Maternal and Child Health Services Title V Block Grant

State Narrative for Kansas

Application for 2014 Annual Report for 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

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

C. Assurances and Certifications

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

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

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An attachment is included in this section. IC - Assurances and Certifications

D. Table of Contents

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

E. Public Input

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

Dear Maternal and Child Health (MCH) stakeholders:

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

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

We wanted to give you a special invitation to review the latest results online if you haven't already. Go to this page to see the MCH 2015 priorities, strategies, and logic models: http://www.datacounts.net/mch2015/results.asp

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

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

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

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

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

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

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

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

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

Children's Alliance, Department of Children and Families contacts, Birth Centers, MCH grantees/reps, WIC grantees/representatives, WIC Advisory Committee, Kansas Breastfeeding Coalition, High 5 for Mom and Baby, and Nutrition Physical Activity Collaborative.

"Dear Kansas Maternal and Child Health Partner:

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

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

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

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

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

The public input was gathered via an on-line survey tool (Survey Monkey). The survey was structured to focus on major and emerging health concerns and unmet needs for the target populations served by the block grant. In addition, the survey asked for input on the service delivery system for these populations to include what is and is not working well. The tool generated 292 responses which expressed overall support for prevention-related

services. The following issues were identified in the comments: support for access to and utilization of reproductive health services; assistance to families with newborns; immunization education and support; developmental screening and early identification services; parenting education and support services; adequate and appropriate nutrition/obesity prevention; mental health screening and services; oral health; strong adolescent health education and services; support infrastructure for health care system; breastfeeding education and support; childhood obesity; and supports for families who have a child or youth with special health care needs. It was suggested the MCH program continue to find ways to make greater use of technology to provide health education and support services; improve access to and utilization of health care system in rural areas; support advocacy for policies to improve public health; improve health literacy of families; and encourage public/private partnerships between existing programs and services. The summary input from the survey and the MCH Grantees are included in the attachment.

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

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

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2014/ Needs Assessment Update for Interim Year

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

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

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

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

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

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

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

Pregnant Women and Infants

Pregnant Women and Infants Update: Low birthweight (LBW) infants born to mothers who smoke tend to weigh less than other infants. LBW (< 2,500 grams) is a key indicator for infant deaths. The following activities are directed toward improving the LBW infants: 1) Utilization of Kansas Tobacco Quitline by those seeking resources to reduce or quit smoking tobacco/using tobacco products, especially before, during and after pregnancy; 2) Promoted use of social media to bring awareness to health-related topics for women before, during and after pregnancy. For example, Healthy Babies Kansas public awareness Facebook campaign and text4baby free health text messaging program for pregnant women and new moms; 3) Kansas Blue Ribbon Panel recommendations to reduce low birth weight babies delivered and other activities focused on decreasing the rate of infant mortality; and 4) formation of the Kansas Perinatal Quality Collaborative in the fall of 2012, established to improve Kansas' maternal and infant health outcomes by assuring quality perinatal care using data-driven, evidence-based practice and quality improvement processes.

Breastfeeding Update: The KDHE Nutrition and WIC Services (NWS) section continues to promote quality training and/or credentialing of health professionals involved in breastfeeding promotion and support by providing information about upcoming

educational opportunities and offering stipends to cover registration and underwrite speakers on breastfeeding topics for the statewide conferences, including provision of the USDA's Grow and Glow In Breastfeeding training to local health department staff.

Children and Adolescents

Reducing Risk Behaviors Update: The KDHE Children and Families Section stakeholders echoed the HP 2020 goal in the development of a Kansas goal: to enhance the health of Kansas children and adolescents across the lifespan. The HP2020 objectives were also reflected in the Kansas objectives: 1) all children and youth receive health care through medical homes; 2) reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs; and 3) all children and youth achieve and maintain healthy weight.

Overweight and Obese Children Update: The NWS section continues work with local and state partners to encourage and promote events aimed at increasing healthy eating behaviors and physical activity of Kansas children. In addition, NWS staff continues to work to increase the number of well-trained MCH staff who plan, facilitate, deliver and evaluate healthy eating and physical activity messages by sponsoring and promoting training opportunities. The Kansas MCH program supports reducing the number of overweight and obese children and encourages local MCH grantees to participate in any relevant, evidence-based programs in support of this goal as part of their staff development process.

Children and Youth with Special Health Care Needs

Medical Home Update: The CYSHCN program continues to promote medical home objectives individually and in cooperation and collaboration with other state and local programs. The focus of this goal is improving access to and expanding services available within a Medical Home. The primary strategies to address this priority objective are: 1) educate families, youth and providers about the components of a medical home; 2) inform community partners and stakeholders of local, state, and national initiatives to support effective and successful system change; and 3) utilize community partnerships by linking community services and resources for CYSHCN and their families. Through these efforts, the program strives to empower consumers to take an active role in their health care and partner with providers in health care decisions.

Youth Transitioning into Adult Services Update: The CYSHCN program continues to be at the forefront of improving the transition of youth with special health care needs into adult services. Specialty clinics supported by CYSHCN offer transition clinics for older youth with special health care needs to begin the transition process from pediatric to adult health care systems. Partnerships with Families Together, Inc. has provided opportunities to promote the personal health care and transition notebooks for families and youth with special health care needs to encourage youth to take a more active role in their health care. Additionally, through this partnership, a number of transition workshops and conferences have been held to educate and inform parents and families about necessary steps for successful transitions. A focus was placed on preparing youth to improve the integration and coordination of transition supports and services including health care, education, employment, and independent community living. A comprehensive transition model was developed with the youth and their families in the center of the model. The model includes tools and resources across disciplines related to family health care supports, medical and school coordination, health care provider engagement, individualized health planning, and youth-directed healthcare education. Additionally, a partnership with the University of Kansas allowed for the development of a transition website, specific to Kansas resources and supports. This website, www.buildingalife.ku.edu, intends to help families and youth navigate the complex world of transition to adulthood.

Financial Impact on the Family Update: The CYSHCN program continues to work towards minimizing financial impact on families, while ensuring that the program itself remains financially solvent. Since July of 2008, the CYSHCN program has experienced an expansion in the number of eligible conditions due to the newborn screening expansion to the 29 conditions (28 metabolic conditions and hearing) recommended by the American College of Medical Genetics. With the economic downturn, more unemployed/underemployed families are seeking financial assistance to cover their child's medical care. Although there has been an increase in demand for services, there has not been an increase in funding to programs that serve CYSHCN. The Maternal and Child Health budget under Social Security's Title V Act has remained level funded, while the State's resources have declined steadily, requiring the state to achieve a balanced budget by reduced spending. To fulfill the mission of the CYSHCN program given by stakeholders, the program has partnered with a variety of agencies to provide providers and consumers with information about the impact of the Patient Protection and Affordable Care Act; assist families that have no insurance to apply for insurance; update the sliding fee scale in the CYSHCN program to better serve the most vulnerable children; and strengthen collaborative efforts to maximize available resources. To address the growing needs of CYSHCN, the program reached out to local communities and implemented a regionalization to offer services at the community level, rather than a state level. In partnership with local health departments and other local entities, four regional offices in Western Kansas began providing a local point of entry into the program in July 2012. Expansion to Eastern Kansas is planned for the coming year, along with an expansion of clinic services through outreach to the Western regions of Kansas. The CYSHCN program is dedicated to providing services to families at the community level and will continue to move towards improved community-based services.

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

MCH epidemiologist continues to collaborate with program(s) staff to coordinate needs assessment activities. These efforts include the collection and analysis of data for the annual MCH Block Grant application that includes State priority needs.

The KDHE Bureau of Family Health (BFH) published the fourth MCH Biennial Summary, 2012. Stakeholders use the 2012 MCH Biennial Summary to track progress on the public health significance of the MCH needs assessment indicators. This document provides trend data and determines how well the priorities have been addressed by state and local programs. The document is posted on the BFH website.

The annual nurses' survey (2011-2012 school year) was completed and analyzed to assess workforce capacity of school nursing services in the state. The results of this voluntary survey inform policy and program decisions. //2014//

III. State Overview

A. Overview

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

Geography/Demography

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

Population Density/Distribution

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

Urban/Rural

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

Population Growth/Change

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

Age

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

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

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

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

Race/Ethnicity

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

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

Diversity/Languages

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

Education

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

Income/Poverty

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

Economy

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

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

Health Insurance Coverage

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

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

Health Care Delivery Environment

Primary Care Access/Workforce

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

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

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

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

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

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

Public Health System

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

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

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

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

Public Health Insurance

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

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

State Health Agency Current Priorities and Initiatives

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

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

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

Title V MCH Roles and Responsibilities in Agency Initiatives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2010. The APC was not significant.

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

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

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

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

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

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

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

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

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

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

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

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

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

Kansas, along with many national and regional organizations, is exploring options to improve health in communities through increasing collaborative relationships between primary care providers and public health. Successful models of integration share common goals of improving population health, involving the community in defining and addressing needs, relying on strong leadership across disciplines, and sharing data and analysis.

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

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

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

Responses: scale of 1 -- 5

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

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

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

- Improving sustainability
- Deepening partnerships
Less frequently selected was:
- Cultivate public health supporters

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

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

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

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

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

In the Family and Community categories, Kansas ranked 23. The percentage of children in single-parent families rose from 27% in 2005 to 31% in 2011. In 2011, 11% of children in families where the household head lacks a high school diploma, compared to 12% in 2005. During the period from 2007 through 2011, 7% of children lived in high-poverty areas, a total of 51,000 children. This represents an increase of 37,000 children since 2000, when the rate was 2%. In 2010, there were 3,865 babies born to females ages 15 to 19. That translates into a birth rate of 39 births per 1,000 teens, which represents a decrease from 2000, when the rate was 41 births per 1,000 teens.
Source: Press Release by Kansas Action for Children, June 24, 2013 and 2013 KIDS COUNT Data Book

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

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

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

This proposal aligns with the Mission of KDHE and the agency's priorities. This proposal will: allow for more collaborative and coordinated work through use of a shared system for three programs utilizing the birth record, improve the effectiveness and efficiency of follow-up, tracking, and services to the community, and enhance the program's capacity

to: 1) identify, collect, and analyze data collected through state mandated NBS and BD reporting; 2) provide better services to our consumers; 3) support future programmatic growth; 4) develop a long-term NBS follow up program and active BD surveillance system; and 5) support collaboration among other KDHE initiatives, such as the Meaningful Use Public Health Reporting activities around surveillance.

The Bureau took note of July 1, 2013, the effective date of several new laws impacting the agency. Officially, the Division of Health (DOH) became the Division of Public Health (DPH). The change reflects the essence of each program in that division and aligns programs with the ongoing initiative to improve collaboration and coordination between the public health and primary care sectors across Kansas. The Kansas Health Information Technology (KHIT) Act transfers the responsibilities of KHIE, Inc., to KDHE. The purpose of the statute amendment was to sustain the program that facilitates the critical sharing of electronic health records (EHRs) among healthcare organizations and providers throughout Kansas. Because KDHE can conduct the same work without the salary and overhead expenses incurred by KHIE, Inc., this transition is expected to save taxpayers approximately $300,000 annually. As of today, responsibility for the following resides in KDHE's Office of the Secretary: (1) Promulgate, publish and enforce policies related to the electronic sharing of health information in Kansas; (2) Monitor the operations of those organizations that provide health information sharing services in Kansas (3) Provide a means by which an individual may elect to restrict access to his/her electronic health information stored in the exchange. KHIT oversight aligns well with health IT work already being performed at KDHE, such as the Medicaid EHR Incentive program and the disease surveillance applications like BioSense and WebIZ. More about KDHE's HIT initiatives can be found in the agency's 2012 Annual Report at http://www.kdheks.gov/reports/2012_Annual_Report.pdf.

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

B. Agency Capacity

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

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

information is utilized to set strategic directions for the Title V program in terms of identification and implementation of organizational strategies to achieve the desired outcomes for the maternal and child health population.

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

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

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

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

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

Title V has access to data sets outside the state agency such as Medicaid data (MMIS & Clearinghouse), hospital discharge data, department of transportation data (motor vehicle accidents), Kansas Bureau of Investigation (intentional injuries), department of social services, education department (school lunch program, school injuries). The annual MCH Block Grant application includes a good representative sample of the types of data in use. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

BFH has two epidemiology positions. Additional epidemiological support would be beneficial. The epi's serve as data analysts and resource persons for: Kansas' five year needs assessment, KDHE Healthy Kansans 2020, analysis of the National CYSHCN Survey, National Child Health Survey, birth defects data, and numerous ad hoc projects throughout the year. There is not sufficient capacity to conduct analyses of MCH data sets that go beyond descriptive statistics,

although there has been some work in this area. BFH epidemiologists and other staff have compared health status measures across populations. The TVIS on the MCHB website is used often as a means of comparing health status measures for Kansas with those of other States.

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

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

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

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

During the 2010 session, statutory authority to utilize birth certificate data to survey recent mothers was obtained largely through the efforts of the Blue Ribbon Panel on Infant Mortality. This legislation opens the way for Pregnancy Risk Assessment Monitoring System (PRAMS) and Fetal-Infant Mortality Review (FIMR) efforts in the state. Increasingly, the MCH epidemiologists serve as the State's expert resource for interpretation of data related to MCH issues. The Title V program is regularly consulted on MCH data issues and staffs participate as experts in planning processes. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the Kansas Perinatal Council. Title V serves on the state Child Death Review Board and serves as interface in information sharing for implementing community-based interventions. Through the MCH needs assessment process, Title V uses epidemiologic methods to forecast emerging MCH/CYSHCN threats that can be addressed through planning processes.

Essential Service #3. Inform and educate the public and families about maternal and child health issues. Title V has no health education plan per se and no dedicated health educators. These functions are incorporated into the job duties of all Title V staff. There is no dedicated funding for health education activities, such as for print or media campaigns, although this may change with new priorities of MCH 2015. The CYSHCN program incorporates information and education to the public and to families about medical home, transition and other at specialty clinics as a routine

part of its activities. Grants to local agencies and organizations encourage health education activities at the local level with the new focus on prevention/wellness, social determinants, life course perspective and health equity.

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

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

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

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

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

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

for this report.

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

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

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

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

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

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

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

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

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

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

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

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

Essential Service #7. Link women, children and youth to health and other community and family services and assure quality systems of care. The Kansas Title V program develops, publicizes and routinely updates its Make a Difference Information Network (MADIN) toll-free line. The program uses the State language assistance contract to obtain interpretation services as well as Spanish-speaking staff. There are plans to use print materials, website and other means to publicize the line. At all points of contact with women, children, and families the Title V program provides verbal information and/or print materials about publicly funded health services. The Title V program assists localities in developing and disseminating information and promoting awareness about local health services through such activities as community resource and referral lists that are maintained at each local service site. There has been no systematic effort to evaluate the effectiveness and appropriateness of efforts to link women and children with services.

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

and serving hard-to-reach populations. BFH disseminates information on best practices to local agencies, providers, and health plans across the State.

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

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

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

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

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

Essential Service #8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. A link between the Title V program, the school of public health, and other professional schools to enhance state and local analytic capacity has been established. Internship/practicum students have been utilized. In 2009, a summer intern assisted with development of H1N1 and Pregnancy: FAQs that was posted on the KDHE Web site and utilized in training for Healthy Start Home Visitors during the fall regional training by MCH staff. For 2010, the CYSHCN program will have a summer intern for its Integrated Systems grant.

Academic partnerships, joint appointments, adjunct appointments, and sabbatical placements have been considered but not undertaken. Title V staff occasionally guest lecture at professional schools in the State such as the school of social welfare and the public health certificate program. MCH/CYSHCN collaborates with the primary care program to monitor changes in the public health workforce. Resource inventories of facilities and programs are also available through this source. Geographic coverage and availability of services and providers are monitored. The 5-

year State needs assessment addresses to some extent workforce issues and workforce gaps as these pertain to overall program planning. Examples of activities to address workforce shortages include: Title V coordination with Medicaid, the Kansas School Nurse Organization, the Kansas Association of Local Health Departments, and others to assure statewide fluoride varnish training for nurses. Another example is coordination with Head Start, Early Head Start and other early childhood providers to adopt a quality curriculum for home visitors in the State and assure consistent training for home visitors across all programs.

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

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

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

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

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

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

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

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

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

C. Organizational Structure

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

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

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

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

needs of the BFH. Each of the Sections is attempting to build data capacity through staff training and education and the rewriting of job descriptions to require data skills for new hires.

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

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

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

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

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

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

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

Kansas town in Greeley County.

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

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

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

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

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

Significant changes within BFH include:

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

The Bureau consists of six sections, three resulting from the merge with Child Care Licensing and three existing in the Bureau of Family Health.
• Administration & Policy (Mary Murphy, Director): Compliance & Regulation Development, Child Care Licensing Admin Professionals, Open Records/Policy
• Children & Families (Sabra Shirrell, Director): Infant-Toddler Services/Part C, Maternal and Child Health/Home Visiting/MIECHV, Reproductive Health, State Interagency Coordinating Council

• Special Health Services (Heather Smith, Director): Special Health Care Needs, Newborn Screening, Newborn Hearing Screening
• Child Placing Agency & Residential Programs (Daric Smith, Director) (24-hour residential care)
• Early Care & Youth Programs (Lori Steelman, Director) (out of home day/child care)
• Nutrition & WIC (David Thomason, Director)

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

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

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

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

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

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

Marc Shiff serves as the State CYSHCN Director. He has a Master's of Public Administration degree from the University of Texas at Dallas with concentrations in Public Health and Resource Management. His Bachelor of Science degree in Management and Social Science is also from the University of Texas at Dallas. Prior to his current position, he served as Director of Operations and Services for the KDHE Bureau of Disease Control and Prevention and as Programs Manager for the University of Kansas Medical Center, Kansas City, providing medical, nursing, and allied health continuing education oversight. He was appointed to the Governor's Commission on Autism Task Force, and is a member of the Kansas Department of Social and Rehabilitation

Services Traumatic Brain Injury advisory board, Kansas Developmental Disabilities Council, Kansas Families Together Advisory Council, and past State Co-Chair of the Kansas Community Planning Group. Shiff was selected to particpate in the MCH Leadership Development program. Fifteen CYSHCN/NBS Topeka staff report to him and he provides CYSHCN program support and guidance to 7 field contractor staff in Kansas City and Wichita. /2013/ Shiff is Region VII AMCHP Director and Chair of the AMCHP Governance Committee. //2013//

Ileen Meyer is a professional registered nurse with experience in services to the pediatric and young adult populations during her 35 year career in public health. She holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 10 FTEs (5 nurses, 2 program planning and evaluation, 1 data entry and 2 clerical). /2013/ The Section Director of the Children and Families section retired in December 2011. The position is vacant at the time of this writing. //2013//

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

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

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

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

The CYSHCN Family Advisory Council is comprised of parents and caregivers of children and youth with special health care needs. Efforts have been made to select families that represent

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

The CYSHCN - HRSA D-70 Integrated Community Systems grant "Systems in Sinc" Advisory Council links families and youth with special health care needs with information and services for YSHCN. As members of the Advisory Council, parents of youth with special health care needs are able to provide feedback and input on project activities to ensure that identified objectives are met. Consumers are the central focus of these efforts. Parents are also represented on the Quality Improvement team that will meet in Washington, D.C. in June 2010 to ensure parent participation and involvement on all levels of the grant project. Family members participated in the 8 regional town hall meetings and provided feedback and input on a variety of topics related to transition and health for youth with special health care needs. A Youth Advisory Council is in development to ensure youth participation and input is central to the project. Parents of our youth advisory members are provided with trainings or opportunities to share information and discuss important issues and topics related to their youth's transition and development.

