help them achieve positive goals while providing the level of support they would like.

Quality improvement methods will be used to monitor care coordination outcomes and make improvements as needed. Quantitative and qualitative outcomes will be measured, including: number of clients/families service, types of assistance provided, topics covered and resources provided, amount of time spent on average per client/family, and the reduction of unnecessary care (e.g. ER/urgent care visits, additional labs or x-rays, or additional medical appointments) due to care coordination, among others. Tools to measure such outcomes have been developed and will be integrated into the new KS-SHCN electronic data system. Boston Children's Hospital Care Coordination program has provided technical assistance to the KS-SHCN program during the care coordination development.

KS-SHCN Care Coordinators will partner with families to find, understand and access services and resources at the medical, school, and community levels to make sure they are receiving the services needed to achieve optimal child and family health outcomes. Each family has individual needs and requires services and supports tailored to meet those needs. As partners, the Care Coordinators will work with families to identify needs/wants and develop an "Action Plan." The Action Plan will consist of family/patient developed goals and the care coordinators will provide the level of support they request or identified they would benefit from. KS-SHCN goal is to empower families to feel confident in navigating services and supports, eventually needing less support as time goes on.

Objective: Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

- Complete the online navigational toolkit to provide resources and services, including expansion to Help Me Grow.
- Increase access to primary and specialty care in underserved areas.
- Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals.
- Connect SHCN care coordinators with foster care and Managed Care Organization case managers to provide technical assistance and support for SHCN clients.
- Increase SHCN providers access to care coordinators for support and assistance in their community (in-person or remote access).

## **Systems Integration and Collaborative Partnerships**

KS-SHCN will continue to strive for systems integration, seeking out new partnerships within the Bureau of Family Health and agency programs, such as school health, WIC, child care, and health promotion, and Medicaid/KanCare. Initiatives are written into the KS-SHCN five year action plan to build partnerships across systems, such as foster care, primary care providers, behavioral health, and oral health, among others. Specific activities planned this coming year include continuous engagement of the managed care organizations to support reciprocal information sharing around KanCare clients on KS-SHCN. Additionally, there are plans to engage behavioral health partners and providers to assess possible opportunities for KS-SHCN to support the behavioral health system and gauge interest in behavioral health telehealth clinics, additional telehealth services, and develop partnerships with the Federally Qualified Health Centers (FQHC) in Kansas. Other efforts are still under development and will be planned upon successful implementation of the Care Coordination Program and as the work plan under the D-70 grant is implemented. Additionally, the state plan under development to integrate and implement the "National Standards for Systems of Care for CYSHCN" will further support these efforts.

### **Kansas Resource Guide Expansion**

The KS-SHCN program is currently working on improvements to the Kansas Resource Guide (KRG). This includes a follow up protocol to make sure that consumers who call are receiving the referral and services they were seeking. All calls are being tracked and key questions are being asked to make sure the program is meeting the needs of the consumers who call for assistance. A navigational tool kit has been developed as a companion for KRG and is being reviewed and added to by the SHS-FAC. This will be attached to the KRG site when completed by the SHS-FAC members.

### **Becoming a Mom Program**

Plans related to SHCN within the *Becoming a Mom* (BaM) program model will include state SHCN and BaM staff working together to identify/develop resources related to newborn screening and SHCN program services that are appropriate for incorporation into the BaM program curriculum. Currently, the Saline County program site is highlighting the state provided brochure on SHCN program services, in combination with the MOD's BaM curriculum handout titled "Newborn Screening and Vaccination".

### **Children with Special Health Care Needs - Annual Report**

The activities, programs, and services detailed below have impacted the FY 2015 National and State MCH performance measures.

- NPM 02: CSHCN - Family Involvement
- NPM 03: CSHCN - Medical Home
- NPM 04: CSHCN - Insurance Status
- NPM 05: CSHCN - Community Service Systems
- NPM 06: CSHCN - Youth Transition to all aspects of adult life
- SPM 04: Medical Home
- SPM 07: Self-Management Skills for Youth w/SHCN

KS-SHCN promotes the functional skills of persons, who have or are at risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction. KS-SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions. Additionally, the program provides services to persons of all ages with metabolic or genetic conditions screened through the Newborn Screening. Services may include diagnostic evaluations, treatment services or care coordination. This program assures that medical specialty services were accessible through a contractual system and provided

diagnostic evaluation, case management, treatment services, and financial assistance to over 3,500 individuals with qualifying conditions and income, and their families, across the state.

### **Transformation of the Title V CYSHCN Program**

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

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

Through quality improvement and strategic planning, the program worked to develop a model that would best meet the needs of those served. It was determined through clinic, services, and programmatic reviews and feedback from partners and families that a more holistic approach, providing more of a wrap-around service delivery model similar to that found in a medical home, were desired. The KS-SHCN program also determined the need existed to continue to focus filling service gaps for uninsured and underinsured families, until a long-term solution could be found. However, the families expressed a need for the program to also focus on assisting with non-medical needs, that would also better support families in meeting their top health concerns and the unmet needs. Additionally, the program continues to review funding allocations and support for direct clinical services, including multi-disciplinary clinics, and make modifications as needed. Throughout this process an increased need for outreach clinics and telehealth services was identified.

As part of the strategic planning, an analysis of how KS-SHCN provides services was conducted, leading to significant change. Ultimately, the largest change was due to the inability for KS-SHCN to monitor and track the level of funding available or authorized at any given time. This was unsettling as the funds to cover direct services is limited and the program was on the verge of making cuts to services if a solution was not found, as each year the program funds would be depleted earlier and earlier in the year. This prompted a change to a "Direct Assistance Program (DAP)" model. This ultimately changed the way services were authorized, not necessary which services were authorized. This allowed the program to set limits per authorization and per year to better track and monitor the funds that were ultimately already spend. This change resulted in better accountability and an ability to identify when funds are running low and cease authorizations for that DAP until funds are released. Each of the DAPs have eligibility criteria and annual maximum assistance amounts.

Eight DAPs were developed, as follows:

1. Co-Payments/Deductibles/Co-Insurance: This is for those with private insurance who have a patient responsibility through co-pays/deductible limits or co-insurance. This allows for up to 50% assistance towards deductible limits and/or limited support towards co-pays/co-insurance for medical specialty services.
2. Medical Services: This is for those with no insurance, or those who are ineligible for KanCare (Medicaid) and/or private insurance through the health insurance marketplace. This allows for direct payment for medical appointments, x-rays, specialty tests, hospitalizations, interpreter services, or other specialty care services. Some of these services require the patient to pay a small co-pay.
3. Orthodontic Treatment Services: This is for those with craniofacial anomalies. This provides for assistance with orthodontic evaluations and comprehensive treatment plans.
4. Hemophilia: This is for those with hemophilia, or other bleeding disorders. This provides up to \$2,500 per factor treatment and a comprehensive hemophilia treatment center visit.
5. Metabolic Products: This is for those with PKU, or other amino acid disorders. This provides assistance for metabolic formula and low protein food items.
6. Medication: This is for anyone who qualifies. This provides assistance with medication, however requires the client pay a \$5 co-pay for every \$100 per medication supported by KS-SHCN.
7. Travel: This is for anyone who qualifies. This provides travel assistance to and from the client's home to medical specialty care appointments.
8. Medical Equipment and Supplies: This is for anyone who qualifies. This provides assistance for durable medical equipment and medical supplies. Client co-pays ranging from \$25 to \$100 are applicable depending on the cost of the equipment. Medical supplies can include items such as catheters, ostomy supplies, diabetic testing equipment (CF clients only), hearing aid molds/repairs, glasses, and other items deemed medically necessary.

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

A new funding request process was implemented in FY14, with minor improvements to the review process and program oversight protocols. The most significant changes occurred in FY16, with the transition of this request process integrating within the agency's Aid-to-Local (ATL) system. Through this integration, partners were provided the outline of the KS-SHCN 5-year plan, and they were asked to identify the community needs related to the priorities and objectives and submit proposals on how they feel they could best address those needs. The applicants were able to demonstrate need, identify anticipated health outcomes of services, and show evaluation measures that will be used. Clinical service requests were required to outline how they will provide, and bill for, services. If seeking funding support for clinical services they were required to complete an exemption request form, showing how the services are either non-billable or non-reimbursable, supporting a stronger accountability for funding.

Partnerships have been strengthened and cost-savings have been abundant allowing for the addition of new partnerships. The process supported partners by providing them opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services. Partners were asked to

think outside the box and consider the true needs of families served through their funding. Another component of the funding request process includes an expectation of matching funds to assure the applicant is financially committed to the services provided or activities to be completed.

## **NPM 2: Family Involvement**

Family involvement within the CYSHCN population has been a priority for many years. This was a primary focus of the strategic planning and embodied throughout the process. Every priority, objective, strategy and outcome measure of the KS-SHCN 5-Year Plan was either developed by, with, or with approval of the SHS-FAC. This is one way the program supported family involvement as decision and policy makers.

Family involvement also goes beyond decision- and policy-making needs for the state. Another focus of KS-SHCN is to educate and equip families for involvement in all aspects of their own lives. This includes parents or caregivers advocating for their children, but also advocating for their own needs or to support the overall functioning of their family. This is why Family Caregiver Health was identified as a high priority during the strategic plan. While this focus was integrated into the care coordination program, this is an independent initiative and focus area. This priority was selected from family input, sharing they find it difficult to take the time to care for themselves and address their own health needs, due to increased responsibilities related to taking care of their child with special health care needs.

The Family Caregiver Health initiative began with identifying and reviewing existing assessments, such as the University of Kansas Beach Center on Disability Family Needs Assessment (developed and researched as a model for the Kansas Early Intervention/Part C program). It was identified this most closely aligned with the vision of the program and the wishes of the SHS-FAC. The SHS-FAC was actively engaged in identifying what needs to be addressed in the assessment that will be used, with the Kansas AMCHP Family Delegate working collaboratively with KS-SHCN staff to adapt this assessment. The goals will be to identify areas of caregiver need and provide appropriate referrals and resources related to the health of the whole family. As part of the KS-SHCN Care Coordination Program, the family caregiver(s) will complete the assessment and the Care Coordinator will provide resources, referrals and supports to assist caregivers with their identified needs. This project remains under development, and selected as one of two SHS-FAC projects for FY17.

Based on feedback throughout the KS-SHCN strategic planning process and the Title V Needs Assessment, a need for a family mentor program – where families who have children with similar special health care needs can communicate with each other and gain support from one another – was identified. In a collaborative partnership the SHS programs are working together to develop the Family Support Network. A mentor/mentee data system has been identified to assist with connecting parents, caregivers, or siblings who have similar experiences or needs, including matches based on the child or youth with special health care needs condition or services. NBHS is currently piloting the program and plans to expand to NBS and KS-SHCN in the coming year. A mentee parent information form has been developed and approved by the SHS-FAC for use. Policies, protocols, tools, recruitment and trainings for SHS staff and mentee parents will be developed over the next year and offered as part of care coordination services.

## **NPM 03: Medical Home**

Each of the new KS-SHCN priorities address one of the components of the medical home, as this is a foundational concept for building stronger systems of care for CYSHCN in our state. However, the Special Health Services Family Advisory Council (SHS-FAC) provided significant input and expertise in developing the new direction of the KS-SHCN Program, therefore the new priorities expand beyond the medical home approach and focus on an even more

coordinated and holistic approach to providing services in Kansas. For example, care coordination 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, such as the one day care coordination training for parents/caregivers have included supporting increased knowledge of medical home services, building medical home partnerships, advocacy, transition, caregiver health, peer support and where to access services.

Behavioral and oral health providers are key partners to integrate into the medical home team, however this doesn't appear to happen as often as desired. This was integrated into the KS-SHCN 5-Year Plan, and has been integrated into the KS-SHCN Care Coordination program. In FY15, KS-SHCN evaluated several care coordination models across the nation to develop program for those served by the program. The program is a multi-phase, tiered coordination approach that will take several years to fully implement. Phase 1 of the program includes implementation of a robust Care Coordination program for KS-SHCN clients and families. Phase 2 of the program includes training and supports for community and medical providers who provide Care Coordination services. This would include workforce development and staff training needs. Phase 3 of the program includes supporting community-based Care Coordinators who would be placed in a medical providers office, most likely part-time, and provide Care Coordination to CYSHCN in the practice.

The planning for Phase 1 took place throughout FY15, and included development of protocols, documentation tools/forms, training, and evaluation methods. The planning concluded and training of staff began in FY16, with the KS-SHCN pilot implementation to take place in early FY17. The development team consisted of staff in both administrative, social work, and nursing capacities from various hospital systems and the state agency. This provided robust conversation and a comprehensive approach to development of the overall plan, something that would work for various systems. Staff identified the primary needs KS-SHCN families face include learning how to navigate healthcare and other systems to best meet their child's needs. With this program, care coordination does not mean doing everything for families – rather partnering with them to learn systems and feel comfortable and skilled at finding supports to meet their child's needs.

### **NPM 5: Community Service Systems**

KS-SHCN continued to house the Kansas Resource Guide (KRG) in an effort to support access to community resources and service systems. In FY15, staffing changes occurred within KRG, delaying the completion and implementation of a "navigational tool kit." However, KS-SHCN was selected as one of four new states to join the current D-70 System Integration Grant cohort, with funding beginning in FY16. The grant objectives align closely with the new program priorities. Three main AIMS are being addressed through this grant: Shared Resource, Cross-System Care Coordination, and Integration. As part of the grant, KS-SHCN developed goals to expand the KRG. These goals will be described in the FY17 Plans.

### **NPM 6 & SPM 7: Transition**

The Kansas Special Health Care Needs (KS-SHCN) program supports multi-disciplinary clinics in Kansas City and Wichita, which include activities around transition to adulthood. Clinic teams and coordinators work with patients and families to assist and assure services are identified and obtained prior to aging out of the program. Transition services will be expanding in the coming year with the implementation of the KS-SHCN care coordination program.

## Cross-Cutting/Life Course

### State Action Plan Table

#### State Action Plan Table - Cross-Cutting/Life Course - Entry 1

##### Priority Need

Professionals have the knowledge and skills to address the needs of maternal and child health populations.

##### NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

##### Objectives

7.1 Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

7.2 Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

7.3 Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

7.4 Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

7.5 Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

## Strategies

7.1.1 Promote provider training on tobacco use and smoking with focus on pregnancy, identifying resources and interventions available. 7.1.2 Expand education and utilization of the Tobacco Quitline (including reminder and fax referral system). 7.1.3 Promote referral to the Baby & Me Tobacco Free Program as an evidence-based intervention where available. 7.1.4 Increase the number of communities implementing the Baby & Me Tobacco Free program. 7.1.5 Increase the number of providers trained on evidence-based tobacco cessation techniques, including motivational interviewing.

7.2.1 Place toolkits (screening, referral, resources, and programs) in the hands of providers. 7.2.2 Facilitate referrals to Baby & Me Tobacco Free for smoking cessation counseling and support based on family risk and need. 7.2.3 Standardize smoking history and screening forms. 7.2.4 Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum. 7.2.5 Leverage consistent, repeat messages about tobacco and nicotine across all systems, using media, social media, texting, videos, peer-to-peer mentoring. 7.2.6 Engage women and families to collect input on additional interventions to support cessation including SCRIPT.

7.3.1 Integrate oral health education and referral into prenatal and infant health education through BAM programs, well visits, dental visits, home visits. 7.3.2 Promote oral health in all programs targeted towards CYSHCN through care coordination activities. 7.3.3 Repeat on-site oral health screenings at child care facilities through the Healthy Smiles initiative in three years. 7.3.4 Continue offering the existing training and develop level 2 and 3 courses to build on education through Healthy Smiles. 7.3.5 Educate health care professionals regarding the child care home population for ongoing screenings and oral health education.

7.4.1 Increase knowledge of providers, partners, and consumers, including families, as it relates to Kansas Maternal and Child Health: purpose, scope, target populations, programs, services, and more. 7.4.2 Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment. 7.4.3 Incorporate MCH competencies more intentionally into MCH position descriptions. 7.4.4 Train paraprofessionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.

7.5.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN. 7.5.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course. 7.5.3 Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

## ESMs

ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline

## NOMs

Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Maternal mortality rate per 100,000 live births

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

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

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

Percent of preterm births (<37 weeks)

Percent of early preterm births (<34 weeks)

Percent of late preterm births (34-36 weeks)

Percent of early term births (37, 38 weeks)

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

Infant mortality rate per 1,000 live births

Neonatal mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Preterm-related mortality rate per 100,000 live births

Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Percent of children in excellent or very good health

## State Action Plan Table - Cross-Cutting/Life Course - Entry 2

### Priority Need

Services and supports promote healthy family functioning.

### SPM

Percent of children living with parents receiving emotional support (help with parenthood)

## Objectives

6.1 Increase opportunities to empower families and build strong MCH advocates by 2020.

6.2 Increase the number of providers with capacity to provide trauma-informed care by 2020.

6.3 Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

## Strategies

6.1.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others). 6.1.2 Conduct “Care Coordination: Empowering Families” trainings for parents of CYSHCN. 6.1.3 Increase the number of fathers and male support persons that are engaged in family health activities. 6.1.4 Identify options to provide supports (e.g., making healthy choices, positive coping mechanisms, violence, substance abuse, and mental health issues) to parents of adolescents, such as home visiting and peer-to-peer networks.

6.2.1 Increase MCH state staff and partner capacity around trauma-informed care. 6.2.2 Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it. 6.2.3 Provide training for MCH grantees including home visitors on trauma-informed care.

6.3.1 Develop and utilize strategies for MCH home visitors to improve effective outreach and engagement of families in universal home visiting services. 6.3.2 Enhance and expand coordinated intake and referral systems across the state to support appropriate referrals and levels of services for families. 6.3.3 Partner with Healthy Start; Maternal, Infant and Early Childhood Home Visiting (MIECHV); and Becoming a Mom (BAM) communities to ensure coordination and referral for home visiting services.

## State Action Plan Table - Cross-Cutting/Life Course - Entry 3

### Priority Need

Information is available to support informed health decisions and choices.

### SPM

Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them

## Objectives

8.1 Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

8.2 Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

8.3 By 2020, create and disseminate a toolkit for preschool through school-aged providers with a curriculum and activities designed to teach children and adolescents about healthy habits and choices.

8.4 Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

8.5 Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

## Strategies

8.1.1 Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education. 8.1.2 Provide resources to increase education and knowledge of healthy decision making. 8.1.3 Work with partners to ensure that well visits incorporate best practices.

8.2.1 Emphasize the importance of health insurance literacy with HLK. 8.2.2 Identify target populations and/or regions that require increased health literacy support. 8.2.3 Promote distribution and use of "What to do when your child gets sick."

8.3.1 Identify effective age-appropriate approaches to assist children ages 6 to 11 years with making informed decisions about health and wellness. 8.3.2 Work with schools to incorporate information about healthy choices into school enrollment and orientation materials. 8.3.3 Work with child and youth programs (Child Care, Girl Scouts, Boy Scouts, Boys and Girls Club, YMCA, etc.) to provide health and wellness information. 8.3.4 Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution to children and adolescents as part of orientation.

8.4.1 Implement the youth leadership program, Faces of Change. 8.4.2 Implement Plan It Live It to support effective transition planning. 8.4.3 Explore opportunities for increased youth leadership. 8.4.4 Provide opportunities for parents to improve their skills in seeking out quality health-related information.

8.5.1 Educate MCH staff regarding ongoing changes to the health care system. 8.5.2 Identify opportunities to optimize changes in the health care system to maximize service delivery to families. 8.5.3 Sponsor and/or host regional training on health transformation. 8.5.4 Provide training and technical assistance to local health departments on MCH service planning and delivery. 8.5.5 Support connection between local health departments and Navigators to increase families' access. 8.5.6 Review and identify steps to incorporate information from the Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the ACA. 8.5.7 Review and incorporate Standards for Systems of Care for CYSHCN.

**Measures**

**NPM-14 A) Percent of women who smoke during pregnancy**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	11.4	10.9	10.4	9.9	9.4	9.0

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	12.0 %	0.2 %	4,681	39,163	
2013	12.5 %	0.2 %	4,834	38,757	
2012	13.7 %	0.2 %	5,498	40,230	
2011	14.5 %	0.2 %	5,709	39,483	
2010	14.9 %	0.2 %	6,014	40,472	
2009	15.3 %	0.2 %	6,130	40,178	

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NPM-14 B) Percent of children who live in households where someone smokes**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.5	21.8	20.2	18.8	17.4	16.2

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	25.3 %	1.4 %	180,387	713,663
2007	26.4 %	1.4 %	182,889	692,539
2003	29.3 %	1.4 %	174,594	595,117

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Cross-Cutting/Life Course - Plan for the Application Year**

**PRIORITY 2:** Services and supports promote healthy family functioning

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

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

- Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others).
- Conduct “Care Coordination: Empowering Families” trainings for parents of CYSHCN.
- Increase the number of fathers and male support persons that are engaged in family health activities.
- Identify options to provide supports (e.g., making healthy choices, positive coping mechanisms, violence, substance abuse, and mental health issues) to parents of adolescents, such as home visiting and peer-to-peer networks.

The KS-SHCN program will increase the parent/caregiver care coordination trainings to one per quarter in FY17. This training will be offered in different location across Kansas in order to minimize participants travel time. The Summer and Fall 2016 training locations have already been determined upon request of community partners. Partnerships have been developed within the communities to help the KS-SHCN program with promotion of the trainings. The training will be translated into Spanish and the Spanish-speaking Care Coordinator will become an approved trainer.

The KS-SHCN program and Newborn Screening (NBS) will be integrated into the Family Support Network data

system over the coming year. The Newborn Hearing Screening (NBHS) program began implementation into this new program over the past year. All SHS programs will work collaboratively to develop policies, protocols, tools, confidentiality contracts, evaluations and parent mentor trainings for the Family Support Network. SHS programs will design a parent mentor recruitment plan and staff training on how to correctly administer the program. This will be offered to all families with children identified with a NBS condition, as well as, those in the Special Health Care Needs program. Full implementation of the Family Support Network for all SHS programs is expected to be completed by summer of 2017. This system will provide an opportunity for expansion to siblings of CYSHCN in coming years. Additionally, the capacity of the system would allow broader MCH integration, such as women, parents in home visiting programs, participants of local health department services, and youth/young adults.

Objective: Increase the number of providers with capacity to provide trauma-informed care by 2020.

- Increase MCH state staff and partner capacity around trauma-informed care.
- Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it.
- Provide training for MCH grantees including home visitors on trauma-informed care.

The 2011/12 National Survey of Children's Health showed that overall 91.5% of Kansas children ages 0-17 living with parents who had someone to turn to for day-to-day emotional help with parenthood/raising children. This was significantly higher than the national average of 88.1%. Child's race/ethnicity, family structure, Parent's education, household income, medical home, and type of insurance all had a significant impact on reported emotional support. Non-Hispanic white children (94.8%) were more likely than Hispanic children (87.4%) and non-Hispanic children of other races (76.5%) to live with parents who had emotional support. Children in two-parent families (biological or adoptive) were more likely to live with parents who had emotional support (94.2%) than were children in single-mother households (82.7%). Children whose parents had more than high school education were more likely to live with parents who had emotional support (94.1%) than children whose parents did not complete high school (76.5%). Similarly, more children at 400 percent federal poverty level (FPL) or higher (95.3%) and 300-399 percent FPL (95.8%) reported living with parents who had emotional support compared to children in the less than 199 percent FPL (87.1%). Children who had a medical home (95.7%) were more likely than those with no medical home to live with parents who had emotional support (85.2%). More privately insured children (94.2%) reported living with parents who had emotional support compared to publicly insured children (87.3%). There were no significant disparities by child's age group, gender, special health care needs, adequacy of insurance, and urban and rural residence.

State MCH staff are looking to learn more from the Geary County Healthy Start/*Delivering Change* model related to the implementation of the *Lemonade for Life* ACEs screening protocol, developed by experts at the Iowa Department of Health and the University of Kansas. This information and program implementation plan will then be shared with other local grantees, to be adapted for incorporation into other community partnerships and programs. This, along with concentrated efforts around fatherhood involvement, are key areas of focus and planning for inclusion in the HBWW/BaM program across the state in the upcoming year. State MCH staff dedicated to the development and expansion of this model will be working closely with HBWW/BaM program sites and the Geary County Healthy Start/*Delivering Change* program, to ensure that successful models do not remain in isolation, but instead are shared and replicated in other communities across the state of Kansas.

The Special Health Services Family Advisory Council (SHS-FAC) selected the following objective from the KS-SHCN 5-Year Plan as one of their projects for FY17, "Provide education about how the role as a caregiver can impact their health and the ability to care for their loved one." As part of their plan for this work, they are completing a

fact sheet titled, "The Need for Family Caregiver Support in Family-Centered Care." Upon completion of the fact sheet, they intend to Focus on education on how to handle trauma that occurs within the family, providing resources and tips to address trauma. The group has identified that the SAMHSA Trauma Informed Approach and Trauma Specific Interventions will be the foundation for their work. Ultimately, they are wanting to create something that bridges the adverse childhood experiences (ACEs) and trauma-informed care work, to make these efforts and concepts 'digestible' for families and caregivers, supporting their overall health and ability to care for their child's needs. They plan to develop a white paper to educate families and caregivers on how to "expect the unexpected (e.g. trauma)." They want to help families anticipate that trauma will occur at some point in and there are ways to get through the trauma in a positive way, such as: using past trauma to their benefit, creating positive outlets for dealing with trauma, and resources to get help if they need it.

Objective: Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

- Develop and utilize strategies for MCH home visitors to improve effective outreach and engagement of families in universal home visiting services.
- Enhance and expand coordinated intake and referral systems across the state to support appropriate referrals and levels of services for families.
- Partner with Healthy Start; Maternal, Infant and Early Childhood Home Visiting (MIECHV); and Becoming a Mom (BAM) communities to ensure coordination and referral for home visiting services.

Detailed information about the MCH Healthy Start Home Visitor (HSHV) program can be found under the Perinatal & Infant Domain. The program is undergoing review and redesign, and these strategies will be addressed through the work outlined.

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**Priority:** Professionals have the knowledge and skills to address the needs of maternal and child health populations

**NPM:** Smoking during Pregnancy and Household Smoking

Objective: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

- Promote provider training on tobacco use and smoking with focus on pregnancy, identifying resources and interventions available.
- Expand education and utilization of the Tobacco Quitline (including reminder and fax referral system).
- Promote referral to the Baby & Me Tobacco Free Program as an evidence-based intervention where available.
- Increase the number of communities implementing the Baby & Me Tobacco Free program.
- Increase the number of providers trained on evidence-based tobacco cessation techniques, including motivational interviewing.

Objective: Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

- Place toolkits (screening, referral, resources, and programs) in the hands of providers.
- Facilitate referrals to Baby & Me Tobacco Free for smoking cessation counseling and support based on family risk and need.

- Standardize smoking history and screening forms.
- Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum.
- Leverage consistent, repeat messages about tobacco and nicotine across all systems, using media, social media, texting, videos, peer-to-peer mentoring.
- Engage women and families to collect input on additional interventions to support cessation including SCRIPT.

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 2014, 12.0% (4,679) of women reported smoking during pregnancy, a slight decrease from 2013 (12.5%). During 2005-2014, there was a statistically significant decreasing trend observed. The smoking rate was highest for non-Hispanic Native American women, at 24.9%, followed by non-Hispanic black women, 14.5%, and non-Hispanic white women, 13.6%. Rates for Hispanic (3.9%) and non-Hispanic Asian women (1.8%) were substantially lower. Teenagers 18-19 years and women in their early twenties had the highest smoking rates (17.7% and 18.1%, respectively). Smoking rates for women in their thirties and older were sharply lower, around 7%. Overall, in 2014, Medicaid paid for the delivery of 12,775 (32.7%) Kansas live births. Among women who reported smoking during pregnancy, 71.0% reported Medicaid as principal source of payment for this delivery. This was a slight increase from 2013 (69.6%).

Based on the 2011/12 National Survey of Children's Health, exposure to environmental smoke—from cigarettes, cigars, or pipes—can be a serious health hazard for children. According to the Centers for Disease Control and Prevention, exposure to secondhand smoke is associated with higher rates of sudden infant death syndrome (SIDS), more frequent and severe asthma, and acute respiratory infections in young children. Parents were asked whether anyone in the household used cigarettes, cigars, or pipe tobacco. Overall, 25.3% of Kansas children were reported to live in households where someone smokes, and 5.7% were exposed to secondhand smoke inside their homes. About 39.9% of non-Hispanic children of other races, 25.8% of non-Hispanic white children, 22.4% of non-Hispanic black children, and 21.9% of Hispanic children lived in households with a smoker. Rates of household smoking decline as income increases. Of children with household incomes below the poverty level, 37.1% lived in a household with a smoker, as did 35.5% of children with household incomes between 100 and 199 percent of the Federal poverty level (FPL). Of children with household incomes between 200 and 399 percent of FPL, 19.5% lived with a smoker, and of children with household incomes of 400 percent or more of FPL, only 13.7% had a smoker in the household.