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

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

Deborah L. (Debbie) Richardson, Ph.D., joined the KDHE Bureau of Family Health in February 2011 as the Program Manager of the Kansas Maternal, Infant, and Early

Childhood Home Visiting (MIECHV) grant. In November 2012, she was also appointed as the Maternal and Child Health (MCH) Unit manager which includes supervising three MCH program consultants and one administrative assistant. Debbie oversees both the MIECHV and MCH programs. Prior to this, she served 10 years (2001-2011) as a parenting and child development specialist with the Oklahoma Cooperative Extension Service and Department of Human Development & Family Science at Oklahoma State University where she administered multiple grants and contracts, home visitation program sites serving families with children prenatal to five years, training and technical assistance for county Extension staff and other agencies, and program evaluation activities. Other previous positions include serving as a Senior Planner at the Oklahoma Commission on Children and Youth (1999-2001), as Executive Director of the Oklahoma Chapter of Prevent Child Abuse America (1990-1999), as well as a coordinator of community-based programs for low income mothers and pregnant and parenting teens and a youth and families services counselor (1984-1990). Dr. Richardson holds a Bachelor's degree in Psychology (1982), a Master of Science degree in Community Counseling (1984), and a Ph.D. specializing in Human Development and Family Science (2009), all from Oklahoma State University. //2014//

E. State Agency Coordination

Coordination within the State Health Agency

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

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

Coordination with Other State Agencies

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

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children.

"Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CYSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CYSHCN have been developed and are also underway for early childhood education programs and child care providers. Others areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

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

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

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

For the high-cost services to special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both Medicaid and CYSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CYSHCN staff has direct access to Medicaid information on children eligible for both Title V and Title XIX/XXI.

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

Through the Farmworker Health Program and with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify

methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

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

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

Coordination with Other Agencies and Organizations

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

MCH works with professional groups, private non-profit organizations and others such as: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Academy of Family Physicians; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Missouri D70 project; Kansas Head Start Collaboration Project.

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

MCH Block Grant dollars support regional public health nurse activities: regional public health

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

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

Coordination with other Kansas MCHB Grants

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

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

There has been strong collaboration among KDHE, KSDE, Kansas In-service Training System (KITS), local infant toddler networks and statewide school districts' Part B programs, to develop,

implement, and provide user training for an outcomes web system that tracks a child's functional progress in three developmental outcomes.

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

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

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

Kansas business case for breastfeeding train the trainer grant has helped us build a coalition of partners committed to workplace reform and policies that better support families. The Medicaid/MCH Interagency Agreement defines collaborative activities between the two programs as required by law. In 2009, an update to the document helped to strengthen our relationship. These are among the numerous collaborative activities and practices engaged in by the Kansas Title V.

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

/2014/ Coordination within the State Health Agency has increased and improved over the last year since the agency reorganization. Within the BFH, Child Care Licensing is working more closely with other sections to identify how local health department surveyors visiting child care facilities can provide information to early care professionals serving children and families. The BFH is working closely with the Local Public Health program: presenting at the local public health regional meetings the last quarter of SFY13 and continuing through the first quarter of SFY14, sharing information about the current organizational structure, strategic planning, initiatives, and priorities for the coming year; working together on the AMCHP compendium pilot project, taking a comprehensive approach to

improve birth outcomes, by using the regional public health meetings to inform health departments and collect input. The BFH worked with the Bureau of Health Promotion, providing strategies to incorporate into a CDC wellness grant to focus on nutrition, physical activity, and wellness in early care and education settings. The MCH program partnered with the KDHE Center for Health Equity (CHE) during SFY2013 to support three Preconception Peer Educator (PPE) community events (Wichita, Topeka, Kansas City) and continue the Healthy Babies Kansas online education campaign. The PPE program's core training topics include: health disparities and social determinants of health, causes of infant mortality and why it's a public health concern, racial and ethnic disparities in birth outcomes (life course perspective), preconception health and care for men and women, overcoming racism and its stress, men's health and fatherhood.

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

Collaboration with the Greater Kansas Chapter of the March of Dimes (MOD) continues but has strengthened as a result of new initiatives. The KDHE MOD announced in March 2013 a joint initiative to reduce the rate of pre-term birth. Dr. Robert Moser, KDHE Secretary and State Health Officer, accepted a challenge from the Association of State and Territorial Health Officials (ASTHO) to reduce the rate of premature birth by 8% by the end of 2014. The March of Dimes 2012 Premature Birth Report Card shows that the premature birth rate in Kansas is currently at 11.2%. This 8% reduction will bring Kansas to 10.3%, which translates to roughly 350 babies. A number of agencies and organizations are working together on the following initiatives related to the Challenge: 1) A Statewide Public Awareness Campaign on issues related to infant mortality. The campaign, launched in 2010 and continuing, includes an informational website, Facebook and Twitter applications, and a virtual resource directory for local, state, and national resource access. National campaigns including "A Healthy Baby Begins with You" and the National Partnership for Action serve as key resources. Media outlets are leveraged in the months of September (Infant Mortality Awareness Month), October (SIDS Awareness Month), and November (Prematurity Awareness Month). The primary goal is to inform pregnant women and their health care providers that "Healthy Babies Are Worth the Wait." Through patient and provider education, women are advised that if their pregnancy is healthy, it's best to wait for labor to begin on its own rather than scheduling an induction or cesarean section. 2) The Kansas Blue Ribbon Panel continues its work utilizing data to identify: leading causes for infant mortality in Kansas and communities with the combination of high infant mortality rates and significant birth numbers. Recommendations for possible interventions are developed and published (see attached). 3) Becoming A Mom/Comenzando bien Birth Disparities Programs developed by the Kansas Chapter of the March of Dimes was piloted and implemented in four targeted communities across the state (Saline, Sedgwick, Shawnee, and Geary counties). The philosophy is that every effort should be made to prevent the occurrence of preterm birth and reduce the associated infant mortality rate. The intent is to advance consumer education, assist and augment existing public health services, and clinically intervene in prenatal and pre/interconception periods. The primary goal was to decrease preterm birth by increasing awareness of

causal factors while changing the attitudes and behaviors in order to impact community-specific risk factors and to implement prevention strategies. Programs are a community collaborative model which creates a long-term, sustainable public/private partnership among clinical and public health partners at the local and state level. 4) The Kansas Perinatal Quality Collaborative (KPQC) was formed in November 2012 to improve service quality and access to care for women and babies statewide. Among the top priorities will be hospital quality improvement projects related to preterm and early term births. One of the first projects of the KPQC will likely be the elimination of elective deliveries before 39 weeks of gestation. //2014//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2014

Narrative:
MCH in a collaborative effort with the Bureau of Epidemiology and Public Health Informatics (BEPHI) launched a formal effort to create linked files of vital events data to other datasets on an annual basis - linking birth records and infant death certificates, linking birth records and Medicaid

eligibility or paid cliams files, linking birth records with WIC eligibility files (Pediatric and Pregnancy Nutrition Surveillance System - PedNSS and PNSS), and linking birth records and hospital discharge dataset. The 2009 and 2010 events were linked to conduct special studies and also to use for the vital statistics quality improvement activities.

The SSDI project director/MCH epidemiologist partners her project with BEPHI, WIC and other national experts utilizing the linked Birth-WIC-Medicaid data. The title of the project is Characteristics of women eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) who were not on WIC during pregnancy, Kansas, 2009-2011. The intended outcome is to identify types of women who do not participate in WIC during pregnancy so that the Kansas WIC program can develop an outreach campaign to target enrollment of these women in WIC.

Kansas Birth Defects Information System (BDIS) does not meet the Centers for Disease Control and Prevention (CDC) standards for a birth defects surveillance system. Significant progress has been made towards institutionalizing this function. However, more work and resources are needed. The data are incomplete and quality is questionable. MCH staff made a tremendous team effort in data quality of BDIS/WebBFH (Kansas Special Health Care Needs data management system) for the period 2005-2011, including data entry and data cleaning, etc. Due to this effort, good quality data were extracted to assist the CDC project, Sickle Cell Trait Incidence and Prevalence Estimates in the U.S. For the first time, data on 47 major birth defects were provided for the 2013 National Birth Defects Prevention Network (NBDPN) Annual Report, and data on 12 major birth defects were provided for the 2013 data submission to the National Environmental Public Health Tracking Network (NEPHTN). The SSDI project director/MCH epidemiologist participated in the NBDPN's pilot project, reviewing and providing feedback on the NBDPN Standards for Birth Defects Surveillance/Data Quality Assessment Tool.

Currently, a survey of recent mothers at least every two years, similar to the Pregnancy Risk Assessment Monitoring System (PRAMS), is not conducted in Kansas. Additional data such as PRAMS are needed in Kansas, not only because the additional Perinatal Period of Risk (PPOR) phase 2 analyses could be supplemented by PRAMS but also to understand maternal behaviors and experiences before, during, and shortly after pregnancy of Kansas mothers. Kansas is discussing the potential of conducting a PRAMS pilot project in 2014 and applying for future CDC PRAMS funding

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Kansas Youth Tobacco Survey	3	Yes

Notes - 2014

Narrative:
Youth Risk Behavior Survey (YRBS): The YRBS is part of a biennial national effort led by CDC and is conducted by the Kansas State Department of Education (KSDE) and KDHE in partnership with local school districts. The YRBS monitors health risks and behaviors in six categories, which are related to the leading causes of mortality and morbidity among both youth and adults. Data is collected on behaviors that contribute to physical activity, nutrition, tobacco use, alcohol and other drug use, violence and injuries, and sexual behaviors. The YRBS has been conducted in Kansas four times: in the spring of 2005, 2007, 2009 and 2011. A weighted high school sample was

achieved each year from 41 to 51 high schools and 1,652 to 2,026 high school students in grades 9-12. A YRBS middle school (grades 6-8) sample was attempted for the first time in 2011, but did not garner sufficient sample for weighted data.

The YRBS results provide useful information that can be used to make important inferences about 9th through 12th grade students statewide due to the rigorous, multi-stage random sampling methodology used to gather the data. Compiled results from the 2005, 2007, 2009 and 2011 Kansas YRBS can be found on the Healthy Kansas Schools Program website at www.kshealthykids.org, or on CDC's Youth Online website at http://apps.nccd.cdc.gov/youthonline/App/Default.aspx .

Healthy Kansas Schools (HKS) is a section of the Bureau of Health Promotion (BHP) at KDHE and is a shared program with KSDE. HKS is conducting the YRBS in Kansas high schools and middle schools for the 2012-2013 school year. HKS will continue to share and promote the use of the data received with partners across the state. Reports are being developed for the dissemination of YRBS trend reports to public health partners and schools across the state.

Kansas Youth Tobacco Survey (YTS): KDHE's BHP conducts YTS. The purpose of the Kansas Youth Tobacco Survey (YTS) is to monitor the prevalence, attitudes and knowledge, and other aspects of tobacco use, physical activity, and nutrition among adolescents in grades 6 to 12. The Kansas YTS is conducted once every two school years. The Kansas YTS was conducted in 2000, 2002, 2006, 2008, 2010 and 2012. Community-specific Kansas YTS were conducted in 9 communities in 2000, in 7 communities in 2002, in 4 communities in 2004, and in 17 communities in 2006 and 2008. The 2010 Kansas YTS was conducted at the state-level only and achieved a weighted sample. The surveys have been analyzed, and the associated reports and fact sheets were provided to county partners. The 2012 Kansas YTS was conducted at the state level and in two counties. The results of the 2012 YTS are available online at http://www.kdheks.gov/tobacco/tobacco_facts.html.

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

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

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

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

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

B. State Priorities

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

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

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

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

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

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

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

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

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

PREGNANT WOMEN AND INFANTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHILDREN AND ADOLESCENTS

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

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

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

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

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

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

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

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

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

NPMs 11 and 14 relate to this priority.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

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

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

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

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

NPMs 2-6 relate to this state priority.

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

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

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

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

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

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	61	57	59	71	67
Denominator	61	57	59	71	67
Data Source	Kansas Newborn Screening data	Kansas Newborn Screening data, 2009	Kansas Newborn Screening data, 2010	Kansas Newborn Screening data, 2011	Kansas Newborn Screening data, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

Notes - 2010

DATASOURCE:
*NOTE: Data for 2010 is not available at the time of this application. 2009 data was used to pre-populate this peformance measure. Data will be available by 1 September 2011.

a. Last Year's Accomplishments
In 2011, 71 newborns confirmed with metabolic conditions received appropriate follow-up.

DS: Services for individuals with metabolic conditions, including medical consultations, metabolic formula and food products, treatment products, and diagnostic testing were available through the CYSHCN program. The newborn screening (NBS) program continued to refer persons identified with a metabolic condition to the CYSHCN program.

ES: Staff participated in the advisory committee and multiple work groups for the Heartland Genetics Collaborative. The program's 2nd Annual Report was developed and continued to be well received by stakeholders. A copy of the report is available on their website. The quarterly NBS newsletter, supporting understanding of conditions screened for in KS, the processes for testing and treatment options, was continued.

PBS: Hospital personnel continued to collect blood spot specimens from infants. Specimens were sent to the Kansas Health and Environmental Laboratory (KHEL) for processing and notified the NBS follow-up program of abnormal screening results. Staff notified the parents by letter and the primary care physician (PCP) by phone of the abnormal results and informed each of the services available through the CYSHCN program. Staff assure that infants had appropriate testing, diagnosis, referral and treatment services up to the point of diagnosis.

New guidelines for infants in the NICU resulted in an increased number of specimens that were taken prior to 24 hours of age, causing a new reporting protocol to be implemented. In response, KHEL no longer reported results for Congenital Hypothyroidism, Cystic Fibrosis or Congenital Adrenal Hyperplasia for specimens taken prior to 24 hours of age. Those results were considered "invalid," which increased the need for follow-up with physicians to ensure that a new specimen is received.

IB: KS continued to screen for 29 of the recommended conditions by the American College of Medical Genetics (ACMG). Although SCID and CCHD have been added to the formal recommendations, these have not yet been implemented in Kansas. The NBS Advisory Council (NBSAC) continued to review these conditions to identify the capacity for the state to recommend screening mandates. The NBS AC supported the implementation of a fee for the costs of NBS testing. Although this was not obtained, new funding was identified to utilize a user fee, obtained from Medicaid Managed Care Organizations, beginning in FY2014.

NBS program and KHEL staff met regularly to coordinate activities and troubleshoot issues. NBS follow-up program staff worked with KHEL, vital statistics and information systems staff to enhance data linkages among KDHE programs. The current data system is unable to verify each infant receiving a newborn screen, resulting in the need for NBS staff to use numerous mechanisms to track results and data. A new laboratory information management system (LIMS) system (in development) will provide web access to reports for providers. The system will not link directly to the NBS follow-up program; however specimens will be patient linked versus specimen driven. Pilots with 2 hospitals revealed data from vital records will effectively match specimens with correct vital information.

Staff provided training to internal and external stakeholders as needs were identified. Additionally, the NBS website contains a practitioner's manual and information for families and physicians. These were updated as procedures were modified. Information is available in English and Spanish.

Staff monitored unsatisfactory rates for NBS specimens and contacts were identified at various

hospitals, resulting in a decrease in unsatisfactory rates at those facilities. NBS staff worked with physicians and parents of infants with unsatisfactory newborn screening specimens to assure that babies return promptly for repeat specimens.

Birth certificate data continues to be exported into the Birth Defects Registry and continued to receive and monitor mandated reports submitted by hospitals, birthing centers, and physicians regarding children under age 5 with a primary diagnosis of congenital anomaly or birth defect. MCH epidemiologists continued to analyze birth defects data.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

DS: KS continues to provide the services listed above.

A reduction of metabolic specialists was experienced this year. The sole pediatric metabolic physician relocated out of state and patients needing these services are now referred to Children's Mercy Hospital in MO. A medical geneticist in AR continues to provide telemedicine services through a genetic counselor in the Wichita area for non-emergent consultations. Additionally, KS lost one pediatric endocrinologist and one pediatric pulmonologist.

ES: Previous services were continued. The quarterly newsletter has grown in recipients and continues to be enjoyed by stakeholders.

PBS: Kansas continues to provide the services listed above.

Program staff monitored national activity and participates in monthly calls regarding the initiation of SCID and CCHD screening.

IBS: Continuation of previous services. NBS follow-up staff remained active in the Heartland Genetics Collaborative by serving as State Genetics Coordinator, advisory board member and standing committee members.

c. Plan for the Coming Year
DS: Continue last year's services. NBS staff will continue to work with CYSHCN staff to develop contracts or methods of funding specialists involved with consultation of NBS conditions.

Funding for Genetic Counselors to support increased service delivery is being reviewed. Genetic Counselors in KS are not licensed; therefore their services are not paid by insurance companies.

ES: Continue last year's services. NBS staff will continue to work on expanding the e-mail list for the quarterly newsletter to encompass private physician office staff.

PBS: Continue last year's services. NBS staff will develop a parent survey for parents of children who had abnormal NBS results.

The NBSAC recommended that a Quality Initiative Project for education, training, resources and follow up with birthing facilities be implemented related to CCHD. This recommendation also included a mechanism for tracking through the vital record. The recommendation came after a CCHD sub-committee was formed and extensive surveying of birthing facilities was completed. Implementation of SCID screening is being reviewed by laboratory staff.

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

Training will take place with hospitals related to the new LIMS system, addition of the NBS kit number which will provide for better tracking of NBS specimens for Kansas infants.

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

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

Total Births by Occurrence:	**40467**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	40233	99.4	9	3	3	100.0
Congenital Hypothyroidism (Classical)	40233	99.4	114	39	39	100.0
Galactosemia (Classical)	40233	99.4	4	0	0	

Sickle Cell Disease	40233	99.4	10	10	10	100.0
Biotinidase Deficiency	40233	99.4	2	1	1	100.0
Cystic Fibrosis	40233	99.4	66	11	11	100.0
Homocystinuria	40233	99.4	44	0	0	
Maple Syrup Urine Disease	40233	99.4	16	0	0	
Tyrosinemia Type I	40233	99.4	21	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	40233	99.4	6	1	1	100.0
Isovaleric Acidemia	40233	99.4	5	0	0	
Carnitine Uptake Defect	40233	99.4	9	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	40233	99.4	20	2	2	100.0
Methylmalonic acidemia (Cbl A,B)	40233	99.4	8	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	40233	99.4	6	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	40233	99.4	8	2	2	100.0

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	70	70	67	66	73
Annual Indicator	65.6	65.6	65.6	72.6	72.6
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you					

cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	73	74	74	75	75

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

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

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

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

Notes - 2010
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 72.6% of Kansas families of Children and Youth with Special Health Care Needs (CYSHCN) partnered in shared decision-making for child's optimal health, compared to

70.3% for the U.S. The Kansas outcome is higher than the U.S. but not significant, and ranks 23rd in the nation.

Of the 72.6% of Kansas CYSHCN families that partnered in shared decision-making, 83.1% reported that doctors discussed range of health care/treatment options. Also 83.1% reported that doctors encouraged parents to ask questions or raise concerns and 86.3% reported that doctors made it easy for parents to ask questions or raise concerns. Nearly 87% reported that doctors considered and respected parents' treatment choices.

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

DS: Support for the CYSHCN Family and Youth Advisory Council (FAC and YAC) continued. Members are paid a stipend, travel and child-care costs (if applicable) for participation in meetings. Family input is sought when the CYSHCN health care plan for families in the CYSHCN Specialty Clinics and recipients of CYSHCN funding.

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

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

PBS: A reduction in CYSHCN bilingual staff occurred this year causing a gap in providing bilingual services. A translation service was utilized to provide culturally competent services. The CYSHCN program worked with other partners, such as Families Together and specialty clinic staff, to continue to assist in the needs of the program.

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

A Google Translate widget was added to the KRG site to allow for translation in a wide variety of languages.

IBS: Support continued for the Parent Support Liaison (PSL) project, to provide care coordination, follow-up, and support services to families and clinic staff in select specialty clinics. Although PSL staff turnover presented challenges in each clinic throughout the year, clinic staff remained engaged and supportive of filling positions and training new staff. Project staff implemented a new evaluation effort utilizing parent and clinic staff surveys.

Engagement of family and youth partners continued through CYSHCN Advisory Councils. The councils are available to support families and youth to ensure the consumer voice is addressed

and to provide opportunities for families and youth to become advocates for themselves or their loved ones. FAC members offer guidance and feedback related to the three CYSHCN state priority objectives. Additionally, the YAC provides an opportunity to learn about transition issues from the youth perspective.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

DS: Support for the CYSHCN Family and Youth Advisory Council (FAC and YAC) continued. The YAC changed their name to LAYRS -- "Leaders Advocating for Youth Resources and Supports" -- to reflect what they hope to accomplish through this group. Challenges in recruitment and youth engagement were experienced this year.

ES: Support for previous activities continued. Staffing reductions for the KRG has resulted in a delay in recruitment of new providers, however a part time temporary solution was identified to ensure phone coverage and support for families existed. Limited recruitment was done during this time, however we have also identified changes to the website for consumer and provider ease of use.

PBS: Continued partnership with others to ensure translation of materials. Updates to CYSHCN correspondence was difficult without our bilingual staff, however through partnerships with Families Together and our clinic staff, the CYSHCN application and letters to families were updated in Spanish as well.

IBS: A change in the name of the PSL project, to Parent Support Navigators (PSN), was to better reflect the purpose of these individuals in the clinic. Additionally, this better aligns with national Affordable Care Act and medical home initiatives. Support for this project continues, however evaluation challenges is causing us to re-evaluate the existing model and will likely result in significant change to the program in the future.

c. Plan for the Coming Year
Continue previous and current program activities.

DS: Continue support of FAC. LAYRS will undergo another transition this coming year. Planning is underway to identify a program to support a stronger youth leadership development program with opportunities to expand education on transition, advocacy, and self-determination for youth across Kansas. This new model will be reflective of other national and state leadership programs, such as the Kansas Public Health Leadership Institute, Partners in Policymaking, Family/Parent Leadership Training Institute, etc).

ES: Recent recruitment for the KRG position has resulted in the hiring of a new bilingual staff member. This will allow for the identified modifications and updates to the website to be completed, as well as a renewed effort for provider recruitment into the directory. This position will also be involved with the FAC and transition of the youth leadership program.

PBS: The newly hired staff member will assist in filling the recent gaps in providing quality services to the Spanish speaking population. This staff person is capable of written and verbal translation and can provide valuable input on how to increase services and supports to our Spanish speaking clients. We will also begin discussions with our IT department to utilize the Google Translate widget to other CYSHCN websites.

IB: Recently the Kansas City PSN resigned from his position due to increased needs of his family. Additionally, challenges in evaluating the program in the current model within the specialty care clinics is resulting in discussions of the future of the program. Support for this type of program continues, however it is anticipated that a shift towards primary care, rather than specialty care, will allow this program to thrive. We are undergoing discussions with a neonatologist to place a PSN in his medical home for NICU graduates. Additionally, we are pursuing other patient navigation program models. Changes to this program are expected in the coming year.

To build capacity of our family leaders in Kansas, a new process for determining the state AMCHP family delegate. A new application proces will be implemented in SFY14 to ensure more families have an opporutnity to build leadership skills and learn about AMCHP and Title V. The family delegate will be asked to provide recommendation for outcome/performance measures for Title V, participate in the block grant review process, participate on MCH-related advisory boards or councils, assist with social media and marketing of Title V programs, and more. Family delegates will be engaged in leadership, skill-building, and collaborative activities with MCH staff and programs initiatives. Additionally, they will participate in HRSA Regional calls and ongoing learning opportunities.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	60	60	60	50
Annual Indicator	55.3	55.3	55.3	49.4	49.4
Numerator					
Denominator					
Data Source	National	National	National	National	National

	CSHCN 2005-2006. Estimate KS	CSHCN 2005-2006. KS Estimate.	CSHCN 2005-2006. KS Estimate.	CSHCN 2009/2010. KS Estimate.	CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	51	52	53	54	54

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. 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.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. 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.

Notes - 2010
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN

survey. The data for the two surveys are not comparable for PM #03.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

a. Last Year's Accomplishments

The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed overall 49.4% of Kansas Children and Youth with Special Health Care Needs (CYSHCN) reported receiving care within a medical home, compared to 43.0% for the U.S. The Kansas outcome is significantly higher ($p<0.05$) than the U.S., and ranks fourth in the nation.

Of the 49.4% of Kansas CYSHCN receiving care within a medical home, 90.7% reported that they had a usual source for both sick and well care and 93.0% had a personal doctor or nurse. About 96.0% of Kansas CYSHCN reported that they had no need of any referrals or no problems obtaining referrals when needed. Nearly 70% of Kansas CYSHCN reported receiving family-centered care (i.e., doctors spent enough time with a child, doctors listened carefully to a child's parent(s), doctors were sensitive to family customs and values, doctors provided information specific to child's health, and doctors helped family feel like partners in care). About 46% of Kansas CYSHCN reported receiving effective care coordination when needed (i.e., received help to coordinate child's health care when needed, received extra help to coordinate child's health care if needed, satisfied with communication among child's doctors when needed, and satisfied with doctors' communication to school or programs when needed).

In Kansas, the "medical home" outcome measure was achieved for more of the younger versus older CYSHCN. Performance on this outcome improved with increasing family incomes. A greater percentage of those with adequate insurance reported receiving coordinated, comprehensive care within medical home, compared to those without adequate insurance. Children with more complicated needs were less likely to have a medical home, although they have great potential to benefit from one.

DS: CYSHCN specialty clinic contracts require that specialty evaluations and recommendations are sent to the PCP within 2 weeks of the clinic appointment in support of the medical home team approach. Contract language continues to support medical home and care coordination.

Planning for the PSN project began in May 2011 as an effort to provide care coordination and parent/peer supports to families attending four CYSHCN-sponsored clinics. This project was developed as an opportunity to better assist families in partnering with their doctor to support improved quality health care and coordination with increased cost-efficiencies. Two PSN's were hired to provide care coordination and support services in select CYSHCN specialty clinics. The PSN's have worked to connect families to needed community-based services, increase attendance and family preparedness for clinic appointments, developed a newsletter for families within a clinic, providing ongoing support for families in these clinics and much more.

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

PBS: Printed materials were provided to consumers in English and Spanish. CYSHCN staff participated in the Heartland Genetics Regional Collaborative Medical Home work group, which began discussion opportunities to engage genetic providers as team members for persons with metabolic conditions within a Medical Home. The work group held monthly conference calls and began writing a white paper related to the geneticists' role within the medical home.

IB: Resources for families and providers on effective partnerships among families and providers were developed by the CYSHCN FAC. Year 3 of the D-70 Integrated Community Systems (ICS) grant began with a shift from addressing transition and medical home as separate activities to a focus on transition and life course within the medical home and how youth, families and providers can be effective partners in this model. This model incorporates a variety of components related to transition, with a focus on how providers and support successful transition as part of the medical home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Clinic reports are provided to the PCP and other providers identified by the family.	X			X
2. CYSHCN promotes medical homes to clients seen in specialty clinics and assists families to obtain a primary care provider, if needed.	X	X	X	X
3. Infants identified with a positive Newborn Screening test are referred to the CYSHCN program and follow-up services are explained to families.		X	X	
4. Develop information & disseminate information about medical home for youth, families and professionals.		X		X
5. Conduct trainings for providers on medical home and how to partner with families.		X		X
6. Continue to expand the KS Resource Guide to provide additional medical home resources, tools and materials for youth, families and professionals.		X		X
7. Participate in the Heartland Genetics Collaborative medical home work group and related activities.		X	X	X
8. Support Family Advisory Council work group on medical home to support family leadership and advocacy.		X	X	X
9. Collaborate with the KS Family-to-Family Health Information Center to support and provide the Parent Support Navigator project to assist clinic staff and families seen in select CYSHCN specialty care clinics.	X	X	X	X
10.				

b. Current Activities

DS: Previous year activities continued. Blended funding from the KS D-70 ICS grant, MCH Block Grant, and external funds through Families Together allowed for continued support of the PSN project -- which began planning for a shift in the PSN project from specialty to primary care in an effort to further support medical providers to build and practice as a medical home in Kansas.

ES: Continued previous year activities. CYSHCN staff and partners continued to monitor and research national medical home initiatives for inclusion and updates of presentations and medical home resources for families.

PBS: Continued previous year activities. A new bilingual CYSHCN staff member has been hired to support cultural competency efforts for all CYSHCN activities; however this person will also be a support staff to identify ways in which the program can more effectively engage the Spanish speaking population with regard to building partnerships and being engaged in a medical home.

IB: Through the D-70 ICS, the Kansas Health Care Transition Model was finalized and electronic

materials have been developed to share with families and providers.

c. Plan for the Coming Year
Continue current medical home initiatives.

DS: Plans for the PSN project include research of primary care models and other patient navigation activities across Kansas and the nation. It is expected and understood that the project is unable to sustain in its current status, therefore changes will be necessary to continue funding through the MCH Block Grant, inclusive of an effective evaluation plan. The program has received high remarks and reviews from clinic staff; however the challenge lies in obtaining family and patient feedback. This is assumed to be caused by a number of factors, including: the large quantity of survey's families are asked to complete, the infrequent interactions between the patient/family and the PSN, the time lapse between clinic appointments and the survey, and the small number of families needing, or interested in, services available through the PSN.

A researcher from the University of Kansas was consulted on evaluation. This consultation resulted in an inability to evaluate patient outcomes in a more quantitative capacity due to the vast scope of the PSN's current roles, especially with the differences in the types of services provided through each clinic. Therefore, it is believed that moving towards a primary care approach will allow more stability to the program, increase interactions between the PSN and patient/family, and will streamline the services provided to a point that evaluation of insurance/Medicaid claim data and long-term patient outcomes can be studied.

IB: The CYSHCN FAC has expressed an interest in writing a white paper for students and professionals in medical career paths that they plan to promote and disseminate and hope to get included as part of a standard curriculum for these professions. The foundation of the paper is the "Impact of Raising CYSHCN" and is very focused on concepts that tie closely with the medical home approach.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	64	64	64	65	61
Annual Indicator	62.9	62.9	62.9	60	60
Numerator					
Denominator					
Data Source	National CSCHN 2005-2006. Estimate KS	National CSCHN 2005-2006. KS Estimate.	National CSCHN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	61	62	62	63	63

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate 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.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate 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.

Notes - 2010
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 60.0% of Kansas children and youth with special health care needs (CYSHCN) had consistent and adequate health insurance coverage, compared to 60.6% for the U.S. The Kansas outcome is slightly lower than the U.S. but not significant, and ranks 28th in the nation.

Of the 60.0% of Kansas CYSHCN who reported having consistent and adequate health insurance, 95.6% of CYSHCN reported having health insurance at the time of survey. Nearly 90% reported having no gaps in coverage during the year before the survey, and 67.3% reported

having adequate current health insurance.

Among the 67.3% of Kansas CYSHCN that reported having adequate current health insurance, 67.3% reported that their current health insurance benefits met the child's needs. About 71.3% reported that costs not covered by insurance were usually or always reasonable, and 91.1% reported that insurance usually or always permitted the child to see needed providers.

In Kansas, there was not much difference among age groups, although adolescent insurance adequacy was slightly lower. Fewer CYSHCN families with incomes <100% poverty reported having adequate insurance: more than half in this group lacked the insurance they needed for services. A greater percentage of CYSHCN receiving services within a medical home had adequate insurance compared to CYSHCN without a medical home. By specific type of special health care needs, CYSHCN with functional limitations were less likely to have adequate insurance compared to CYSHCN with a need managed by prescription medication.

DS: Individuals with eligible conditions are able to apply to the CYSHCN program for services such as payment of direct health care costs, prescriptions, low protein food products/PKU formula, durable medical equipment, limited hospitalizations or therapy services, and other approved services. Financial eligibility requirements are associated with the federal poverty income guidelines. For those with metabolic conditions there is a sliding fee scale for services due to the high cost of treatment. A large percentage of clients receiving these services do not have adequate insurance and often the CYSHCN funding is the only source of medical coverage.

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

CYSHCN staff continued to direct those in need to apply for public assistance (ie: Medicaid/CHIP, SSDI, etc). Expanded oral health services in select CYSHCN clinics were implemented to provide these services to families who are unable to obtain dental care due to lack of insurance or funding. The PSN's also addressed the financial needs of families and assisted in connecting families with appropriate opportunities.

ES: Applicants are available via phone, mail, fax, and web and continue to be sent to those referred to the program or whose newborn had a positive screening result.

The KS Equipment Exchange Program is utilized frequently by families of CYSHCN specialty clinics. This program provides an opportunity to "recycle" durable medical equipment when a child no longer has a need for it (or has outgrown the current equipment).

PBS: Families of CYSHCN have experienced similar hardships and coverage for necessary services continues to be an issue. The CYSHCN program continues to support medically and financially eligible CYSHCN from all areas throughout the state. The CYSHCN program applications are available in both English and Spanish.

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

The FAC Financial Impact Work Group created a Community Resource Brochure -- a quick reference guide for families on common state and community resources. Dissemination of this brochure began in March 2012 and has been well received by both consumers and providers.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
Continuation of previous activities.

DS: As mentioned in NPM #1, a reduction in state metabolic providers has caused added difficulty for families in accessing evaluation and treatment services for those with metabolic conditions, in addition to the financial barriers experienced by families and/or lack of or inadequate insurance coverage.

PBS: Continued to serve the undocumented population, the largest population subgroup without insurance coverage.

IBS: A data uplink from the KDHE Bureau of Health Informatics to the CYSHCN web-based data system was implemented to ensure information from the birth record is synchronized to the CYSHCN and NBS data systems. This enhanced data capacity allows for searching of all Kansas newborns to ensure coordination, outreach, eligibility, and enrollment within CYSHCN the web-based portal. This new data creates opportunities for a more streamlined referral process from NBS to CYSHCN and sets the programs up for more collaboration and coordination on care for these families.

Efforts to provide local entry points into the program began in late 2011 with implementation beginning in July 2012. This provides a local contact for families to the CYSHCN program and an opportunity to educate more families about the services available through the CYSHCN program. There are now 4 regional offices in Garden City, Hays, Salina and Wichita in addition to the central office in Topeka and the existing field office in Kansas City.

c. Plan for the Coming Year
Continue current and previous activities.

DS: A comprehensive review of all CYSHCN activities will begin this coming year to look at how funds are being spent and the services being provided. This review will be compared against other Kansas services and those being provided through the Affordable Care Act to ensure services are not being duplicated. Additionally, this review will accompany a systematic planning session, engaging key partners, stakeholders, families, and other parties as appropriate. This review and planning process will take place over the State Fiscal year 2014 (July 1, 2013 -- June 30, 2014) with expected changes to the program to begin, incrementally, July 2014.

The program identified the necessity to periodically review our services and ensure we are meeting the needs of our families while utilizing state and federal funding in the most effective and efficient way. It is anticipated that the approach will be focused on key aspects of the medical home approach, specifically care coordination and navigation of services. A focus on improving access to health insurance coverage is anticipated as the Affordable Care Act implementation begins, program activities will support and complement changes in the federal system. Guidance and expertise from other CYSHCN Directors and MCHB staff will be requested.

ES: Improvements to the CYSHCN and KRG websites will be made to enable families and partners to better access resources and services. As Affordable Care Act implementation begins, information and resources will be developed and shared with families on the impact of CYSHCN services to enable them to make educated choices about their health insurance coverage.