Local MCH agencies utilize the Kansas Tobacco Quitline as a referral resource for pregnant women to encourage them to quit smoking, as well as local tobacco cessation resources. MCH grantees provide education on the use of the Quitline and online resources to assist women to quit smoking. Training on the 5 A's method of tobacco cessation counseling is encouraged for grantee staff. MCH grantees trained in the 5 A's counseling method provide interventions to pregnant women. Local grantee Healthy Start Home Visitors link pregnant women to smoking cessation resources, make referrals to the Quitline, and provide education and supportive services. In addition to referring to the Quitline, local MCH agencies providing Becoming a Mom (HBWW/BaM) program utilize the Baby and Me Tobacco Free evidence-based program and practices. The local MCH grantee in Southeast Kansas, also the FQHC, screen 100% of those served for tobacco use and extensive education is provided one-on-one by a physician or women's health nurse. Ongoing education through the American Lung Association is provided at no cost to pregnant women. Another local MCH grantee in South Central Kansas, also an FQHC, screens all pregnant women for tobacco use, refer to the Quitline, and provide ongoing education throughout pregnancy.

The MIECHV-funded evidence-based and promising approach home visiting programs have collected and reported data on screening for smoking in the households of enrolled families. Beginning October 1, 2016, in accordance with

redesigned federal MIECHV Program performance indicators, programs will specifically track data on pregnant women and primary caregivers who reported using tobacco or cigarettes at the time of enrollment in the home visiting program and were referred to tobacco cessation counseling or services within 3 months of enrollment. Training opportunities and additional resource information for home visitors will be facilitated to encourage use of effective tobacco cessation information, referrals, and support practices.

*NOTE: Extensive information related to this NPM and objectives can be found under the Women & Maternal domain.*

Objective: Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

- Integrate oral health education and referral into prenatal and infant health education through BAM programs, well visits, dental visits, home visits.
- Promote oral health in all programs targeted towards CYSHCN through care coordination activities.
- Repeat on-site oral health screenings at child care facilities through the *Healthy Smiles* initiative in three years.
- Continue offering the existing training and develop level 2 and 3 courses to build on education through *Healthy Smiles*.
- Educate health care professionals regarding the child care home population for ongoing screenings and oral health education.

As preliminary conversations took place in February 2016 between Kansas BaM Program Coordinator and Dental Project Director for Oral Health Kansas, full plans for collaborative work development should begin by late summer 2016. Oral Health Kansas is currently waiting on response to a grant proposal that was submitted to support collaborative work between the two bureaus specific to BaM program oral health curriculum development. Oral health content within the original March of Dimes BaM curriculum is limited to one bullet point on one handout. Although program sites across the state have incorporated additional oral health resources, there have been requests for further curriculum development by these sites. Preliminary plans include the development of toolkits for each BaM program site, which will include educational resources on the risks related to poor oral health in pregnancy, as well as disposable mirrors used for guided self-exam of teeth and gum health during the group session. Upon acceptance of the grant proposal, work will begin towards a goal of implementation by late fall 2016 or early spring 2017. Training for this oral health *integration* component will occur in-person, similar to those held this past year for other BaM program integration components.

The existing partnership with Oral Health Kansas will continue with dental hygienist services in the special health services clinics. KS-SHCN Care Coordinators will continue working with families to assure they have a dental health home and are receiving preventive oral health care services. For program participants with Cleft Lip/Cleft Palate, KS-SHCN will work with Medicaid, dentist, oral surgeons, and community partners invested in oral health care in Kansas to assure children receive the care they need to support optimal health. The SHS-FAC is also interested in looking at oral health coverage gaps in the future, as part of their large group project focused on KS-SHCN Objective to "Identify needed insurance policy advocacy needs and partner with organizations to inform insurers on the needs for CYSHCN."

A nice example of local MCH grantee efforts is the Sedgwick County Health Department. The MCH clinic provides dental screenings for school age children, reaching them through multiple locations: Juvenile Detention Facility, Community Health Fairs and Sedgwick County Schools. The local program provides prenatal dental screenings and continues to work with internal partners (Healthy Start, WIC) to increase participation. They utilize the Health Fairs to screen for children and prenatal women that qualify for the services. They participate with the School Based Dental

Hygiene Collaborative to ensure all Sedgwick County schools have access to state mandated school screenings. The clinic also provides preventive and restorative services to clients in partnership with the Wichita State University Dental Hygiene Department. Area Dentists volunteer their time to provide dental services. MCH Care Coordinators and Healthy Babies program staff discuss oral health with clients, refer to area dentists, and discuss best practice for good oral health for the entire family.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

- Increase knowledge of providers, partners, and consumers, including families, as it relates to Kansas Maternal and Child Health: purpose, scope, target populations, programs, services, and more.
- Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment.
- Incorporate MCH competencies more intentionally into MCH position descriptions.
- Train paraprofessionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.

One goal of the MCH Perinatal Health Consultant and Kansas BaM Program Coordinator in her first year coordinating the program at the state level was to improve training opportunities for all BaM programs, in an effort to: reduce the burden of program development and staff training felt by local programs; better support and prepare group facilitators; bring a level of standardization to the program across sites. During the past year, two full day in-person trainings were hosted at two locations in the state, as well as multiple webinars. In March 2016, regular monthly BaM webinars started, that occur the last Monday of every month. Already, a two-year schedule has been made for webinars based on training and integration requests from program sites. Foundational training and work has also been done for the development of the online training program that will be required for completion by all program site staff.

Work is currently underway for the creation of an online training program for the Kansas *Becoming a Mom* (BaM) program. This online course will consist of 10 training modules. Program staff across sites will develop an individualized training plan with designated modules for required completion. Completion of the required components of the online training program will then certify the staff person for his/her role in program implementation. From early stages of program implementation in Kansas, the need for more comprehensive training related to the implementation of the program and group facilitation, has been apparent. With KDHE Bureau of Family Health committing dedicated staff time and funding for the project, we are now in the early stages of making this a reality. This will ease the burden of implementation on new sites, as well as with existing sites that are facing staff turnover. It will also support the standardization of curriculum delivery across sites, leading to improved program outcomes. From here, we hope to start the process of establishing the Kansas model as an evidence-based program. Course completion will provide staff with continuing education units approved by the Kansas State Board of Nursing.

Objective: Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

- Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN.
- Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course.

- Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

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**Priority:** Information is available to support informed health decisions and choices

**SPM:** Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them.

Objective: Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

- Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education.
- Provide resources to increase education and knowledge of healthy decision making.
- Work with partners to ensure that well visits incorporate best practices.

Objective: Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

- Emphasize the importance of health insurance literacy with Health Literacy Kansas (HLK).
- Identify target populations and/or regions that require increased health literacy support.
- Promote distribution and use of "*What to do when your child gets sick.*"

Many local MCH agencies, including Finney County Health Department, Saline County Health Department and Shawnee County Health Agency provides clients with a copy of the book "*What do you do when your child gets sick*" during home visits.

All KS-SHCN Care Coordinators have received the Kansas Head Start Association Health Literacy training. As implementation of the care coordination project moves forward, building health literacy of program participants will be supported through one-on-one or groups settings for families with children who have special health care needs. This is another method to equip and empower clients and their families to be able to navigate the health care system. In addition, the KS-SHCN Care Coordinators will continue to assist clients/families in making informed health decisions by assisting them to learn about their options, make informed decisions, and assisting in problem solving solutions. The Care Coordinators will continue to provide training and support to clients/families to equip and empower them to be able to make health decisions independently.

Objective: By 2020, create and disseminate a toolkit for preschool through school-aged providers with a curriculum and activities designed to teach children and adolescents about healthy habits and choices.

- Identify effective age-appropriate approaches to assist children ages 6 to 11 years with making informed decisions about health and wellness.
- Work with schools to incorporate information about healthy choices into school enrollment and orientation materials.
- Work with child and youth programs (Child Care, Girl Scouts, Boy Scouts, Boys and Girls Club, YMCA, etc.) to provide health and wellness information.

- Distribute *The Future is Now THINK BIG – Preparing for Transition Planning* workbooks to schools for distribution to children and adolescents as part of orientation.

Many local MCH agencies, including Ellsworth County Health Department, Lincoln County Health Department, and Stevens County Health Department provide age-appropriate education and information to assist children in making informed decisions about health and wellness. Ford County Health Department and Nemaha County Community Health Services collaborate with local school districts to provide health and wellness information in after school programs.

Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

- Implement the youth leadership program, *Faces of Change*.
- Implement Plan It Live It to support effective transition planning.
- Explore opportunities for increased youth leadership.
- Provide opportunities for parents to improve their skills in seeking out quality health-related information.

KS-SHCN will continue to partner with the Kansas Youth Empowerment Academy (KYEA) on completion of the first session series and implementation of the second series in a seven month training and educational program for youth with disabilities and special health care needs that fosters attitudes of civic engagement and services through the development of leadership skills. Monthly weekend sessions began in April 2016 and continue through November 2016. Immediately following the completion of the first session series recruitment for the second session series will begin. The second series is slated to include youth with and without disabilities (based upon completion and evaluation findings from the first session series). Evaluations are being completed throughout and at the conclusion of the program, including a youth-completed pre/post self-efficacy and leadership assessment. Additionally, the evaluation plan includes long-term initiatives at one and three years after completion of the program. KS-SHCN is dedicated to offering an internship opportunity to at least one youth leader who successfully completes the program in the future. The pilot and initial implementation will occur for youth with special health care needs or disabilities, with plans for integrating youth without disabilities as part of the annual participant cohort.

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

- Educate MCH staff regarding ongoing changes to the health care system.
- Identify opportunities to optimize changes in the health care system to maximize service delivery to families.
- Sponsor and/or host regional training on health transformation.
- Provide training and technical assistance to local health departments on MCH service planning and delivery.
- Support connection between local health departments and Navigators to increase families' access.
- Review and identify steps to incorporate information from the *Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the ACA*.
- Review and incorporate *Standards for Systems of Care for CYSHCN*.

The KS-SHCN program continues to build infrastructure and capacity for increased services for all CYSHCN in Kansas. KS-SHCN has been aligning program services and contractual supports with the "Standards for System of Care for Children and Youth with Special Health Care Needs." This began with the strategic planning, however has been enhanced with the KS-SHCN 5-Year Plan and the recently awarded D-70 Systems Integration Grant. As a requirement of the grant, a "state plan" must be developed. Rather than developing a plan specific to the grant, the

team decided it would be most worthwhile to develop a plan around the overall system of care in place for CYSHCN. The “Kansas State Plan for Systems of Care for CYSHCN” is being submitted as part of the 2016 Grant Progress Report.

Since this plan encompasses much more than the KS-SHCN or Title V systems, and it is desired will create a plan for the 10 system standard domains, the plan is being developed in 4 stages over the course of two years. This will allow for sufficient review and assessment of each domain and related standards, utilizing a community engagement process and engaging the most appropriate partners for each domain. The process includes six regional meetings (one in each public health region of the state), a statewide survey, and a full-day planning meeting with key stakeholders. Through the qualitative data received through the regional meetings, the quantitative data received through the survey, and the strategies presented at the planning meeting, a shared vision was achieved for the domains discussed.

This first stage began in February and concluded in May 2016 and focused on the Medical Home and Community-Based Services and Supports domains. The second stage will begin in August and conclude in October 2016 and focus on the Screening, Assessment, and Referral and Eligibility and Enrollment domains. The third stage will take place February through May 2017, focusing on Family Professional Partnerships and Transition to Adulthood. The final stage will occur August through October 2017 focusing on the final three domains: Health Information Technology, Quality Improvement, and Financing. Each stage will utilize the same process with the ultimate objective being a plan that includes shared vision and ownership among all systems that make up the overall System of Care for CYSHCN.

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

The Cross-cutting or Life course domain became a new MCH population domain effective FFY 2016 as part of the MCH Block Grant Transformation. Although a National Performance Measure (NPM) and State Priorities were identified for this domain, objectives and strategies were not finalized until this application, along with the Title V State Action Plan for the period 2016-2020. Activities and programming planned for this domain, tied directly to objectives and strategies, will be monitored over the next year and incorporated into the FFY 2016 annual report component of the FFY 2018 application. A number of initiatives are underway and programs in place to address the NPM (smoking during pregnancy and household smoking) and priority issues.

Progress specifically related to the National Performance Measure follows.

### **NPM 14: Smoking During Pregnancy and Household Smoking**

*Infant Mortality CoIIN:* Since 2014 Kansas has focused on *smoking cessation* as a national-state strategy through involvement with the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) initiative. As Kansas is committed to advancing the national CoIIN agenda and Blueprint for Change to address state priorities, this has been the driving force behind much of the work that has been done in Kansas related to smoking cessation before, during, and after pregnancy. Participation in the Smoking Cessation Learning Network has provided the platform, structure, support, and motivation to take smoking cessation efforts in the perinatal period to a new level in our state. A state “CoIIN Smoking Cessation Workgroup” was formed with participating members from multiple agencies, including: the University of Kansas Medical Center, March of Dimes, KDHE Bureau of Family Health and Bureau of Health Promotion Tobacco Program, private providers, and local public health departments. This group has developed and prioritized an extensive action plan, measurement strategy, and change package, which outlines our state’s smoking cessation work plan, not only for the duration of the CoIIN initiative, but for the entirety of the Title V state action plan. The plan is very extensive, covering several tiers of interventions that are categorized according to

the Primary Drivers that have been designated by National ColIN. State selected strategic priorities around smoking cessation include *building community capacity to promote education, screening, referral, and treatment for women*. Throughout 2015 and into 2016, our state's work has been focused on the following Primary Drivers: PD2: Providers and support personnel refer women to evidence-based programs like Quitline; PD4: Women in child bearing years avoid smoking or stop and stay quit; P5: Providers recognize role in coaching and supporting women to stop and stay quit.

The focus of strategies this past year has been on engaging women in smoking cessation services and increasing the number of referrals to evidence-based programs such as the Kansas Tobacco Quitline, improving quit rates before and during pregnancy and continued cessation in the postpartum period, as well as increasing the number of providers that are trained in the 5 A's of tobacco cessation. Part of these efforts have included increased promotion of the online training course on *Brief Tobacco Interventions* that was developed and provided by the Bureau of Health Promotion, offering 1.0 CEU credit free of charge to providers completing the course. Promotion has occurred thru many venues, including multiple state level conferences such as the Governor's Public Health Conference. This promotion has resulted in a private OB practice (from our *Delivering Change* Healthy Start project) and the *Becoming a Mom* perinatal education program requiring all staff to complete the training. Course participant numbers have steadily increased, from three per month in December of 2014 to 57 per month in January 2016. Reports show course participants from a variety of professional backgrounds, including: nurses, dieticians, administrators, physicians, social workers, care coordinators, educators and home visitors.

Throughout the year, state Title V staff have developed and coordinated tests of change that have been implemented through PDSA cycles at two local program level pilot sites. These pilot sites, in Saline and Crawford counties, are two of our *Becoming a Mom* Perinatal Collaboratives with the highest rates of smoking in pregnancy. The first PDSA cycle focused on developing and providing an inventory tool for use in assessing current screening and referral efforts for smoking cessation at their agency (which included assessing all MCH programs, WIC, and Family Planning). This test confirmed the following predictions: screening tools are not standardized and most often only verbal; resources are limited mostly to KS Quitline brochures with no other evidence-based program available; referrals are most often soft referrals, relying on client to contact KS Quitline on their own; no follow-up process is in place, nor is there any data tracking system in place to track efforts and outcomes. These findings clearly lead to our second PDSA cycle, which focused on the development of a smoking cessation integration plan and the training of the two pilot sites on the implementation of the "MCH Integration of Perinatal Smoking Cessation Services – BaM Program Model". This plan included a process flow sheet and associated screening tool, targeted resources, referrals, follow-up, and data collection process. Data collection has included rates of: screening, fax referrals to KS Quitline, engagement in Quitline services, smoking cessation, and continuation of cessation in the postpartum period. Following a brief but successful pilot period, this package was replicated in the remaining eight *Becoming a Mom* programs in our state. In-person training was provided to all sites in November 2015. The training and smoking cessation integration package was well-received by all sites, as smoking in pregnancy has been a recognized priority issue in all ten communities, but sites did not feel they had the staffing resources available to develop such a plan. Following successful implementation in the *Becoming a Mom* programs in our state, the package has been made available for adaptation and use across other Bureau of Family Health programs delivered by local Title V grantees. This was done so during a break-out session at our April 2015 Governor's Public Health Conference. During this session, our state lead for the ColIN Smoking Cessation Learning Network co-presented with the Medical Director for our Geary County *Delivering Change* Healthy Start project. Together, presenters shared two toolkits for implementation across different perinatal care settings. The above mentioned package, or toolkit, was provided as a resource for public health program settings. In addition, session attendees were provided the "Delivering Change: Tobacco Cessation Toolkit", which was developed by the Medical Directory, and is targeted for delivery in a medical prenatal care setting. This toolkit includes: education resources for medical providers and support staff; implementation of 5As, including medical chart sticker reminders; tobacco treatment options chart; warm referral to the KS Quitline and follow-up at next appointment; patient educational materials, including multi-

media messaging during prenatal visits along with pre and post-messaging testing.

Local MCH agencies continue to utilize the Kansas Tobacco Quitline as a referral resource for pregnant women to encourage them to quit smoking, as well as local tobacco cessation resources. MCH grantees are provided education on use of the Quitline and online resources to assist women to quit smoking. Training in the 5 A's method of tobacco cessation counseling is encouraged for grantee staff. Local grantee Healthy Start Home Visitors link pregnant women to smoking cessation resources as well and make referrals to the Quitline. Even though the MCH program continues to work with the Tobacco Program to promote the Quitline and expanded Pregnancy Program, preliminary data collection/analysis in this area has shown only a very small increase in engagement of and enrollment in Quitline services.

Additional evidence-based smoking cessation program options were identified as a need. In an effort to fill this need, collaborative efforts between KDHE Title V, the March of Dimes Kansas Chapter, and Amerigroup (WellPoint/Medicaid MCO) brought the BABY & ME – Tobacco Free\* (BMTF) program to our state in August 2015. At this time, nine of the *Becoming a Mom* perinatal collaboratives were trained on program implementation. The BMTF program is one of the evidence-based smoking cessation programs highlighted through the CoIIN Smoking Cessation Learning Network, demonstrating smoking cessation rates of 60-70% in other states. Collaborative sites were given the opportunity to apply for Title V funding of start-up equipment required for program implementation. All nine sites applied and received funding, and began implementation of the program in January 2016, following contract signing with WELCO, Inc. (owner of the BMTF program). The March of Dimes Kansas Chapter secured funding from Amerigroup for the provision of diaper incentives across all nine participating sites. These diaper incentives are a required component of the BMTF program, creating a financial barrier to implementation of the program in many communities. This funding partnership was hence crucial in getting this program piloted in our state. Following a slow start, program enrollment numbers reached 34 by April 2016.

\*BABY & ME – Tobacco Free (BMTF) ([www.babyandmetobaccofree.org](http://www.babyandmetobaccofree.org)) is a smoking cessation program created to reduce the burden of tobacco use on the pregnant and post-partum population. Women who quit smoking are less likely to have premature and low-birth weight babies and reduce the damaging effect of secondhand smoke on their children. The program's design has proven effective in decreasing the number of women who smoke during and after pregnancy. The program uses a unique approach, combining cessation support specific to pregnant women, offering practical incentives, targeting low-income women (the largest group of smokers during pregnancy), and monitoring success. Currently, 13 U.S. States participate in the program: Kansas, Colorado, Illinois, Indiana, Louisiana, Nebraska, New York, North Dakota, Oklahoma, Ohio, Oregon, South Carolina, and Tennessee. Three-year data collected from New York and Colorado indicate a 60-72% success rate. The BMTF program follows the *Clinical Best Practice Guidelines for Treating Tobacco Dependency* (HHS 2008 update) and integrates *Motivational Interviewing* skills to help pregnant women quit smoking and stay quit. Pregnant women are referred by their physician, clinic, health department or word of mouth to contact the participating agency to enroll in the program. The participating agency conducts four prenatal cessation sessions, (approximately 10 minutes each), provides support for quitting and staying quit, and tests each participant using a carbon monoxide (CO) monitor (breath test). To verify CO monitor test results, agencies may conduct random saliva tests, if necessary. After the birth of the baby, the mother returns monthly to continue CO testing and, if smoke-free, she receives a \$25 voucher for diapers for up to 12 months postpartum, or as program funds are available. The mother may use her voucher for any brand or size of diapers at Wal-Mart Stores and/or local participating stores. The BABY & ME – Tobacco Free Program underwent a 3 year research analysis from 2006 to 2009 by the NY State Department of Health's Tobacco Control Program. As a pilot program, the independent researched data was reported by Anne M. Gadowski, MD, MPH, Bassett Research Group and shared with the programs developer and national based agencies. Results were published in the *National Maternal and Child Health Journal*, January 2011. In 2005 the program was awarded a "Model Practice Award" by the National Association of City and County Health Officials (NACCHO). The published

results indicate a 60%+ quit rate of women enrolled in the program, 6-months postpartum. Data from the BABY & ME – Tobacco Free Program, implemented from 2008 to 2011 by Rocky Mountain Health Plans Foundations, Grand Junction CO., showed 2/3 of the counties in Colorado participated in the program. Within the statewide program, over 2,000 women enrolled, over 6,500 cessation sessions were conducted; helping 1,450 women quit smoking and stay quit. Rocky Mountain Health Plans Foundation distributed over 7,000 diaper vouchers to the smoke-free women. In 2013, the Colorado program’s data results indicate a 72% success rate at 6-months postpartum.

## BMTF Promo Card

SIDE PANEL THAT FOLDS IN
BACK PANEL
FRONT PANEL



**Are you willing to quit smoking?  
If so, we are committed to help.**

If you are ready to quit smoking and want to enroll in this program, call the local agency listed on the back of this page.

They will set up your first appointment and provide the positive support you need to quit.

**You and your baby can be tobacco free!**

This program is provided in partnership with:



The National BABY & ME — Tobacco Free Program  
babyandmetobaccofree.com



**Healthy babies born on time.**

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— 3-PANEL INSIDE SPREAD —

**Quitting smoking is the single most important thing you can do for your health and the health of your baby!**



**Benefits for your baby:**

- Increases the amount of oxygen your baby will get
- Increases the chances your baby's lungs will work
  - Lowers the risk that your baby will be born too early or too small
- Increases the chance that your baby will come home from the hospital with you on time

**Benefits for you:**

- Gives you more energy and helps you breathe easier
- Reduces your risk of developing smoking-related cancer and other chronic diseases
  - Saves money
- Makes your clothes, hair and home smell better
  - Makes your food taste better
- Helps you feel good about what you've done for yourself and your baby

**How does the BABY & ME — Tobacco Free Program work?**



**What you need to do:**

- Commit to quit smoking and stay quit during your pregnancy
- Enroll in the BABY & ME — Tobacco Free Program
- Attend 4 prenatal smoking cessation sessions
- Agree to take a monthly breath test to prove that you are tobacco free
- Stay smoke free after your baby is born and receive a monthly voucher for free diapers, for up to 12 months!

**To enroll in your local BABY & ME — Tobacco Free Program get in touch with:**

(Name, Address, Phone label goes here)



- Quit Smoking**
- Get Free Diapers**
- Enroll Today!**

## BMTF Diaper Voucher



Participating Stores  
**Walmart**  
*Saw money. Live better.*  
 and stores as noted by your local  
 BABY & ME - Tobacco Free Program.

Sponsored by the National  
**BABY & ME™ - Tobacco Free Program**  
 Kansas March of Dimes  
 and Kansas Department of Health



This entitles bearer to **\$25** towards the purchase of diapers.

Name (print) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Total Value of Diapers \_\_\_\_\_

**NO CASH BACK**

Vouchers are redeemable at participating stores in Kansas. They are non-transferable and only for purchase of diapers. Vouchers can be used for any brand/size diapers. "BABY & ME - Tobacco Free" Program and participating stores reserve the right to verify the authenticity of the voucher and ask for personal identification, before redeeming its value. All persons participating in the Program must be registered with the "BABY & ME - Tobacco Free" Program. Vouchers may not be reproduced. Vouchers expire within 90 days of issued date. Not negotiable unless signed on issued signature line. No cash back.

Redeemable at participating Walmart® stores in Kansas, and other stores as noted by your local BABY & ME - Tobacco Free Program. Voucher valued up to 25.00, including sales tax.

OFFICE USE ONLY	
Store Name	_____
Store Number	_____

Participant Signature \_\_\_\_\_ Issued Date \_\_\_\_\_

Participant Signature \_\_\_\_\_ Redeemed Date \_\_\_\_\_

THIS VOUCHER MAY NOT BE COPIED. DO NOT REPRODUCE UNDER PENALTY OF LAW. Questions regarding vouchers, please call WELCO 716-484-3325

Kansas identified three of eight new priorities as a result of the most recent needs assessment that have been linked to the Cross-cutting or Life course domain:

- Services and supports promote healthy family functioning
- Communities and providers support physical, social and emotional health
- Information is available to support informed health decisions and choices

Progress specifically related to the National Performance Measure follows.

**Priority: Services and supports promote healthy family functioning**

**ACEs & Trauma Informed Care:** Strengthening Family Resilience has been a common goal among all MCH related programs at the state level in the past year. Great effort has been made by KDHE to create an awareness among local grantees of the need for focused initiatives in this area. Again this year, the annual Governor's Public Health Conference presented breakout sessions supporting this kind of work. Many local grantees have been partnering with other community agencies, referring into early childhood and parenting support programs. Focus on kindergarten readiness, centering around the social emotional health of the child, is a part of collaborative efforts at the community level, as highlighted by partnerships in the HBWW/BaM collaborative models in Saline and Reno counties. As a part of the Healthy Start/Delivering Change initiative in Geary County, the ACEs Screening Tool and the Protective Factors Survey have actually been implemented as a part of the role of the OB Navigator. In April 2016, an ACEs training was held in Geary County. Although this training was part of the federal Healthy Start initiative, plans are to replicate this training through other venues that are open to a broader scope of MCH programs across the state. As a follow-up to the ACEs training, Geary County Healthy Start also provided the Lemonade for Life training on building resiliency. This too was attended by a representative of Kansas Title V staff, in an effort to gain insight into ways this training might be provided to local Title V grantees as well.

**Healthy Families Services:** Healthy Families Services (HFS) funding began in SFY 2006 as a budget enhancement to KDHE for the purpose of expanding healthy family services in Wyandotte and Geary Counties. The purpose of the program was to reduce health disparities for women and children through the provision of intensive nurse case management for low income, high risk families. Through SFY 2015 the grant continued to address the issue of

reducing health disparities with a focus on reducing infant mortality rates in Geary and Wyandotte counties. A variety of social and health services were provided directly to individual program participants utilizing a public health, targeted case management model. Funds could also be used to draw down Medicaid dollars to support or expand services. Grantees receiving HFS funds were required to engage in collaborative partnerships with related community providers to ensure the services provided were those needed by the program participants and integrated with other community efforts. In SFY 2015 HFS programs served 299 women and 238 children. For SFY 2016, HFS funds will be included in the total amount of funding available to support MCH programs at the local level throughout the state, increasing the total amount of funding available statewide, rather than targeting funds solely in Geary and Wyandotte Counties.

*Care Coordination Training:* In FY15, the KS-SHCN Program Manager and 1 of the KS-SHCN Care Coordinator participated in a train-the-trainer model with the Regional Heartland Genetics Collaborative to be able to offer the Region IV “Care Coordination: Empowering Families” training to families served by the KS-SHCN program. The training occurred at the end of FY15 and in early FY16, KS-SHCN implemented the first one-day parent/caregiver care coordination trainings to assist parents/caregivers and increase their knowledge of medical homes, health homes, community services and supports, obtaining insurance coverage, advocacy and to develop skills to better partner with their child’s providers.

The trainings are facilitated by KS-SHCN staff who also are parents of children who have special health care needs. Trainings begin with the staff sharing their personal story to help families feel comfortable in knowing that they are in a non-judgmental environment where they are free to openly share their hopes, dreams and daily struggles of being a parent of a child with special health care needs. Participants complete a pre-, post-, and one-year evaluation, providing information that can then be used to improve the training. Data is currently being captured in RedCAP. The response to this program by participants has been very favorable and KS-SHCN plans to conduct quarterly parent/caregiver care coordination trainings across the state in the future.