PBS: Discussions with CYSHCN families and clients, clinic patients, and the Spanish-speaking population will be initiated during the review and planning period to ensure all services and the impact of any potential changes are being considered. It is acknowledged that with pending changes of the Affordable Care Act, many individuals will not benefit due to citizenship status. It is desired to have additional discussions with the undocumented population to ensure critical services and supports are not decreased without appropriate replacement services.

IB: A detailed analysis, being completed by a KDHE epidemiologist, of the financial impact on families will be utilized for CYSHCN planning purposes. This analysis is based on the 2009/10 NSCSHCN data.

Staff will work with families and external stakeholders on a toolkit to assist families in navigating and identifying available healthcare funding opportunities.

The CYSHCN regionalization effort will continue in the Eastern half of the state with the conversion of the existing field office into the Kansas City Regional Office, and the addition of the Crawford County (southeast KS) regional office. The central office will continue to serve as the administrative office, as well as the north central regional office.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	95	95	99	93	67

Annual Indicator	92.5	92.5	92.5	66.8	66.8
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	68	68	69	69	69

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

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

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

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

Notes - 2010
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and

the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

*The Annual Performance Objective of 99 is unrealistic and should be revised to 93 for 2010.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 66.8% of Kansas children and youth with special health care needs (CYSHCN) families reported that community-based service systems were easy to use (i.e., no difficulties or frustration accessing services needed for their child in the past 12 months), compared to 65.1% for the U.S. The Kansas outcome is higher than the U.S. but not significant, and ranks 19th in the nation.

Of the 66.8% of Kansas CYSHCN families who reported that community-based service systems were easy to use, 66.9% reported that they experienced no difficulties or delays getting services. About 64.3% of parents reported experiencing no frustration in getting services for their child.

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

DS: CYSHCN funded a total of 20 specialty clinics in Kansas City and Wichita. From these clinics, approximately 6,206 patients were seen throughout the year. A dental hygienist was available to provide screening and preventative services to patients in the cerebral palsy, cleft lip/cleft palate, and spinal cord/spina bifida clinics.

Local resources are identified in the CYSHCN health care plan and are provided to the family, primary care provider, and authorized service providers along with community resources. Parent Support Navigators have created additional opportunities to connect families with community-based services and resources based upon their individual child/family needs.

ES: In the past, families identified that they were unable to find the resources and services they needed in a timely fashion. Based upon this feedback, it was determined the most effective way to address this was through the development of a comprehensive resource guide and navigational tool kit. The Kansas Resource Guide (KRG) was developed to provide a comprehensive, multi-system approach to providing resources. The directory will house resources of all major systems impacting children and families, as well as the disability community. This guide is intended to serve as a "one-stop-shop" for resources so families and professionals can find the resources and services they need in a more time-effective manner. A formal marketing and promotion campaign of the KRG was done as an effort to expand the number of providers listed in the directory.

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

A translation widget was added to KRG to provide the searchable directory resources and services in languages other than English.

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Prior year activities continued.

DS: The CYSHCN clinics experienced a number of challenges this year with decreases in the number of providers available to staff these clinics. As mentioned in previous sections of this report, we have had a number of clinicians leave the state and retire and others have left the field or simply decide to stop serving in the clinics. Despite efforts to recruit and retain new providers in these clinics, a significant gap has been recognized.

ES: The KRG position has been vacant for most of this year, however through shared staff within the Bureau providing coverage for the phone and website; however the extent of provider recruitment and other KRG activities was decreased. A new staff person, starting in June 2013, will allow us to resume prior activities and move forward.

PBS: Prior year activities continued.

IBS: The CYSHCN FAC created and disseminated a community resource brochure. This brochure was very popular and well received by the community, however keeping it updated and printed was a challenge. Updates will be made periodically and re-prints done on an as needed basis. Additionally, the FAC has continued to look for opportunities to educate others about resources available and is in the process of writing a white paper for medical professionals on the impacts of raising children with special health care needs or disabilities, including a resource section to assist providers in sharing needed resources with families.

c. Plan for the Coming Year

Continue current initiatives to provide community-based services and resources to families in KS in a way that families can easily identify and access these services.

DS: A new initiative with the Cerebral Palsy Research Foundation to host outreach clinics in the Western part of the state will begin this coming year. The PSN project will undergo a transition to identify a more stable and evaluative model for services. A comprehensive review of all services in our clinics and services paid directly by the program will begin in July 2013 and span the course of the year. This review will result in modifications to the services provided, based upon family and partner feedback on how the program can best address the needs of the community.

ES: New KRG staff will allow recruitment of providers to be included in the searchable resource directory to resume. Increase marketing efforts through cost-effective methods and utilizing social media. Coordinate social medial efforts with the KDHE Communications Team.

Efforts to develop a navigational tool kit to assist families in navigating and understanding the various service systems in KS will begin this year, with support and assistance from the CYSHCN Family Advisory Council. A focus on caregiver health has been identified by the council and will be included in this toolkit. Additionally, other state agencies will be asked for input regarding agency/program-specific information to ensure accurate information is provided to families.

PBS: Continue working towards expansion of the KS Resource Guide to ensure rural and underserved populations are being reached, as well as the resources available to various ethnic populations. Recruitment from underserved areas will continue to be a focus for all advisory councils and input for program activities to ensure access, promote health equity, and knowledge of community-based systems is being addressed for these populations. Continue providing interpretation services. New bilingual staff will support these initiatives.

IB: Continue prior activities. Phase 2 of the CYSHCN regionalization effort will begin in July 2013, with the implementation of the final three regional offices in the Eastern portion of the state. A focus on community resources and supports is expected this coming year with existing and new regional offices.

The CYSHCN biannual survey will be conducted in the Fall in partnership with the Kansas Family Voices affiliate and will include specific questions from the NSCSHCN questions. This partnership will allow for a more extensive survey to be completed and will be developed and questions selected that will provide state-level data in between national survey collection years. Additionally, these questions will be identified based on both MCH block grant and the Family-to-Family Health Information Center performance measures and reporting requirements to ensure valuable data that can be utilized in many ways.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	53	53	55	53	53
Annual Indicator	50.3	50.3	50.3	52.7	52.7
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	54	54	55	55	55

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

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

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the

questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

Notes - 2010
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

* The 2010 Annual Performance Objective of 55 is unrealistic and should be revised to 53.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 52.7% of Kansas youth with special health care needs (YSHCN), 12-17 years, received the services necessary to make appropriate transitions to adult health care, work and independence. While Kansas outcome ranks 1st in the nation and is significantly higher (p-value<0.05) than the national average of 40.0%, this means that almost half of Kansas youth do not receive the necessary transitions services.

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

The main focus of the D-70 Integrated Community Systems (D-70 ICS) grant was on transition to adulthood. Through partnership with the Kansas University Center on Developmental Disabilities (KUCDD), Kansas has increased consumer awareness of health care transition, worked with medical providers to develop tools for transition and strengthened the capacity of the state, and their partners, to provide transition services for YSHCN in KS.

ES: A web-based program for YSHCN has been developed. The curriculum is intended to be used by youth to promote independence and provide opportunities for skill-building, self-determination and support in becoming an empowered patient. Youth also learn how to communicate with peers, parents and health care providers. The program consists of the following six modules: About Me, Taking Charge, Staying Healthy, Empowered Patient, Taking Care of Myself and After High School. Each module consists of an overview of that section, the youth's personal learning goal, a status check to see if the youth met their goal and a "Very Important Points" section. The modules are progressive and each one builds on skills and information learned previously. The interactive system will save their responses and place this in their "Plan" for the youth to look back on and use in future transition planning.

PBS: Through a partnership with Families Together, transition-related issues were embedded into regional and statewide conferences for parents/families, educators, community and health providers, and other interested parties. A strong focus on engaging youth early and providing resources to parents prior to the formal transition period was evident.

IB: The D-70 ICS grant sponsored youth to attend the Youth Empowerment Academy's week long Youth Leadership Forum held on the Washburn University campus. The CYSHCN Youth Advisory Council continued to build capacity for the state by ensuring the youth voice is addressed. The Kansas Youth Empowerment Academy continued to work with youth through the Youth Advisory Council to become self-advocates and active members of the community to support successful transition.

The D-70 ICS grant shifted from addressing transition and medical home as separate activities to a focus on transition within the medical home. This includes how youth, families and providers can be effective partners in this model. This model incorporates a variety of components to support capacity and infrastructure building in Kansas, including: the Parent Support Navigator project; the JumpStart project; a self-determination curriculum; partnership with the Heartland Genetics Collaborative; and individualized healthcare plans.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide transition resources to families, youth, and community service providers.			X	X
2. Coordinate with family and education partners' transition workshops.		X		X
3. CYSHCN staff participate in local, regional, state and national workshops to promote inclusion and increase awareness of the needs of YSHCN.			X	X
4. Family Advisory Council Group will provide feedback and guidance on state transition efforts.				X
5. The Parent Support Navigator project will assist in providing transition services to families within the pilot clinics.	X	X	X	X
6. Dissemination of a youth-focused model for health care transition that includes a care coordination, provider policy development, system integration, partnerships, and resources/tools for youth, families and providers.		X	X	X
7. Expansion of the Kansas Resource Guide with the development of a transition navigational tool kit.		X		X
8.				
9.				
10.				

b. Current Activities

Continue previous on ongoing transition-related activities.

ES: The web-based curriculum was completed; however an oversight in the development of an ongoing maintenance agreement with the University has resulted in a delay in dissemination of the program. Necessary security updates were not deployed and the site had to be temporarily deactivated. IT staff at KDHE have worked diligently to identify a solution to this problem and a vendor has been identified that can deploy all necessary security updates and get the website back online. Contract negotiations are underway at the time of this report.

PBS: Continued focus on transition across Kansas and materials provided to those in requested languages.

IB: The D-70 ICS grant project, through a no-cost extension, finalized the model for transition within the medical home. CYSHCN staff participated in transition resource fairs to learn and share community connections to assist in transitioning not only to adult health care providers but to address other aspects of work and community living. CYSHCN staff and partners continue to serve on councils and committees that address youth issues and disability concerns.

c. Plan for the Coming Year
Continue previous transition activities.

ES: The web based curriculum, called "Plan It, Live It!," will be made available online, pending the development and approval of a hosting and maintenance agreement with a state sanctioned vendor. Upon dissemination of the web based modules, the program and IT staff will identify a vendor to assist in ongoing updates. A particular challenge of the agency is that the programming was developed under a system that the KDHE IT Department does not utilize, nor have expertise in. Therefore, they are not able to provide ongoing maintenance and support for this site. The vendor that will be contracted to deploy and provide maintenance will submit a proposal for updates and any future programming or content needs. It will also be reviewed by KDHE IT staff to determine the potential for re-development or transfer of the programming code to a .net application for KDHE ongoing maintenance and support.

PBS: Continue previous initiatives. New bilingual CYSHCN staff will support translation of the KS Transition Model into Spanish.

IBS: Continue previous year activities.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	79	79	83
Annual Indicator	78.2	77.5	80.1	83.6	83.6
Numerator					
Denominator					
Data Source	CDC National Immunization Survey 2008, KS	CDC National Immunization Survey 2009, KS	CDC National Immunization Survey 2010	CDC National Immunization Survey 2011	CDC National Immunization Survey 2011
Check this box if you cannot					

report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	85	85	87	87	89

Notes - 2012
The 2012 column is populated with 2011 data. 2011 data will be available Fall 2013.

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

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

Notes - 2010
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, 2010. Adhoc report.

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

a. Last Year's Accomplishments
According to the 2011 National Immunization Survey (NIS), Kansas immunization rates for 4:3:1:3:3 combination (DTaP-Polio3-MMR1-Hib3-HepB3) increased from 80.1% to 83.6%. This was above the national average (78.7%) and met the Healthy People 2020 goal of 80%.

There was an increasing trend over the interval 2002-2004, followed by a stable trend from 2004 to 2011. The APCs (annual percent change) were not statistically significant (i.e., non-significant change).

The statewide coverage levels at school entry (i.e., on the first day of school for the 2011-2012 academic year) for all vaccinations required for school entry (DTaP5, Polio4, MMR2, Var2, HepB3) were at or above 86%, with HepB3 having the highest coverage at 96%. HepB3 was the only vaccination to meet the Healthy People 2020 goal of at least 95% coverage for kindergarten

immunizations. The complete series for all 5 required vaccinations (5-4-2-2-3) had a coverage level of 80% at school entry. Vaccination coverage levels for most immunizations increased within the first 30 days of school. Children enrolled in public schools had significantly higher coverage levels than children enrolled in private schools throughout Kansas for all required vaccines.
The 105 counties were grouped into 3 categories based on population density, and coverage levels were compared among these groups. "Urban" (=150 persons per square mile) counties had the highest coverage level for MMR2 compared to counties that were "sparsely populated" (<20 persons per square mile). DTaP5, Polio4, Var2, and HepB3 showed no significant variation in coverage levels between population density groups. Seven counties had =95% coverage for all 5 required vaccinations.

Direct Services: None reported

Enabling Services: None reported

Population Based Services:
Kansas Immunization Program (KIP) provided Vaccines for Children (VFC) program on a sliding scale basis.

Medical home providers and the majority of schools across Kansas now have access to KSWebIZ to update demographics, historical vaccinations, and track school immunization rates pending parental consent.

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor, evaluate and communicate provider vaccine management performance to reduce wasted, spoiled, expired or unaccounted-for vaccines			X	X
2. Conduct compliance site visits				X
3. Update and maintain list of participating health providers				X
4. Monitor and assess completeness and timeliness of case reporting to CDC for vaccine preventable conditions			X	X
5. Monitor and assess the accuracy , timeliness, and series completeness of vaccinations in children			X	X
6. Increase the number of health providers providing information to the immunization registry			X	X
7. Continue MOBI-KS project that has physician trainers educate and train providers on site at about immunization policies			X	X
8. Continue and expand the providers and families participating in ‘Immunize and Win Prize’ initiative			X	

9. Continue to assess immunization coverage for the 4-3-1-3-3 series for children enrolled in kindergarten using the retrospective immunization survey			X	X
10.				

b. Current Activities
Direct Services and Enabling Services: None

Population Based Services:
KIP continues Vaccines for Children (VFC) program.

Kansas WIC interfaced with KIP to meet federal guidelines that WIC clinics check each client's immunization status. By checking WebIZ, local staff have accurate records allowing them to update immunizations or make a referral to do so. This has served a role to increase state immunization rates.

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

Infrastructure Building Services:
KIP is updating the annual retrospective immunization report that assesses the completeness of immunizations at 24 months of age in children enrolled in kindergarten during the 2012-2013 school years.

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

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

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

c. Plan for the Coming Year
Direct Services: None reported.

Enabling Services: None reported .

Population Based Services:
KIP will continue support of VFC program.

WIC will continue to expand their services to increase referrals for immunizations.

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

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

IKK, with specific assistance of the Kansas American Academy of Pediatrics chapter, is developing a new manual, training presentations, webinars and a webpage regarding vaccinations and to particularly address vaccine hesitancy. The resources and training will be distributed and made available to health care providers, school nurses, MCH staff and others who work with children and families statewide.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	18	20	20	20	18
Annual Indicator	22.0	20.6	19.1	15.5	15.5
Numerator	1261	1162	1106	896	896
Denominator	57321	56277	57952	57687	57687
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	15	14	14	13	13

Notes - 2012
The 2012 column is populated with 2011 data. 2011 data will be available Fall 2013.

Notes - 2011
The 2011 column is populated with 2010 data. 2010 data will be available Fall 2012.

Notes - 2010
Data Source:
Numerator = Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census; 2010 data are actual Census counts, not estimates.

a. Last Year's Accomplishments
The Kansas teen birth rate (ages 15-17) declined 18.8% from 2010 (19.1%) to 2011 (15.5%). The difference was statistically significant at the 95% confidence level. In 2011 (the most recent year

preliminary national data for this age group is available) the birth rate for Kansas young teenagers was about the same as the national rate (15.4 per 1,000). The significant declines in teen birth rates were observed by 18.3% for non-Hispanic white, by 45.8% for non-Hispanic black, and by 19.3% for Hispanic teenagers from 2010 to 2011. There was a slight increasing trend over the interval 2002-2008, followed by a strong decreasing trend from 2009 to 2011. However, the APCs (annual percent change) were not statistically significant (i.e., non-significant change).

Direct Services:
Title X Family Planning program provided local contraceptive services, STD screening, and counseling services accessible to teens.

Enabling Services:
In late SFY 2011, KDHE received state general funds to implement Teen Pregnancy Targeted Case Management (TPTCM) programs. Ten local programs were funded to support pregnant and parenting adolescents up to age 21 in order to reduce negative pregnancy outcomes and delay future pregnancies.

Starting in 2011, KDHE received Section 510 Abstinence Education of Title V funds for the Kansas Abstinence Education Program (KAEP). The program focuses on youth in foster care ages 10-18 with the goal to use positive youth development principles to teach them how to make responsible choices. This information was added to foster care curricula and foster parents were given incentives to teach KAEP information to the foster children. In 2011, 467 students received training from 64 new trainers.

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

Population-Based Services:
MCH continued to partner with KDHE's STD Prevention Program for early identification and treatment of Chlamydia cases. Disparate populations continue to be the target of teaching and intervention efforts though schools and health fairs. In 2011, the Chlamydia rate among female adolescents aged 15--19 years was 29.4 cases per 1,000 women, an 8.1% increase from the 2010 rate of 27.2 cases per 1,000. The Chlamydia rate among black females aged 15--19 years was 62.1 cases per 1,000 women, which was almost six times the rate among white females in the same age group (10.5). The Chlamydia rate among Hispanic females aged 15-19 years was 18.4 cases per 1,000 women, which is nearly two times the rate among white females in the same age group. KDHE STD Section reported rising Chlamydia rates are due to increased testing availability and increases in disease. Several birth control methods do not prevent infections. They recommend a population-based intervention (i.e., Expedited Partner Therapy) is necessary to decrease rates.

MCH staff targeted school nurses to provide information to students relating to pregnancy and STD prevention. At the annual state school nurse conference, sessions were provided on teen pregnancy and appropriate referrals for sexually active teens, and brochures were provided on STDs.

Infrastructure Building:
MCH adolescent health staff collaborated with the Kansas State Department of Education (KSDE) and seven states to provide an educational conference on HIV/AIDS/STDs. The conference had 156 participants.