*Family Support Network:* Based on feedback throughout the KS-SHCN strategic planning process and the Title V Needs Assessment, a need for a family mentor program – where families who have children with similar special health care needs can communicate with each other and gain support from one another – was identified. In a collaborative partnership the SHS programs are working together to develop the Family Support Network. A mentor/mentee data system has been identified to assist with connecting parents, caregivers, or siblings who have similar experiences or needs, including matches based on the child or youth with special health care needs condition or services. NBHS is currently piloting the program and plans to expand to NBS and KS-SHCN in the coming year. A mentee parent information form has been developed and approved by the SHS-FAC for use. Policies, protocols, tools, recruitment and trainings for SHS staff and mentee parents will be developed over the next year and offered as part of care coordination services.

**Priority: Communities and providers support physical, social and emotional health**

*Oral Health Services in Specialty Clinics:* KS-SHCN currently partners with Oral Health Kansas and GraceMed to assure a dental hygienist is integrated as part of the Cleft Lip/Cleft Palate and Specialty Team Clinics. Through this partnership, the hygienist provides the following services at each clinic every time the child visits: complete an oral assessment, including the nationally standardized Basic Screening Survey; document findings for families and clinic records; explain findings to families by showing signs of health and oral disease; demonstrate appropriate daily oral home care to child and families, followed with written descriptions and samples of toothbrushes appropriate for the child’s condition; apply fluoride varnish when appropriate, and respond to family’s request for names of dental clinics in their respective community that can serve the child. These services will provide families with the opportunity to improve and maintain their children’s oral health by adopting effective daily oral hygiene and eating habits that eliminate or reduce tooth decay and periodontal disease, which are the most common chronic disease among

children.

**Priority: Information is available to support informed health decisions and choices**

*Youth Leadership Development:* KS-SHCN, in partnership with the Kansas Youth Empowerment Academy (KYEA), has developed a youth leadership program called Faces of Change. Faces of Change is focused on leadership development through civic engagement for youth ages 16-22 with disabilities. The program is seven months long, with monthly sessions focusing on an area contributing to effective leadership, such as: what it means to be a true leader, authentic leadership, effective communication, and team motivation. Youth participants will be using the new leadership qualities that they are learning throughout the program through a Community Change Project, which will be created and led by the youth.

This program was developed to address risk factors for youth with disabilities and special health care needs. It is believed that this program will decrease the following risk factors for youth with disabilities: low self-esteem and self-efficacy, high unemployment, and bullying. During the stage of young adulthood, youth need to find abilities within and connect with others. This program will have a strong emphasis on civic engagement, this provides participants the opportunity to explore abilities and realize their worth to society by giving back to others. The rate of unemployment for youth with disabilities ages 16-19 is more than twice the number of youth without disabilities. Youth participants will have enhanced employability skills such as communication, active listening, team work, time management and dress attire, and more. Lastly, youth with disabilities are more likely to be bullied compared with their nondisabled peers; contributing to secondary mental health conditions and increased risk for depression and suicide. These youth are not only victims of bullying by their peers, but also experience intimidation from medical professionals, family members and school faculty. Building communication and assertiveness skills, developing problem solving skills, and creating a network of peers and adults are intended outcomes of this program and will lead to positive outlets and create resiliency. Our belief is that by enhancing leadership skills, youth with disabilities and special healthcare needs will demonstrate increased self-efficacy, self-determination, and feel connected on a social and civic level to their community.

The curriculum was based on evidence-based leadership practices, with monthly in-person sessions focused on the following:

Job Description of a Leader – Provide an introduction to the program, expectations as a participant, initial youth assessments, and an overview of leadership characteristics.

What is your PACE? – Support youth in discovering their individual passions, tapping into their authenticity, realizing the commitment level needed to lead, and learning how to express themselves as a leader.

Language of Leadership – Educate on various forms of communication, identifying their strengths and weakness in communicating, becoming familiar with the financial cost of change, and the art of listening.

Leading from the Front – Assist youth in learning how to accept praise and criticism, learn from and become role models, and managing emotions and boundaries.

Leading from the Side – Guide youth through developing skills necessary for the ability to follow, learning to delegate and receiving delegation, and learning to be a team player.

Leading from the Back – Teach youth about motivating and enabling others to act, taking responsibility for failures, letting others lead, and self-care.

Going in Circles – Promote the value of evaluating change, celebrating progress, reassessing their commitment, and educating on the cycle of leadership.

SHCN requested that MCH concepts be integrated throughout the leadership curriculum in the following sessions: Language of Leadership, Leading from the Front, Leading from the Side, and Leading from the Back. This includes concepts such as communicating with medical professionals, communicating about their disability and medical needs, emergency preparedness, management of emotions, peer supports and mentoring that promote healthy mental functioning, delegating medical needs, transition, self-care and wellness, and the impact of stress on the body.

There are two primary components that enhance the participants' pathway to leadership. Their leadership development plan highlights their individual goals to enhance their leadership skills. Participants are asked to develop a community change project, where they will develop and begin implementation of a plan to meet this need. KYEA provided a list of potential maternal and child health topics for project focus, including but not limited to: alcohol and drug abuse, teen pregnancy, bullying, healthy living activities, sexual health, and other maternal and child health topics. Participants are matched with a local mentor to support their challenges and triumphs through this project. Upon completion of the program, the youth will participate in a "graduation ceremony" where participants will present on their community change project, including the perceived impact of change in their community and the personal growth within themselves.

*Epidemiology Support / Resources:* Kari Teigen (MPH) began working for the Title V program since October 2015. She served as a KDHE intern/ GSEP fellow (HRSA-sponsored Graduate Student Epidemiology Program) from May to August 2015. During her time as a GSEP fellow, Kari created a profile of the selected life course indicators and preconception health indicators for the state of Kansas. She analyzed data from the 2011/2012 National Survey of Children Health (NSCH) and the 2013 Behavioral Risk Factor Surveillance Survey (BRFSS) to provide a profile of the select life course indicators and preconception health indicators. For all the indicators she made comparisons of the prevalence levels of Kansas and the United States, excluding territories, and she evaluated the prevalence of risk or protective factors, stratified by relevant demographics. The life course indicators analyzed are as follow: adverse childhood experiences among children, prevalence of children with special health care needs, diabetes, children exposed to second-hand smoke at home, hypertension, obesity in both children and adults, medical home for children, inability or delay in medical care or dental care for children, oral health preventive visit for children and mental health status among adults. The preconception health indicators were only evaluated for women between the ages of 18-44. The two reports were finalized and efforts has been made to disseminate the information written in the reports. Kari has made a presentation which includes an overview of life course theory and its relationship with preconception health, and the overall findings from the two reports. She presented on March 24, 2016, to KDHE staff members and plans to present at the Kansas Maternal and Child Health Council meeting on June 22, 2016. Furthermore, the full reports are available on the KDHE website and Kansas Maternal and Child Health Council website.

## **Other Programmatic Activities**

**Aid to Local Application and Reporting Improvements:** Catalyst, the agency system for all aid to local program applications, budgets, and reports, allows for a single point of access so local partners can view and actively manage all of their grants with KDHE. Catalyst is web-based and uses cloud technology so it is always accessible with an internet connection and allows for unlimited user accounts. Through the Catalyst system, local MCH agencies submit their application/budget that includes their goals, objectives, outcome measures and plans for each domain served. These are then reviewed by KDHE MCH staff, program staff in the Bureau of Family Health, MCH council

members, and other partners. As part of the review, the individual uses a scoring rubric to assess each application and budget. Each application is reviewed by two reviewers. As of SFY16, a funding formula was developed to ensure fair and equitable funding based on MCH populations. The formula components include a three-year average of children under 18 years of age in poverty (75% weight) and the number of children 0-22 years of age and females 18-44 years of age (25%) for each county. Each year, the program works to fund all applicants at a minimum level that equals the amount once the base funding formula is applied. Other criteria taken into account for funding levels are compliance with reporting and contract requirements and existing programs/services/interventions (evidence-based, coordinated within the community, partnerships, etc.). If the program identifies that an applicant is over-funded based on the formula, previous performance, service numbers, and existing services are taken into account before reductions are recommended. Program protocol limits reductions to no more than 10% of their previous award amount if possible. Applicants were given additional funds if they are providing home visiting services and/or serving as a special health care needs regional office. We had 72 applicants for the 2016-2017 grant year. There were 63 agencies that provide home visiting services and 8 agencies serving as a special health care needs regional offices.

Once awarded with the grant, agencies report progress in the Catalyst system. KDHE MCH staff created progress reports in Catalyst for local MCH agencies to complete every quarter. KDHE MCH staff review all progress reports to verify grantees are completing the work outlined in their applications.

**DAISEY - Comprehensive Data Collection & Reporting System:** The Bureau of Family Health entered into an agreement with the University of Kansas Center for Public Partnerships & Research (KUCPPR) for 1) development of a superior performance management infrastructure, 2) training and technical assistance, and 3) analytics to allow for the best use of data to improve accountability and continuous quality improvement for best practices at the state and local levels. The scope of work centers on a phased approach to building necessary data and analytics infrastructure to support KDHE's vision for integrated and coordinated community-level maternal and child health initiatives through the *Data Application and Integration Solution for the Early Years (DAISEY)* system. This agreement is responsive to a primary objective of incrementally designing and building components of a community-level performance management system for coordinated maternal and child health services. KUCPPR currently has more than 50 grants in the areas of early childhood, child welfare, child abuse/prevention, K-12 education, and at-risk families. KUCPPR has extensive experience providing performance management solutions and technical assistance for states implementing home visiting and early childhood programs under federal (MIECHV) and state funding initiatives. KDHE and KUCPPR have a history of strong collaboration, working together on multiple early childhood programs. The team lead is KUCPPR's Associate Director and will serve as Principal Investigator for this project by providing overall conceptual design, implementation supervision, and quality assurance on deliverables. The Associate Director serves as Principal Investigator for four large-scale state performance management solution projects that implement *Research Electronic Data Capture (REDCap)* and *DAISEY* to assist funders in the analysis, monitoring, and measurement of grantee/site performance on outcome indicators. The system was piloted in November 2015 and launched statewide in phases between January and April 2016. The following details accomplishments for year one of the implementation.

#### What we anticipated accomplishing in Year 1:

- Data Governance Documents
- Org Structure / Hierarchy for 7 BaM Sites
- Client Forms, Service Encounter Form, and Referral Form
- DAISEY Training
- DAISEY Launch
- On-going DAISEY Technical Assistance and system support
- DAISEY Report Design Development (up to 4)

Feasibility Plan for scaled Statewide DAISEY training and launch, Phase 11 planning and design preparation; organizational management plan; recommendations

What we accomplished in Year 1:

Data Governance Documents

Org Structure: 192 Orgs and Grantee Orgs built in DAISEY

Form Development:

- 17 Client-based forms developed: 436 questions
- 3 Aggregate Entry forms developed: 1,120 questions

Training:

- 12 Webinars (intro to DAISEY; program-specific for each program; considering Import; Importing for KIPHS and EHR; Preparing to Implement for 2 phases of launch)
- 9 User Training Webinars (Direct Entry and Import)
- 28 Open Mic webinars (Direct Entry and Import)

Four Health Dept Site Visits

Org and User Launch:

- 84 Orgs in Live; 35 in Sandbox (some overlap)
- 426 users in Live; 174 in Sandbox (some overlap)

*Note: by June 30, 2016 ALL users and orgs should be in Live*

Data Successfully Entered in Live as of May 24, 2016

- 13,211 Client Profiles: 8,937 Caregivers; 4,274 Children
- 10,875 Visit Forms: 9,082 Adult Visit Forms; 1,793 Child Visit Forms
- 14,711 Service Forms: 8,172 MCH; 4,857 FP; 791 PMI; 584 BaM; 307 TPTCM

On-going Technical Assistance: dedicated KDHE e-mail with full time helpdesk staff; 413 'tickets' Feb 1 through May 1, roughly 144 per month; Average per-ticket time to resolution = 3 ½ hours. Import inquiries often require phone calls and/or screen-sharing.

On-going Technical Assistance: working with EHR users and Vendors including Insight, KIPHS, Champs

Four Service Reports (MCH, TPTCM, PMI, BaM); One Referral Report filterable by program; available to State and Grantees, based on requirements mutually agreed upon prior to report development beginning.

Data Dictionary and Data Collection Crosswalk, initial and updated

KDHE DAISEY Videos & Data Dictionary Videos

Website

QA in the form of (roughly) monthly exported data, compiled into a report

System Enhancements Requested and Delivered

- Auto-Fill
- Safety Mode
- Reviewer Role

- Printable Forms
- Frame Rename
- User Names added to data export
- Form Confidentiality (Major enhancement)

KDHE MCH staff have gathered Terms of Use agreements and Confidentiality agreements from all local MCH agencies. Once the agreements were received, local agencies were given access to the “sandbox” environment to have a chance to see the forms that need to be completed during a client visit. Staff held multiple webinars, one-on-one over the phone trainings, on-site training and made recordings to walk local agencies through the data dictionary, data crosswalk, and navigating the DAISEY system form by form. DAISEY information listed above is available at <http://daiseysolution.com/kdhe/> to local agencies.

The data dictionary is a tool that provides information on the data elements collected in DAISEY. Each section of the document represents a form. Each form section has information about the data elements in that form, including definitions/descriptions, possible responses, and the purpose of each element.

The data crosswalk is a tool that provides information necessary for importing data into DAISEY. There is a section for each form with details on data elements, allowable responses, and response formatting. The tool can help local agencies map fields between their Electronic Health Record (EHR) and DAISEY. Each form section includes a place to document information about elements captured by an organizations EHR system. Completing the mapping section of this document may assist organizations working with EHR vendors to prepare EHR data extracts for import into DAISEY.

KDHE MCH staff have worked diligently to engage local MCH agencies to implement DAISEY to collect client level data. There have been rollout groups every month starting in January 2016. The first rollout included agencies that do not have a method to collect client level data and will use DAISEY to direct enter client level data. Since the first rollout, we have 34 agencies to implement in DAISEY remaining. As the rollout progressed, we offered local agencies the opportunity to order mobile technology (tablets, laptops) to allow real time direct entry into DAISEY while with the client. We also allowed local agencies to purchase mobile technology using their grant awards.

KDHE MCH staff have worked with KU-CPPR to create reports for staff and local MCH agencies to be able to run aggregate reports to use on their quarterly progress reports. This will also allow them an opportunity to see any trends in their communities for the targeted populations. Local MCH agencies will also be collecting referral information and track follow-up in DAISEY. Tracking this will allow them to run a report to show completed referrals and those that need follow-up completed.

The local agencies that have an EHR or another system they are using to collect client level data will need to be able to extract the data from their system and import it using DAISEY templates. We have faced challenges related to data import into DAISEY and have come up with an interim solution, Aggregate forms. KDHE MCH staff have created an aggregate form that local agencies will complete every month to meet the reporting requirements.

All local agencies will start using DAISEY on July 1, 2016. This will include the local agencies that are direct entering into DAISEY and those that will be completing the aggregate forms.

**MCH On-Site Monitoring & Technical Assistance Visits:** Local MCH agencies are notified 30 days before a scheduled site visit once a date is agreed upon. KDHE MCH staff have updated the MCH Monitoring Tool to be used during site visits. The monitoring tool sections include administration/management, data, program effectiveness,

target populations/interventions (populations served, community needs, state priorities, services provided by population domains, home visitation services, education, referrals, and challenges/barriers), outreach, and partnership/collaboration. Local MCH agencies complete the tool prior to the site visit which allows KDHE staff the opportunity to review responses to facilitate discussion topics for the visit. During the site visit, agency staff provide evidence to their responses. At the end of the site visit, KDHE staff discuss with agency staff their strengths, challenges and any technical assistance needs they may have. If there are action items noted during the visit, local MCH agencies will have 30 days to comply with the findings. KDHE staff have developed a site visit schedule on a three-year cycle. During a review of quarterly progress reports, if KDHE MCH staff identify a local MCH agency needing assistance, or would like to know more about the work they are providing, a special/off-cycle site visit may occur in addition to the three-year cycle.

**Special Health Care Needs (SHCN) Program:** Significant transition has occurred in the last couple of years within KS-SHCN, with much more planned for the coming year. In the past little cross-system collaboration was occurring among programs including those within the Special Health Services (SHS) Section itself. SHS consists of services to identify and provide services for those with a disability or developmental delay from birth to death through screening, early intervention, care coordination, and direct assistance to families. KS-SHCN is the link among each of these programs, spanning all ages and disabilities and the long-term support system for those served in the other programs.

KS-SHCN has initiated new collaborative efforts with each of the other programs in SHS: Newborn Metabolic Screening (NBS), Newborn Hearing Screening (NBHS) and Infant-Toddler Services (ITS). A shared position between KS-SHCN and NBS was created in FY 2015 and filled with a Care Coordinator to assist with NBS long-term follow up and KS-SHCN Care Coordination for individuals who screen positive for a genetic/metabolic condition through the newborn screen. Referral processes and protocols has been developed between NBS and KS-SHCN for those infants identified through newborn screening with a genetic/metabolic condition. Currently program managers are working collaboratively to develop a long term follow up program for those with a genetic/metabolic condition. KS-SHCN does an automatic referral to the ITS program for infants and children age three and under. The KS-SHCN manager will be working with the new ITS manager and current NBHS manager to develop protocols and procedures for referrals to the KS-SHCN program. These new steps will strengthen the collaborative relationships among these programs and allow for better services for families.

The KS-SHCN program participated in the Cohort 2 of the Association of Maternal and Child Health Programs (AMCHP) Workforce Development Center (WDC) to address the needs of families of CYSHCN through collaboration, systems integration, and increased capacity for telemedicine/telehealth. The target population included Kansas CYSHCN and their families in rural and frontier communities. The primary objective of this project was to increase capacity for utilization of telemedicine in rural communities. The project was developed to support health transformation through improved access to care and systems integration. The project centered on the development of a telehealth tool kit that can be shared with providers to assist them in telehealth implementation. It was the intent of this project to increase the capacity of providers to meet the needs of those who live in rural and frontier parts of the state where access to care is a barrier. Other components of this project were a prospective ROI to identify if conducting the specialty clinic services via telehealth would be a cost effective alternative since attendance has slowly been reducing over the last few years and the other component was a partner who developed a telehealth system in their rural hospital to meet the needs of the community. The leadership team of this project consists of the state Title V CYSHCN Director and KS-SHCN Program Manager as co-leads and includes representation from Medicaid/KanCare, a community hospital partner, a parent partner, and coordinator for the HRSARegional Telehealth Resource Center.

**Newborn Metabolic Screening Follow Up (NBS-FU):** During FY17, the 2016 revision of the State Genetics Plan will be finalized. The shared position between the NBS-FU and SHCN programs will continue to allow for

opportunities to expand NBS-FU community supports around family and parent education initiatives and family-centered care coordination around needed resources and services. The position will continue to assess the ability of a long-term follow-up (LTFU) program in the coming years. We anticipate visits to and technical assistance from other states who have LTFU programs in place.

NBS-FU will continue to provide training and education on CCHD screening for any birthing facilities requesting technical assistance. In addition, NBS-FU will expand outreach and education to those birthing facilities who are not reporting on the EBC and providing parent educational materials to obstetricians, primary care providers, and nursery staff related to CCHD and SCID screening. In partnership with the Newborn Hearing Screening (NBHS) program, NBS-FU will provide training, education, and resources to midwives in order to ensure all midwives are screening for CCHD. Only midwives associated with a licensed birthing center were part of the initial training efforts. NBS-FU staff will continue to monitor the screening status and reporting efforts for all Kansas births.

NBS-FU and KHEL will continue to work together on the implementation of SCID. KHEL will be the lead on the majority of SCID activities this next year since activities are primarily focused on lab equipment and training protocols. NBS-FU will participate when appropriate, especially in regard to planned site visits. NBS-FU and KHEL staff will receive consultation regarding workflow processes and protocols, and how to incorporate the new equipment into the existing lab structure. KHEL will assure validation of the equipment and a pilot study, using samples received for the metabolic screening, will be conducted. This will assure validity and reliability of the new equipment and provide quality improvement data to KHEL and NBS-FU on timing and need to modify work processes. The SCID Subcommittee will continue to meet to assist in the development of develop the NBS-FU algorithm and flow-cytometry specimen collection protocols, parent and provider education materials, and provide recommendations on lab collection needs for Kansas communities.

NBS-FU and KHEL will also begin working on a QI project related to timeliness of NBS. A workgroup consisting of FU, KHEL and 2 birthing facilities in Kansas have begun preliminary work and are working to develop baseline data related to specimen collection, transport and reporting of results.

**Newborn Hearing Screening (NBHS) - Sound Beginnings:** FY17, NHBS program staff will continue to participate in activities or initiatives that lead to the reduction of Kansas' overall loss to follow-up rate. Staff will focus on maintaining the national JCIH goals for EHDI, improving understanding of the hearing screening process and the benefits to professionals touching the lives of our children, and improving the health and quality of life for children with hearing loss and their families in Kansas. Over the next fiscal year, NBHS program will continue to work with Sound START, and the Kansas School for the Deaf on enhancing the Family Network Support system and the Deaf/Hard of Hearing Liaison programs. The advisory committee will work on updating the family resource guide for families of infants newly identified with hearing loss. NBHS will begin work on Quality Improvement for Early Intervention and Audiology facilities which will provide a report, help them to understand the state system, view the overall need of the newborn hearing screening programs to meet the state and national goals and identify areas of strength and areas of need.

**Safe Haven for Newborns:** Kansas law, KSA 38-2282 Newborn Infant Protection Act, was amended July 1, 2014, to expand the list of locations where an infant can be surrendered to include police stations, sheriff's office and law enforcement centers. A Safe Haven for Newborns in Kansas public awareness campaign was launched across the state. The United Way 2-1-1 Call Center in Kansas City and Wichita were there to answer questions. A Safe Haven for Newborns sign has been presented to all 105 county health departments. Collaboration with the Safe Haven for Newborns Coalition of Greater Kansas City, KDHE Bureau of Family Health and United Way of the Plains, Wichita, provided the safe haven for newborns message across Kansas. The goal was to raise community awareness about

the Safe Haven laws and at the same time, prevent a tragedy.

## **II.F.2 MCH Workforce Development and Capacity**

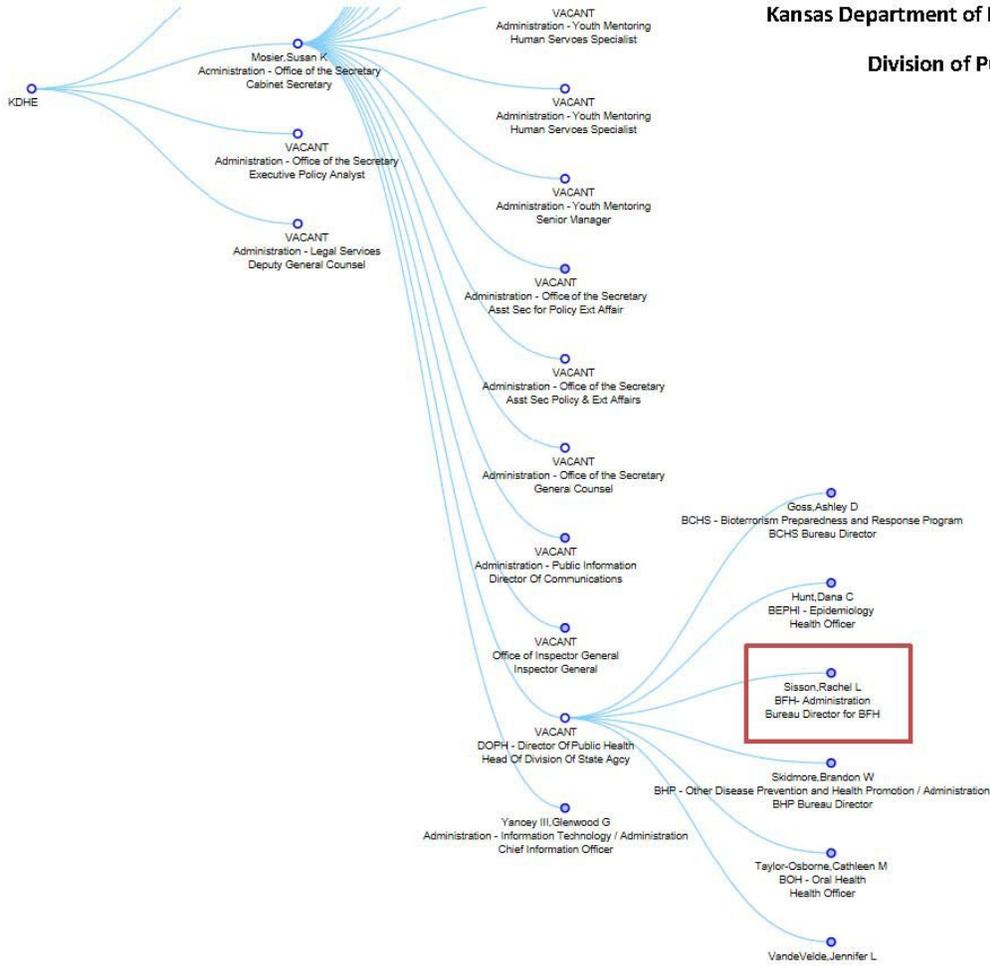
**Title V & Organizational Structure:** The State's public health agency, Kansas Department of Health and Environment (KDHE), is responsible for the administration of programs carried out with allotments under Title V [Section 509(b)]. The agency has three divisions: Public Health, Health Care Finance (Medicaid/State Health Insurance), and Environment. The Division of Public Health has six bureaus: Family Health; Disease Control & Prevention; Community Health Systems; Health Promotion; Oral Health; and Epidemiology & Public Health Informatics. The Title V Maternal & Child Health (MCH) Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH has five sections: Children & Families; Special Health Services; Nutrition & WIC Services; Early Care & Youth Programs; and Administration & Policy.

The BFH programs partially funded by the federal-state Title V Block Grant include MCH, CYSHCN, and Child Care. Within the Division of Public Health, other Bureaus that receive support include the Bureau of Epidemiology and Public Health Informatics (Vital records data sharing, analysis, reporting) and the Bureau of Community Health Systems (workforce development, training, capacity building, systems development). Local agencies including health departments and Federally Qualified Health Centers are independent entities that apply for MCH funds annually as part of the agency's competitive Aid to Local application process.

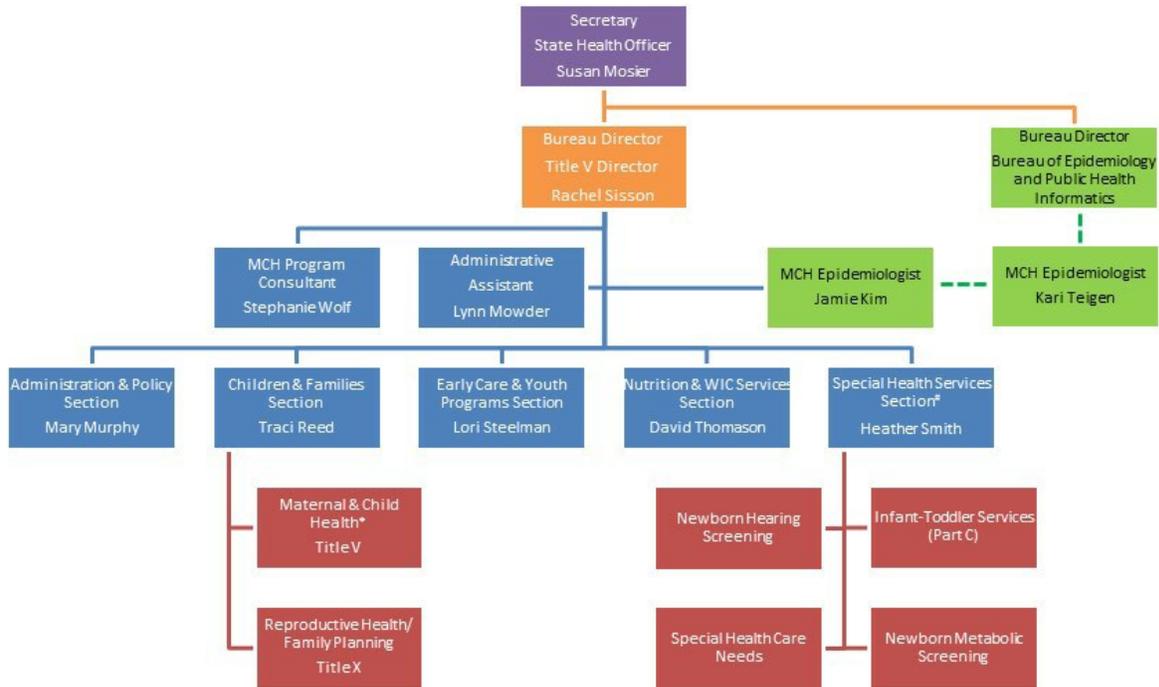
The agency organizational charts and a local agency/grantee map are included in this section as images.