MCH staff served on Department for Children and Families (DCF) Kansas Child Welfare Quality Improvement Committee. The committee worked on coordination, policies, and legislation to improve the permanency of teens in the foster care systems that are pregnant or parenting.

MCH staff actively participated in the Kansas Fatherhood Coalition which included training activities that focused on adolescent males.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

Enabling Services:
Ten local TPTCM programs continued serving 429 adolescents in July-December 2012.

KAEP trained 160 foster care providers on working with teens and 1,045 teens received the curriculum (with an 88% completion rate). There were 27 new trainers. Evaluations report teens are making better decisions.

KDHE STD Section continued PREP in 3 counties.

Population Based Services:
Teen pregnancy prevention month messages were sent to approximately 800 MCH grantees and school nurses.

Fetal Alcohol Spectrum Disorder (FASD) training was provided to teens and groups that work

with teens. MCH staff trained 49 community members on the dangers of alcohol and pregnancy.

Infrastructure Building
MCH and KSDE provided AIDS/HIV/STD education for teachers and nurses; topics included teen sexuality, human trafficking, and abstinence programs.

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

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

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

Enabling Services:
Ten local TPTCM programs will continue to be funded. An estimated 535 adolescents will be served.

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

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

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

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

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

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

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance	40	40	40	40	41

Objective					
Annual Indicator	38.2	38.2	38.2	35.7	35.7
Numerator	13176	13176	13176		
Denominator	34506	34506	34506		
Data Source	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	38	38	40	40	42

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

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

Notes - 2010
Data Source: KDHE. Office of Oral Health. Smiles Across Kansas: 2007 Update - unpublished weighted data.

Data for 2010 is not available. 2007 data was used to pre-populate this performance measure. A report of 2009 data will be released in September 2011.

a. Last Year's Accomplishments
The 2012 Smiles Across Kansas, A Survey of The Oral Healh of Kansas Children (Third Grade), indicated that the oral health status of Kansas children is improving. Approximately one out of ten (9.4%) Kansas children has untreated, active dental decay. This is a remarkable improvement over the 2004 Smiles survey where one out of four children had untreated decay. A large number of Kansas children still experience dental decay. About 48.0% of Kansas children have decay currently or have had it in the past. In spite of the significant investments in oral health across the state, dental disease is still very common. Dental sealants are underutilized to prevent decay, especially in minorities. The placement of dental sealants on permanent molars is an evidence based public health best practice. Fewer than 36% of Kansas children have sealants on their first molars. Even fewer African American and Latino children have sealants. Most Kansas third graders (86.2%) have some form of dental insurance, and see their dentist annualy (85.4%). Some children continue to have difficulty getting dental care. Approximately 8% of Kansas parents reported that their child needed dental care but could not get it. More information can be found at www.kdheks.gov/ohi/download/
Smiles_Across _Kansas_2012.pdf.

Direct Health Care Services:

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

Enabling Services:

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

2. Bureau of Oral Health staff provides education to primary care pediatric providers on oral health topics including caries risk assessment and fluoride varnish education. Staff visits medical providers in their offices to encourage the use of fluoride varnish in EPSDT (KanBe Healthy) exams.

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

4. Updated the Kansas Oral Health Screening Initiative Calibration/Training Course (1029736) offered through Kansas Train.

Support Services:
1. The Bureau partners with Douglas County Dental Clinic, GraceMed, and Community Health Center Southeast Kansas, to provide an access point for dental care for patients with special needs who require sedations services. Funding provided by the Bureau's MCH Targeted Oral Health Service Systems grant funds a special needs day at the clinic.

2. The Bureau has contracted with eighteen clinics or programs to create and maintain school sealant programs. Last school year (11-12) those that participated in the Kansas School Sealant Program placed 22,156 sealants on 5,085 students. The Bureau provides funding and technical assistance.

Population Based Services:
Oral Health Screening - Kansas law requires each child to have a yearly oral health screening. The Bureau of Oral Health assists schools in complying with this statute. Bureau staff trains screeners and helps schools organize screening dates. Screening data is collected and housed at the Bureau. In the 2011-12 school year, over 140,000 children were screened.

Infrastructure Building Services:

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide fluoride varnish training and oral health education to		X		X

non-dental professionals.				
2. Establish school oral health screenings and referrals.		X	X	X
3. Provide consultation and technical assistance to school based dental sealant projects.		X		X
4. Provide support and technical assistance to the Medicaid Agency on dental matters.				X
5. Provide leadership to the Oral Health Kansas Coalition.				X
6. Provide leadership to the Kansas Public Health Association Board Oral Health Section.				X
7. Provide education and dental access to Children and Youth with Special Health Care Needs.		X		X
8. Provide a forum for discussion of Dental Workforce policy, the Dental Workforce Cabinet.				X
9. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations.				X
10. Targeted education and outreach to families to improve the oral health of children across Kansas.		X	X	X

b. Current Activities
Enabling Activities:

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

Population Based Services:
1. The school based screening initiative screened over 140,000 children in the 2011-2012 school year.
2. The "Smiles Across Kansas" 3rd grade survey was released in 2012.
3. "Elders Smile" report released in 2013.
4. The Kansas School Sealant Plan was released in April 2013.

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

Collect data from the eighteen sealant sites on services performed in the 2012-13 school year and evaluate the program.

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3.8	3.6	3.6	2.5	3.6
Annual Indicator	3.6	2.7	4.0	2.8	2.8
Numerator	21	16	24	17	17
Denominator	582572	588523	606823	605120	605120
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	2.6	2.6	2.4	2.4	2.2

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

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

Notes - 2010
Data Source:
Numerator = Death certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census; 2010 data are actual Census counts, not estimates.

a. Last Year's Accomplishments
In 2011, the mortality rate for children ages <= 14 as a result of unintentional injury-motor vehicle crash was 2.8/100,000 children, a 30.0% decrease from 2010 (4.0). Overall, there is a significant decreasing trend observed over the 10 year period, 2002-2011. The APC (annual percent change) was significant (-7.15).

According to the 2012 Annual Report (2010 Data) of the Kansas State Child Death Review

Board, 55 children died in Kansas as a result of a motor vehicle crash (MVC). There were slightly more females involved than males, and 42% of the decedents were rear-seat passengers. There were no fatalities of children under one year of age. Seventy-one percent of the total number of decedents were not using a safety restraint and of those 40% were in the 15-17 year-old age group. Driver inexperience and inattentive driving were noted as risk factors in 36% of the cases and excessive speed was noted in 17%.

Direct Services: None reported.

Enabling Services: None reported.

Population Based Services:
The majority of the MCH Healthy Start Home Visitors (HSHV) across the state were certified Child Passenger Safety (CPS) Technicians; 70 technicians were located in local health departments.

The child safety seats installation/inspection continued with additional training offered by Kansas Traffic Safety Resource Office (KTSRO). KTSRO and Safe Kids partnered to offer child car seat installation classes across Kansas.

The Safe Routes to School program was successfully continued in many schools.

KSTRO has adopted child safety as a focus. They have developed campaigns along with instructions on nonuse and improper use of child safety seats and seat belts. KSTRO partners with KDHE in a campaign that addresses "Is your child in the right seat?", and promotes the message that the car seat offers absolutely the best protection for children in the event of a crash.

Infrastructure Building Services:
State MCH staff continued to serve on the Safe Kids Advisory Committee and KDHE's Emergency Medical Services for Children (KEMSC) Coalition. These committees develop and implement strategic plans to decrease accidental childhood deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Title V staff collaborates with Safe Kids, KTSRO and the Emergency Medical Services for Children Coalition to coordinate delivery of motor vehicle injury/death prevention information and resources.			X	X
2. Link local health departments to data resources that provide information of motor vehicle unintentional injury to facilitate development of regional/ community strategies targeting specific populations/injuries/deaths.			X	X
3. Local MCH staff provides installation expertise, education and instruction to families with infants and young children on Child Passenger Safety Seats.			X	
4. Encourage community collaboration to seek out resources to assist in injury prevention programs such as Booster to Belts, Cycle Smart, Walk This Way, Spot the Tot and Safe Routes to School. .			X	X
5. MCH provides education/resources for developing/ delivering targeted MCH services for specific populations through annual orientation session for new MCH staff, the monthly MCH newsletter, and participation on statewide coalitions/committees.			X	X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services: None reported.

Enabling Services:

Population-Based Services:
HSHVs with local health departments continued to serve and be certified as CPS technicians.

Child safety seats installation/inspection continue with training offered by KTSRO.

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

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

Infrastructure Building Services:
Safe Kids has 28 local coalitions covering 74% of Kansas children age 0-14. State MCH staff serves on the Safe Kids Advisory Committee, and KEMSC Coalition.

Safe Kids and MCH are looking closely at car crashes in relationship to where the occurrences happen, race of victims, and the age and gender of the driver of vehicle involved in the crash.

c. Plan for the Coming Year
Direct Services: None reported.

Enabling Services: None reported.

Population-Based Services:
Child safety seats installation/inspection will continue with additional training offered by KTSRO.

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

Infrastructure Building Services
KDHE will continue to serve on the Safe Kids, KTSRO, and KEMSC Advisory Committee, and look for other organizations with goals to improve child safety.

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

The motor vehicle related deaths of children 14 and younger has prompted Safe Kids to form an

Injury Priority Workgroup comprised of coalitions, agencies and community. The workgroup will develop an action plan that will include strategies for training, media, and partnerships and look for evidence based programs that will target the demographics most in need of interventions.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	24	45	45	50	42
Annual Indicator	43.8	47.4	41	45.1	45.1
Numerator					
Denominator					
Data Source	National Immunization Survey, 2006 birth cohort	National Immunization Survey, 2007 birth cohort	National Immunization Survey, 2008 births	National Immunization Survey, 2009 births	National Immunization Survey, 2009 births
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	47	47	49	49	50

Notes - 2012
The 2012 column is populated with 2011 data (provisional data, 2009 births). Data will be available in 2014.

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

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

Notes - 2010
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

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

a. Last Year's Accomplishments
In the 2012 Breastfeeding Report Card, breastfeeding at 6 months increased from 41.0% in 2008 to 45.1% in 2009 (provisional). This compares to 47.2% for U.S children born in 2009 (provisional). This estimate remains below the national Healthy People 2020 objective (60.6%). Over the 10 year period (2000-2009), there was a significantly increasing trend in the proportion of Kansas infants breastfed at 6 months of age. A similar trend was observed at the national level. The survey also shows that low income mothers are less likely to breastfeed than their higher income counterparts.

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

Infrastructure Building Services:

Provided financial support to the Kansas LaLeche League 2012 spring conference for all health professionals.

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

Approximately 270 local and state health department staff attended the Seventh annual Governor's Public Health Conference in April 2012. The conference featured a breakout session on "The Business Case for Breastfeeding"

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

Supported Certified Breastfeeding Educator Training in September 2012.

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

Population Based Services:

Kansas WIC expanded their peer counseling program to cover 45 of the 105 counties in the state.

Sponsored a breastfeeding promotion and support billboard campaign.

Participated in a planning and implementation workgroup for "High 5 for Mom and Baby" hospital education campaign to improve Kansas breastfeeding statistics through policy and practices changes.

Enabling Services:

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

23 recognition awards were presented to Kansas businesses who successfully support their breastfeeding employees.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support state agencies, LHD and private businesses to implement new or enhance existing breastfeeding friendly worksite policies.				X
2. Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.		X		
3. Provide or support evidence-based continuing education on breastfeeding promotion and support.				X
4. Support breastfeeding credentialing efforts of LHD staff for both MCH and WIC programs.				X
5. Sustain a statewide public awareness campaign that supports breastfeeding.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building Services

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

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

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

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

95 nutritionists attended "The Business Case for Breastfeeding" session at Kansas Nutrition Council meeting.

Population Based Services

Sustain WIC Breastfeeding Peer Counselor programs in existing counties.

Support World Breastfeeding Week activities.

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

Enabling Services

KBC sponsored a coalition building summit to foster development of local breastfeeding support groups with quarterly follow-up conference calls.

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

Support development of local breastfeeding support groups for minorities.

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

c. Plan for the Coming Year

Infrastructure Building Services

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

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

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

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

Population Based Services

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

Sustain Breastfeeding Peer Counselor programs in existing counties.

Support World Breastfeeding Week activities.

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

Enabling Services

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

Foster development of local breastfeeding coalitions.

Foster development of local breastfeeding support groups for minority populations.

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

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	98	98.2	98.2	99
Annual Indicator	89.5	98.0	98.5	98.7	98.7
Numerator	37661	41645	40962	39908	40631
Denominator	42060	42515	41593	40452	41175
Data Source	KDHE. Kansas Newborn Screening program, 2008	KDHE. Kansas Newborn Screening program, 2009	KDHE. Kansas Newborn Screening program, 2010	KDHE. Kansas Newborn Screening program, 2011	KDHE. Kansas Newborn Screening program, 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	99	99	99	99	99

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

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

Notes - 2010
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2010.
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

a. Last Year's Accomplishments
SoundBeginnings (SB) Newborn Hearing Screening (NBHS) program's purpose is to improve the health and quality of life of children with hearing loss and their families in Kansas. The goal of the program is to screen all babies before one month of age, to identify permanent hearing loss before three months of age and if identified with hearing loss to receive the appropriate services for normal development of speech and language.

Kansas birthing hospitals and facilities screened 99% of the babies before one month of age and have continued to screen at 98% or better since 2009. 53% of the infants who failed the hearing screen were diagnosed with normal hearing or hearing loss before 3 months of age. This is 19% higher than the 2011 national average. 65% of the infants who were identified with hearing loss received infant toddler early intervention services before 6 months of age. This too is higher than the national average by 22%. The percent of infants who are Lost to Follow-Up/Lost to Documentation (LFU/LTD), those infants who never completed the hearing screening process, is 27% for 2011. This is a decrease of 15% from the previous year. In 2008, Kansas' NBHS Program reported that 84% of the infants who failed the newborn hearing screen never completed the hearing screening process and/or it was not reported to the state. Great measures have been implemented throughout the past several years that have proven to be indicators in reducing the LFU/LTD.

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

ES: Collaboration and funding was provided for assistance with parent-to-parent support, and continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization.

Dedicated staff attempts to resolve issues that lead to the reduction of Kansas' overall loss to follow-up rate. Staff continued to focus on: maintaining the national JCIH goals for EHDI, improve understanding of the hearing screening process and the benefits to professionals touching the

lives of our children, and to improve the health and quality of life for children with hearing loss and their families in Kansas.

PBS: The screening is implemented at the local level by hospitals, birthing centers or other obstetrical/newborn services licensed facilities. SB administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance.

IBS: Staff, parent representatives attended an EHDI Family Support National Meeting and the Alexander Graham Bell conference to assist with the development of family support infrastructure and services for children and their families. Information resources to outpatient and diagnostic Audiology Providers were provided.

The SB Advisory Committee meets quarterly to review, endorse, provide guidance and promote elements of the state EHDI program.

Presentations were provided at the Kansas Academy of Family Physicians, Kansas Chapter AAP, Sound START Train the Trainer conference, Kansas Speech Language Hearing Association, Academy of Audiology Association and the 2011 Annual National EHDI conference.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data submission through the web-based birth certificate (VRV) reporting system.				X
2. Continue quarterly meetings of the SoundBeginnings Advisory Committee				X
3. Continue the education training to professionals on early intervention				X
4. Collaborate to assist Kansas Hands and Voices chapter enabling parental input and parent to parent support			X	
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc				X
6. Support to hospitals to enhance screening equipment				X
7. Family and Audiologist Consultants to assist reduce loss to follow-up				X
8. Formalization of a regional program to assist newly identified families at first contact.				X
9. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations.				X
10. Continued attendance at EHDI, parent support and deaf education focused meetings				X

b. Current Activities
Continued previous activities.

ES: Support through grants to assist with reducing refer rate to include Automated Auditory Brainstem Response equipment has been provided to Level III NICU Hospitals.

Staff collaborated with WIC services, Home Visitor programs, Parents As Teachers and Early Head Start programs training the staff to conduct the hearing screenings and share data to help identify and locate those babies who were not completing the hearing screen. It is felt that this

collaboration was a large asset to the decrease in the percentage of those infants lost to follow-up and documentation.

IBS: Advisory Committee activities continued and site visits were made to hospitals and Audiologists. Information and technical assistance is provided to all stakeholders on program via phone and/or email. Continued work with support through grants is ongoing for reducing loss to follow-up and loss to documentation and tracking, surveillance and integration.

Screening and diagnostic evaluation results received through direct database input, fax, mail and email. Follow-up is completed on missed, NICU, and failed screens by staff and by EHDI Coordinator for confirmed hearing loss to medical home providers, Part C local networks and families.

Continued enhancement of the current SB database allowing hospitals and audiologist to manually enter hearing screening data was implemented. It is felt that this enhancement will continue to decrease the state's rate of LFU and documentation.

c. Plan for the Coming Year

Continue previous and current activities.

ES: Continue support for family organizations, specifically those serving families of children who are deaf or hard of hearing, to promote Parent-to-Parent program services to families, assist with family support activities and assist parent consultants. Audiologist Consultants and Family Consultants will be contracted to assist local communities in reducing LTF/LTD.

Continue technical assistance and education for: midwives and out of hospital births; hospital personnel; Audiologists; early interventionists; community providers such as Early Head Start, Parents and Teachers, and others; and other stakeholders of NBHS and intervention services. Collaboration with county health departments provide training and funding for the purchase of hearing screening equipment.

Training curriculum developed for Parents as Teachers (PAT) Otoacoustic Emission Hearing screenings. The PAT networks are to be trained and have the hearing screening protocols in place by 2014.

Collaborations with the Kansas School for the Deaf, Infant Toddler Services, the University of Kansas Deaf Education program, tiny-K networks, WIC, Healthy Start Home Visit programs, Hartley Family Center will continue to: 1) provide assistance and training for personnel at tiny-K networks and 2) develop a regional program to assist in first contacts with families.

IBS: Continue submission of hearing screening results through the web-based birth certificate system and the SB database to accept the required Healthy People 2020 data fields including race, ethnicity, language spoken in the home, birth defects, and transferring hospital.

The SB Advisory Committee will continue to meet quarterly to provide guidance and promote elements of the state EHDI program. The members of the advisory committee represent a varied group including parents and family members of deaf and hard of hearing children, community and medical providers -- such as early intervention, educators, pediatric speech language pathologists and audiologists, hospital staff, and a pediatrician -- and representatives from state agency partners such as Children's Developmental Services, the State Part C program, Newborn Metabolic Screening, Children and Youth with Special Health Care Needs, Special Education Services, the Kansas Commission of the Deaf and Hard of Hearing, and the Kansas School for the Deaf. The Committee has established goals including parent communication and family concerns; education to all members involved in early intervention, including a focus on the family

perspective; and information sharing of legislative issues or advocacy. Support will be provided to hospitals that have a Level II or III NICU to purchase Automated Auditory Brainstem Response (AABR) equipment.

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	7	7	10.5	8	7.5
Annual Indicator	10.4	7.3	7.5	9.4	9.4
Numerator					
Denominator					
Data Source	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	9.2	9.2	9	9	8.8

Notes - 2012
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition

information can be found at
http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm

Data for 2012 is not available. 2011 data was used to pre-populate this performance measure. Data for 2012 will be available in fall, 2013.

Notes - 2011
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at
http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm

Data for 2011 is not available. 2010 data was used to pre-populate this performance measure. Data for 2011 will be available October 2012.

Notes - 2010
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm

a. Last Year's Accomplishments
The percent of children in Kansas without insurance coverage decreased from 2008 (11%) to 2010 (7.6%). This increase may have been due to easier public insurance coverage application process and a more expedite renewal process for children. However, data from the U.S. Census Current Population Survey (CPS) show that the percentage of Kansas children under 18 years old without health insurance rose from 7.5% in 2010 to 9.4% in 2011, a 25.3% increase. The U.S. percentage decreased slightly from 9.8% in 2010 to 9.4% in 2011. Over the 10 year period (2002-2011), the percentage of Kansas children without health insurance increased, while the US percentage decreased.

Direct Services:
MCH clinics provided immunizations, well child checks and Healthy Start Home Visitor (HSHV) services on a sliding fee scale to families unable to afford care.

Enabling Services:
HSHVs provided outreach to all pregnant women, families and new infants to assist their enrollment in KanCare (i.e., Medicaid, CHIP).

All local MCH programs worked to enroll clients into a medical home as required by their MCH grants.

Population Based Services:
KanCare enrollment activities were conducted in community settings including information and sign up opportunities at Kindergarten roundup and school registration.

Infrastructure Building Services:
Online registration was made available for KanCare. Local health departments, Federally Qualified Health Centers (FQHC), physician offices, and other providers could easily access the applications and assist the uninsured in completing the applications on line.

Kansas Association for the Medically Underserved (KAMU) is recognized as the State's Primary Care Association (PCA) and is charged with providing training, technical assistance and advocacy on behalf of federally funded Community Health Centers in Kansas which include the

15 FQHCs in Kansas.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

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

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

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

Population Based Services:
MCH supports/promotes outreach and enrollment activities in local agencies and schools for KanCare-eligible women/children encouraging health services in a medical home and referring ineligible families to safety net clinics.

Infrastructure Building Services:
Kansas Medical Assistance Program (KMAP) website provides information to KanCare beneficiaries and providers. Links are available to the health plan providers, questions and

answers, and eligibility criteria and information.

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

Enabling Services:
Local MCH clinics and HSHVs will continue to screen and assist with enrollment for KanCare services.

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

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

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

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	29	29	28	28	28
Annual Indicator	30.0	29.8	28.7	28.4	28.4
Numerator	10306	11013	10860	10657	10657
Denominator	34352	36956	37838	37524	37524
Data Source	Kansas PedNSS, 2008	Kansas PedNSS, 2009	Kansas PedNSS, 2010	Kansas PedNSS, 2011	Kansas PedNSS, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	27	27	27	26	26

Notes - 2012
The 2012 column is populated with 2011 data. 2011 data will be available Fall 2013.

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

Notes - 2010
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2010 (Kansas WIC database).

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

Infrastructure Building

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

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

Two state staff attended the 2012 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

Population Based Services:

Approximately 270 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2012. The conference featured a keynote presentation on "Healthy People 2020."

Enabling Services:

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				X
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Infrastructure Building

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

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

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

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

University of California Davis Human Lactation Center Baby Behavior train-the-trainer was attended by 2 State and 2 LHD staff. This program discourages overfeeding and future overweight.

Population Based Services

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

Enabling Services

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

c. Plan for the Coming Year
Infrastructure Building:

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

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

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

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

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

Develop and implement a Kansas Baby Behavior staff training based on the University of California Davis Human Lactation Center model. This program discourages overfeeding and future overweight.

Population Based Services:

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

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

Enabling Services:

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.5	13	13	12.5	12.5
Annual Indicator	13.8	12.7	12.7	12.2	12.2
Numerator	5720	5246	5005	4795	4795
Denominator	41570	41210	39409	39441	39441
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	12	12	11.8	11.8	11.6

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

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

a. Last Year's Accomplishments
Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. In 2011, 12.2% (4,795) of women reported smoking during the last three months of pregnancy, a slight decrease from 2010 (12.7%). Over the seven year period (2005-2011), there was a statistically significant decreasing trend detected. The annual percent change was significant (APC=-2.61). Among women who reported smoking during the last three months of pregnancy, 70.8% reported Medicaid as principal source of payment for delivery (68.1%).

Direct Services:
MCH grantees provided pregnant women with referrals to smoking cessation resources locally or to the Kansas Tobacco Quitline. MCH grantee trained in the use of the 5 A's counseling method of smoking cessation provide brief interventions to pregnant women to assist in their ability to quit.

Enabling Services:
MCH grantees provide pregnant women, children and adolescents with health education and support on the positive benefits associated with quitting tobacco use and/or never starting.

Population Based Services:
Kansas is participating as a State partner in the text4baby free text messaging program for pregnant women and new moms. Health messages discouraging smoking during pregnancy and around children are included as part of this service. The Kansas text4baby Partnership has grown to include 20 actively participating partners spanning the government, health care and education sectors. The Kansas text4baby partnership meets via telephone conference call annually and as needed to share best practices in promoting text4baby in Kansas to healthcare and social service professionals and communities statewide.

Infrastructure Building Services:
Birth outcomes and smoking rates are monitored ongoing in relation to local agency efforts in prenatal smoking prevention and cessation. Kansas TUPP and MCH staff provide education and encouragement to local agencies and support use of the Quitline and other materials to aid in smoking cessation efforts. MCH grantees and prenatal providers are encouraged to use CDC and March of Dimes tobacco cessation web resources and to participate in the promotion of the

text4baby program to support pregnant women and new mothers.
The Kansas TUPP and MCH staff provide support and technical assistance to local grantees.
Kansas Clean Indoor Air Act of 2010 serves as a foundational piece of legislation to decrease smoking in our state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH grantees attend tobacco cessation trainings to help decrease the number of pregnant women that smoke tobacco.				X
2. MCH grantees refer pregnant women to the Kansas Tobacco Quitline.	X			
3. MCH grantees provide a linkage for pregnant women to local tobacco cessation services.		X		
4. MCH grantee staff trained in the use of the 5 A's counseling approach to smoking cessation provide brief interventions to assist pregnant women to quit smoking.	X			
5. MCH staff link grantees and partnering perinatal health care organizations to web resources provided by the CDC and the March of Dimes.		X	X	X
6. MCH staff provides grantees and partnering perinatal health care staff with other relevant tobacco cessation resources via the Web, educational conferences, newsletter articles and through routine communications.		X	X	X
7. MCH staff educates local health depts and perinatal health care staff to routinely screen pregnant women for smoking behaviors and tobacco use, provide information on benefits of quitting and links to local smoking cessation services.		X		
8. MCH staff will monitor for changes in tobacco-related legislation. Landmark legislation: Kansas Clean Air Act of 2010.				X
9. Kansas will serve as state-level text4baby partner.			X	X
10. Surveillance of smoking during pregnancy through Kansas Health Matters.				X

b. Current Activities

Direct Services:
Pregnant women are referred to the Kansas Quitline and local tobacco cessation services for tobacco cessation assistance by MCH grantees. MCH grantees trained in the 5 A's counseling method of smoking cessation will provide brief interventions to pregnant women. Schools and health fairs are sites of where activities focused on cessation are provided by community coalitions and youth organizations to support families ability to quit.

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

Population Based Services:
KDHE serves as a State partner in the text4baby free text messaging program for pregnant women and new moms. Health messages discouraging smoking during pregnancy and around children are included. The Kansas text4baby Partnership consists of 20 state-wide member organizations.

Infrastructure Building Services:
The 2010 Kansas Clean Indoor Air Act serves as a standard in the continued ability of our state to reduce the number of pregnant women and the community at large who smoke tobacco.

c. Plan for the Coming Year
Direct Services:
MCH grantees will provide referrals to the Quitline and evidence-based information on the health benefits associated with smoking cessation to pregnant women. MCH grantees trained in the 5 A's counseling method of smoking cessation will provide brief interventions to pregnant women.

Enabling Services:
MCH staff will provide evidence-based information on tobacco cessation via Web links, newsletter articles and routine communications to local grantees and partnering organizations. MCH Healthy Start Home Visitors will provide outreach, education and support services to pregnant women including linking them to smoking cessation resources and referrals to the Quitline and local smoking cessation services.

Population Based Services:
Work with existing programs in communities with high rates of pregnant women that smoke by providing them with messages focusing on the health benefits of smoking cessation.
MCH local grantees will be encouraged to utilize existing evidence-based smoking cessation resources for pregnant women and women of childbearing age like the Quitline and information from the CDC and March of Dimes websites.

Infrastructure Building Services
MCH staff will monitor for changes in local and State policy regarding smoking cessation. MCH staff will participate with existing advisory councils on implementing strategies to decrease smoking in pregnant women in women of childbearing age. MCH grantees will be linked to Kansas Health Matters website for dashboard surveillance tools to monitor indicators on women who smoked during pregnancy in their service area.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9.4	9.3	11	9	10
Annual Indicator	11.1	9.1	10.1	10.5	10.5
Numerator	67	55	61	64	64
Denominator	604131	602256	604262	608906	608906
Data Source	Kansas Vital Statistics, 2006-2008	Kansas Vital Statistics, 2007-2009	Kansas Vital Statistics, 2008-2010	Kansas Vital Statistics, 2009-2011	Kansas Vital Statistics, 2009-2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	10	9.8	9.8	9.6	9.6

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

Notes - 2011
Data Source:
Numerator = Death certificate (resident) data, 2009-2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: U03, X60-X84, Y87.0.

Denominator =U.S. Bureau of the Census
2009-2011 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

Notes - 2010
Data Source:
Numerator = Death certificate (resident) data, 2008-2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: U03, X60-X84, Y87.0.

Denominator =U.S. Bureau of the Census
2008-2009 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

a. Last Year's Accomplishments
In 2011, the suicide rate among Kansas youth ages 15-19 was 11.7 per 100,000. This was lower than 2010 (13.7). For the period 2000-2011, using rolling 3 year averages, overall, there was a slight increasing trend observed in completed suicides by Kansas youth (15-19) during 2000-2002 and 2009-2011. The annual percent change (APC) was not significant.

According to the 2011 Kansas Youth Risk Behavior Survey (YRBS), 11.8% of Kansas high school students had seriously considered attempting suicide during the 12 months before the survey, a slight decrease from 12.6% in 2009. The percentage of students who made a plan about how they would attempt suicide during the 12 months before the survey was 9.9% in 2011, a slight increase from 9.5% in 2009. The percentage of students that attempted suicide one or more times during the 12 months before the survey was 5.9% in 2011, a decrease from 6.1% in 2009. The percentage of students that attempted suicide resulted in an injury, poisoning, or overdoes that had to be treated by a doctor or nurse during the 12 months before the survey was 2.5% in 2011, an increase from 1.8% in 2009. Often the youth who attempt suicide have associated mental health or other behavioral concerns such as depression, substance abuse, and a sense of

hopelessness, increased stress and a lack of family support.

Direct Services: None reported.

Enabling Services:
The schools and school counselors continued to link with family therapy counseling through the local mental health consortium and the use of telemedicine technology.

Population Based Services:
According to school nurse survey data, in the 2007-08 school year 32% of the nurses reported a suicide prevention program within their school. In 2008-09, 42% reported such a program existed and in 2010-11, 44%. However, in 2011-2012 respondents to the school nurse survey indicated a decline to 24% in suicide prevention/intervention plans within their schools.

School nurses offer Yellow Ribbon training but, due to funding cuts, now charge for the training.

Infrastructure Building Services:
The mental health consortiums continued to provide education and conferences for training in best practices.

Kansas Department of Social and Rehabilitative Services (now the Department for Children and Families) and National Alliance on Mental Illness (NAMI) offered an annual conference in Kansas. Consumers, family members and providers receive support and training in best practices.

The Suicide Prevention Subcommittee (SPS), an entity of the Governor's Mental Health Services Planning Council continued to promote the Kansas Suicide Prevention Plan and look for collaborative partners. The SPS had a proclamation signed by Governor Brownback for Suicide Prevention Week the first week of September.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate in the Governor's Mental Health Services Planning Council and Suicide Prevention Subcommittee (SPS) to promote statewide suicide prevention strategic plan.				X
2. Work with the SPS to develop culturally appropriate, effective suicide prevention strategies for adolescent populations in Kansas.			X	X
3. Support the activities offered by Headquarters Counseling Center as they implement activities from a Garrett Lee Smith grant.				X
4. Develop infrastructure and provide awareness of mental health/suicide specialist so referral sources will be available when needed.		X		X
5. Assist making linkages from Kansas schools to regional mental health centers for counseling and mental health services to decrease suicide ideology.		X		X
6. Ask school nurses for feedback if they are implementing a suicide prevention program in their schools through a school nurse survey to evaluate program implementation.				X
7. Support the first statewide conference on Kansas Youth Suicide Prevention offered with Garrett Lee Smith grant funding.				X
8.				

9.				
10.				

b. Current Activities
Direct Health Care Services: None reported.

Enabling Services:
Kansas schools continue to connect to the Telemedicine network, their regional mental health centers, and KU to provide mental health services to rural areas of KS.

Population Based Services:
Technical assistance is available to Kansas school nurses on how to develop a Yellow Ribbon Suicide Prevention Program in their schools and communities.

Articles on suicide awareness and prevention are in MCH newsletters to local health department and school nurse staff.

Infrastructure Building Services:
MCH staff was asked to serve on an advisory board for the federal Garrett Lee Smith Suicide Prevention grant awarded to the Headquarters Counseling Center in Kansas, a statewide collaboration to reduce the number of suicide attempts and deaths among Kansans10-24 years of age.

c. Plan for the Coming Year
Direct Services: None reported.

Enabling Services: None reported.

Population Based Services:
MCH and school nursing staff will continue to support prevention of suicide occurrences.

Infrastructure Building Services:
The Garrett Lee Smith suicide prevention grant recipient, Headquarters Counseling Center, Inc., will begin to offer Local Activities Grants for up to $3000 and Coalition Development Grants for up to $10,000. The grants will all work toward the goal of preventing suicide attempts and deaths and decreasing suicidal behavior in Kansas youth.

KDHE will continue to promote the goals and strategies of the Kansas Suicide Prevention Plan and efforts of Headquarters Counseling Center to decrease 10-24 year olds' suicide attempts and deaths in Kansas.

MCH staff and school nurses will be offered training on suicide prevention and intervention. School nurses will be taught how to develop a suicide action plan with trained staff to prevent suicide from occurring and/or dealing with the survivors. The Headquarters Counseling Center, Inc. is working to offer school nurses Applied Suicide Intervention Skills Training (ASIST). ASIST is designed to train caregivers who can recognize individuals who are at risk and who know how to intervene to prevent the risk of suicidal thoughts becoming suicidal behaviors. The Kansas MCH school nurse consultant will help facilitate training activities with the school nurses.

The SPS will continue to pursue changes to the KS Board of Healing Arts asking for general practitioners to have additional training in mental health in order to treat suicidal patients more effectively in a small community. SPS is asking the Behavioral Sciences Regulatory Board to increase certification requirements for professionals specialized in suicide prevention.

KDHE will support efforts through consortiums to reduce access to lethal means and methods of self-harm. This will include supporting Safe Kids initiatives to enact stricter gun laws in Kansas.

The Headquarters Counseling Center will partner with Fort Hays State University's Department of Psychology to host the first statewide conference addressing youth suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	86	86	87	87
Annual Indicator	78.9	80.8	82.3	86.6	86.6
Numerator	412	437	377	425	425
Denominator	522	541	458	491	491
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	88	88	89	89	90

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

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

Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).

Notes - 2010

Data Source: Birth certificate (resident instate births) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Kansas's level III hospitals are 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), Via Christi-St Joseph and Wesley Medical Center (Wichita).

a. Last Year's Accomplishments

In 2011, the percent of very low birth weight infants delivered in subspecialty perinatal care facilities was 86.6%, a 5.2% increase from 2010 (82.3%). This increase was statistically significant. Over the ten year period (2002-2011), there was a stable trend detected in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. Kansas residents who live in less densely populated areas who deliver VLBW babies fall well below the Healthy People 2020 goal of 90 percent for VLBW infants born in hospitals self-designated as having a Level III nursery, as follows: Frontier as well as Densely-Settled Rural areas 60.0%, Rural 76.5%, Semi-Urban 82.9%, and Urban areas 95.7%.

Direct Services:

Services for VLBW infants were only available in subspecialty perinatal care facilities (hospitals with self-designated Level III nurseries) located in the most densely settled areas in Kansas - Wichita, Topeka and Kansas City metropolitan areas.

Enabling Services:

Obstetrical providers in public and private practice settings continued to utilize a variety of methods to identify women at risk for preterm delivery or other complications that are associated with the delivery of very low birthweight infants and provide treatment or referral to services that will reduce this likelihood.

Education on a broad range of perinatal health topics, including where VLBW babies should be born, was provided to perinatal health care providers in hospitals with Level II and below nurseries by physician teams from a few of the hospitals with Level III nurseries.

MCH staff instructed and provided resources to local MCH grantees to educate pregnant women on the signs and symptoms of preterm labor and when to seek further medical care.

The University of Kansas Hospital in the Kansas City area and Wesley Medical Center in Wichita both have neonatal transportation services available for high-risk obstetrical cases in outlying areas.

Population-Based Services: None reported.