# Kansas Department of Health & Environment

## Division of Public Health



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



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

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

**Title V Maternal & Child Health (MCH) Workforce:** Effective June 2016, the Bureau of Family Health (BFH) has 81.2 full-time equivalent (FTEs) positions. Two FTEs including the Title V Director and an Assistant are located in administration. Section staffing follows. Special Health Services staffs the core Title V CYSHCN team and has 20 FTEs including a Director (MPH) and program staff including: 6 Special Health Care Needs (SHCN); 3 Newborn Metabolic Screening; 6 Infant Toddler Services; 4 Newborn Hearing Screening (one audiologist). Children & Families staffs the core Title V MCH team and has 12 FTEs including a Director (LMSW) and RN (3 vacancies). Nutrition & WIC has 15 FTEs including 3 nutritionists. Child Care Licensing has 20.2 FTEs including a Director and 5 Coordinator of Children's Services staff located in KDHE District Offices across the state with responsibility for supporting regulatory inspections and services at the community level. Administration & Policy has 12 FTEs including a Director, 4 Lead Hazard Prevention positions and 7 administrative and support staff.

MCH Block Grant funds provide salaries for approximately 18% of the staffing in the Bureau, supporting administration, CYSHCN, and MCH. MCH funding also supports part-time staff in the Bureau of Community Health Systems' Local Public Health Program for workforce development, capacity building, and training and the Office of Vital Statistics for data access and analysis. Additionally, MCH funding supports two full time epidemiologists within the Bureau of Epidemiology and Public Health Informatics. The epidemiologists interface with epidemiological work conducted in other Bureaus inside the agency and with other organizations and efforts in the state. Both epidemiologists coordinate all data analyses for the Title V needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH.

**Title V MCH Capacity to Provide Services for MCH Populations:** The Bureau of Family Health has experienced vacancies and staff turnover at the state level consistently over the past few years, which has presented ongoing challenges. At the same time, it has created an opportunity to build partnerships and increase/enhance community capacity in each of the population health domains. Recognizing the staff on the MCH and CYSHCN teams are key to building partnerships at the state level and providing support to the local level, the new structure has led to improved state-local coordination and alignment with vision. The current Title V staff (with expertise by domain) are listed below:

Women/Maternal: Stephanie Wolf, MCH Program Consultant; Carrie Akin, MCH Administrative Consultant; Kay White, MCH Administrative Consultant; Deborah Richardson, Home Visiting Program Manager; Phyllis Marmon, Home Visiting Consultant

Perinatal/Infant: Stephanie Wolf, MCH Program Consultant; Carrie Akin, MCH Administrative Consultant; Kay White, MCH Administrative Consultant; Deborah Richardson, Home Visiting Program Manager; Phyllis Marmon, Home Visiting Consultant

Child: Stephanie Wolf, MCH Program Consultant; Deborah Richardson, Home Visiting Program Manager; Traci Reed, Children & Families Director; Vacant, MCH Child & Adolescent Health Consultant; Lori Steelman, Child Care Licensing Program Director; Mary Murphy, Administration & Policy Director  
CYSHCN: Heather Smith, Special Health Services Director; Kayzy Bigler, SHCN Program Manager; Michelle Black, Geno Fernandez, and Portia Taylor, SHCN Program Staff; Kelly Totty, Lead Care Coordinator

Adolescent: Traci Reed, Director, Children & Families Section; Vacant, MCH Child & Adolescent Health Consultant; Lori Steelman, Child Care Licensing Program Director; Mary Murphy, Administration & Policy Director

Cross-cutting or Life Course: MCH and CYSHCN teams, led by Rachel Sisson, Bureau Director; Jamie Kim, MCH Epidemiologist; Kari Teigen, MCH Epidemiologist

*Kansas (State) Maternal & Child Health Council (KMCHC):* The KMCHC ([www.kansasmch.org](http://www.kansasmch.org)) serves in an advisory capacity to the Title V Program; monitors progress; and addresses specific needs for MCH populations. The Kansas Chapter of the American Academy of Pediatrics (KAAP\*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas, resulting in improved outcomes. The Council is comprised of a multidisciplinary team of professionals with expertise in MCH. The council members are identified and, in consultation with KDHE, selected to serve on the Council by the KAAP. The Title V needs assessment and state action plan is the guiding document as it relates to the ongoing work of the Council. KDHE and KAAP convene the Council at least once each quarter. A decision was made in September 2015 to merge the Blue Ribbon Panel on Infant Mortality with the KMCHC, resulting in greater coordination and impact. The Panel was established in 2009 to develop a set of recommendations to reduce infant mortality in Kansas. Work and membership is now integrated into the KMCHC, with most of the members previously on the Panel serving on the Perinatal/Infant Health workgroup. The KMCHC is chaired by Dennis Cooley, MD, FAAP, and has between 30-35 members at any given time. A KMCHC member roster is provided in this section.

\*KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas, KAAP is willing to assemble individuals with professional expertise to assist and advise KDHE to achieve the best possible health outcomes for Kansas MCH populations.

**2015-2016 Kansas Maternal & Child Health Council (KMCHC)**

Last Name	First Name	Organization	Email	Phone	Domain
<b>Adamson</b>	Rebecca	Crawford County Health Department	radamson@crawfordcoh.d.org	620-704-0239	WM
<b>Baines</b>	Stefanie	University of Kansas Hospital	sbaines@kumc.edu	757-748-1052	C
<b>Benyshek</b>	Katrina	Kansas School Nurse Organization	rbeny@pld.com	620-353-3109	A
<b>Cohorst</b>	Kami	Child Care Aware of Kansas	kami@ks.childcareaware.org	855-750-3343	PI
<b>Collie-Akers</b>	Vicki	University of Kansas	vcollie@ku.edu	785-550-7367	PI
<b>Connellis</b>	Julia	Kansas Youth Empowerment Academy	juliat@kyea.org	785-215-6655	A
<b>Cooley*</b>	Dennis	Pediatrics Associates of Topeka	cooleymd@aol.com	785-235-0335	WM
<b>Cotsoradis</b>	Shannon	Kansas Action for Children	shannon@kac.org	785-232-0550	C
<b>Daldrup</b>	Diane	Community Volunteer	dmdaldrup@yahoo.com	816-718-9545	WM
<b>Fawcett</b>	Stephen	University of Kansas	sfawcett@ku.edu	785-766-0464	PI
<b>Fisher</b>	Beth	Hays Area Children's Center	Beth@hacc.info	<b>785-625-3257</b>	C
<b>Gabel</b>	Lisa	Amerigroup Kansas, Inc.	Lisa.Gabel@amerigroup.com	913-563-1623	C
<b>Garrison</b>	Terrie	Wyandotte County Public Health	tgarrison@wycokck.org	913-602-4530	WM
<b>Harris</b>	Kari	University of Kansas – Wichita	Kari.Harris@wesleymc.com	316-200-7575	A
<b>Harris</b>	Shalae	March of Dimes Greater Kansas Chapter	SHarris@marchofdimes.org	316-619-6187	WM
<b>Hoehn</b>	K. Sarah	Sunflower Health Plan	khoehn@sunflowerhealthplan.com	913-401-4222	C
<b>Hortenstine</b>	Sara	State Child Death Review Board	sara.hortenstine@ag.ks.gov	785-296-7970	PI
<b>Johannes</b>	Elaine	Kansas State University Research & Extension	ejohanne@ksu.edu	785-410-2249	A
<b>Jones</b>	Wes	Mental Health Ctr-East Central KS	fhccc@myvalunet.net	620-343-2211	A
<b>Kuhlmann</b>	Zachary	Associates in Women's Health, PA	zkuhlmann@awhobgyn.com	316-207-1863	WM
<b>Lauer</b>	Steve	Dept. of Pediatrics	slauer@kumc.edu	913-484-4956	A
<b>McNamar</b>	Patricia	Medicine Lodge Memorial Hospital & Clinic	rivervue@sctelcom.net	620-886-5949	WM
<b>Morgan</b>	Randall	Associates in Women's Health, PA	randall.morgan@awhobgyn.com	316-219-6706	WM
<b>Pate</b>	Brian	Wesley Medical Arts Tower	bpate@kumc.edu	316-962-2681	C
<b>Pence</b>	Susan	Community Health Center of SE Kansas	slpence@gmail.com	620-231-9873	PI
<b>Pezzino</b>	Gianfranco	Kansas Health Institute	gpezzino@khi.org	785-233-5443	A
<b>Rodriguez</b>	Melissa	Family Representative	jeepaholic74@hotmail.com	620-408-5108	A

<b>Sage</b>	Cherie	SAFE KIDS Kansas	CSage@kdheks.gov	785-296-1223	C
<b>Schunn</b>	Christy	KS Infant Death & SIDS Network	edirector@kidsks.org	316-682-1301	PI
<b>Shaw</b>	Pam	KUMC Department of Pediatrics	pshaw@kumc.edu	913-588-5908	C
<b>Smith</b>	Sharla	KUMC Dept. of Preventative Med & Public Health	ssmith37@kumc.edu	316-293-1816	PI
<b>Spainhower</b>	Michele	Sedgwick County Health Department	michele.spainhower@sedgwick.gov	316-660-7172	WM
<b>Vaughn</b>	Erick	Kansas Head Start Association	evaughn@ksheadstart.org	785-856-3132	WM
<b>Wallace</b>	Annie	Kansas State Nurses Organization	awallace@kssdb.org	913-210-8162	A
<b>Yadrich</b>	Donna	Kansas Title V Family Delegate	donna@audreyspirit.com	913-980-6282	A
<b>Young</b>	Phyllis	Center for Child Health & Development	pyoung@kumc.edu	913-588-5741	C
<b>Ex-Officio Members</b>					
<b>Akin</b>	Carrie	KDHE - Bureau of Family Health	cakin@kdheks.gov	785-296-1234	PI
<b>Bigler</b>	Kayzy	KDHE - Bureau of Family Health	kbigler@kdheks.gov	785-296-1316	C
<b>Crawford</b>	Greg	KDHE - Epidemiology & Public Health Informatics	gcrawford@kdheks.gov	785-296-8627	
<b>Haskett</b>	Lori	KDHE - Bureau of Health Promotion	lhaskett@kdheks.gov	785-296-8163	C
<b>Kim</b>	Jamie	KDHE - Bureau of Family Health	jkim@kdheks.gov	785-296-6467	
<b>Marmon</b>	Phyllis	KDHE - Bureau of Family Health	pmarmon@kdheks.gov	785-296-7433	WM
<b>Mosier</b>	Susan	KDHE - Office of the Secretary	smosier@kdheks.gov	785-296-0461	
<b>Reed</b>	Traci	KDHE - Bureau of Family Health	treed@kdheks.gov	785-296-6136	A
<b>Richardson</b>	Debbie	KDHE - Bureau of Family Health	drichardson@kdheks.gov	785-296-1311	C
<b>Seymour-Hunter</b>	Fran	KDHE - Health Care Finance Medicaid	fseymour-hunter@kdheks.gov	785-296-2212	WM
<b>Sisson</b>	Rachel	KDHE - Bureau of Family Health	rsisson@kdheks.gov	785-291-3368	
<b>Smith</b>	Heather	KDHE - Bureau of Family Health	hsmith@kdheks.gov	785-296-4747	
<b>Steelman</b>	Lori	KDHE - Child Care Licensing	lsteelman@kdheks.gov	785-296-8026	PI
<b>Teigen</b>	Kari	KDHE - Epidemiology	kteigen@kdheks.gov	785-296-8212	WM
<b>Thomason</b>	David	KDHE - Nutrition & WIC Services	dthomason@kdheks.gov	785-296-1324	PI
<b>White</b>	Kay	KDHE - Bureau of Family Health	kwhite@kdheks.gov	785-296-1305	PI
<b>Wolf</b>	Stephanie	KDHE - Bureau of Family Health	swolf@kdheks.gov	785-212-0085	WM
<b>Council Staff</b>					
<b>Steege</b>	Chris	Kansas Chapter of AAP	chris.steege@kansasaap.org	913-780-5649	
<b>Satzler</b>	Connie	Envisage Consulting, Inc	csatzler@kansas.net	785-587-0151	

\*Chair

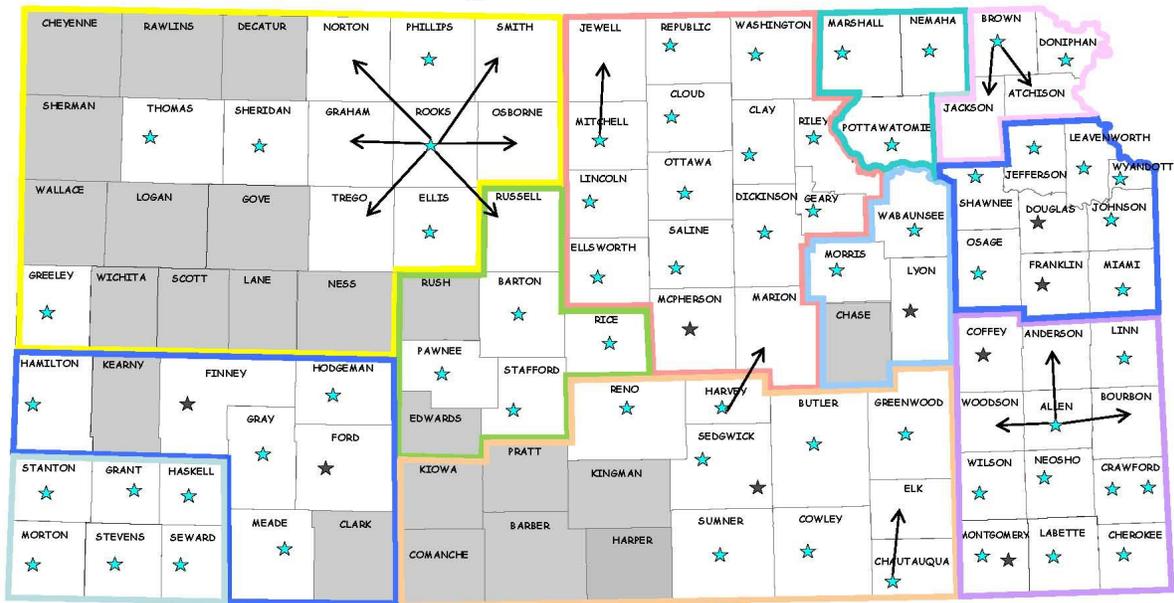
Domain: Women & Maternal (WM); Perinatal & Infant (PI); Child (C); Adolescent (A)

**Service Delivery System, Structure, & Partnerships:** The majority of programs funded by the Block Grant are delivered by health departments and safety net clinics (independent entities). These agencies are positioned to provide many core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The services delivered by local agencies are designed to address ongoing needs and those identified as part of the most recent needs assessment. When funds are allocated to external programs, the Bureau maintains contracts for the use of the funds to outline the nature of the work in support of the MCH priorities. Services are to be in compliance with Title V legislation and in accordance with the [Kansas MCH Services Manual \(http://www.kdheks.gov/c-f/downloads/MCH\\_Manual.pdf\)](http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf).

The contractual process with local agencies begins with the development of Grant Application Guidance/Reporting Materials annually in December. These materials are available by mid-January to local agencies to apply for Title V funding as part of the aid to local funding process. The review process which informs funding recommendations involves external reviewers applying guidance and a scoring matrix, funding formula based on poverty and population by county/target area, and willingness/ability to comply with grant requirements. Detailed client and service data is required to be collected, aggregate progress reports and affidavits of expenditures are required quarterly, and site visits are conducted to verify compliance with funding requirements and progress toward priorities, goals, objectives, and measures. More information about the [MCH Aid to Local Program](http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html) including program guidance is available online ([http://www.kdheks.gov/doc\\_lib/MaternalAndChildHealthServices.html](http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html)). Aid to Local contract documents and the list of local 2017 MCH grantees statewide are attached as supporting documents.

A map of 2017 MCH grantees/local agencies is provided in this section. The map indicates Special Health Care Needs regions as well.

### MCH Unit Local Program Grantees – SFY 2017



SPECIAL HEALTH CARE NEEDS SATELLITE OFFICES			
1	Stevens County HD	7	Nemaha County HD
2	Topeka Administrative Office (Temporary)	8	Northeast KS Multi-County HD
3	Hays Area Children's Center	9	Morris County HD
4	Barton County HD	10	Topeka Administrative Office (Temporary)
5	University of Kansas School of Medicine, Department of Pediatrics	11	Crawford County HD
6	Saline County HD		

★	Maternal Child Health (MCH) with HSHV
☆	Maternal Child Health (MCH) without HSHV
↗	Indicates other counties that are funding partners
■	No Maternal Child Health (MCH) grantee program

**Local MCH Workforce Development:** State Title V staff facilitated FY 2016 3<sup>rd</sup> quarter meetings in all six public health regions to local health department administrators and staff. In addition, Title V staff provided extensive support for the Annual Kansas Governor's Public Health Conference which included a pre-conference session focused on Public Health and Maternal and Child Health/Family Planning (MCH/FP). The Public Health training was focused on public health law and workforce planning making the most of change and transitions. The MCH/FP session focused on the Title V Priorities and NPMs as well as aid to local program requirements, data collection, reporting, technical assistance and training. The MCH and FP programs also discussed Becoming a Mom program expansion and trainings; MIECHV/KIDOS program overview; and coordination and collaboration across programs. The conference featured nationally recognized keynote speakers on topics including cultural competency, consequences for adult health, prescription drug abuse and epidemiologic overview of high-profile public health events. A wide selection of breakout sessions tailored to meet the changing needs of the populations served through public health programs and initiatives were offered. The MCH and Healthy Start Home Visitor conference sessions focused on safe sleep, family caregiver health, home safety, developmental screening using ASQ-3 and ASQ-SE, infant mental health, perinatal smoking cessation, engaging mothers and families in home visiting, adolescent health needs assessment results and bullying prevention. State Title V staff facilitated and presented the majority of sessions. The Public Health sessions next will include brain health (ACEs), public health law, quality improvement, environmental health, chronic disease management in schools, sexual violence prevention, financial planning/budgeting, and building community collaboratives.

### *Additional Local Training*

State Title V staff provide technical assistance and training throughout the year to local MCH agencies through webinars. A wide variety of topics, including how to complete the MCH application and progress report in Catalyst; how to complete a budget; introduction to DAISEY; DAISEY implementation; DAISEY data dictionary; completing DAISEY forms; and open mic session (agencies could discuss anything).

<b>Date</b>	<b>Title/Topic</b>	<b>Attendees</b>
12/15/2014	MCH Reporting Requirements	39
12/16/2014	PMI Reporting Requirements	8
12/16/2014	MCH Reporting Requirements	23
12/16/2014	TPTCM Reporting Requirements	11
2/5/2015	MCH Catalyst Grant Application	47
2/5/2015	PMI Catalyst Grant Application	13
2/6/2015	TPTCM Catalyst Grant Application	11
2/6/2015	MCH Catalyst Grant Application	30
2/16/2015	CVR Changes	3
2/17/2015	CVR Changes	16
2/18/2015	CVR Changes	5
2/20/2015	CVR Changes	10
7/29/2015	MCH Webinar	59
7/30/2015	MCH Webinar	35
8/4/2015	Introduction to DAISEY	87
8/5/2015	Introduction to DAISEY	61
8/26/2015	MCH Progress Reports in Catalyst	68
8/27/2015	MCH Progress Reports in Catalyst	37

9/2/2015	PMI Progress Report in Catalyst	13
9/10/2015	TPTCM Progress Report in Catalyst	12
9/16/2015	Introduction to DAISEY	15
10/14/2015	DAISEY Discussion with vendors	7
10/27/2015	DAISEY Launch Q&A for BaM Sites	9
11/3/2015	DAISEY Data Dictionary--MCH	71
11/3/2015	DAISEY Data Dictionary--PMI	17
11/9/2015	DAISEY Data Dictionary--MCH	77
11/12/2015	DAISEY Data Dictionary--TPTCM	15
12/10/2015	MCH December TA Webinar	45
12/14/2015	DAISEY Implementation	37
12/14/2015	DAISEY - KIPHS Webinar	15
12/17/2015	DAISEY - KIPHS Webinar	23
12/17/2015	MCH December TA Webinar	27
1/11/2016	DAISEY - EHR Webinar	34
1/13/2016	MCH January TA Webinar	54
1/21/2016	MCH January TA Webinar	37
2/4/2016	TPTCM FY17 Application	14
2/12/2016	PMI FY 2017 Application	13
2/16/2016	KIPHS Users Webinar regarding DAISEY	45
2/18/2016	MCH TA Webinar Open-Mic	14
2/24/2016	BaM Integration Training	11
4/25/2016	BaM Monthly Integration Webinar	13

*Local Public Health program staff funded with Title V facilitated/offered the following:*

Staff provided state and local MCH professionals free learning opportunities on developing content for adult learners during a two day Instructional Design training and TRAIN Course Provider and Administrator training as well as

technical assistance pre/post adding courses to the KS-TRAIN learning management system. The Stephanie Wolf, MCH Consultant, completed the course.

Staff provided a training developed by Local Public Health staff called Health in 3D: Diversity, Determinants and Disparities. This training is Kansas specific and is designed to increase the cultural competence of public health professionals. It is mandated for KDHE staff and highly recommended for local public health department staff. It is available as a course on KS-TRAIN.

Staff and the KS-TRAIN team collaborated with the University of Kansas Medical Center and Area Health Education Centers to provide Kansas Public Health Grand Rounds topics, presenters, promotion and archiving of the facilitated webinars on KS-TRAIN. Opportunities for the public health MCH workforce:

- Kansas Public Health Grand Rounds Fall 2014 "Human Trafficking in Healthcare" Archived WEBCAST (1054003)
- Kansas Public Health Grand Rounds Spring 2015 "You are the Key to HPV Cancer Prevention" Archived WEBCAST (1067346)

Staff provided support for an annual Local Public Health Leadership Series which provides workforce development for local and state health department staff.

#### *Ongoing Workforce Development Activities*

Staff convene and conduct 30 regional meetings for local public health agency administrators (and/or staff) held in locations in the six public health regions of Kansas for the purpose of furthering statewide collaboration on public health topics. Each meeting provides, at a minimum, an update on state MCH activities and will also provide an opportunity for state MCH staff to deliver relevant content in face-to-face settings.

Technical assistance to local health departments to identify, integrate and enhance evidence-based practices that directly impact Maternal Child Health, Family Planning, and School Health programmatic priorities.

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.

Collaborate/promote QI and performance management activities available to all 100 health departments in partnership with state agencies and organizations in work toward strategic planning and accreditation application readiness.

Promote awareness and attainment of public health accreditation standards and quality improvement concepts by incorporating and defining targeted content in technical assistance visits, regional public health meetings, Connections publications, workforce development efforts such as the Governor's Public Health Conference, and monthly statewide KDHE public health "briefing" calls as well as by posting resources on the Local Public Health KDHE webpage.

**State Title V Workforce Development & Training Needs:** A Workforce Development Plan was implemented for KDHE in 2015. Training needs identified through a workforce assessment that informed the plan will result in face to face and online training for the state staff in the coming year. In addition to required agency training programs like Quality Improvement and Active Shooter Mitigation, the Bureau and Title V state staff participate in annual training. Past events that applied to all staff in the Bureau include The Change Cycle, Leadership Challenge, and Bridges Out of Poverty. The MCH Navigator and online MCH Assessment are utilized and fully integrated into the professional development planning and performance reviews for all staff. Staff are in need of training related to Medicaid, QI-

cycles/data collection, program evaluation, drafting aim and outcome statements, monitoring subrecipients, care coordination, and telehealth.

### **II.F.3. Family Consumer Partnership**

Family engagement and family partnership are a critical components to moving program services in the right direction. Families can provide firsthand knowledge and insight to areas that state program staff may not have considered, as well as suggestions on how to make positive changes for the CYSHCN population. To support opportunities for family engagement, the Title V Block Grant input survey is promoted to families across the state to share their thoughts and ideas for ways to improve the system. The survey includes a place to put personal comments and ideas to be integrated into block grant applications and annual reports.

Additional family consumer engagement is critical to the KS-SHCN program and is sought in a variety of ways. Throughout the past year community meetings were held across the state to engage consumers and partners on the merging of the “Standards for Systems of Care for Children and Youth with Special Health Care Needs”. This is an ongoing project that will continue over the next year. Family and consumer partners of all backgrounds, education levels, and ethnicities were invited to participate in the meetings. Specific demographic data regarding race or ethnicity was not collected. The standards for systems of care meetings provided an opportunity for participants to register in advance and notify meeting organizers of needed language or disability accommodations. While this was offered and available, no meeting participants required or requested these accommodations. Throughout these meetings, parents, siblings, and other family members were engaged in public forum discussions, both large and small large group formats. It was clear throughout the meetings that those in attendance were extremely passionate about improving the health of children and youth in Kansas. Many participants were in attendance to support both personal and professional interests, however they often identified which “hat” they were wearing during the discussions – often times, the “parent hat” was more prominent than the “business hat.”

Families are encouraged to participate in the yearly block grant survey to share their opinions. This is reviewed by all staff and used to make corrections or modification. These initiatives focused heavily on families and consumers, with the intent to gain meaningful input and feedback regarding MCH services to support positive outcomes across the lifespan.

*SPECIAL HEALTH SERVICES FAMILY ADVISORY COUNCIL (SHS-FAC):* Family consumer partnerships continue to be the strength of the KS-SHCN program. Program staff understand that any initiative or project must be vetted through families in order to know that it is a valid project that families will find value in. The program exist to improve the lives of individuals with special health care needs and the program has adopted the philosophy “nothing without us”, so buy in from those who will be directly affected by programmatic changes needs to occur frequently. For this reason, the SHS-FAC is supported, including providing the family members a consultant fee and travel reimbursement. The Council is made up of a variety of families who have children with a wide range of special health care needs and vary in age from newborn to adulthood. This council not only advises the SHS programs but assist in developing programs, materials and promotional activities to spread the word about program services. SHS-FAC members receive valuable training on Title V and MCH core competencies. Program staff are constantly working towards recruiting FAC members of more diverse ethnic backgrounds.

KS-SHCN staff serve as the agency lead, with support from the Executive Committee, three FAC members assist in the development of agendas, bringing key issues to the table, and overview of FAC operations. The Executive Committee was created to provide an expanded leadership opportunity and allow interested FAC members to be more engaged, in addition to assuring the meetings remained focused on member interests. The FAC holds the

responsibility for assuring the KS-SHCN program is accountable in moving the strategic plan forward with family/consumer partnership as the central focus.

FAC members are encouraged to engage in community initiatives to support their interests. This can include members participating in local peer support groups, community projects and charitable organizations, research and advocacy efforts associated with their child's condition, and as engaged family members of other state agencies or systems, such as part of the Managed Care Organization (MCO) Consumer Groups. While financial support is not offered for these other activities, encouragement, resources, information, and assistance is available from agency staff liaisons and programs. FAC members engaged in these other efforts will share information on these activities with other members, allowing for dialogue and resource sharing during and in-between meetings.

Another type of direct support provided to FAC members is assistance with developing and delivering presentation to local and statewide audiences. This past year, FAC members presented at the Governor's Public Health Conference. Four FAC members participated in a panel discussion during the conference, with support from the KS-SHCN Program Manager and SHS Director.

The FAC hold a strategic planning session once per year to outline tasks and objectives they want to focus on for the upcoming year. This year that was done during a two day retreat in February. They will be working on caregiver health and the Kansas Resource Guide (KRG) navigational tool kit. Work groups decide on their tasks and determine the frequency they will meet to work on their project. The KS-SHCN staff is there for support and guidance when needed. A group leader is selected to monitor the progress and report back to the SHS staff.

This year, the FAC members developed an FAC Alumni and Mentorship Program (AMP). AMP was developed for members who have to leave the Council due to term limits or personal reasons, but would still like to be involved with the FAC at some level. Continued engagement opportunities are offered to these seasoned and motivated family professionals, allowing them to continue their contributions and see the impact of their foundational work. The mentor program is to assist new member in learning about the FAC and their role as a member. Former or current members who have served 2 or more years as an FAC member can participate in a mentor capacity. Additionally, we hope to nurture their investment and expand the cross cutting community of Title V family and consumer partners.

*FAMILY DELEGATE PROGRAM:* The Kansas AMCHP Family Delegate appointment process was initiated by the CYSCHN Director in 2013 to increase the opportunities for family leadership within Title V and to ensure comprehensive supports and resources are available for delegates. A competitive application process was developed to involve a mentorship plan resulting a mutually agreed-upon project, advancing the MCH/Title V 5-year plan. Delegates are allowed to continue for two consecutive years, if interested. Donna Yadrich was appointed the first delegate through this process (2013-2014) and has continued on as the 2014-2015 Delegate. Due to being a family delegate on the AMCHP board Donna has been allowed to continue as the Family Delegate for an additional term. The Family Delegate also fully participates in the annual block grant review process and during the in-person site visit in 2014, shared FAC updates and input. The Family Delegate will assist Title V in developing a structured family leadership program using national guidelines and standards.

*FAMILY REPRESENTATION ON KANSAS MATERNAL AND CHILD HEALTH COUNCIL (KMCHC):* Family representation on the statewide MCH Council began May 2014. This council serves to advise the Kansas Department of Health and Environment on cross-cutting issues across the lifespan of Kansas women, children and families. This is the first time a family representative has been present during these meetings. During the FY16 an additional family member has been added to the council bring a new perspective to council initiatives.

*BECOMING A MOM:* Family Consumer Partnership is certainly an area of interest for the Becoming a Mom program – Kansas Model. Intentions are to build in an *integration* component centered on this concept. Sites will be

encouraged to have former BaM participants and support people serve on the local perinatal/MCH coalition that serves as a backbone to program implementation in that community. Input from consumers will be utilized in making decisions around program implementation, priority areas for focus in the upcoming year, etc.

#### **II.F.4. Health Reform**

Local MCH grantees across the state are embracing the need to support health reform efforts and ensure consumer assistance related to the health insurance marketplace and coordination/collaboration with the Medicaid Managed Care Organizations (MCOs). A number of MCH grantees employ or refer to Certified Application Counselors and/or Navigators to assist families with acquiring insurance. Additionally, on-site KanCare (Medicaid) Intake Specialists are available to assist with eligibility and enrollment. In most cases, families are screened for medical home and payor source. Clients indicating no medical home/payor source will be immediately referred to a counselor, navigator, or home visitor for assistance. Coordination with the KDHE Outstationed worker/specialist housed is expected. The Outstationed worker can assist with expediting applications for pregnant women (Presumptive Eligible - PE) versus them routing through the clearinghouse until PE is integrated into the eligibility system, reducing the amount of time it takes to receive Medicaid assistance/services. This supports early access to services including prenatal care. Many individuals served are not eligible for KanCare or the marketplace due to immigration status.\*\* In these cases, the health department may provide services to the individual or refer to the federally qualified health center or other safety net/primary clinic for services. Since many uninsured prenatal clients cannot afford to pay private practice physicians for prenatal care, they find themselves utilizing the local public health department as their prenatal medical home.

Kansas did not expand Medicaid and few formal Title V activities have taken place at the state level; however, MCH staff presented information to the group of Kansas Medicaid Outstationed Eligibility/Outreach workers March 2014. Additionally, the Medicaid Eligibility Supervisor presented to the State MCH Coordination team April 2014, sharing changes in Kansas Medicaid as a result of health reform. The Outstationed worker list was distributed to all grantees to support referral and support for the application/eligibility process with a "no wrong door" approach to referral for eligibility/applications support. The state's capacity to address health reform from the context of the National Workforce Development Center's definition\* of "health transformation" is higher due to program changes which shift the focus to the integration of public health and primary care, collaborative service delivery models, and from disease management to prevention and population health management.

There is also a shift specifically from direct clinical services to care coordination and family empowerment/self-sufficiency as it relates to special health care needs. Additionally, the focus has historically revolved around a multidisciplinary approach to the provision of services under the medical home approach. As the Title V agency, the Kansas Department of Health and Environment has been working on efforts to integrate traditional health care models (primary, specialty and tertiary care) with public health models. The Kansas Special Health Care Needs (KS-SHCN) program primarily provides diagnostic evaluations, specialized medical treatment services and care coordination. A strategic planning process began in July 2013 to identify new priorities for the program and improved service opportunities for families. Participants were asked to brainstorm ideas on new priorities to be considered by KS-SHCN for the 2020 Title V Needs Assessment. The five adopted priorities include: Care Coordination, Behavioral Health, Family Caregiver Health, Training and Education, and Direct Health Services. Throughout this process, it has been determined the KS-SHCN should support a service delivery model that shift from direct services to more community and population-based, enabling, and infrastructure building activities. In addition to an extensive cost analysis and funding review of direct, clinical services provided through KS-SHCN, the program launched development of a cross-system care coordination model and expansion of clinical services through building telemedicine capacity in rural communities. Primary hospital partners across the state have established

varying telemedicine programs. The Kansas University Medical Center (KUMC), Center for Child Health and Development (CCHD) has established, through a grant award from the KS-SHCN program, telemedicine specialty clinics for patients with cystic fibrosis. The Kansas University School of Medicine, Wichita (KUSM-W) has established telegenetic clinics through a Kansas genetic counselor and a pediatric medical and metabolic geneticist in Little Rock, Arkansas. This is a project often supported by the KS-SHCN program and a current initiative is in place to expand the genetic services in this area, utilizing telemedicine and partnerships with providers from other communities and states. Wesley Medical Center has established the Wesley Care Telemedicine Network, including specialty services for neurology and stroke care.

*\*The National Workforce Development Center's definition of health transformation is reflected throughout Center activities and provides an opportunity for all states/territories, regardless of their environment, to embrace the changes and opportunities to promote maternal and child health. Health transformation:*

- *Shifts the emphasis of health care from disease management to prevention and population health management, while improving access to affordable health care*
- *Develops an interprofessional/interdisciplinary approach to health care*
- *Integrates primary care, specialty care and public health*
- *Develops efficient health systems that better incorporate ongoing quality improvement, and*
- *Drives partnerships across sectors to optimize the well-being of maternal and child health populations.*

*\*\*Those prenatal clients that are without U.S. Legal Residence or Citizenship are screened by the Social Workers for eligibility of SOBRA for the cost of emergency services (including labor and delivery). This coverage is available only for those people who would, except for legal status, be eligible for KanCare Medicaid.*

## **II.F.5. Emerging Issues**

The leading issue that emerged through the needs assessment process was community norms. KDHE recognizes that it is not enough to identify and respond to needs, but that as implementation of the 2016-2020 Action Plan continues, more work will need to be done to identify and address underlying norms that prevent access to services, interest in services, and stigma associated with utilizing services. Addressing community norms is one of the guiding principles of our work. To better understand the overall MCH community norms issues, an initial scan was included in the Title V Needs Assessment survey conducted January-February 2015. Results indicate that there is a need for further work in identifying, understanding, and addressing community norms. Ten pairs of questions which were asked to better understand the relationship between individual beliefs and collective beliefs, or norms. This process provides insight into perceptions of key issues that may be barriers to service utilization, to identifying risk factors, or to engaging in behaviors that lead to negative outcomes. In interpreting the results, the mean difference is the difference between mean scores for each pair of questions, or the difference between the average score of what "I believe" and the average score of what "most adults in my community believe." Each of the pairs had a statistically significant difference between the statements, with the exception of health, weight, and nutrition for infants and children. Moreover, two areas that were identified as key components of the Five-Year Action Plan, reproductive health and breastfeeding, are the areas with the largest differences between individual and collective perceptions. These are indicators of lacking of a common understanding of key issues.

Since the needs assessment, another significant emerging issue impacting public health and MCH is prescription drug use/abuse. Specifically for the MCH staff, mandatory of child abuse and neglect has been identified as an area where more training and guidance is needed.

## II.F.6. Public Input

UPDATE

### **Title V Block Grant Application/Annual Report Feedback**

This survey is intended to collect information on the DRAFT Application and Annual Report from consumers and partners across the state that are informed of and concerned about the needs of MCH populations.

Public Comment Period: June 18-July 6, 2015

Methods: The following email was sent by the Title V Director to partners statewide. The survey link was posted on the BFH website, announcements were posted online, via social media, and in newsletters.

*Dear Kansas Maternal & Child Health Partner:*

*As the Kansas Title V Maternal & Child Health (MCH) Director, it is my pleasure to release the (draft) Kansas MCH Block Grant 2016 Application and 2014 Annual Report. The MCH Block Grant is administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health (BFH). Please take time to review this year's block grant application and provide comments/additional detail you might have to strengthen the application. After reviewing the draft document, we ask that you complete a short online survey (<https://www.surveymonkey.com/r/HY95QLT>). Please respond to the survey by July 6 in order to ensure that your comments are reviewed and considered for incorporation into the application. The survey and draft application are posted on the KDHE BFH website.*

*Resources to increase your knowledge about the block grant and Kansas' priority issues for 2016-2020 can be found on the MCH Block Grant website (<http://www.kdheks.gov/c-f/mch.htm>). Your input is valuable and needed to assure the MCH Program is guided by the needs of Kansas families and MCH priority populations: women of reproductive age, pregnant women, infants, children, adolescents, and individuals with special health care needs. Whether you are a parent, health professional, government official, advocate, or member of the general public, the MCH block grant activities touch your life. Success lies in the strength of partnerships and collaborations to maximize reach and promote efficiency.*

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

### Results:

A total of 46 responses were received. There were a number of opportunities for partners, families, and the public to provide feedback related to MCH services and populations. Nearly half (45.7%) provided input through MCH Services Input Survey (Online), followed by Public Health Regional Meetings (AMCHP Compendium) (34.8%), Title V Needs Assessment Survey (Online) (17.4%), Communities for Kids Meetings (13.0%), Special Health Care Needs Strategic Planning Meetings (13.0%), Family Advisory Council Meetings (13.0%), Adolescent Health Survey (Online) (10.9%), MCH Council Meetings (6.5%), Adolescent Health Focus Groups (4.3%), Blue Ribbon Panel on Infant Mortality Meetings (2.2%), and Parent Leadership Conference (2.2%). Eleven (23.9%) responded that they did not provide input.

The majority of the respondents strongly agreed, or agreed that the current Needs Assessment process:

- increased understanding of the Title V MCH Block Grant, initiatives, and services (100.0%).
- was effective for public input (95.3%).
- reflected broad public input (93.0%).
- was accessible (90.5%).
- was reasonable (95.3%).

Based on the information contained in the draft application/annual report, the majority of the respondents strongly

agreed, or agreed that they had a better understanding of the state MCH Priorities and plans for population health domains:

- Women/Maternal Health (100.0%)
- Perinatal/Infant Health (100.0%)
- Child Health (100.0%)
- Adolescent Health (10.0%)
- Children and Youth with Special Health Care Needs (97.4%)
- Cross-Cutting/Life Course (86.5%)

The majority responded that the 2016 Application/2014 Annual Report:

- clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities (94.7%)
- demonstrates strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas (100.0%)
- accurately reflects the capacity/work/activities across Kansas as they relate to the state priorities (94.7%)

After reviewing “Five Year State Action Plan” and “Budget Narrative & Forms”, the majority responded that:

- the state action plan and strategies were adequately addressed (91.4%)
- the MCH Workforce Development and Capacity, Family/Consumer Partnership, Health Reform, and Emerging Issues were adequately addressed (94.3%)
- the resource allocation/expenditures were adequately addressed (91.4%)

#### Needs Assessment INPUT 2015 - UPDATE from last year

The Title V Maternal Child Health (MCH) five-year needs assessment is designed to be an opportunity to review data, gather input from stakeholders, build capacity, and identify priorities. Central to the needs assessment planning and process to identify priorities was to work with the KS MCH Council to determine the status of MCH progress since *MCH 2015* (2010 Needs Assessment) was implemented. This analysis assisted with identifying which priorities were still priorities five years later and therefore should be continued. More information about the key role of the state-level Council can be found under the Needs Assessment Process (II.B.1) and Partnerships (II.B.2.c.) sections.

The Kansas Department of Health and Environment (KDHE) spent 18 months conducting the needs assessment with an approach focused on not only creating a meaningful, responsive action plan, but also building a strong platform to maximize resources, develop and sustain mutually reinforcing relationships, and deliver outcomes. Early on in the needs assessment, a broad approach was taken in order to capture a wide scope of input from state and local partners using in person meetings and surveys. The input came from stakeholders, local public health, health care providers, educators, consumers, and other community health programs including injury prevention, mental health, and Medicaid. The team covered six regions of the state in person, facilitating MCH regional meetings and attended, facilitated, or presented at three MCH council meetings, the Blue Ribbon Panel on Infant Mortality, and various meetings with stakeholders. The broad approach continued with three large-scale surveys distributed over nine months. The following provides an overview of the input/data collection process.

#### Community In-Person Meetings

Activity	Purpose	Domain Focus	Participation	Timeframe
MCH Services Input Survey	Annual feedback to KDHE on MCH services and community needs	All	222 respondents	November 20, 2013-May 15, 2014

Public Health Regional Meetings (AMCHP Compendium served as key planning resource)	Develop partnerships at the local level to improve MCH services; identify needs at the local level related to MCH populations	All	209 (5 meetings)	May 2014-February 2015
Kansas MCH Council	Advises on Title V/MCH	Women, Infants, Children, Adolescents	17 attendees 20 attendees 19 attendees	September 2014, December 2014, April 2015
Blue Ribbon Panel on Infant Mortality	Through infant mortality CollN, reduce infant mortality in the State	Women, Infants	20 attendees	August 2014
Communities for Kids Meetings	Gather broad stakeholder input on needs of MCH populations; provide opportunity for local communities to connect with KDHE staff	All	253 attendees (17 meetings)	November 2014-February 2015
Adolescent Health Input Survey	Understand needs of youth ages 10-19	Adolescents	854 respondents	Fall 2014
Adolescent Health Focus Groups	Understand needs of youth ages 10-19	Adolescents	401 attendees	Fall 2014
SHCN Strategic Planning Meeting	Identify priority needs and shift work/realign program as necessary	SHCN	110 attendees (4 meetings)	July 2013, August 2013, November 2013, September 2014
Family Advisory Council (FAC) Meetings	Collect input from existing council/families and consumers with lived experience, especially families providing care for children and youth with special health care needs	SHCN, Children, Adolescents	15 attendees	August 2013, November 2013, February 2014, May 2014, November 2014, February 2015, May 2015
Parent Leadership	Target families and the public, especially	All	150 respondents	November 2014

Conference	parents			
Title V Needs Assessment (Community Norms) Survey	Assess shared understanding of key community issues and beliefs/norms	All	540 respondents	January-February 2015
KDHE MCH State Coordination Meetings	Identify shared priorities and needs; align vision and approach to MCH efforts; align and integrate where appropriate	All Family Health (MCH, WIC, Family Planning, Part C, etc.)	Monthly meetings	Ongoing

The team facilitated 22 regional and community meetings to gain broad public input on the development of priority needs for MCH populations (see Meeting Timeline below). Two forums, Public Health Regional meetings (using the AMCHP Birth Outcomes Compendium as a key resource) and *Communities for Kids (C4K)* meetings, were utilized to gain input from key partners, stakeholders, service providers, and community members. NOTE: several Communities for Kids meetings were held twice at the same location - day and evening.

- October 21, 2014 Regional, Wichita
- November 13, 2014 Regional, Garden City
- December 10, 2014 C4K, Roeland Park
- December 16, 2014 C4K, Great Bend
- December 17, 2014 C4K, Concordia
- January 12, 2015 C4K, Colby
- January 13, 2015 Regional, Colby
- January 14, 2015 C4K, Garden City
- January 21, 2015 C4K, Topeka
- February 10, 2015 C4K, Junction City
- February 11, 2015 Regional, Concordia
- February 19, 2015 C4K, Wichita
- February 25, 2015 Regional, Topeka
- February 26, 2015 C4K, Parsons

#### Public Health (AMCHP) Regional Meetings

In an effort to collect comprehensive input while also increasing partner awareness, KDHE launched an initiative aimed at improving the health of Kansas mothers and infants. Using a collective impact framework, KDHE partnered with the March of Dimes Greater Kansas Chapter (MOD) and AMCHP to engage more than 200 stakeholders across the state between May 2014 and February 2015. This effort was not exclusively about health care, but instead focused on forging partnerships to collectively and comprehensively address issues families face in the context of their communities throughout the course of life. The primary goal has been to develop collaboration at the state and

local levels, assessing what's working and what's not, and utilizing existing resources to guide the process. The MCH project team invited key partners and stakeholders to the Regional meetings to participate. Objectives:

#### Communities for Kids Meetings

The Special Health Care Needs (SHCN) Director facilitated "Communities for Kids" forums in nine locations across the state. Keeping in mind children with special health care needs are children first and foremost, KDHE was able to intimately and in detail capture the needs of all children as well as their parents and caregivers. This was an opportunity to learn from families, community and health providers, school professionals, and any member of the community interested in the health of Kansas children to voice the most prevalent maternal and child needs are within these communities. Each meeting consisted of a presentation on the state of SHCN in Kansas as well as the programs goals and philosophy of children first and the Title V needs assessment overview. The community meetings were essentially open forum and group process and comments were recorded by staff. Meeting participants actively engaged in discussing what they believed to be were needs or service gaps relating to each of the five domains. An overwhelmingly number of the meetings engaged participants at the community level and included parents as well as extended family, providers, and educators including home visitors. Families, communities and key partners had the opportunity to share information, experiences, and ideas about how maternal and child health programs can improve support and services in their community for children and adolescents, including those with special health care needs or disabilities. All were invited to attend the meetings to learn more about MCH services and provide input: parents, local officials, advocates, education professionals, and anyone interested in maternal and child health. Most locations offered two meeting times (2 p.m./6 p.m.) to support participation at the community level.

#### **Title V Needs Assessment (Community Norms) Survey**

Addressing community norms is one of the guiding principles of our work. To better understand the overall MCH community norms issues, an initial scan was included in the Title V Needs Assessment survey conducted in January-February 2015. Results indicate that there is a need for further work in identifying, understanding, and addressing community norms. Ten pairs of questions were asked to better understand the relationship between individual beliefs and collective beliefs, or norms. This process provides insight into perceptions of key issues that may be barriers to service utilization, to identifying risk factors, or to engaging in behaviors that lead to negative outcomes. In interpreting the results (540 respondents), the mean difference is the difference between mean scores for each pair of questions, or the difference between the average score of what "I believe" and the average score of what "most adults in my community believe." Each of the pairs had a statistically significant difference between the statements, with the exception of health, weight, and nutrition for infants and children. Moreover, two areas that were identified as key components of the Five-Year Action Plan, reproductive health and breastfeeding, are the areas with the largest differences between individual and collective perceptions.

#### **II.F.7. Technical Assistance**

**Subrecipient Monitoring:** The agency and Title V program has a need for targeted technical assistance related to developing protocol, processes, procedures, and tools for effective and efficient subrecipient monitoring (contract development and oversight, monitoring visits, sound budget and expense tracking, audits and compliance, and more). The agency recently created a centralized position to provide guidance on this including OMB requirements.

**Title V MCH/Medicaid Intragency Coordination & Collaboration:** ERO 38 introduced in the 2011 Legislative Session, mandated the merger of the KDHE (Title V MCH State Agency) and the Kansas Health Policy Authority

(State Medicaid Agency). Since 2012, the two Divisions have been a part of the same agency. Consultation with a national expert is needed to take steps to strengthen the mandated relationship, especially where data sharing is concerned, and identify collaborative projects aimed at reducing disparities, advancing work/efforts related to shared priorities and needs, improving outcomes, and reducing health care costs. Medicaid and CHIP provide prenatal, labor and delivery, and postpartum services for a large proportion of births in Kansas, covering 37 percent of all births in 2013. As the largest single payer for maternity care, Medicaid and CHIP play a key role in promoting access to care and ensuring the quality of care during the perinatal period. The Medicaid/CHIP Core Sets of health care quality measures contain nine maternity care measures to help drive quality improvement efforts at the state and national levels. The child Core Set includes six maternity measures (timeliness of prenatal care, frequency of ongoing prenatal care, behavioral health risk assessment for pregnant women, Cesarean rate, low birth weight rate, and well-child visits in the first 15 months of life) and the adult Core Set includes three maternity measures (antenatal steroid use, elective delivery, and timeliness of postpartum care). Two of these measures, low birth weight rate and Cesarean rate, are specified for use with vital records, although linkage to Medicaid/CHIP administrative data is often necessary to identify women covered by Medicaid or CHIP. The state's participation in the Collaborative Improvement and Innovation Network (CoIIN) expansion to reduce infant mortality through improved availability and reporting of timely provisional data to inform efforts and tract outcomes that drive quality improvement and collaborative learning requires the state's abilities to access/use the linked vital records with Medicaid/CHIP administrative/claims data. One of the CoIIN measures, initiation of progesterone in women on Medicaid with prior preterm birth is specified for use of linked vital records birth data and Medicaid/CHIP claims data.

Planning and Collaboration with Title X: The KDHE Children & Families Section as of March 2014 includes the MCH Title V and Title X programs. The programs spent several days together with a facilitator to set priorities, goals, objectives, and identify linkages between MCH and Title X/Family Planning. The staff also identified needed resources and potential impact on local agencies and clients/families served. Technical assistance would support continuing this work and further develop the state-level plan to leverage Title X funds and/or increase coordination and collaboration between the Kansas Title V and Title X programs. Once the state has developed a vision/plan for integrating services and programs where appropriate, messaging and activities must take place with the local level grantees/programs. The outcomes would be improved reproductive, maternal, and infant health and a continuum of care and integrated community-based services.

Other Technical Assistance Areas for Consideration: collecting measurable evidence related to program impact, program evaluation, school health, strategies and approaches for bullying prevention and building strong character/social-emotional development for children and youth

### III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$4,670,131	\$2,445,517	\$4,670,131	\$3,537,640
<b>Unobligated Balance</b>	\$0	\$0	\$0	\$0
<b>State Funds</b>	\$3,972,344	\$3,527,860	\$3,722,188	\$3,625,272
<b>Local Funds</b>	\$4,190,160	\$4,403,168	\$4,740,394	\$4,264,315
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$0	\$0	\$0	\$0
<b>SubTotal</b>	\$12,832,635	\$10,376,545	\$13,132,713	\$11,427,227
<b>Other Federal Funds</b>	\$70,032,836	\$78,292,923	\$80,287,199	
<b>Total</b>	\$82,865,471	\$88,669,468	\$93,419,912	\$11,427,227

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$4,682,822	\$2,684,453	\$4,686,020	
<b>Unobligated Balance</b>	\$0	\$0	\$0	
<b>State Funds</b>	\$3,524,276	\$3,533,493	\$3,567,032	
<b>Local Funds</b>	\$4,401,548	\$4,016,345	\$4,401,548	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$0	\$0	\$0	
<b>SubTotal</b>	\$12,608,646	\$10,234,291	\$12,654,600	
<b>Other Federal Funds</b>	\$76,927,990	\$68,796,517	\$69,994,218	
<b>Total</b>	\$89,536,636	\$79,030,808	\$82,648,818	

	2017	
	Budgeted	Expended
<b>Federal Allocation</b>	\$4,689,065	
<b>Unobligated Balance</b>	\$0	
<b>State Funds</b>	\$3,557,713	
<b>Local Funds</b>	\$3,981,689	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$0	
<b>SubTotal</b>	\$12,228,467	
<b>Other Federal Funds</b>	\$58,007,639	
<b>Total</b>	\$70,236,106	

### III.A. Expenditures

The State maintains budget documentation for all Block Grant funding allocations and expenditures for reporting. Expenses are tracked through the state's accounting system, SMART. All federal and non-federal (state and local) expenditures are tracked and reported separately. Expenditure detail for State Fiscal Year (SFY) 2015 is reflected on Forms 3a and 3b. Similar to previous reporting years, at the time the block grant application was prepared, several months of the current federal budget period remains, so block grant spending and aid to local disbursements for only two (and in some cases three) of four quarters have been made. Final payouts are made in the last quarter of the fiscal year/first quarter of the new state fiscal year. Therefore, what was budgeted for Fiscal Year 2015 and what is being reported for Fiscal Year 2015 may result in more than a 10% variance/difference. This difference can be accounted for by the process by which the Title V program funds local programs and manages Title V funds with authority to spend over a period of two years.

**2015 Expenditures:** The SFY 2015 block grant partnership expenditures were updated to reflect actual expenditures based on the state accounting system at the time the application was compiled (reflected on Forms 2, 3a and 3b). The following expenditures were reported: \$2,684,453 federal (of the total \$4,758,053 budgeted and authorized); \$3,533,493 state; and \$4,016,345 local for total MCH expenditures of \$10,234,291.

At the time of application compilation, the total SFY 2015, federal spending to support MCH/SHCN initiatives within the state health department included: \$86,198 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics and \$16,798 Local Public Health. Within the Bureau of Family Health (MCH Section) \$330,824 in federal MCH funds was spent for staff and operating costs related to overseeing the MCH grantees/local agencies and aid to local program activities, conducting site monitoring visits, supporting local and state initiatives, and more. Special Health Care Needs (SHCN) staff, operating costs, contracts and supplies total \$495,072. Direct Services accounted for \$104,017 of the total SHCN expenditures. Expenses for Direct Services are tracked separately through the Kansas SHCN program (effective SFY 2014) and break down as follows by type of service: DME \$9,131; Hospital \$18,821; Pharmacy \$38,887; Physician/Office \$6,965; Lab \$102; Specialty Clinic \$16,100; and Orthodontic \$14,011. MCH Aid to Local payments to providers for services total \$1,283,574. Child

Care Licensing federal expenditures total \$92,714. Salary and operating expenditures for the director, assistant, and fiscal support total \$123,014.

Form 2 reveals the Title V expenditures for FY 2015 are in compliance with the 30% - 30% requirements: preventive and primary care for children \$813,688 (30%) and children with special health care needs \$803,345 (30%), similar to previous reporting periods. Other requirements related to expenditures such as administrative costs (less than 10%) and maintenance of effort are maintained.

Form 2 also provides expenditures for other federal funds administered through the Bureau of Family Health, overseen by the Title V Director. The total expenditures for FY 2015 at the time of compilation are \$68,796,517 and include the following: Women, Infants, and Children (WIC) \$59,889,492; Breastfeeding Peer Counselor Program \$440,967; Early Childhood Comprehensive Systems \$39,583; Systems Integration \$22,223; Newborn Hearing Screening \$172,423; Maternal, Infant and Early Childhood Home Visiting (MIECHV) \$2,755,570; Part C Infant-Toddler Services \$2,016,683; Abstinence Education \$364,984; Family Planning \$2,235,685; Toxic Substances (Lead Hazard) \$299,228; and Healthy Start \$559,679.

Form 3a. Including Block Grant partnership expenditures (excluding administrative costs) totaling \$9,934,291 (federal, state, and local), totals by "Types of Individuals Served" (MCH population groups) include: Pregnant Women \$2,374,611 (458,710 federal/1,915,901 nonfederal); Infants <1 Year \$2,374,611 (458,710 federal/1,915,901 nonfederal); Children & Adolescents 1-22 Years \$3,392,775 (813,688 federal/2,579,087 nonfederal); and SHCN\* \$1,792,294 (803,345 federal/988,949 nonfederal).

\*no local match required

Form 3b. Including all Block Grant partnership expenditures, totals by "Types of Services" (MCH pyramid) include: \$135,270 (104,017 federal/31,253 nonfederal) (2%) for Direct Services; \$5,607,621 (1,222,571 federal/4,385,050 nonfederal) (54%) for Enabling Services; and \$4,491,400 (1,357,865 federal/3,133,535 nonfederal) (44%) for Public Health Services and Systems. The continued decline of CYSHCN expenditures from Direct Services to other types of services can be attributed to the shift to focus on promoting and supporting other critical services including outreach, education, care coordination, and medical homes. In addition, SHCN strictly adheres to the mandate of Title V as the payer of last resort, and the direct services paid only reflect services that were not covered or reimbursed through another provider. All expenditures are in line with previous reporting periods with no significant variations to be discussed. The state is well within its required maintenance of effort of \$2,352,511 with expenditures of \$3,533,493 in SFY 2015. Kansas meets its match requirement through the use of State funds that support Maternal and Child Health programming.

### III.B. Budget

Kansas Maternal & Child Health (MCH) and Special Health Care Needs (SHCN) Directors in partnership with the state Council and programs provide input into the allocation and budgeting process for the Title V MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based on the State MCH Needs Assessment.