Infrastructure Building Services:

The Kansas Maternal Child Health Council (KMCHC), a multidisciplinary panel with expertise in the area of perinatal health, provided a forum to discuss issues associated with VLBW infants being delivered in Level III NICU's. They looked into strategies to address/implement an increase in the number of babies (VLBW) delivered in level III hospitals by attempting to standardize the use of prenatal/preterm risk assessments, suggested the benefit of a payment system for services rendered versus a global fee based on paying the service provider only where the delivery occurs and ideas for identifying and implementing best practices among hospitals for making transfers that will most benefit patients' health.

Kansas has maintained its system of provider-driven referrals to facilitate access to consultation across various jurisdictions between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system includes several hospitals that are self-designated subspecialty perinatal care centers that provide both in-patient and out-patient high risk

obstetrical/fetal and neonatal services and education mentioned previously. All of the subspecialty perinatal care centers are located in the Wichita, Kansas City and Topeka metropolitan areas.

The Kansas Perinatal Quality Collaborative (KPQC) was formed as the result of a coordinated effort by the Greater Kansas Chapter of the March of Dimes and various Kansas perinatal health care stakeholders. The KPQC's goal is to improve service quality and access to care for women and babies in Kansas. This is to be achieved by assuring quality perinatal care using data-driven, evidenced-based practices and quality improvement processes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Formation of Kansas Perinatal Quality Collaborative coordinated by Kansas Chapter of March of Dimes.				X
2. Perinatal outcome data is provided in an electronic format to delivering hospitals who request data about their hospital or hospital group.				X
3. Sub-specialty perinatal health care services in Wichita, Kansas City, and Topeka metropolitan areas.	X			
4. KMCHC advises KDHE on MCH issues and advocates for practice that supports VLBW infants are born in Level III hospitals.				X
5. Local OB providers identify women with high-risk pregnancies.	X			
6. KPQC work on QI projects to improve best practice.				X
7. MCH staff work with perinatal experts to promote birth of VLBW infants in Level III hospitals to OB providers in local communities.		X		X
8.				
9.				
10.				

b. Current Activities

Direct Services:
Subspecialty perinatal care services are provided in Wichita, Kansas City and Topeka metropolitan areas.

Local obstetrical care providers use many strategies to identify women at high-risk for premature birth and delivery of LBW and VLBW infants.

Enabling Services:
Kansas promotes the use of the national Healthy Mothers, Healthy Babies text4baby free text messaging service for new moms and pregnant women.

Population Based Services:
MCH staff and the Perinatal Association of Kansas (PAK) share perinatal education web resources and links for interested stakeholders.

Infrastructure Building Services:
KDHE maintains an electronic database of perinatal data and provides data to hospitals upon request. Additional resources such as the Kansas Health Matters interactive website with data useful for communities working on community health assessment and community health improvement projects is available through KDHE.

MCH staff monitors hospitals that self-designate as having Level III NICU's and those who provide maternal/infant transport.

The KMCHC meet quarterly and discuss a wide variety of perinatal health issues and are seeking broader representation by inviting new members to represent the three Kansas Medicaid Managed Care Organizations and the business sector.

MCH staff worked with the PAK and KMCHC on advocating to obstetrical care providers for the delivery of VLBW infants in subspecialty perinatal care facilities.

c. Plan for the Coming Year

Direct Services:
Subspecialty perinatal care services will be provided in Wichita, Kansas City and Topeka metropolitan areas.

Local OB providers will continue to identify pregnant women at high-risk for premature delivery and delivery of LBW and VLBW infants.

Enabling Services:
MCH grantees will provide outreach, support and education on the signs and symptoms of premature labor and other pertinent topics as well as referral to appropriate social and health care services using a culturally-relevant approach to women of childbearing age and their families in local communities.

Population Based Services
MCH staff will work on linking to web resources on healthy pregnancy and conditions related to pregnancy and childbirth.

MCH will continue to partner with the text4baby program to provide healthy messages to pregnant women and new mothers.

Infrastructure Building Services:
MCH grantees are encouraged to be actively involved in local community health needs assessment processes and in developing health improvement plans. Training needs of local communities will be assessed by MCH and other KDHE staff and addressed in collaboration with them. Principles of the life course and social determinants of health theories will be utilized to ensure greatest program impact as they are tied to local community health needs.

MCH staff will meet with PAK and KMCHC in addressing the need to provide focused professional education and consultation to obstetrical delivery facilities as well as to advocate for delivery of very low birthweight infants in subspecialty perinatal care facilities.

The KMCHC will continue to meet to provide expertise to seek improvements in health for women of reproductive age and pregnant women and their infants.

MCH will work with the KMCHC to update a list of delivering hospitals with levels of NICU as part of Kansas' developing system of hospitals' self-designation of perinatal health services.

KDHE will provide perinatal health information to hospitals via electronic means upon request.

MCH provides staff and resources to support meetings and activities of the KPQC and Kansas Blue Ribbon Panel on Infant Mortality that are working to promote system changes to positively

impact the health of women of reproductive age and infants through quality improvement, implementation of best practices and data analysis. One project underway is in collaboration with the Kansas Health Care Collaborative (Hospital Engagement Network) project to reduce the number of early elective deliveries. Other potential KPQC projects are: increasing the number of women receiving first trimester prenatal care; increasing the number of VLBW infants born in hospitals with sub-specialty care services; and increasing the number of infants being exclusively fed breastmilk.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	78	79	79	80	80
Annual Indicator	73.1	74.1	75.1	77.3	77.3
Numerator	29089	29244	29552	29618	29618
Denominator	39776	39481	39362	38296	38296
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	80	80	80	80	80

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

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

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

a. Last Year's Accomplishments

In 2011, 77.3% of infants were born to pregnant women receiving prenatal care in the first trimester, a slight increase from 2010 (75.1%). The U.S. data for 2010 (the latest data available) on this measure was 73.1%. Kansas exceeded the U.S. on this measure by 2.7% in 2010 (75.1%). However, this was below the Healthy People 2020 goal of 77.9%. During 2005-2011, Joinpoint regression analysis showed a decreasing trend over the interval 2005-2007 followed by a significantly increasing trend from 2007-2011. Kansas 2011 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.

Direct Services:
In 2012, 85 MCH grants were awarded to local agencies/organizations that provided prenatal and postpartum services to 11,536 women and medical services to 10,694 infants. Direct prenatal medical care services continued to be provided in Lyon, Reno, Ford, Finney, Seward, Montgomery, Bourbon, Crawford and Johnson counties due to a lack of available providers of these services and for persons who don't qualify for health care insurance.

Enabling Services:
MCH grantees provided linkages to local prenatal care services.

Healthy Start Home Visitors (HSHV) in local health agencies conducted outreach and home visits with pregnant women, and provided support and referrals for prenatal care.

KDHE continued to receive state general funds targeted to provide services to low-income, high risk families in Geary and Wyandotte counties, identified as high-risk in terms of poor birth outcomes. In turn, "Healthy Families" grants continued to be provided to health departments in both counties to provide intensive prenatal and postnatal case management services.

MCH staff provided professional education on smoking cessation resources, implementation of the Safe Haven law, Kansas Newborn Hearing Screening resources and resources and tips on how to best work with families who have children with Fetal Alcohol Spectrum Disorders to HSHV using a regional approach.

Outreach and services to a primarily Hispanic migrant population, speaking Low German and Spanish, were provided services in collaboration with the Kansas Farm Worker Health Program.

MCH grantees provided prenatal care services to women at risk for no prenatal care or late entry into prenatal care using community-specific approaches adapted from national evidence-based programs (e.g., Centering Pregnancy Model and Nurse Family Partnership and others).

Population Based Services:
Local MCH grantee staff used the online Kansas Resource Guide and the state hotline number to link clients to services.

Infrastructure Building Services:
MCH staff assisted in planning educational conferences with partners from a variety of organizations in the health care sector involved in caring for pregnant women. Emphasis was placed on the benefits of early and comprehensive prenatal care and how to reach women in high-risk situations utilizing culturally sensitive practices and lower literacy level materials.

MCH staff monitored trends in data for prenatal care usage via the annual Adequacy of Prenatal Care Index produced by KDHE as well as county and state data found in the Kansas Health Matters dashboard tool. These results were shared back to MCH grantees locally and to the Kansas MCH advisory council when significant issues arise for expert input.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH grantees provide Prenatal Care/Care Coordination services per capacity and training.	X	X		
2. Identify women at risk for late entry or no prenatal care.	X	X		
3. Grantees using evidence-based prenatal care models.	X	X		
4. Utilize prenatal, delivery and postnatal provider resources.		X	X	
5. Provide/encourage use of Kansas Resource Guide.		X	X	
6. Greater use of readily available data systems (e.g., KIC, Kansas Health Matters, etc.) documented.				X
7. Healthy Babies Kansas Facebook campaign in collaboration with KDHE Center for Health Equity conducted.			X	X
8. Promote optimal health during the interconception period.			X	X
9. Support/encourage local efforts to overcome disparities in the provision of prenatal care and incidence of low birth weight.		X		
10. Work with KDHE Center for Health Equity on messaging related to healthy pregnancy information to various cultures in Kansas.			X	X

b. Current Activities

Direct Services:
Local health departments, Federally Qualified Health Centers, hospitals, and local obstetrical and perinatal health care providers compose the comprehensive prenatal care coordination system.

Enabling Services:
Local MCH agencies use care coordination and case management models to provide prenatal services.

Family Planning, WIC and MCH programs coordinate prenatal care outreach and help clients with navigation in the health care system and KanCare (Medicaid/SCHIP).

Population Based Services:
The Kansas text4baby Partnership involves 20 organizations. There are 7,670 participants in Kansas that receive text4baby health messages. MCH staff promotes use of text4baby by new mothers and pregnant women.

Infrastructure Building Services:
MCH staff participates in the Kansas Fatherhood Coalition and assists with providing fathers accurate and reliable health care information in regard to promoting healthier pregnancies.

MCH staff worked with the KDHE Center for Health Equity to develop and disseminate accurate health care information and special events to improve health of women in high-risk communities through social media and other channels. The Center conducted a Healthy Babies Kansas campaign using a Facebook presence as part of this collaboration.

MCH grantees have increased use of the Kansas Health Matters website when looking at local needs and services. The site provides tools and resources for community health assessment and community health improvement activities

c. Plan for the Coming Year

Direct Services:
Where service gaps exist, local agencies will assist in linking clients to or facilitate direct prenatal medical services for them.

Enabling Services:
MCH will continue to fund and support outreach and case management services such as HSHVs and other programs to improve engagement in early prenatal care.

MCH will collaborate with Family Planning and WIC programs to better coordinate efforts that improve local grantees involvement in prenatal outreach to clients and offering clients assistance in navigating the health care system and filling out paperwork.

Population Based Services:
MCH will encourage Kansas text4baby partners to promote and fully engage in the national enrollment event.

MCH will continue work with KDHE Center for Health Equity to develop and disseminate accurate and reliable health care information, workforce development opportunities and special events to improve health of women in disparate communities.

MCH staff will continue collaboration with the Kansas Fatherhood Coalition to provide educational opportunities for fathers to increase their ability to make appropriate health care decisions for their families and increase fathers' awareness of resources to serve in becoming better dads and to be play a more supportive role for their families.

MCH will promote use of the Kansas Resource Guide and other resources to MCH grantees, the public and perinatal care providers for information on access to local services and accurate health care information.

Infrastructure Building Services:
MCH staff will provide professional education and technical assistance to its grantees in moving toward systems of comprehensive prenatal care coordination and case management services.

MCH will collaborate with the Kansas Fatherhood Coalition to reach more fathers in Kansas with accurate and helpful information to support their family role.

D. State Performance Measures

State Performance Measure 2: *The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				14.4	13.5
Annual Indicator	12.7	14.5	14	17.7	17.7
Numerator					
Denominator					
Data Source	Kansas BRFSS,	Kansas BRFSS,	Kansas BRFSS,	Kansas BRFSS,	Kansas BRFSS, 2011

	2008	2009	2010	2011	
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	13	12.5	12	11.5	11

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

Notes - 2011
Data Source: Kansas BRFSS 2011
Note: The 2011 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

Notes - 2010
Data Source: Kansas BRFSS 2010

a. Last Year's Accomplishments
According to the Kansas Behavioral Risk Factor Surveillance System (BRFSS), in 2011, 17.7% of women ages 18-44 years old reported consuming four or more alcoholic drinks (i.e., binge drinking) on an occasion in the past 30 days. White women ages 18-44 years old reported the highest levels of binge drinking (18.5%), compared to black women (13.4%) and Hispanic women of all races (15.4%).

A Healthy People 2020 recommendation is that women who may become pregnant completely abstain from alcohol.

Direct Services:
Screening for alcohol and tobacco use is routinely conducted during initial and annual family planning visits. Local agencies have been provided with sample/template Female and Male History Forms which include screening questions. Education and counseling appropriate to the client's history is provided. If, during the course of an assessment, problems are identified which are beyond the scope of the clinic, appropriate referrals are made. All agencies maintain a list of providers, hospitals, voluntary agencies and other federal programs to be used for referral purposes. MCH grantees refer women with substance and alcohol use issues to regional and local treatment services.

Enabling Services:
Parts of a voluntary, incentive-based program to help pregnant women abstain from alcohol and drugs were maintained in local Department for Children and Families (DCF) Services programs. One MCH staff serves on state-level speakers' bureau on the topic of Fetal Alcohol Spectrum Disorders (FASD) prevention.

Population Based Services:
KDHE tracked Behavioral Risk Factor Surveillance System (BRFSS) data on binge drinking of reproductive age women (18-44 years old).
MCH tracked the incidence of FAS through the birth defects information system.
KDHE monitors the occurrence of binge drinking during pregnancy through BRFSS.

Infrastructure Building Services:
MCH staff participates in the National Association of Fetal Alcohol Spectrum Disorders State

Coordinators (NAFSC) group in quarterly meetings and at the state-level with the Kansas Leadership to Keep Children Alcohol Free Coalition in order to support educational efforts and system maintenance activities in the area of alcohol prevention for women and children in Kansas.
The Kansas Chapter of the American Academy of Pediatrics was granted affiliate status with the National Organization of Fetal Alcohol Spectrum Disorders (NOFAS).
KDHE maintains a birth defects surveillance system where FAS is tracked.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide local health care practitioners and MCH grantee staff with professional education on the science behind the effects of alcohol during pregnancy.				X
2. Develop, disseminate and promote use of evidence-based information on reducing alcohol consumption in the perinatal health population using web links and raising awareness of the need to abstain from alcohol during pregnancy.		X	X	X
3. KDHE will report data on the occurrence of binge drinking during pregnancy from the BRFSS.				X
4. MCH will facilitate discussion of strategies to approach binge drinking during pregnancy with Kansas Leadership to Keep Children Alcohol Free, Mental Health and Alcohol and Prevention Services in DCF, KCSL and other interested stakeholders.				X
5. MCH will facilitate discussion of strategies to approach binge drinking during pregnancy with Kansas Leadership to Keep Children Alcohol Free, Mental Health and Alcohol and Prevention Services in DCF, KCSL and other interested stakeholders.				X
6. KDHE tracks number of FAS cases through the birth defects information system.				X
7. Kansas Leadership to Keep Children Alcohol Free annually present facts on underage drinking impacts to legislators.				X
8. “No safe amount of alcohol during pregnancy” message and other alcohol prevention messages from the U.S. Surgeon General’s Office and CDC are promoted by MCH and other stakeholders.		X	X	
9. MCH and DCF staff creating plans to educate local health care providers on use of SBIRT in practices with women of childbearing age at risk for alcohol, tobacco and other substances use.				X
10.				

b. Current Activities
Direct Services:
Screening for alcohol and tobacco use is routinely conducted during initial and annual family planning visits. Local agencies have been provided with sample/template Female and Male History Forms which include screening questions. Education and counseling appropriate to the client's history is provided. If, during the course of an assessment, problems are identified which are beyond the scope of the clinic, appropriate referrals are made.

Enabling Services:

MCH grantees educate pregnant women and women of reproductive age they serve with messages to abstain from alcohol and other substances during pregnancy and if breastfeeding.
MCH staff trained through MRFASTC program provided professional education on the prevention of FASD to MCH grantees, health care providers and other interested stakeholders.
Local MCH staff provides outreach, education and evidenced-based resources from the Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and Fetal Alcohol Syndrome Community Resource Center websites to women they serve.

Population Based Services:
KDHE tracks Behavioral Risk Factor Surveillance System (BRFSS) data on binge drinking of reproductive age women (18-44 years old).
MCH reports the incidence of FAS through the birth defects information system.

Infrastructure Building Services:
MCH provides leadership and education to bring awareness to the importance of preconception health, abstaining from alcohol, negative effects and direct impact on birth outcomes.

c. Plan for the Coming Year
Direct Services:
Pregnant women will continue receiving services in Community Mental Health Centers and in local alcohol and drug treatment facilities on a priority basis.

Enabling Services:
Women are referred to local services to assist them in maintaining abstinence from alcohol and other substances prior to and during pregnancy. MCH grantees will provide education and resources to women of reproductive age and pregnant women to abstain from alcohol and other substances during.
MCH staff is working with partners in DCF on a plan to educate health care providers on benefits of providing screening, brief intervention, referral and treatment (SBIRT) process to women of childbearing age in their practices with respect to those who may be using tobacco, alcohol or other substances.

Population Based Services:
MRFASTC trained MCH staff will provide annual trainings on the identification, diagnosis and treatment of FASD's in Kansas.MCH provides access to evidence-based research, FASD awareness and prevention resources from the FASD Center for Excellence and Fetal Alcohol Syndrome Community Resource Center websites to all interested stakeholders.
MCH promotes awareness for the prevention of FASD statewide in a variety of settings with stakeholders. MCH staff will receive annual MRFASTC training to help maintain capacity to provide quality education on the science behind FASD prevention. MCH will encourage local grantees to participate in an FASD Awareness Day event for September 9 to elevate awareness of FASD to enlist more support for statewide prevention efforts in concert with NAFSC member states. MCH staff will collaborate with Kansas Leadership to Keep Children Alcohol Free Coalition in promoting prevention efforts in schools and other settings and in preparing briefs for legislators of the impacts of underage drinking.

Infrastructure Building Services:
KDHE reports FAS in its birth defects information system with ongoing improvements being made to the system. KDHE monitors binge drinking data for women of reproductive age using BRFSS data.