**2017 Budget:** The total State budget submitted for Fiscal Year 2017 and detailed on Form 2 is \$70,236,106. This amount represents the budgeted MCH federal allocation, state contribution/funds, local contribution/funds, and other federal funds administered under the direction of the Title V Director in the Bureau of Family Health. The amounts break down as follows: budgeted MCH federal allocation \$4,689,065 (based on the allocated amounts in the State budget and a projected award amount estimated based on FFY15 and FFY16 authorized amounts); state MCH funds \$3,557,713; local MCH funds \$3,981,689; and other federal funds \$58,007,639. Other federal funds includes the following: Women, Infants, and Children (WIC) \$48,076,962; Breastfeeding Peer Counselor Program \$534,256; Early Childhood Comprehensive Systems \$136,941; Systems Integration \$300,000; Newborn Hearing Screening \$242,308; Maternal, Infant and Early Childhood Home Visiting (MIECHV) \$739,790; Part C Infant-Toddler Services \$4,046,135; Abstinence Education \$592,705; Family Planning \$2,335,979; Toxic Substances (Lead Hazard) \$322,313; and Healthy Start \$680,250. Note: Some "other" federal funds budgeted amounts reflect the state's budget at the time of the application submission. The actual amount the agency receives will not be known until the official Notice of Award is received from the funding agency.

Form 2. Overall, Kansas' MCH federal-state partnership budget totals \$12,228,467 (federal MCH funds \$4,689,065; state MCH funds \$3,557,713; local MCH funds \$3,981,689). The federal allocation is budgeted to support MCH/SHCN initiatives within the state health department as follows: \$118,148 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics; \$54,636 Local Public Health Program. Within the Bureau of Family Health, \$157,300 to support Child Care Licensing activities related to health and safety regulations; \$538,430 for staffing, MCH aid to local programming, monitoring, and other operations; \$201,590, director, assistant, and fiscal support; \$1,043,443 for SHCN programming, outreach, care coordination; \$115,938 for direct services (not reimbursed by other providers); \$100,000 for safe sleep initiatives (training, capacity and infrastructure building); \$2,129,580 for local agencies providing community-based, family centered MCH services; and \$230,000 for administration costs.

The Kansas budget for FY 2017 meets the maintenance of effort requirement of \$2,352,511. The Title V match requirement is achieved through projected State matching funds budgeted at \$3,557,713 which include \$35,100 for MCH aid to local operations; \$237,914 for universal home visiting services delivered by MCH grantees/local health departments; \$96,374 for Kansas Infant Death and SIDS (KIDS) Network of Kansas (safe sleep initiative); \$496,600 for newborn screening follow up; \$195,570 for SHCN administration, case management and services; \$2,169,614 for MCH aid to local programming; \$105,537 for seating clinics; \$199,274 for PKU services; and \$21,730 for SHCN direct services. Local match is projected to total \$3,981,689 (estimated based on total SFY15 and SFY16 match reported by local grantees).

The Title V budget and funding allocations are in compliance with the 30% - 30% requirements: preventive and primary care for children \$1,449,067 (31%) and children with special health care needs \$1,433,102 (31%), similar to previous reporting periods (see Form 2). Other requirements related to budget categories such as administrative costs (less than 10%) and maintenance of effort are maintained. The current indirect cost rate for KDHE is 19.7%. 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, \$230,000 is budgeted (4.3%), in line with previous years.

Considering the total budget of \$12,228,467, Form 3a details the (federal/nonfederal) budgeted amounts by types of individuals served including \$788,448 federal and \$1,842,641 nonfederal for pregnant women; \$788,448 federal and \$1,842,640 nonfederal for infants < 1 year; \$1,449,067 federal and \$3,656,415 nonfederal for children 1-22 years; \$1,433,102 federal and \$427,706 nonfederal for SHCN. Form 3b details the (federal/nonfederal) budgeted amounts of types of services including approximately \$115,938 federal and \$21,730 nonfederal for direct services (1%); \$2,146,346 federal and \$4,308,705 nonfederal for enabling services (53%); and \$2,426,781 federal and \$3,208,967 nonfederal for public health services and systems (46%). There are no significant variations in the budgeted amounts reported by the state on Forms 2 and 3, as compared to previous years' reporting.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [KS DHCF-DOPH Agreement DRAFT 5-24-16.pdf](#)

## V. Supporting Documents

No Supporting documents were provided by the state.

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Kansas**

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 4,689,065	
A. Preventive and Primary Care for Children	\$ 1,449,067	(30.9%)
B. Children with Special Health Care Needs	\$ 1,433,102	(30.6%)
C. Title V Administrative Costs	\$ 230,000	(4.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,557,713	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 3,981,689	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,539,402	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,352,511		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 12,228,467	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 58,007,639	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 70,236,106	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 739,790
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 136,941
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 680,250
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 300,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 242,308
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,335,979
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 534,256
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 48,076,962
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 4,046,135
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead	\$ 322,313
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 592,705

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 4,682,822		\$ 2,684,453	
A. Preventive and Primary Care for Children	\$ 1,598,811	(34.1%)	\$ 813,688	(30.3%)
B. Children with Special Health Care Needs	\$ 1,477,508	(31.6%)	\$ 803,345	(29.9%)
C. Title V Administrative Costs	\$ 200,000	(4.3%)	\$ 150,000	(5.6%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,524,276		\$ 3,533,493	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 4,401,548		\$ 4,016,345	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,925,824		\$ 7,549,838	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,352,511				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 12,608,646		\$ 10,234,291	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 76,927,990		\$ 68,796,517	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 89,536,636		\$ 79,030,808	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 364,984
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 2,755,570
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 39,583
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 559,679
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 172,423
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,235,685
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 440,967
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 59,889,492
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 2,016,683
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead	\$ 299,228
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	\$ 22,223

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The total amount authorized/budgeted for FFY15 is obligated at 100%; however, expenditures for Aid to Local payments and contracts will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between the two budget periods per agency fiscal protocol.
2.	<b>Field Name:</b>	<b>Federal Allocation, B. Children with Special Health Care Needs:</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The total amount authorized/budgeted for FFY15 is obligated at 100%; however, expenditures for Aid to Local payments and contracts will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between the two budget periods per agency fiscal protocol. The total expenditures will be at or above the required 30% allocation once the expenditures are updated within the next quarter.
3.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The total amount authorized/budgeted for FFY15 is obligated at 100%; however, expenditures for Aid to Local payments and contracts will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between the two budget periods per agency fiscal protocol.
4.	<b>Field Name:</b>	<b>1.FEDERAL ALLOCATION</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The total amount authorized/budgeted for FFY15 is obligated at 100%; however, expenditures for Aid to Local payments and contracts will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between the two budget periods per agency fiscal protocol.

**Data Alerts:**

1.

The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. Please add a field level note indicating the reason for the discrepancy.

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Kansas**

**I. TYPES OF INDIVIDUALS SERVED**

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 788,448	\$ 443,404
2. Infants < 1 year	\$ 788,448	\$ 443,404
3. Children 1-22 years	\$ 1,449,067	\$ 949,456
4. CSHCN	\$ 1,433,102	\$ 698,189
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 4,459,065	\$ 2,534,453

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 1,842,641	\$ 1,748,454
2. Infants < 1 year	\$ 1,842,640	\$ 1,748,454
3. Children 1-22 years	\$ 3,656,415	\$ 3,575,390
4. CSHCN	\$ 427,706	\$ 327,540
5. All Others	\$ 0	\$ 0
Non Federal Total of Individuals Served	\$ 7,769,402	\$ 7,399,838
Federal State MCH Block Grant Partnership Total	\$ 12,228,467	\$ 9,934,291

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts:**

1.	Children 1 to 22 Years, Annual Report Expended does not equal Form 2, Line 1A, preventive and Primary Care for Children, Annual Report Expended. Please add a field level note to explain.
2.	CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. Please add a field level note to explain.

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Kansas**

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 115,938	\$ 104,017
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 115,938	\$ 104,017
2. Enabling Services	\$ 2,146,346	\$ 1,222,571
3. Public Health Services and Systems	\$ 2,426,781	\$ 1,357,865
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 38,887
Physician/Office Services		\$ 6,965
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 18,821
Dental Care (Does Not Include Orthodontic Services)		\$ 14,011
Durable Medical Equipment and Supplies		\$ 9,131
Laboratory Services		\$ 102
Other		
Clinic Fees		\$ 16,100
Direct Services Line 4 Expended Total		\$ 104,017
<b>Federal Total</b>	<b>\$ 4,689,065</b>	<b>\$ 2,684,453</b>

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 21,730	\$ 31,253
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 21,730	\$ 31,253
2. Enabling Services	\$ 4,308,705	\$ 4,385,050
3. Public Health Services and Systems	\$ 3,208,967	\$ 3,133,535
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 31,253
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 31,253
<b>Non-Federal Total</b>	\$ 7,539,402	\$ 7,549,838

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Kansas**

**Total Births by Occurrence: 40,132**

**1. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	40,132 (100.0%)	360	77	77 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methylglutaric aciduria	Holocarboxylase synthase deficiency	β-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, β-thalassemia	S,C disease
Biotinidase deficiency	Cystic fibrosis	Classic galactosemia		

**2. Other Newborn Screening Tests**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	39,609 (98.7%)	606	70	70 (100.0%)

### 3. Screening Programs for Older Children & Women

None

### 4. Long-Term Follow-Up

Newborn Metabolic Screening (NBS): NBS Follow-up generally ends at the onset of treatment, however referrals into the Special Health Care Needs (SHCN) program can provide opportunity for ongoing long-term follow-up. Additionally, a new staff position, shared by NBS and SHCN, will be utilized to develop a long-term NBS follow-up program in the coming years.

Newborn Hearing Screening (NBHS): The SoundBeginnings program follows hearing screens on infants from the initial screens in the hospital to appointments with hearing specialists and to other agencies that provide services for children with hearing loss. Infants identified with hearing loss are referred to early intervention so they can receive the appropriate services to support normal speech and language development. As with NBS, NBHS will refer children with identified hearing loss to SHCN, providing opportunity for ongoing follow-up and support for specialty services.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Core RUSP Conditions - Positive Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Provisional: calendar year 2014
2.	<b>Field Name:</b>	<b>Newborn Hearing - Receiving At Lease One Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Final: Calendar year 2014
3.	<b>Field Name:</b>	<b>Newborn Hearing - Positive Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Final: Calendar year 2014
4.	<b>Field Name:</b>	<b>Newborn Hearing - Confirmed Cases</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Final: Calendar year 2014
5.	<b>Field Name:</b>	<b>Newborn Hearing - Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Final: Calendar year 2014

**Data Alerts:**

None

**Form 5a  
Unduplicated Count of Individuals Served under Title V**

**State: Kansas**

**Reporting Year 2015**

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	5,696	23.9	13.5	14.9	32.0	15.7
2. Infants < 1 Year of Age	8,587	35.0	17.5	11.4	15.6	20.5
3. Children 1 to 22 Years of Age	52,796	28.1	13.9	20.0	24.3	13.7
4. Children with Special Health Care Needs	3,840	40.7	46.4	4.5	6.9	1.5
5. Others	2,610	39.5	9.2	32.2	16.2	2.9
Total	73,529					

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

None

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Kansas**

**Reporting Year 2015**

Types Of Individuals Served	Total Served
1. Pregnant Women	5,696
2. Infants < 1 Year of Age	40,132
3. Children 1 to 22 Years of Age	900,213
4. Children with Special Health Care Needs	3,840
5. Others	2,610
<b>Total</b>	952,491

**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

None

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Kansas**

**Reporting Year 2015**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	40,330	33,194	2,919	254	1,152	57	880	1,874
Title V Served	5,696	4,948	324	38	70	13	195	108
Eligible for Title XIX	12,244	9,472	1,816	280	237	20	0	419
2. Total Infants in State	40,132	33,055	2,896	254	1,142	57	872	1,856
Title V Served	8,587	7,459	488	58	105	20	294	163
Eligible for Title XIX	17,661	13,599	2,488	401	397	41	0	735

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	34,047	6,236	47	40,330
Title V Served	4,133	1,563	0	5,696
Eligible for Title XIX	10,310	1,934	0	12,244
2. Total Infants in State	33,889	6,198	45	40,132
Title V Served	6,230	2,357	0	8,587
Eligible for Title XIX	13,070	4,511	80	17,661

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

None

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Kansas**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2017 Application Year</b>	<b>2015 Reporting Year</b>
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 332-6262	(800) 332-6262
2. State MCH Toll-Free "Hotline" Name	Kansas Resource Guide	Kansas Resource Guide
3. Name of Contact Person for State MCH "Hotline"	Genoveva Fernandez	Portia Taylor
4. Contact Person's Telephone Number	(800) 332-6262	(800) 332-6262
5. Number of Calls Received on the State MCH "Hotline"		1,073

<b>B. Other Appropriate Methods</b>	<b>2017 Application Year</b>	<b>2015 Reporting Year</b>
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	<a href="http://www.kdheks.gov/c-f/mch.htm">http://www.kdheks.gov/c-f/mch.htm</a> ; <a href="http://www.kansasmch.org">http://www.kansasmch.org</a>	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	<a href="http://www.facebook.com/kansasmch">http://www.facebook.com/kansasmch</a>	
6. Number of Hits to the State Title V Program Social Media Websites		

**Form Notes for Form 7:**

None

**Form 8**  
**State MCH and CSHCN Directors Contact Information**  
**State: Kansas**

1. Title V Maternal and Child Health (MCH) Director	
Name	Rachel Sisson
Title	Bureau of Family Health Director
Address 1	1000 SW Jackson Street, Suite 220
Address 2	
City/State/Zip	Topeka / KS / 66612
Telephone	(785) 296-1310
Extension	
Email	rsisson@kdheks.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Heather Smith
Title	Special Health Services Section Director
Address 1	1000 SW Jackson Street, Suite 220
Address 2	
City/State/Zip	Topeka / KS / 66612
Telephone	(785) 796-1316
Extension	
Email	hsmith@kdheks.gov

### 3. State Family or Youth Leader (Optional)

Name	Donna Yadrich
Title	Owner, AudreySpirit LLC
Address 1	13605 Rolfer Road
Address 2	
City/State/Zip	Topeka / KS / 66109
Telephone	(913) 980-6282
Extension	
Email	donna@audreyspirit.com

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: Kansas**

**Application Year 2017**

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

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	Continued	
2.	Services and supports promote healthy family functioning.	New	
3.	Developmentally appropriate care and services are provided across the lifespan.	New	
4.	Families are empowered to make educated choices about nutrition and physical activity.	Replaced	
5.	Communities and providers support physical, social, and emotional health.	New	
6.	Professionals have the knowledge and skills to address the needs of maternal and child health populations.	New	
7.	Services are comprehensive and coordinated across systems and providers.	Continued	
8.	Information is available to support informed health decisions and choices.	New	

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

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**Field Name:**

Priority Need 1

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**Field Note:**

Priorities are more comprehensive for this new period. Previous priorities are not lost, rather they are being addressed even though they don't stand alone in the state's list of 8 current priorities. For example, two previous priorities for Women/Maternal related to mental/behavioral health and preterm birth. These issues are objectives and strategies under the new priority.

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**Field Name:**

Priority Need 2

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**Field Note:**

This is a new cross-cutting priority.

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**Field Name:**

Priority Need 3

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**Field Note:**

This is a new priority addressing children and adolescent health needs such as developmental screening, child care safety/healthy and safe environments, injury prevention, and more.

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**Field Name:**

Priority Need 4

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**Field Note:**

This priority doesn't specifically call out breastfeeding as the previous priority but includes targeted work related to increased breastfeeding rates: initiation, exclusivity and duration. In addition, it includes work related to childhood obesity and addresses the previous priority for children and adolescents "All children and youth achieve and maintain healthy weight".

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**Field Name:**

Priority Need 5

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**Field Note:**

This priority is new wording but objectives and strategies address the previous priority "Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs".

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**Field Name:**

Priority Need 6

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**Field Note:**

New priority focusing on the capacity, skills, and competencies of professionals--are the prepared and "ready" to address unique issues MCH populations are facing in their community?

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**Field Name:**

Priority Need 7

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**Field Note:**

This priority is comprehensive in nature, with objectives and strategies focusing on more targeted issues/focus areas. This priority address previous CYSHCN priorities "All CYSHCN receive coordinated, comprehensive care within a medical home"; "Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence"; and "Financing for CYSHCN services minimizes financial hardship for their families".

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**Field Name:**

Priority Need 8

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**Field Note:**

This is a new priority focusing on health literacy, navigating the health system, individuals being proactive when it comes to health care, services, coverage, transition, and more.

**Form 10a  
National Outcome Measures (NOMs)**

**State: Kansas**

**Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	82.5 %	0.2 %	32,285	39,137
2013	79.6 %	0.2 %	30,846	38,743
2012	78.9 %	0.2 %	31,663	40,128
2011	77.4 %	0.2 %	29,663	38,337
2010	75.3 %	0.2 %	29,814	39,611
2009	74.8 %	0.2 %	29,610	39,605

**Legends:**

- Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts:**

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	92.8	5.1 %	335	36,083
2012	111.6	5.5 %	417	37,351
2011	97.4	5.1 %	362	37,177
2010	103.3	5.2 %	394	38,142
2009	103.6	5.1 %	411	39,673
2008	95.2	4.9 %	380	39,917

**Legends:**  
🚩 Indicator has a numerator ≤10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	19.6	3.1 %	39	198,694
2009_2013	20.4	3.2 %	41	200,867
2008_2012	17.7	2.9 %	36	203,861
2007_2011	15.6	2.8 %	32	205,524
2006_2010	15.0	2.7 %	31	206,850
2005_2009	14.1	2.6 %	29	206,089

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

#### NOM 3 - Notes:

None

#### Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.0 %	0.1 %	2,759	39,207
2013	7.0 %	0.1 %	2,721	38,824
2012	7.1 %	0.1 %	2,879	40,324
2011	7.2 %	0.1 %	2,854	39,620
2010	7.1 %	0.1 %	2,881	40,628
2009	7.3 %	0.1 %	3,011	41,381

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.1 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.3 %	0.1 %	493	39,207
2013	1.3 %	0.1 %	484	38,824
2012	1.3 %	0.1 %	531	40,324
2011	1.3 %	0.1 %	509	39,620
2010	1.2 %	0.1 %	487	40,628
2009	1.4 %	0.1 %	567	41,381

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.2 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.8 %	0.1 %	2,266	39,207
2013	5.8 %	0.1 %	2,237	38,824
2012	5.8 %	0.1 %	2,348	40,324
2011	5.9 %	0.1 %	2,345	39,620
2010	5.9 %	0.1 %	2,394	40,628
2009	5.9 %	0.1 %	2,444	41,381

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.3 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.7 %	0.1 %	3,423	39,209
2013	8.9 %	0.1 %	3,447	38,824
2012	9.0 %	0.1 %	3,635	40,322
2011	9.1 %	0.1 %	3,596	39,601
2010	8.8 %	0.1 %	3,563	40,589
2009	9.2 %	0.1 %	3,808	41,325

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.1 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.5 %	0.1 %	989	39,209
2013	2.7 %	0.1 %	1,035	38,824
2012	2.7 %	0.1 %	1,078	40,322
2011	2.6 %	0.1 %	1,043	39,601
2010	2.5 %	0.1 %	1,014	40,589
2009	2.6 %	0.1 %	1,082	41,325

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.2 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.1 %	2,434	39,209
2013	6.2 %	0.1 %	2,412	38,824
2012	6.3 %	0.1 %	2,557	40,322
2011	6.5 %	0.1 %	2,553	39,601
2010	6.3 %	0.1 %	2,549	40,589
2009	6.6 %	0.1 %	2,726	41,325

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.3 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	24.3 %	0.2 %	9,525	39,209
2013	23.0 %	0.2 %	8,936	38,824
2012	24.6 %	0.2 %	9,905	40,322
2011	25.4 %	0.2 %	10,043	39,601
2010	25.7 %	0.2 %	10,447	40,589
2009	26.8 %	0.2 %	11,067	41,325

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts:**

None

**NOM 7 - Percent of non-medically indicated early elective deliveries**

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	8.0 %			

**Legends:**  
📅 Indicator results were based on a shorter time period than required for reporting

**NOM 7 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.6	0.4 %	258	38,954
2012	6.9	0.4 %	281	40,479
2011	6.1	0.4 %	243	39,762
2010	6.2	0.4 %	252	40,759
2009	6.7	0.4 %	277	41,529

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.5	0.4 %	252	38,839
2012	6.3	0.4 %	254	40,341
2011	6.2	0.4 %	247	39,642
2010	6.2	0.4 %	252	40,649
2009	7.1	0.4 %	294	41,396

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.1 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.4	0.3 %	169	38,839
2012	4.3	0.3 %	174	40,341
2011	4.0	0.3 %	159	39,642
2010	4.2	0.3 %	172	40,649
2009	4.3	0.3 %	178	41,396

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.2 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.1	0.2 %	83	38,839
2012	2.0	0.2 %	80	40,341
2011	2.2	0.2 %	88	39,642
2010	2.0	0.2 %	80	40,649
2009	2.8	0.3 %	116	41,396

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	213.7	23.5 %	83	38,839
2012	205.8	22.6 %	83	40,341
2011	204.3	22.7 %	81	39,642
2010	196.8	22.0 %	80	40,649
2009	236.7	23.9 %	98	41,396

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**

None

**Data Alerts:**

None

**NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	133.9	18.6 %	52	38,839
2012	111.6	16.6 %	45	40,341
2011	106.0	16.4 %	42	39,642
2010	100.9	15.8 %	41	40,649
2009	118.4	16.9 %	49	41,396

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts:**

None

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**FAD Not Available for this measure.**

**NOM 10 - Notes:**

None

**Data Alerts:**

None

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.9	0.4 %	213	36,087
2012	4.7	0.4 %	174	37,355
2011	4.2	0.3 %	157	37,177
2010	3.4	0.3 %	129	38,142
2009	2.3	0.2 %	93	39,677
2008	1.8	0.2 %	71	39,917

**Legends:**  
🚩 Indicator has a numerator ≤10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts:**

None

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts:**

None

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

**FAD Not Available for this measure.**

**NOM 13 - Notes:**

None

**Data Alerts:**

None

**NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.1 %	1.3 %	120,620	666,589

**Legends:**  
🚫 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	15.7	2.1 %	57	363,940
2013	24.1	2.6 %	88	365,495
2012	19.6	2.3 %	72	366,922
2011	22.2	2.5 %	81	365,569
2010	27.0	2.7 %	99	367,153
2009	21.8	2.5 %	79	362,262

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	35.7	3.0 %	143	400,763
2013	31.9	2.8 %	128	401,152
2012	32.9	2.9 %	132	400,793
2011	32.2	2.8 %	130	404,061
2010	38.2	3.1 %	154	402,705
2009	39.0	3.1 %	157	402,855

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	15.1	1.6 %	91	601,943
2011_2013	14.4	1.5 %	87	605,975
2010_2012	18.2	1.7 %	111	609,260
2009_2011	20.2	1.8 %	124	613,565
2008_2010	23.4	2.0 %	144	615,409
2007_2009	24.1	2.0 %	149	619,073

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	12.6	1.5 %	76	601,943
2011_2013	13.0	1.5 %	79	605,975
2010_2012	13.6	1.5 %	83	609,260
2009_2011	10.3	1.3 %	63	613,565
2008_2010	9.6	1.3 %	59	615,409
2007_2009	8.7	1.2 %	54	619,073

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts:**

None

**NOM 17.1 - Percent of children with special health care needs**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	139,623	720,400
2007	20.7 %	1.3 %	144,683	699,044
2003	20.4 %	1.1 %	141,515	692,847

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts:**

None

**NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system**

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	22.8 %	2.1 %	25,499	111,748

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts:**

None

**NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.0 %	0.3 %	5,857	604,484
2007	1.0 %	0.3 %	5,819	582,082

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts:**

None

**NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.8 %	1.1 %	53,268	603,604
2007	7.2 %	0.8 %	41,542	580,463

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts:**

None

**NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.6 % ⚡	5.5 % ⚡	37,787 ⚡	52,077 ⚡
2007	72.2 %	5.1 %	38,051	52,674
2003	62.9 % ⚡	5.5 % ⚡	32,093 ⚡	51,056 ⚡

**Legends:**  
 🚩 Indicator has an unweighted denominator <30 and is not reportable  
 ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts:**

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	86.8 %	1.2 %	624,437	719,046
2007	85.3 %	1.2 %	596,113	698,929
2003	86.3 %	1.0 %	597,734	692,666

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts:**

None

**NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.2 %	2.3 %	95,210	315,762
2007	31.1 %	2.1 %	90,333	290,635
2003	30.0 %	1.9 %	93,959	312,892

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	29.7 %	0.3 %	8,901	29,964

**Legends:**  
 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.9 %	1.4 %	40,990	141,855
2011	24.1 %	1.1 %	32,928	136,688
2009	25.1 %	1.5 %	33,233	132,280
2007	25.3 %	1.6 %	32,253	127,528
2005	24.9 %	1.3 %	35,358	141,896

**Legends:**

 Indicator has an unweighted denominator <100 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts:**

None

**NOM 21 - Percent of children without health insurance**

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.6 %	44,705	723,985
2013	6.7 %	0.6 %	48,325	718,520
2012	6.9 %	0.5 %	49,694	719,066
2011	6.1 %	0.5 %	44,263	721,601
2010	7.7 %	0.6 %	55,698	725,339
2009	8.2 %	0.6 %	57,156	700,793

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts:**

None

**NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	76.5 %	3.6 %	44,149	57,728
2013	68.7 %	3.6 %	39,644	57,726
2012	65.0 %	3.4 %	37,798	58,137
2011	73.5 %	3.6 %	43,953	59,803
2010	54.9 %	3.8 %	32,378	58,955
2009	46.0 %	4.4 %	28,749	62,455

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts:**

None

**NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	55.5 %	2.4 %	380,682	685,790
2013_2014	57.5 %	2.0 %	391,033	680,154
2012_2013	45.9 %	1.9 %	310,168	676,228
2011_2012	47.8 %	2.4 %	313,530	656,064
2010_2011	47.0 %	3.2 %	308,085	655,501
2009_2010	39.0 %	1.6 %	271,928	697,252

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts:**

None

**NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	38.3 %	4.9 %	36,873	96,340
2013	39.9 %	5.0 %	38,897	97,402
2012	42.7 % ⚡	5.4 % ⚡	41,349 ⚡	96,737 ⚡
2011	37.2 %	4.5 %	36,187	97,259
2010	40.2 %	4.3 %	38,353	95,491
2009	44.1 % ⚡	5.4 % ⚡	41,245 ⚡	93,442 ⚡

**Legends:**  
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	32.8 %	4.4 %	33,498	102,029
2013	25.1 %	4.4 %	25,770	102,720
2012	13.5 %	3.5 %	13,813	101,998
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩

**Legends:**  
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts:**

None

**NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	79.8 %	2.9 %	158,243	198,370
2013	84.6 %	2.5 %	169,347	200,122
2012	92.2 %	1.7 %	183,268	198,735
2011	79.1 %	2.8 %	158,210	199,999
2010	76.8 %	2.4 %	151,261	196,881
2009	63.6 %	3.5 %	122,436	192,607

**Legends:**

- 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts:**

None

**NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	65.1 %	3.3 %	129,129	198,370
2013	55.9 %	3.5 %	111,787	200,122
2012	55.9 %	3.7 %	111,176	198,735
2011	47.7 %	3.4 %	95,410	199,999
2010	50.2 %	2.9 %	98,866	196,881
2009	38.3 %	3.5 %	73,838	192,607

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts:**

None

**Form 10a  
National Performance Measures (NPMs)**

**State: Kansas**

**NPM 1 - Percent of women with a past year preventive medical visit**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	73.7	75.7	77.7	79.8	81.9	84.0

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	63.7 %	1.2 %	309,668	486,081	
2013	68.2 %	0.9 %	332,196	487,313	
2012	66.4 %	1.4 %	322,447	485,511	
2011	66.7 %	1.0 %	323,032	484,259	
2010	71.6 %	1.6 %	340,609	475,647	
2009	71.7 %	1.1 %	346,490	483,018	

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	87.2	88.6	90.0	91.5	92.9	94.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	84.4 %	3.1 %	32,770	38,808
2011	77.4 %	3.3 %		
2010	79.4 %	3.2 %		
2009	76.8 %	3.6 %		
2008	78.0 %	2.9 %		
2007	78.8 %	3.0 %		

**Legends:**  
 Indicator has an unweighted denominator <50 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.7	29.4	31.2	33.2	35.2	37.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	24.5 %	3.6 %	9,415	38,396
2011	11.4 %	2.2 %		
2010	14.1 %	2.4 %		
2009	16.2 %	2.3 %		
2008	12.2 %	1.8 %		
2007	16.4 %	2.5 %		

**Legends:**  
 Indicator has an unweighted denominator <50 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	40.7	44.8	49.3	54.2	59.6	65.5

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	37.0 %	3.2 %	70,393	190,075
2007	24.7 %	2.7 %	45,829	185,459

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	80.9	75.1	69.8	64.8	60.2	55.9

**Data Source: State Inpatient Databases (SID) - CHILD**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	87.1	4.6 %	360	413,488
2012	92.6	4.7 %	381	411,684
2011	87.7	4.6 %	360	410,327
2010	101.3	5.0 %	406	400,844
2009	121.7	5.6 %	474	389,481
2008	129.7	5.8 %	498	384,092

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	184.0	172.7	162.0	152.1	142.7	133.9

**Data Source: State Inpatient Databases (SID) - ADOLESCENT**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	196.1	6.9 %	800	407,907
2012	226.1	7.5 %	911	403,006
2011	215.0	7.3 %	859	399,500
2010	231.4	7.7 %	910	393,330
2009	270.8	8.3 %	1,065	393,331
2008	277.8	8.4 %	1,101	396,356

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	9.9	8.9	8.0	7.2	6.5	5.9

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	11.0 %	1.8 %	25,495	231,663
2007	15.4 %	2.0 %	36,286	235,034

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	27.9 %	1.6 %	39,871	142,707
2011	26.4 %	1.3 %	36,724	138,964

**Legends:**  
 Indicator has an unweighted denominator <100 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	85.5	87.6	89.8	92.1	94.4	96.7

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	83.4 %	2.2 %	191,615	229,749
2007	88.8 %	1.6 %	207,786	233,876
2003	78.2 %	1.8 %	185,944	237,889

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs having a medical home**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62.1	65.2	68.4	71.8	75.4	79.2

**Data Source: National Survey of Children's Health (NSCH) - CSHCN**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	53.8 %	3.6 %	74,319	138,094
2007	49.3 %	3.5 %	68,915	139,663

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: National Survey of Children's Health (NSCH) - NONCSHCN**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	60.4 %	1.8 %	343,986	569,398
2007	64.4 %	1.7 %	346,478	538,116

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**NPM 14 - A) Percent of women who smoke during pregnancy**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	11.4	10.9	10.4	9.9	9.4	9.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.0 %	0.2 %	4,681	39,163
2013	12.5 %	0.2 %	4,834	38,757
2012	13.7 %	0.2 %	5,498	40,230
2011	14.5 %	0.2 %	5,709	39,483
2010	14.9 %	0.2 %	6,014	40,472
2009	15.3 %	0.2 %	6,130	40,178

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**NPM 14 - B) Percent of children who live in households where someone smokes**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.5	21.8	20.2	18.8	17.4	16.2

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	25.3 %	1.4 %	180,387	713,663
2007	26.4 %	1.4 %	182,889	692,539
2003	29.3 %	1.4 %	174,594	595,117

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**Form 10a**  
**State Performance Measures (SPMs)**  
**State: Kansas**

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.3	8.1	7.9	7.8	7.6

**Field Level Notes for Form 10a SPMs:**

None

**SPM 2 - Percent of children living with parents receiving emotional support (help with parenthood)**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	92.4	93.3	94.3	95.2	96.2

**Field Level Notes for Form 10a SPMs:**

None

**SPM 3 - Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	29.6	31.1	32.6	34.3	36.0

**Field Level Notes for Form 10a SPMs:**

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5,000.0	5,500.0	6,000.0	6,500.0	7,000.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Field Note:</b>	FY2017
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Field Note:</b>	FY2018
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Field Note:</b>	FY2019
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Field Note:</b>	FY2020
5.	<b>Field Name:</b>	<b>2021</b>
	<b>Field Note:</b>	FY2021

**SPM 5 - Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	44.7	42.4	40.3	38.3	36.4

**Field Level Notes for Form 10a SPMs:**

None

**Form 10a**  
**Evidence-Based or-Informed Strategy Measures (ESMs)**

**State: Kansas**

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 4.1 - Number of communities achieving the “Community Supporting Breastfeeding” designation**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	13.0	15.0	17.0	19.0	20.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
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**Field Note:**

Baseline: 10 communiites in 2016

The following communities that have received the “Communities Supporting Breastfeeding” designation: Abilene, Emporia, Great Bend, Gove County, Hays, Lawrence, Liberal, Salina, Wichita, Winfield

The Communities Supporting Breastfeeding is a designation recognizing communities that provide multifaceted breastfeeding support across several sectors: businesses, employers, hospitals, child care providers and peer support. “Community” may be defined as a city or county.

**ESM 6.1 - Percent of parents of child program participants receiving education on child development and developmental screening**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.1 - Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.1 - Number of school-age students that received information on bullying or social-emotional development**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	15.0	20.0	25.0	30.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 10.1 - Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 11.1 - Percent of families who experienced a decreased need of care coordination supports**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	10.0	15.0	20.0	25.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	70.0	80.0	90.0

**Field Level Notes for Form 10a ESMs:**

None

**Form 10b**  
**State Performance Measure (SPM) Detail Sheets**

**State: Kansas**

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

**Population Domain(s) – Women/Maternal Health**

<b>Goal:</b>	To reduce the proportion of all preterm, early term, and early elective deliveries.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of live births before 37 weeks of complete gestation</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of live births</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of live births before 37 weeks of complete gestation	<b>Denominator:</b>	Number of live births	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of live births before 37 weeks of complete gestation									
<b>Denominator:</b>	Number of live births									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	Identical to Maternal, Infant, and Child Health (MICH) Objective 9.1: Reduce total preterm births (PTB). (Baseline: 12.7% in 2007, Target 11.4%)									
<b>Data Sources and Data Issues:</b>	Kansas birth certificate, Bureau of Epidemiology and Public Health and Informatics, Kansas Department of Health and Environment									
<b>Significance:</b>	<p>Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born "late preterm" (34 to 36 weeks' gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality.</p> <p>Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth.</p> <p>Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.</p>									

**SPM 2 - Percent of children living with parents receiving emotional support (help with parenthood)**  
**Population Domain(s) – Child Health, Adolescent Health, Cross-Cutting/Life Course**

<b>Goal:</b>	To increase the proportion of children living with parents receiving emotional support (help with parenthood)									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of children age 0-17 years have parents who have someone to go to for emotional help with parenting when they need it</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of children age 0-17 years</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of children age 0-17 years have parents who have someone to go to for emotional help with parenting when they need it	<b>Denominator:</b>	Number of children age 0-17 years	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
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<b>Denominator:</b>	Number of children age 0-17 years									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	Related to Early and Middle Childhood (EMC) Objective 1 (Developmental): Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development									
<b>Data Sources and Data Issues:</b>	National Survey of Children's Health									
<b>Significance:</b>	The demands of parenting can cause considerable stress for families. Children and adolescents were less likely to engage in externalizing (acting out behavior) and display depression symptoms (sadness, feelings of worthlessness or withdrawn behavior), or have to be retained in a previous grade, when their mothers reported having emotional support with childrearing. These children and adolescents were also likely to display social competence and school engagement than were their counterparts whose mothers did not report having emotional support.									

**SPM 3 - Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day**

**Population Domain(s) – Child Health, Adolescent Health**

<b>Goal:</b>	To increase the number of children and adolescents who are physically active.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH), and adolescents in grades 9 through 12 (YRBSS) who report being physically active at least 60 minutes per day in the past week</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH) and number of adolescents in grades 9 through 12 (YRBSS)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH), and adolescents in grades 9 through 12 (YRBSS) who report being physically active at least 60 minutes per day in the past week	<b>Denominator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH) and number of adolescents in grades 9 through 12 (YRBSS)	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH), and adolescents in grades 9 through 12 (YRBSS) who report being physically active at least 60 minutes per day in the past week									
<b>Denominator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH) and number of adolescents in grades 9 through 12 (YRBSS)									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	<p>Related to Physical Activity (PA) Objective 4.1: Increase the proportion of the Nation's public and private elementary schools that require daily physical education for all students. (Baseline: 3.8%, Target: 4.2%)</p> <p>Related to Physical Activity (PA) Objective 3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. (Baseline: 18.4%, Target: 20.2% for adolescents to meet current physical activity guidelines for aerobic physical activity)</p>									
<b>Data Sources and Data Issues:</b>	National Survey of Children's Health (NSCH) and Youth Risk Behavior Surveillance System (YRBSS). The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day.									
<b>Significance:</b>	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.									

**SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals**  
**Population Domain(s) – Perinatal/Infant Health**

<b>Goal:</b>	To increase the number of professionals who have received Safe Sleep trainings.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of professionals who have received Safe Sleep training</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>20,000</td> </tr> </table>	<b>Numerator:</b>	Number of professionals who have received Safe Sleep training	<b>Denominator:</b>	Not applicable	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20,000	
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<b>Denominator:</b>	Not applicable									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	20,000									
<b>Healthy People 2020 Objective:</b>	Related to Maternal, Infant, and Child Health (MICH) Objective 1.3 Reduce the rate of all infant deaths (within 1 year); MICH Objective 1.8 Reduce the rate of infant deaths from sudden infant death syndrome (SIDS); MICH Objective 1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed); MICH Objective 20: Increase the proportion of infants placed to sleep on their backs									
<b>Data Sources and Data Issues:</b>	Kansas Infant Death and SIDS (KIDS) Network									
<b>Significance:</b>	Sleep-related infant deaths, called Sudden Unexpected Infant deaths (SUIDS), are the leading cause of infant death after the first month of life. Risk of SUIDS increases when babies are placed on their side or stomach to sleep. Placing babies on their back, on a firm surface, and without loose bedding are the recommended practices to follow according to AAP.									

**SPM 5 - Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them**  
**Population Domain(s) – Cross-Cutting/Life Course**

<b>Goal:</b>	To decrease the proportion of adults that report difficulty in understanding the information doctors, nurses and other health professionals tell them.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of adults aged 18 or older</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them	<b>Denominator:</b>	Number of adults aged 18 or older	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them									
<b>Denominator:</b>	Number of adults aged 18 or older									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	Related to Health Communication and Health Information Technology (HC/HIT) Objective 1.1: Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition.									
<b>Data Sources and Data Issues:</b>	Behavioral Risk Factor Surveillance System (BRFSS)									
<b>Significance:</b>	Communication barriers often go undetected in health care settings and can have serious effects on the health and safety of patients. Limited literacy skills are one of the strongest predictors of poor health outcomes for patients. Health literacy can affect health status, health outcomes, health care use and health care costs. The entire health care systems relies on the assumption that patients can understand complex written and spoken information. If patients cannot understand health information, they cannot take necessary actions for their health or make appropriate health decisions.									

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Kansas**

No State Outcome Measures were created by the State.

**Form 10c**  
**Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets**

**State: Kansas**

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

**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Goal:</b>	To ensure supportive programming for well woman visits/preventive health care.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of women (including pregnant and postpartum) program participants who have received education on the importance of a well woman/ preventative visit in the reporting year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of women (including pregnant and postpartum) program participants</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of women (including pregnant and postpartum) program participants who have received education on the importance of a well woman/ preventative visit in the reporting year	<b>Denominator:</b>	Number of women (including pregnant and postpartum) program participants	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of women (including pregnant and postpartum) program participants who have received education on the importance of a well woman/ preventative visit in the reporting year									
<b>Denominator:</b>	Number of women (including pregnant and postpartum) program participants									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	DAISEY (a web-based shared measurement system)									
<b>Significance:</b>	A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, shots, screenings, education, and counseling.									

**ESM 4.1 - Number of communities achieving the “Community Supporting Breastfeeding” designation  
 NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

<b>Goal:</b>	To increase the number of communities, defined as either a city or county, that have been designated as a “Community Supporting Breastfeeding” by the Kansas Breastfeeding Coalition, Inc.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of communities with the designation of “Community Supporting Breastfeeding”</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of communities with the designation of “Community Supporting Breastfeeding”	<b>Denominator:</b>	Not applicable	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of communities with the designation of “Community Supporting Breastfeeding”									
<b>Denominator:</b>	Not applicable									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Kansas Breastfeeding Coalition, Inc.									
<b>Significance:</b>	<p>Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. If mothers get the support they need in the first 4 weeks of a new baby's life, they are more likely to keep breastfeeding. Mothers may need help finding people who are trained to assist with breastfeeding after they leave the hospital. Without help, some mothers may stop breastfeeding. Communities often provide a number of resources and programs to help breastfeeding mothers. The Surgeon General recommends programs which provide mother-to-mother support and peer counseling, use a variety of media venues to reach young women and their families, and the expansion of the use of programs in the workplace that allow lactating mothers to have direct access to their babies.</p>									

**ESM 6.1 - Percent of parents of child program participants receiving education on child development and developmental screening**

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

<b>Goal:</b>	To ensure supportive programming for developmental screenings.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of parents of child program participants receiving education on child development and developmental screening</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of parents of child program participants 10 to 71 months</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of parents of child program participants receiving education on child development and developmental screening	<b>Denominator:</b>	Number of parents of child program participants 10 to 71 months	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of parents of child program participants receiving education on child development and developmental screening									
<b>Denominator:</b>	Number of parents of child program participants 10 to 71 months									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	DAISEY (a web-based shared measurement system)									
<b>Significance:</b>	The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows: Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.									

**ESM 7.1 - Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit**

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

<b>Goal:</b>	To increase the proportion of program participants receiving car seat and/or booster seat safety education during an MCH visit.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of program participants receiving car seat and/or booster seat safety education during an MCH visit</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of program participants</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of program participants receiving car seat and/or booster seat safety education during an MCH visit	<b>Denominator:</b>	Number of program participants	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of program participants receiving car seat and/or booster seat safety education during an MCH visit									
<b>Denominator:</b>	Number of program participants									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	DAISEY (a web-based shared measurement system)									
<b>Significance:</b>	<p>Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.</p> <p>Motor vehicle injuries are a leading cause of death among children in the United States. A correctly used car seat or seatbelt can keep a child from being ejected during a car crash. Many times, child restraint systems are used incorrectly. An estimated 46% of car and booster seats (59% of car seats and 20% of booster seats) are misused in a way that can reduce their effectiveness. The Community Preventive Service Task Force recommends car seat laws and car seat distribution plus education programs to increase restraint use and decrease injuries and death to child passengers.</p>									

**ESM 9.1 - Number of school-age students that received information on bullying or social-emotional development**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Goal:</b>	To increase the number of school-age students that received information about bullying or social-emotional/character development to reduce the negative impact on overall health and well-being.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of schools school-age students that received information on bullying or social-emotional development</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of schools school-age students that received information on bullying or social-emotional development	<b>Denominator:</b>	Not applicable	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of schools school-age students that received information on bullying or social-emotional development									
<b>Denominator:</b>	Not applicable									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	DAISEY (a web-based shared measurement data system); KS Department of Education									
<b>Significance:</b>	Bullying is one type of youth violence that threatens young people’s well-being. Bullying can result in physical injuries, social and emotional difficulties, and academic problems. Training school staff and students to prevent and address bullying can help sustain bullying prevention efforts across time. There are some multiple evidence-based programs or curricula available for schools to implement to help reduce bullying.									

**ESM 10.1 - Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year**

**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Goal:</b>	To ensure supportive programming for well adolescent visits/preventive health care.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of adolescent program participants (12-22 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of adolescent program participants (12-22 years)</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of adolescent program participants (12-22 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year	<b>Denominator:</b>	Number of adolescent program participants (12-22 years)	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
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<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	DAISEY (a web-based shared measurement system)									
<b>Significance:</b>	Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.									

**ESM 11.1 - Percent of families who experienced a decreased need of care coordination supports**  
**NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Goal:</b>	To increase the proportion of families who within a year decreased their need of care coordination support.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of families who show a decrease in the level of care coordination in their initial survey to follow up survey</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of families who receive support for care coordination and have completed a follow-up survey in past year</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of families who show a decrease in the level of care coordination in their initial survey to follow up survey	<b>Denominator:</b>	Number of families who receive support for care coordination and have completed a follow-up survey in past year	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of families who show a decrease in the level of care coordination in their initial survey to follow up survey									
<b>Denominator:</b>	Number of families who receive support for care coordination and have completed a follow-up survey in past year									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Care Coordination Measurement Tool									
<b>Significance:</b>	<p>Care coordination involves the “deliberate organization of patient care activities between two or more participants (including the patient) involved in the patient’s care to facilitate the appropriate delivery of health services.” Care coordination is a key function of the medical home.</p> <p>The Family Advisory Council for Kansas defines care coordination as a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and financial needs to achieve optimal health. Key activities of care coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.</p> <p>The care coordination curriculum developed by Boston Children’s Hospital is an evidence-informed program designed to help individuals, including patients and families, articulate the principles and activities necessary to serve as a care coordinator. The curriculum was designed to be adapted for multiple settings, including a state’s Title V program.</p>									

**ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline**  
**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Goal:</b>	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of pregnant women program participants who smoke referred to the Tobacco Quitline</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of pregnant women program participants who smoke</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of pregnant women program participants who smoke referred to the Tobacco Quitline	<b>Denominator:</b>	Number of pregnant women program participants who smoke	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
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<b>Denominator:</b>	Number of pregnant women program participants who smoke									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	DAISEY (a web-based shared measurement system)									
<b>Significance:</b>	Secondhand smoke is a mixture of mainstream smoke and the more toxic side stream smoke which is classified as a “known human carcinogen” by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. In addition, women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby.									

**Form 10d  
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Kansas**

**Form Notes for Form 10d NPMs and SPMs**

None

**NPM 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.**

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	71	72	81	77	85
Denominator	71	72	81	77	85
Data Source	Kansas Newborn Screening data, 2011	Kansas Newborn Screening data, 2012	Kansas Newborn Screening data, 2013	Kansas Newborn Screening data, 2014	Kansas Newborn Screening data, 2015
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

None

**Data Alerts:**

None

**NPM 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)**

	2011	2012	2013	2014	2015
Annual Objective	66.0	73.0	73.0	74.0	74.0
Annual Indicator	72.6	72.6	72.6	72.6	72.6
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**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. **Field Name:** 2014

**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.

3. **Field Name:** 2013

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**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.

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4. **Field Name:** 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.

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5. **Field Name:** 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.

**Data Alerts:**

None

**NPM 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)**

	2011	2012	2013	2014	2015
Annual Objective	60.0	50.0	51.0	54.0	56.0
Annual Indicator	49.4	53.8	53.8	53.8	53.8
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.			
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**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 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.

2. **Field Name:** 2014

**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 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.

3. **Field Name:** 2013

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**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 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.

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4. **Field Name:** 2012

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**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 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.

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5. **Field Name:** 2011

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**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 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.

**Data Alerts:**

None

**NPM 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)**

	2011	2012	2013	2014	2015
Annual Objective	65.0	61.0	61.0	76.0	78.0
Annual Indicator	60.0	75.2	75.2	75.2	75.2
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.			
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**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 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.

2. **Field Name:** 2014

**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 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.

3. **Field Name:** 2013

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**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 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.

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4. **Field Name:** **2012**

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**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 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.

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5. **Field Name:** **2011**

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**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 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.

**Data Alerts:**

None

**NPM 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)**

	2011	2012	2013	2014	2015
Annual Objective	93.0	67.0	68.0	68.0	69.0
Annual Indicator	66.8	66.8	66.8	66.8	66.8
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. Estimate KS.				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**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. **Field Name:** 2014

**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.

3. **Field Name:** 2013

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**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.

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4. **Field Name:** **2012**

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**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.

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5. **Field Name:** **2011**

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**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.

**Data Alerts:**

None

**NPM 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.**

	2011	2012	2013	2014	2015
Annual Objective	53.0	53.0	54.0	54.0	55.0
Annual Indicator	52.7	52.7	52.7	52.7	52.7
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**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 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.

2. **Field Name:** 2014

**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 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.

3. **Field Name:** 2013

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**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 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.

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4. **Field Name:** **2012**

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**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 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.

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5. **Field Name:** **2011**

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**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 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.

**Data Alerts:**

None

**NPM 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.**

	2011	2012	2013	2014	2015
Annual Objective	79.0	83.0	85.0	70.0	70.0
Annual Indicator	77.7	68.0	68.7	76.5	76.5
Numerator					
Denominator					
Data Source	CDC National Immunization Survey 2011	CDC National Immunization Survey 2012	CDC National Immunization Survey 2013	CDC National Immunization Survey 2014	CDC National Immunization Survey 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

The 2015 column is populated with 2014 data. 2015 data will be available Fall 2016.

2. **Field Name:** 2014

**Field Note:**

DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3:1:4 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2014. [http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/14/tab03\\_antigen\\_state\\_2014.pdf](http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/14/tab03_antigen_state_2014.pdf).

The combined 7-vaccine series (4:3:1:3\*:3:1:4) includes ≥4 doses of DTaP, ≥3 doses of Polio, ≥1 dose of measles-containing vaccine, Hib full series, ≥3 HepB, ≥1 Var, and ≥4 PCV. (In 2013 data, referred to as 4:3:1:4:3:1:4-FS)

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. **Field Name:** 2013

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**Field Note:**

DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3:1:4 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2013. [http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/13/tab03\\_antigen\\_state\\_2013.pdf](http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/13/tab03_antigen_state_2013.pdf)

The 2013 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine [ $\geq 3$  or  $\geq 4$  doses (full series) depending on brand type], 3 or more doses of HepB vaccine, 1 or more doses of varicella vaccine, and 4 or more doses of pneumococcal conjugate vaccine (PCV). The 2013 data are 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.

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4. **Field Name:** 2012

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**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](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 doses 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.

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5. **Field Name:** 2011

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**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 doses 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.

**Data Alerts:**

None

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

	2011	2012	2013	2014	2015
Annual Objective	20.0	18.0	15.0	14.0	14.0
Annual Indicator	15.5	14.5	12.5	11.8	10.0
Numerator	896	833	721	683	574
Denominator	57,687	57,341	57,704	57,687	57,687
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	Kansas Vital Statistics, 2015
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

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1. **Field Name:** 2015
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- Field Note:**  
 Data Source:  
 Numerator = Birth certificate (resident) data, 2015 (provisional). Bureau of Epidemiology and Public Health Informatics, KDHE  
 Denominator = U.S. Census Bureau, 2014
- 
2. **Field Name:** 2014
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- Field Note:**  
 Data Source:  
 Numerator = Birth certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE  
 Denominator = U.S. Census Bureau
- 
3. **Field Name:** 2013
- 
- Field Note:**  
 Data Source:  
 Numerator = Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE  
 Denominator = U.S. Census Bureau
- 
4. **Field Name:** 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
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5. **Field Name:** 2011

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**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

**Data Alerts:**

None

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

	2011	2012	2013	2014	2015
Annual Objective	40.0	41.0	38.0	38.0	40.0
Annual Indicator	35.7	35.7	35.7	35.7	35.7
Numerator					
Denominator					
Data Source	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012	KDHE, Smiles Across Kansas: 2012	KDHE, Smiles Across Kansas: 2012	KDHE, Smiles Across Kansas: 2012
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
**Field Note:**  
Data Source: KDHE, Bureau of Oral Health. Smiles Across Kansas: 2012.

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2. **Field Name:** 2014  
**Field Note:**  
Data Source: KDHE, Bureau of Oral Health. Smiles Across Kansas: 2012.

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3. **Field Name:** 2013  
**Field Note:**  
Data Source: KDHE, Bureau of Oral Health. Smiles Across Kansas: 2012.

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4. **Field Name:** 2012  
**Field Note:**  
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

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5. **Field Name:** 2011  
**Field Note:**  
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

**Data Alerts:**

None

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

	2011	2012	2013	2014	2015
Annual Objective	2.5	3.6	2.6	3.1	2.4
Annual Indicator	2.8	3.3	2.6	2.6	2.6
Numerator	17	20	16	16	16
Denominator	605,120	606,608	605,708	604,155	604,155
Data Source	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	Kansas Vital Statistics, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
The 2015 column is populated with 2014 data. 2015 data will be available Fall 2016.

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2. **Field Name:** 2014  
  
**Field Note:**  
Data Source:  
Numerator = Death certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE  
Denominator = U.S. Census Bureau; 2014 estimates.

---

3. **Field Name:** 2013  
  
**Field Note:**  
Data Source:  
Numerator = Death certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE  
Denominator = U.S. Census Bureau; 2013 estimates.

---

4. **Field Name:** 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.

---

5. **Field Name:** 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.

**Data Alerts:**

None

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective	50.0	42.0	47.0	44.0	44.0
Annual Indicator	45.1	41.8	40.3	51.7	51.7
Numerator					
Denominator					
Data Source	National Immunization Survey, 2009 births	National Immunization Survey, 2010 births	National Immunization Survey, 2011 births	National Immunization Survey, 2012 births	National Immunization Survey, 2012 births
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

- 
1. **Field Name:** 2015
- 
- Field Note:**  
The 2015 column is populated with 2014 data (2012 births). Data will be available in 2017.
- 
2. **Field Name:** 2014
- 
- Field Note:**  
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.  
[http://www.cdc.gov/breastfeeding/data/nis\\_data/rates-any-exclusive-bf-state-2012.htm](http://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-state-2012.htm)
- 
3. **Field Name:** 2013
- 
- Field Note:**  
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. [http://www.cdc.gov/breastfeeding/data/nis\\_data/rates-any-exclusive-bf-state-2011.htm](http://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-state-2011.htm)
- 
4. **Field Name:** 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>
- 
5. **Field Name:** 2011

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**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>

**Data Alerts:**

None

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	98.2	99.0	99.0	99.0	99.0
Annual Indicator	98.7	98.7	98.6	98.6	98.7
Numerator	39,908	40,636	39,214	39,609	39,737
Denominator	40,452	41,177	39,773	40,154	40,259
Data Source	KDHE. Kansas Newborn Screening program, 2011	KDHE. Kansas Newborn Screening program, 2012	KDHE. Kansas Newborn Screening program, 2013	KDHE. Kansas Newborn Screening program, 2014	KDHE. Kansas Newborn Screening program, 2015
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

- 
1. **Field Name:** 2015
- 
- Field Note:**  
 DATA SOURCE:  
 Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2015; Provisional.  
 Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences; Provisional.
- 
2. **Field Name:** 2014
- 
- Field Note:**  
 DATA SOURCE:  
 Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2014.  
 Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences.
- 
3. **Field Name:** 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.
- 
4. **Field Name:** 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.
- 
5. **Field Name:** 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.

**Data Alerts:**

None

**NPM 13 - Percent of children without health insurance.**

	2011	2012	2013	2014	2015
Annual Objective	8.0	7.5	9.2	5.8	5.5
Annual Indicator	9.4	6.1	6.7	6.2	6.2
Numerator					
Denominator					
Data Source	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	U.S. Census, American Community Survey, 2013	U.S. Census, American Community Survey, 2014	U.S. Census, American Community Survey, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	Data for 2015 are not available. 2014 data were used to pre-populate this performance measure. Data for 2015 will be available in Spring 2017
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data Source: U.S. Census Bureau, American Community Survey 2014.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Data Source: U.S. Census Bureau, American Community Survey 2013. Due To change in data source, data beginning 2013 are not comparable with previous years.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	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. <a href="http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html">http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html</a>
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	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. <a href="http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html">http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html</a>

**Data Alerts:**

None

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

	2011	2012	2013	2014	2015
Annual Objective	28.0	28.0	27.0	27.0	27.0
Annual Indicator	28.4	28.4	23.7	23.6	28.4
Numerator	10,657	10,657	10,399	9,682	6,886
Denominator	37,524	37,524	43,946	40,979	24,220
Data Source	Kansas PedNSS, 2011	Kansas PedNSS, 2011	Kansas WIC, 2013	Kansas WIC, 2014	Kansas WIC, 2015
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  


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**Field Note:**  
 Data source for 2015 is Kansas WIC data base, KWIC. The 2013, 2014 and 2015 data are not comparable to previous years. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.
2. **Field Name:** 2014  


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**Field Note:**  
 Data source for 2014 is Kansas WIC data base, KWIC. The 2013 and 2014 data are not comparable to previous years. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.
3. **Field Name:** 2013  


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**Field Note:**  
 Data source for 2013 is Kansas WIC data base, KWIC. The 2013 data are not comparable to previous years. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.
4. **Field Name:** 2012  


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**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.
5. **Field Name:** 2011  


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**Field Note:**  
 Data Source: Pediatric Nutrition Surveillance System (PedNSS), 2011(Kansas WIC database).

**Data Alerts:**

None



**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.5	12.0	11.0	10.0
Annual Indicator	12.2	11.5	10.5	9.9	9.9
Numerator	4,795	4,624	4,072	3,875	3,875
Denominator	39,441	40,212	38,730	39,136	39,136
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	Kansas Vital Statistics, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
Data for 2015 are not available. 2014 data were used to pre-populate this performance measure. Data for 2015 will be available in Fall 2016.

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2. **Field Name:** 2014  
  
**Field Note:**  
Data Source: Birth certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE  
  
Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

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3. **Field Name:** 2013  
  
**Field Note:**  
Data Source: Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE  
  
Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

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4. **Field Name:** 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.

---

5. **Field Name:** 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.

**Data Alerts:**

None

**NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

	2011	2012	2013	2014	2015
Annual Objective	9.0	10.0	10.0	13.0	12.0
Annual Indicator	10.5	13.8	13.2	12.8	12.8
Numerator	64	84	80	77	77
Denominator	608,906	609,260	605,975	601,943	601,943
Data Source	Kansas Vital Statistics, 2009-2011	Kansas Vital Statistics, 2010-2012	Kansas Vital Statistics, 2011-2013	Kansas Vital Statistics, 2012-2014	Kansas Vital Statistics, 2012-2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

- 
1. **Field Name:** 2015
- 
- Field Note:**  
Data for 2015 are not available. 2014 data were used to pre-populate this performance measure. Data for 2015 will be available in Fall 2016
- 
2. **Field Name:** 2014
- 
- Field Note:**  
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. Census Bureau  
2012-2014 data are U.S. Census estimates (Bridged-Race Vintage data set); Provisional
- 
3. **Field Name:** 2013
- 
- Field Note:**  
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. Census Bureau  
2011-2012 data are U.S. Census estimates (Bridged-Race Vintage data set)
- 
4. **Field Name:** 2012

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**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. Census Bureau

2010-2012 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

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5. **Field Name:** **2011**

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**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. Census Bureau

2009-2011 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

**Data Alerts:**

None

**NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

	2011	2012	2013	2014	2015
Annual Objective	87.0	87.0	88.0	88.0	89.0
Annual Indicator	86.6	87.1	86.6	82.7	82.7
Numerator	425	438	387	374	374
Denominator	491	503	447	452	452
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	Kansas Vital Statistics, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  


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**Field Note:**  
 Data for 2015 are not available. 2014 data were used to pre-populate this performance measure. Data for 2015 will be available in fall 2016
2. **Field Name:** 2014  


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**Field Note:**  
 Provisional: 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. **Field Name:** 2013  


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**Field Note:**  
 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).
4. **Field Name:** 2012  


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**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).
5. **Field Name:** 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).

**Data Alerts:**

None

**NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	80.0	80.0	82.0
Annual Indicator	77.3	78.9	79.4	80.0	80.0
Numerator	29,618	31,457	30,618	30,981	30,981
Denominator	38,296	39,871	38,546	38,731	38,731
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	Kansas Vital Statistics, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
Data for 2015 are not available. 2014 data were used to pre-populate this performance measure. Data for 2015 will be available in fall 2016.

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2. **Field Name:** 2014  
  
**Field Note:**  
Data Source: Birth certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE

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3. **Field Name:** 2013  
  
**Field Note:**  
Data Source: Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE

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4. **Field Name:** 2012  
  
**Field Note:**  
Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

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5. **Field Name:** 2011  
  
**Field Note:**  
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

**Data Alerts:**

None

**Form 10d**  
**State Performance Measures (SPMs) (Reporting Year 2014 & 2015)**

**State: Kansas**

**SPM 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.**

	2011	2012	2013	2014	2015
Annual Objective	14.4	13.5	13.0	12.5	12.0
Annual Indicator	17.7	15.7	14.1	14.2	14.2
Numerator					
Denominator					
Data Source	Kansas BRFSS, 2011	Kansas BRFSS, 2012	Kansas BRFSS, 2013	Kansas BRFSS, 2014	Kansas BRFSS, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**Field Note:**

The 2015 column is populated with 2014 data. 2015 data will be available fall 2016.

2. **Field Name:** 2014

**Field Note:**

Data Source: Kansas BRFSS 2014

Note: The 2011, 2012, 2013 and 2014 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. **Field Name:** 2013

**Field Note:**

Data Source: Kansas BRFSS 2013

Note: The 2011, 2012 and 2013 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.

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4. **Field Name:** 2012

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**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.

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5. **Field Name:** 2011

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**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.

**Data Alerts:**

None

**SPM 3 - The percent of live births that are born preterm less than 37 weeks of gestation.**

	2011	2012	2013	2014	2015
Annual Objective	9.1	8.6	8.6	8.4	8.4
Annual Indicator	9.1	9.0	8.9	8.7	8.7
Numerator	3,598	3,629	3,448	3,419	3,419
Denominator	39,593	40,282	38,789	39,179	39,179
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	Kansas Vital Statistics, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

- Field Name:** 2015

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**Field Note:**  
The 2015 column is populated with 2014 data. 2015 data will be available fall 2016.
- Field Name:** 2014

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**Field Note:**  
Data Source: Birth certificate (resident) data, 2014, 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.
- Field Name:** 2013

---

**Field Note:**  
Data Source: Birth certificate (resident) data, 2013, 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.
- Field Name:** 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.
- Field Name:** 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.

**Data Alerts:**

None

**SPM 5 - The percent of children age 0 to 17 who received coordinated, ongoing, comprehensive care within a medical home.**

	2011	2012	2013	2014	2015
Annual Objective	63.0	63.0	62.0	62.0	64.0
Annual Indicator	59.1	59.1	59.1	59.1	59.1
Numerator					
Denominator					
Data Source	NSCH, 2011/2012. Kansas Estimate.				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**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. **Field Name:** 2014

**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. **Field Name:** 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.

4. **Field Name:** 2012

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**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.

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5. **Field Name:** **2011**

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**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.

**Data Alerts:**

None

**SPM 6 - The percent of high school students who had at least one drink of alcohol during the past 30 days.**

	2011	2012	2013	2014	2015
Annual Objective	37.0	37.0	30.0	30.0	28.0
Annual Indicator	32.6	32.6	27.6	27.6	27.6
Numerator					
Denominator					
Data Source	YRBS, 2011	YRBS, 2011	YRBS, 2013	YRBS, 2013	YRBS, 2013
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  


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**Field Note:**  
 The 2015 columns are populated with 2013 data.  
 The YRBS is conducted in the spring of odd-numbered years and results are released in the summer of the following year.
2. **Field Name:** 2014  


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**Field Note:**  
 The 2014 columns are populated with 2013 data.  
 The YRBS is conducted in the spring of odd-numbered years and results are released in the summer of the following year.
3. **Field Name:** 2013  


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**Field Note:**  
 DATA SOURCE:  
 CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2013.  
<http://nccd.cdc.gov/YouthOnline/App/Results.aspx?LID=KS>
4. **Field Name:** 2012  


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**Field Note:**  
 The 2012 columns are populated with 2011 data. The YRBS is conducted in the spring of odd-numbered years and results are released in the summer of the following year.
5. **Field Name:** 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>.

**Data Alerts:**

**SPM 7 - The Percent of children who are obese.**

	2011	2012	2013	2014	2015
Annual Objective	13.1	12.6	12.4	12.2	12.0
Annual Indicator	12.8	12.8	13.7	13.3	13.0
Numerator	4,803	4,803	5,493	4,553	3,138
Denominator	37,523	37,523	40,076	34,323	24,220
Data Source	Kansas PeNSS, 2011	Kansas PeNSS, 2011	Kansas WIC, 2013	Kansas WIC, 2014	Kansas WIC, 2015
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d SPMs:**

- 
1. **Field Name:** 2015
- 
- Field Note:**  
CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports. Data source for 2015 is Kansas WIC data base, KWIC. The 2015 data are not comparable to previous years.
- 
2. **Field Name:** 2014
- 
- Field Note:**  
CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports. Data source for 2014 is Kansas WIC data base, KWIC. The 2014 data are not comparable to previous years.
- 
3. **Field Name:** 2013
- 
- Field Note:**  
CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports. Data source for 2013 is Kansas WIC data base, KWIC. The 2013 data are not comparable to previous years.
- 
4. **Field Name:** 2012
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- Field Note:**  
The 2012 column is populated with 2011 data.
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5. **Field Name:** 2011
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- Field Note:**  
Data Source: Pediatric Nutrition Surveillance System (PedNSS), 2012

**Data Alerts:**

None

**SPM 9 - The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.**

	2011	2012	2013	2014	2015
Annual Objective	84.0	84.0	85.0	85.0	86.0
Annual Indicator	83.5	83.5	83.5	83.5	83.5
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

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

2. **Field Name:** 2014

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

3. **Field Name:** 2013

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**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 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.

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4. **Field Name:** **2012**

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**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 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.

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5. **Field Name:** **2011**

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**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 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.

**Data Alerts:**

None

**SPM 11 - The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective			66.0	66.0	68.0
Annual Indicator	65.1	55.3	54.0	83.3	87.9
Numerator	41	52	34	45	29
Denominator	63	94	63	54	33
Data Source	SoundBeginnings, 2011	SoundBeginnings, 2012	SoundBeginnings, 2013	SoundBeginnings, 2014	SoundBeginnings, 2015
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  


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**Field Note:**  
 Data Source: SoundBeginnings Program data, 2015, provisional  
 Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age  
 Denominator = Number of infants identified with PCHL
2. **Field Name:** 2014  


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**Field Note:**  
 Data Source: SoundBeginnings Program data, 2014  
 Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age  
 Denominator = Number of infants identified with PCHL
3. **Field Name:** 2013  


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**Field Note:**  
 Data Source: SoundBeginnings Program data, 2013  
 Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age  
 Denominator = Number of infants identified with PCHL
4. **Field Name:** 2012  


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**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
5. **Field Name:** 2011

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**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

**Data Alerts:**

None

**SPM 12 - The percent of Non-Medically Indicated (NMI) early term deliveries (37,38 weeks) among singleton early term deliveries (37,38 weeks).**

	2011	2012	2013	2014	2015
Annual Objective				26.0	23.1
Annual Indicator	35.8	33.0	8.0	4.0	4.0
Numerator	2,689	2,368			
Denominator	7,503	7,169			
Data Source	Kansas birth certificate, 2011.	Kansas birth certificate, 2012.	CMS Compare, 2013	CMS Compare, 2014	CMS Compare, 2014
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

- Field Name:** 2015

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**Field Note:**  
The 2015 column is populated with 2014 data. 2015 data will be available spring 2017.
- Field Name:** 2014

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**Field Note:**  
Data source: CMS Hospital Compare, 2014
- Field Name:** 2013

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**Field Note:**  
Data source: CMS Hospital Compare, 2013
- Field Name:** 2012

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**Field Note:**  
Data Source: Birth certificate (in state resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE
- Field Name:** 2011

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**Field Note:**  
Data Source: Birth certificate (in state resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

**Data Alerts:**

None

**SPM 13 - The percentage of newborns who have been screened for critical congenital heart defects (CCHD) before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective				70.0	99.0
Annual Indicator	66.7	66.7	66.7	98.7	98.7
Numerator	25,895	25,895	25,895	38,858	38,858
Denominator	38,801	38,801	38,801	39,368	39,368
Data Source	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2014.	KDHE. Kansas Newborn Screening Data, 2014.
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
**Field Note:**  
Annual Objective for 2015 is 99%.  
Data Source: Kansas newborn screening data based on the 2014 survey.

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2. **Field Name:** 2014  
**Field Note:**  
Data Source: Kansas newborn screening data based on the 2014 survey.

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3. **Field Name:** 2013  
**Field Note:**  
Data Source: Kansas newborn screening data based on the 2013 survey.

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4. **Field Name:** 2012  
**Field Note:**  
Data Source: Kansas newborn screening data based on the 2013 survey.

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5. **Field Name:** 2011  
**Field Note:**  
Data Source: Kansas newborn screening data based on the 2013 survey.

**Data Alerts:**

None

**Form 11**  
**Other State Data**

**State: Kansas**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

## State Action Plan Table

State: Kansas

Please click the link below to download a PDF of the full version of the State Action Plan Table.

[State Action Plan Table](#)

## Abbreviated State Action Plan Table

State: Kansas

### Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	NPM 1 - Well-Woman Visit	ESM 1.1	
Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.			SPM 1

### Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Families are empowered to make educated choices about infant health and well-being.	NPM 4 - Breastfeeding	ESM 4.1	
Families are empowered to make educated choices about infant health and well-being.			SPM 4

### Child Health

State Priority Needs	NPMs	ESMs	SPMs
Developmentally appropriate care and services are provided across the lifespan.	NPM 7 - Injury Hospitalization	ESM 7.1	
Developmentally appropriate care and services are provided across the lifespan.	NPM 6 - Developmental Screening	ESM 6.1	
Developmentally appropriate care and services are provided across the lifespan.			SPM 3

### Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Communities and providers support physical, social, and emotional health.	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Communities and providers support physical, social, and emotional health.	NPM 9 - Bullying	ESM 9.1	
Communities and providers support physical, social, and emotional health.	NPM 7 - Injury Hospitalization	ESM 7.1	

### Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Services are comprehensive and coordinated across systems and providers.	NPM 11 - Medical Home	ESM 11.1	

### Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Services and supports promote healthy family functioning.			SPM 2
Professionals have the knowledge and skills to address the needs of maternal and child health populations.	NPM 14 - Smoking	ESM 14.1	
Information is available to support informed health decisions and choices.			SPM 5



**KANSAS TITLE V MATERNAL & CHILD HEALTH (MCH) SERVICES**  
FFY 2017 Block Grant Application

**State Priorities**

*States conduct a 5-year needs assessment to identify 7-10 state MCH priorities.*

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

**National Performance Measures (NPMs) & Evidence-Based or -Informed Strategy Measures (ESMs)**

*States select 8 of 15 NPMs that address the state priority needs; at least one from each population domain\* area.*

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

- ESM: Percent of women program participants that received education on the importance of a well-woman visit in the past year

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

- ESM: Number of communities achieving the “Community Supporting Breastfeeding” designation

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

- ESM: Percent of parents of child program participants receiving education on child development and developmental screening

**NPM 7:** Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)

- ESM: Percent of child program participants that received car seat and/or booster seat safety education during an MCH visit

**NPM 9:** Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

- ESM: Number of school-age students that received information on bullying or social-emotional development

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

- ESM: Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year

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

- ESM: Percent of families who experienced a decreased need of care coordination supports

**NPM 14:** Smoking during Pregnancy and Household Smoking (Percent of women who smoke during pregnancy; Percent of children who live in households where someone smokes)

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

**State Performance Measures (SPMs)**

*States select measures to address state priorities not addressed by the National Performance Measures.*

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

**SPM 2:** Percent of children living with parents receiving emotional support (help with parenthood)

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

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

**SPM 5:** Percent of adults who report that it is somewhat difficult or very difficult to understand information from doctors, nurses and other health professionals

**\*MCH Population Domains**

1. Women & Maternal Health
2. Perinatal & Infant Health
3. Child Health
4. Adolescent Health
5. Children & Youth with Special Health Care Needs
6. Cross-cutting or Life Course

## Title V Maternal & Child Health Action Plan

Revised June 6, 2016

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

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

- ESM: Percent of women program participants that received education on the importance of a well-woman visit in the past year

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

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

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

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

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

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

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

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

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

**OBJECTIVE 1.5:** Decrease non-medically indicated births between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5% by 2020.

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

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

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

**OBJECTIVE 2.1:** Increase opportunities to empower families and build strong MCH advocates by 2020.

- 2.1.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others).
- 2.1.2 Conduct "Care Coordination: Empowering Families" trainings for parents of CYSHCN.
- 2.1.3 Increase the number of fathers and male support persons that are engaged in family health activities.
- 2.1.4 Identify options to provide supports (e.g., making healthy choices, positive coping mechanisms, violence, substance abuse, and mental health issues) to parents of adolescents, such as home visiting and peer-to-peer networks.

**OBJECTIVE 2.2:** Increase the number of providers with capacity to provide trauma-informed care by 2020.

- 2.2.1 Increase MCH state staff and partner capacity around trauma-informed care.
- 2.2.2 Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it.
- 2.2.3 Provide training for MCH grantees including home visitors on trauma-informed care.

**OBJECTIVE 2.3:** Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

- 2.3.1 Develop and utilize strategies for MCH home visitors to improve effective outreach and engagement of families in universal home visiting services.
- 2.3.2 Enhance and expand coordinated intake and referral systems across the state to support appropriate referrals and levels of services for families.
- 2.3.3 Partner with Healthy Start; Maternal, Infant and Early Childhood Home Visiting (MIECHV); and Becoming a Mom (BAM) communities to ensure coordination and referral for home visiting services.

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

- NPM 6:** Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
  - o ESM: Percent of parents of child program participants that received education on child development and developmental screening
- NPM 7:** Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)
  - o ESM: Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit
- SPM 3:** Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes/day

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

- 3.1.1 Conduct an environmental scan to identify providers conducting developmental screening and determine the tools being utilized.
- 3.1.2 Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention.
- 3.1.3 Build MCH capacity for screening and follow-up through complete referrals to providers and community-based services.
- 3.1.4 Provide training to MCH grantees on developmental screening and use of Ages and Stages Questionnaires (e.g., ASQ-3; ASQ:SE2).

**OBJECTIVE 3.2:** Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.

- 3.2.1 Develop a standard and consistent message to communicate importance of developmental screening among child care programs.
- 3.2.2 Make available and provide training to child care providers on social-emotional development, milestones, and age-appropriate activities using the Kansas Early Learning Standards.
- 3.2.3 Build child care provider capacity to support coordination and referrals with other providers and community-based services.
- 3.2.4 Partner with statewide networks such as Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs.

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

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

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

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

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

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

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

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

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

**NPM 4:** Breastfeeding (Percent of infants who are ever breastfed; Percent of infants breastfed exclusively through 6 months)

- **ESM:** Number of communities achieving the “Community Supporting Breastfeeding” designation

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

**OBJECTIVE 4.1:** Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020.

- 4.1.1 Expand the number of communities that achieve the criteria for the *Community Supporting Breastfeeding* designation.
- 4.1.2 Partner with the Kansas Breastfeeding Coalition (KBC) and WIC in their efforts to promote and support breastfeeding with businesses through the *Breastfeeding Friendly Business* and *Business Case for Breastfeeding* initiatives.
- 4.1.3 Develop standard curriculum for infant feeding for use by local communities across the state, integrating it into the Becoming a Mom prenatal education sessions.
- 4.1.4 Increase access to professional support through referrals and linkages between birthing facilities and community resources.
- 4.1.5 Partner with Medicaid and Managed Care Organizations to increase awareness of and access to breastfeeding supportive benefits.

**OBJECTIVE 4.2:** Increase the proportion of births delivered at Baby Friendly hospitals by 2020.

- 4.2.1 Partner with WIC and KBC to expand the *High 5 for Mom and Baby* program by increasing the number of hospitals trained and number implementing the program.
- 4.2.2 Promote and support the Empower Initiative in partnership with United Methodist Health Ministries Fund (UMHMF), KBC and WIC.
- 4.2.3 Provide education to hospital and maternity care/OB staff to support implementation of baby friendly hospital policies and practices.

**OBJECTIVE 4.3:** Increase the proportion of women and pregnant women receiving education related to the impact of prenatal and postpartum nutrition and exercise on optimal infant feeding by 2020.

- 4.3.1 Develop prenatal education content to support an accurate, consistent message for women and families.
- 4.3.2 Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including Becoming a Mom, home visiting, and WIC.
- 4.3.3 Increase the number of referrals to WIC and breastfeeding peer counselors for breastfeeding support and education, including the expansion of breastfeeding peer counseling sites.

**OBJECTIVE 4.4:** Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2018.

- 4.4.1 Enhance safe sleep instructor skill sets to include training home visitors and facilitating community baby showers expanding to address safe sleep, smoking cessation, and breastfeeding.
- 4.4.2 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need.

- 4.4.3 Expand promotion of the AAPs Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention and the Safe Sleep Toolkit for outpatient clinics.
- 4.4.4 Increase the number of Safe Sleep instructors by approximately 5 per year through targeted recruitment in areas with identified need for instructors, high rates of sleep-related injury or mortality, and low levels of related resources.

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

**NPM 9:** Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

- o ESM: Number of school-age students that received information on bullying or social-emotional development

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

- o ESM: Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year

**OBJECTIVE 5.1:** Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

- 5.1.1 Identify evidence-based programs in partnership with the Bureau of Health Promotion (BHP) that decrease risk factors associated with bullying through parental involvement, curriculum integration, and school staff-wide training.
- 5.1.2 Work with BHP to help schools improve school-based bullying policies to meet best practices.
- 5.1.3 Provide information to school nurses and counselors on how to respond to bullying.
- 5.1.4 Partner with school nurses and counselors to provide access to behavioral health services in schools.
- 5.1.5 Explore options for educating and reporting unsafe social media and digital content.

**OBJECTIVE 5.2:** Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

- 5.2.1 Provide annual training on Adverse Childhood Experiences (ACEs) and trauma-informed responses and approaches for MCH staff, grantees, and partners working with adolescents and their families.
- 5.2.2 Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments to reduce risky behaviors and promote healthy relationships including abstinence.
- 5.2.3 Partner with communities to connect adolescents with supports that promote protective factors (Faith-based, pediatricians, schools).
- 5.2.4 Support public awareness campaigns to prevent adolescent self-injury.
- 5.2.5 Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence and avoiding risky behaviors more easily available to youth and their families.
- 5.2.6 Identify methods to increase adolescent awareness of services and programs available to them in their community.

**OBJECTIVE 5.3:** Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

- 5.3.1 Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received.
- 5.3.2 Behavioral health awareness days with free screenings across the state.
- 5.3.3 Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.
- 5.3.4 Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time.
- 5.3.5 Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

**OBJECTIVE 5.4:** Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

- 5.4.1 Engage health care providers, Medicaid and Managed Care Organizations to promote annual well-child visits through adolescence into adulthood.
- 5.4.2 Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan (IHP) who have not had a well visit in the past year.
- 5.4.3 Partner with schools to evaluate the capacity and infrastructure to provide school-based services for physical, social, and emotional health needs.

**OBJECTIVE 5.5:** Increase the number of adolescents receiving immunizations according to the recommended schedule by 2020.

- 5.5.1 Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program.
- 5.5.2 Provide parent education on immunizations, including schedules, and the importance to child and adolescent health.
- 5.5.3 Identify and promote existing vaccination programs and campaigns.
- 5.5.4 Work with Immunize Kansas Coalition (IKC) to increase HPV vaccination completion for youth ages 13-17 years.

**PRIORITY 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations**  
(Domain: Cross-cutting/Life course)

- NPM 14:** Smoking during Pregnancy and Household Smoking (Percent of women who smoke during pregnancy; Percent of children who live in households where someone smokes)
- o ESM: Percent of pregnant women program participants who smoke referred to the Tobacco Quitline

**OBJECTIVE 6.1:** Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

- 6.1.1 Promote provider training on tobacco use and smoking with focus on pregnancy, identifying resources and interventions available.
- 6.1.2 Expand education and utilization of the Tobacco Quitline (including reminder and fax referral system).
- 6.1.3 Promote referral to the Baby & Me Tobacco Free Program as an evidence-based intervention where available.
- 6.1.4 Increase the number of communities implementing the Baby & Me Tobacco Free program.
- 6.1.5 Increase the number of providers trained on evidence-based tobacco cessation techniques, including motivational interviewing.

**OBJECTIVE 6.2:** Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

- 6.2.1 Place toolkits (screening, referral, resources, and programs) in the hands of providers.
- 6.2.2 Facilitate referrals to Baby & Me Tobacco Free for smoking cessation counseling and support based on family risk and need.
- 6.2.3 Standardize smoking history and screening forms.
- 6.2.4 Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum.
- 6.2.5 Leverage consistent, repeat messages about tobacco and nicotine across all systems, using media, social media, texting, videos, peer-to-peer mentoring.
- 6.2.6 Engage women and families to collect input on additional interventions to support cessation including SCRIPT.

**OBJECTIVE 6.3:** Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

- 6.3.1 Integrate oral health education and referral into prenatal and infant health education through BAM programs, well visits, dental visits, home visits.
- 6.3.2 Promote oral health in all programs targeted towards CYSHCN through care coordination activities.
- 6.3.3 Repeat on-site oral health screenings at child care facilities through the *Healthy Smiles* initiative in three years.
- 6.3.4 Continue offering the existing training and develop level 2 and 3 courses to build on education through *Healthy Smiles*.
- 6.3.5 Educate health care professionals regarding the child care home population for ongoing screenings and oral health education.

**OBJECTIVE 6.4:** Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

- 6.4.1 Increase knowledge of providers, partners, and consumers, including families, as it relates to Kansas Maternal and Child Health: purpose, scope, target populations, programs, services, and more.
- 6.4.2 Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment.
- 6.4.3 Incorporate MCH competencies more intentionally into MCH position descriptions.
- 6.4.4 Train paraprofessionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.

**OBJECTIVE 6.5:** Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

- 6.5.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN.
- 6.5.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course.
- 6.5.3 Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

**PRIORITY 7: Services are comprehensive and coordinated across systems and providers**  
(Domain: Children & Youth with Special Health Care Needs - CYSHCN)

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

**OBJECTIVE 7.1:** Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.

- 7.1.1 Support family-centered medical homes through increased awareness among families, including communicating with their doctors and building effective health advocacy skills.
- 7.1.2 Provide professional development opportunities to health care providers to increase family-centered medical home supports.
- 7.1.3 Implement communication and referral protocols for SHCN Care Coordinators and providers.

**OBJECTIVE 7.2:** Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.

- 7.2.1 Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers.
- 7.2.2 Expand KS-SHCN to have care coordinators located in all six Kansas public health regions.
- 7.2.3 Engage Managed Care Organizations and primary care providers in collaborative coordination for SHCN clients.
- 7.2.4 Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care.
- 7.2.5 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients and BAM participants.

**OBJECTIVE 7.3:** Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

- 7.3.1 Complete the online navigational toolkit to provide resources and services, including expansion to Help Me Grow.
- 7.3.2 Increase access to primary and specialty care in underserved areas.
- 7.3.3 Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals.
- 7.3.4 Connect SHCN care coordinators with foster care and Managed Care Organization case managers to provide technical assistance and support for SHCN clients.
- 7.3.5 SHCN providers will have access to care coordinators for support and assistance in their community (in-person or remote access).

**PRIORITY 8: Information is available to support informed health decisions and choices (Domain: Cross-cutting/Life course)**

**SPM 5:** Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them

**OBJECTIVE 8.1:** Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

8.1.1 Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education.

8.1.2 Provide resources to increase education and knowledge of healthy decision making.

8.1.3 Work with partners to ensure that well visits incorporate best practices.

**OBJECTIVE 8.2:** Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

8.2.1 Emphasize the importance of health insurance literacy with HLK.

8.2.2 Identify target populations and/or regions that require increased health literacy support.

8.2.3 Promote distribution and use of "What to do when your child gets sick."

**OBJECTIVE 8.3:** By 2020, create and disseminate a toolkit for preschool through school-aged providers with a curriculum and activities designed to teach children and adolescents about healthy habits and choices.

8.3.1 Identify effective age-appropriate approaches to assist children ages 6 to 11 years with making informed decisions about health and wellness.

8.3.2 Work with schools to incorporate information about healthy choices into school enrollment and orientation materials.

8.3.3 Work with child and youth programs (Child Care, Girl Scouts, Boy Scouts, Boys and Girls Club, YMCA, etc.) to provide health and wellness information.

8.3.4 Distribute *The Future is Now THINK BIG – Preparing for Transition Planning* workbooks to schools for distribution to children and adolescents as part of orientation.

**OBJECTIVE 8.4:** Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

8.4.1 Implement the youth leadership program, *Faces of Change*.

8.4.2 Implement Plan It Live It to support effective transition planning.

8.4.3 Explore opportunities for increased youth leadership.

8.4.4 Provide opportunities for parents to improve their skills in seeking out quality health-related information.

**OBJECTIVE 8.5:** Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

8.5.1 Educate MCH staff regarding ongoing changes to the health care system.

8.5.2 Identify opportunities to optimize changes in the health care system to maximize service delivery to families.

8.5.3 Sponsor and/or host regional training on health transformation.

8.5.4 Provide training and technical assistance to local health departments on MCH service planning and delivery.

8.5.5 Support connection between local health departments and Navigators to increase families' access.

8.5.6 Review and identify steps to incorporate information from the *Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the ACA*.

8.5.7 Review and incorporate *Standards for Systems of Care for CYSHCN*.