State Performance Measure 3: *The percent of live births that are born preterm less than 37 weeks of gestation.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				9.1	8.6
Annual Indicator	9.3	9.2	8.8	9.1	9.1
Numerator	3873	3804	3534	3598	3598
Denominator	41747	41313	40381	39593	39593
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	8.6	8.4	8.4	8.2	8.2

Notes - 2011
The 2010 column is populated with 2009 data. 2010 data will be available Fall 2011.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

a. Last Year's Accomplishments
Reducing premature births is a Kansas MCH priority in MCH 2015, the Kansas MCH Five-Year Needs Assessment. In 2011, the preterm birthrate, those occurring before 37 weeks gestational age, was lower in Kansas than the U.S. [9.09% and 11.72% (preliminary), respectively]. The Kansas prematurity rate met the Healthy People 2020 goal of 11.4%. Among racial/ethnic groups, the black non-Hispanic prematurity rate was 53.4% higher than the white non-Hispanic rate (13.5% and 8.8%, respectively). Hispanic premature births (8.5%) were lower than the State average. During 2002-2011, Poisson Joinpoint regression analysis showed an increasing trend over the interval 2002-2004 (APC=4.79) followed by a statistically significant decreasing trend from 2004-2011 (APC=-1.11).

Direct Services:
Pregnant women who screened positive for tobacco use received referrals to the Kansas Tobacco Quitline (Quitline) and to available tobacco cessation clinical provider services.

Enabling Services:
MCH grantees continued a partnership with the Kansas Tobacco Use Prevention Program (TUPP) to screen and make referrals to locally available tobacco cessation services for pregnant women and women of reproductive age. Use of the Quitline, local tobacco cessation services and activities of local community coalitions helped assure education and support to help pregnant women quit using tobacco.
MCH home visitation staff provided outreach services to pregnant women and their families offering support, education and referrals to smoking cessation resources.
KDHE's Center for Health Equity built on momentum from last year's "A Healthy Baby Begins with You" campaign by using social and other electronic media channels to promote a theme of

healthy babies in Kansas by presenting health information to women and communities in an engaging manner.
MCH supported the March of Dimes promotion of the National Birth Defects Prevention Network's campaign to increase use of folic acid.

Population Based Services:
MCH staff continued to promote use of text4baby and other outreach efforts to women in typically hard to reach communities with positive messages that promoted healthy pregnancies.
The KDHE Center for Health Equity sponsored presentations on the national Culturally and Linguistically Appropriate Services (CLAS) standards to support improvements in client services through health literacy and cultural competency in an effort to decrease gaps in prematurity, low birthweight and infant mortality between various racial groups at the annual Governor's Public Health Conference.

Infrastructure Building Services:
MCH staff provided prenatal risk assessment tools and online resources for local programs use.
MCH continued to monitor local and state-wide smoking/tobacco cessation ordinances and legislation.
KDHE continued to support the March of Dimes on-going Prematurity Awareness Campaign.
MCH participated in activities related to formation of the Kansas Perinatal Quality Collaborative that was coordinated by the Kansas March of Dimes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH grantee agencies and local prenatal care providers provide screening, counseling and referral services for pregnant women and women of reproductive age.	X			
2. MCH Healthy Start Home Visitors provided outreach, education and support to women to promote healthy pregnancies.		X		
3. Kansas promotes text4baby free healthy text messaging service for outreach to pregnant women in high-risk populations .		X	X	X
4. Public and health care providers are provided information and education resources that identify contributing factors leading to preterm birth, low birthweight, and infant mortality.			X	X
5. MCH participates in Kansas Perinatal Quality Collaborative, Kansas Blue Ribbon Panel on Infant Mortality and Healthy Kansans 2020 to decrease number of infants born prematurely and infant mortality.				X
6. MCH participates with the KDHE Center for Health Equity in efforts to target and work with disparate populations in Kansas where prematurity is an issue.		X	X	X
7. Pregnant women who use tobacco utilize services of the Kansas Tobacco Quitline.		X		
8. . MCH staff and partners provide local health care professionals with tools on prenatal risk assessment and access to other information to improve the health of women of childbearing age.		X		X
9. KPQC develops plans to address prematurity through various quality improvement initiatives.				X
10.				

b. Current Activities
Direct Services:
Pregnant women are referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services.

Enabling Services:
The Kansas text4baby partnership has grown in capacity to 20 local partners that have reached about 7,600 pregnant women and new moms with health-related messages focused on pregnancy and women's health, child health and safety.

Population Based Services:
MCH participates with the KDHE Center for Health Equity (CHE) in efforts to target and work with disparate populations in Kansas on topics that will positively impact the prematurity rate. The current campaign is called Healthy Babies are Worth the Wait with a Facebook page.

Infrastructure Building Activities:
MCH and other KDHE staff participated in efforts with local communities working on infant mortality issues using PPOR and FIMR methodologies.
MCH supports the work of the March of Dimes, Kansas Blue Ribbon Panel on Infant Mortality and Center for Health Disparities in raising awareness of prematurity issues in Kansas.
March of Dimes coordinated formation of the Kansas Perinatal Quality Collaborative (KPQC). The KPQC is dedicated to improving perinatal health in Kansas in a multi-stakeholder effort to improve service quality and access to care for women and infants. KDHE's Kansas Health Matters and other data resources are used to support community health assessment and health improvement activities to address preterm birth.

c. Plan for the Coming Year
Direct Services:
Pregnant women who use tobacco will continue to be referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services.

Enabling Services:
MCH will promote the text4baby program to physicians and other local health care practitioners and participate in the annual national enrollment contest with its partners.

Population Based Services:
MCH will continue its work in providing website updates to include more comprehensive and user-friendly information and tools for local health care providers, the public and other stakeholders interested in reducing prematurity.
MCH staff will support the work of the CHE at KDHE in promoting the development of a network of peer-to-peer mentors providing education and support to young women in communities with high rates of low birth weight and infant mortality.

Infrastructure Building Services
MCH staff will participate with the Kansas TUPP on strategies to increase smoking cessation among women of childbearing age and pregnant women.
MCH will partner with the Kansas Fatherhood Coalition in promoting the message that there is "no safe amount of alcohol use during pregnancy," and other health-related messages and how fathers can support the women in their lives to make healthier choices.
MCH staff will work with the KPQC to develop a work plan and to move forward with quality improvement projects. One of their likely first projects is to work with the Kansas Health Care Collaborative Hospital Engagement Network (HEN) in reducing early elective deliveries. This project would leverage the communication provided by CHE's public health campaign, "Healthy

Babies are Worth the Wait" and serve to reduce the number of preterm births in Kansas.

State Performance Measure 5: *The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				63	63
Annual Indicator	61.3	61.3	61.3	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2011/2012	National Survey Of Children's Health, 2011/2012
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	62	62	64	64	66

Notes - 2012
DATA SOURCE:
National Survey of Children's Health. NSCH 2011/2012. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Notes - 2011
DATA SOURCE:
National Survey of Children's Health. NSCH 2011/2012. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Notes - 2010
DATA SOURCE:
National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Data for 2010 is not availabe so 2007 data was used to pre-populate this field.

a. Last Year's Accomplishments
According to the 2011/2012 National Survey of Children's Health, the care received by 59.1% of Kansas children met this medical home standard, compared to 54.4% for the U.S. This varies substantially by household income in Kansas: 42.6% of children in households with incomes at less than 100 percent of the Federal poverty level ($22,350 for a family of four in 2011) had a

medical home, compared to 69.2% of children in households at or above 400 percent of the Federal poverty level. Receipt of care from a medical home also varies by race and ethnicity. Non-Hispanic white children are the most likely to receive care in a medical home (67.3%), followed by non-Hispanic black children (43.0%). Hispanic children are the least likely to have a medical home (35.4%).

Direct Services:
MCH grantees assessed each client they served for medical home. If none reported, then grantees would either assist clients in filling out medical insurance applications or refer them to DCF outreach workers for this service.

Enabling Services:
MCH grantees linked clients to local mental health, medical, dental and social services through Healthy Start Home Visitors (HSHV) who provided outreach to families in their communities. MCH staff provided technical assistance to local grantees in how to measure medical home as an outcome objective for reporting purposes. MCH grantees worked with Farmworker Health programs to link pregnant women with health resources.

Population Based Services:
The Kansas Head Start Association provided two annual Basic Home Visitation trainings for new HSHV and other State home visitation program staff. Medical home and the facilitation of linkages and referrals to local services for their clients was one focus of these trainings.

Infrastructure Building Services:
KanCare, the Kansas Medicaid Program, including SCHIP was rolled out this year. All three Kansas MCO's were fully engaged in a process of making sure physicians in all parts of Kansas were signed up with them. As part of the program rollout, listening tours were provided across the State to get out information about KanCare and to hear back from various parts of the State about any concerns or comments they might have.
MCH staff collected data that served as a proxy measure for medical home from local grantees.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adapt resources within KDHE to measure medical home.				X
2. MCH grantees assess clients served for medical home and provided assistance in linking them with local health and family services.	X	X		
3. Kansas promotes text4baby free healthy text messaging service for outreach to pregnant women in high-risk populations to promote medical homes.		X	X	
4. Healthy Start Home Visitors work with clients to help them gain understanding of navigating the health care system and in gaining access to health care services.		X		
5. Kansas has legislation (KSA 75-7429) that defines medical home that became effective July 1, 2008.				X
6. MCH collects proxy medical home data in its data system to measure grantees' progress on this objective.				X
7. MCH staff provides technical assistance and professional education homes to local MCH grantees and health care providers on the importance of access to medical.				X
8. MCH staff will reassess how its data system collects medical home data and implement any improvements that are feasible.				X

9. MCH grantees worked with Farmworker Health programs to link pregnant women with health resources.		X		X
10.				

b. Current Activities
Direct Services:
MCH grantees assessed clients served for medical home and provided assistance in linking them with local health and family services.

Enabling Services:
HSHV works with clients to help them gain an understanding of and navigating the health care system and in gaining access to health care services. MCH staff provides technical assistance to local grantees in working toward increasing the percentage of clients served in a medical home.

Population Based Services:
Basic Home Visitation trainings are provided by the Kansas Head Start Association to train HSHV and other State home visitation program staff on the importance of medical home and the facilitation of linkages and referrals to local services for their clients.

Infrastructure Building Services:
Kansas has legislation (KSA 75-7429) that defines medical home that became effective July 1, 2008. MCH collects proxy medical home data in its data system to assist in the measurement of grantees' progress on this objective.

c. Plan for the Coming Year

Direct Services:
MCH grantees will assess clients for medical home and provide assistance in linking them to local medical and family services according to need.

Enabling Services:
MCH staff will continue to provide technical assistance to local grantees in working toward the objective of assisting clients they serve in obtaining a medical home. MCH grantees will assist clients in filling out KanCare application forms or in referring them to DCF outreach workers for same. MCH staff provides technical assistance and professional education on the importance of access to medical homes to local MCH grantees and health care providers.

Population Based Services:
KanCare will serve as the Medicaid/SCHIP program for Kansans who qualify for its services.
Local school districts will assist in promoting KanCare to parents who may qualify for services during Kindergarten round-up and school enrollment events.
MCH staff provides a list of pregnant women on Medicaid to its grantees in an effort to provide targeted outreach to populations at high-risk for poor birth and health outcomes.

Infrastructure Building Services:
MCH staff will monitor and evaluate data from the National Survey of Children's Health on medical homes. MCH staff will participate in meetings with various statewide partners including representatives from the local health department association, school nursing, child care provider organizations, faith-based and other community-level organizations that will lead toward development of a system to provide outreach, identification and referral services for eligible children in KanCare.
MCH staff will reassess how its data system collects medical home data and implement any improvements that are feasible.

State Performance Measure 6: *The percent of high school students who had at least one drink of alcohol during the past 30 days.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				37	37
Annual Indicator			38.7	32.6	32.6
Numerator					
Denominator					
Data Source			YRBS, 2009	YRBS, 2011	YRBS, 2011
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	30	30	28	28	26

Notes - 2012
DATA SOURCE:
CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2011.
http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.

Notes - 2011
DATA SOURCE:
CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2011.
http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.

Notes - 2010
DATA SOURCE:
CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2009.
http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS

a. Last Year's Accomplishments
According to the 2011 Kansas Youth Risk Behavior Survey (YRBS), fewer students reported having at least one drink of alcohol (32.6%) on at least 1 day during the 30 days before the survey compared to the 2009 Kansas YRBS survey (38.7%).

Direct Services:
Law enforcement officials and community alcohol prevention centers provided enforcement of alcohol-related laws and cessation services for those who become addicted to its use.

Enabling Services:
Information and resources on alcohol use and preventive services available in Kansas are provided to school nurses, MCH grantees and teachers through newsletter articles and routine communications. SADD events are promoted among stakeholders interested in preventing underage drinking.
Safe Streets coalitions in communities across Kansas serve to educate and inform parents and teenagers of the dangers of alcohol use and of the laws that exist to protect families from the inappropriate handling and use of alcohol.

Population-Based Services:
Students Against Destructive Decisions (SADD) students and their sponsors received leadership training including information on capacity building, refusal skills, peer mentoring, using media to promote positive youth development and Kansas laws.

Kansas State Department of Education (KSDE) staff presented on alcohol use and related risky behavior at the summer HIV/AIDS/STD conference that MCH staff helped plan.

Infrastructure Building:
MCH staff participated in the Kansas Family Partnership's (KFP) committee, Kansas Leadership to Keep Children Alcohol Free, which includes members from Kansas Highway Patrol, KSDE, Kansas Department of Transportation, Kansas Sheriff's Association, Kansas SADD Chapter, Kansas State Nurses Association, Kansas Legislature, American Indian Tribal Council, American Automobile Association (AAA) of Kansas, Kansas Funeral Home Directors, Addiction and Prevention Services, local school districts and drug and alcohol treatment centers.
MCH staff participates as active members of the Kansas Speakers Bureau on the prevention of Fetal Alcohol Spectrum Disorders (FASD). MCH staff received training through the Midwest Regional Fetal Alcohol Syndrome Training Center (MRFASTC) in Kansas.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase stakeholder knowledge of adolescent health issues related to alcohol consumption and risky behavior.			X	X
2. Participate in activities of the Kansas Leadership to Keep Children Alcohol Free to leverage funds from several groups in an effort to decrease underage alcohol use.			X	X
3. Continue development of peer educator role program model with SADD chapter leaders that educate teens and parents.			X	X
4. Educate public and private partners and families on issues associated with underage consumption of alcohol and available prevention and treatment resources.		X	X	X
5. Make available information on training school/community members on how to establish SADD chapters in schools.			X	X
6. Assess Kansas Leadership to Keep Children Alcohol Free committee's membership to help ensure a broad representation of statewide stakeholders.				X
7. MCH staff serves as State Coordinator with NAFSC.				X
8. Kansas laws prohibit the sale, possession and consumption of alcohol by anyone under age 21 years and social hosting laws.				X
9. Law enforcement and community prevention centers provide enforcement and cessation services to teens and parents.		X		
10. Develop State capacity to better address FASD prevention.				X

b. Current Activities

Direct Services:
Law enforcement officials and community alcohol prevention centers provide enforcement of alcohol-related laws and cessation services for addicted teens.

Enabling Services:
Resources on alcohol use and prevention are provided to MCH grantees and shared among interested stakeholders through newsletter articles, the Web and routine communications. SADD events are promoted among stakeholders interested in preventing underage drinking in schools.

Population-Based Services:
MCH staff provided FASD training to SADD groups and providers that work with teens on FASD prevention in the children of adolescents. MCH staff also provided this training to Healthy Start

Home Visitors and Topeka area United Way service providers giving them resources and tools to use with the families they serve.

Infrastructure Building Services:
KDHE staff participated in the KFP's Kansas Leadership to Keep Children Alcohol Free committee that addressed underage alcohol use issues, alcohol-related legislation and assessed impacts from member activities. The committee reviewed and updated educational materials like pamphlets and fact sheets that are distributed to various community and parent groups.
MCH staff serves as the Kansas coordinator for FASD with the National Association of Fetal Alcohol Spectrum Disorders State Coordinators (NAFSC) in collaboration with the FASD Center for Excellence under the Substance Abuse and Mental Health Services Administration (SAMHSA).

c. Plan for the Coming Year
Direct Services:
Law enforcement officials and community alcohol prevention centers will provide enforcement of alcohol-related laws and cessation services for those who become addicted to its use.

Enabling Services:
SADD chapters will engage students and parents in promoting positive activities for youth and providing them with education on the impact of underage alcohol consumption.
MCH staff will provide current research and resources related to the prevention of underage alcohol consumption and alcohol-exposed pregnancies using a variety of electronic and print materials by pooling its resources with those of partnering organizations.
MCH staff will provide FASD prevention trainings to any interested stakeholder groups.

Population-Based Services
KSDE and MCH staff will continue to collaborate on trainings focused on adolescent risky behaviors and alcohol use by minors at annual HIV/AIDS/STD conference.

Infrastructure Building Services:
MCH staff will address the prevention of alcohol-exposed pregnancies to stakeholders currently involved with a variety of topics that have an impact on perinatal health: Kansas Perinatal Quality Collaborative, Kansas Maternal and Child Health (advisory) Council and local perinatal quality collaboratives and FIMR groups.
MCH staff will serve as Kansas Coordinator with NAFSC to work toward developing state capacity to fully address FASD prevention (FASD Task Force) and evidence-based training on screening, brief intervention, referral and treatment (SBIRT) for health care providers caring for women of reproductive age at risk for alcohol-exposed pregnancies.

State Performance Measure 7: *The Percent of children who are obese.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				13.1	12.6
Annual Indicator	13.3	13.2	13.0	12.8	12.8
Numerator		4878	4919	4803	4803

Denominator		36956	37838	37523	37523
Data Source	Kansas PeNSS, 2008	Kansas PeNSS, 2009	Kansas PeNSS, 2010	Kansas PeNSS, 2011	Kansas PeNSS, 2011
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	12.4	12.2	12	12	11.8

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

Notes - 2011
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2012(Kansas WIC database).

Notes - 2010
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2010(Kansas WIC database).

a. Last Year's Accomplishments
According to the 2011 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families (below 185% of poverty level) participating in WIC, 12.8% of low-income children ages 24-59 months in Kansas were obese (above 95%). Kansas prevalence (12.8%) was significantly lower than the prevalence nationally (14.4%). Over the 10-year period (2002-2012), there was an increasing trend during 2002-2004, since 2004 a downward trend observed. For both periods, the annual percent changes (APCs) were not significant.

Infrastructure Building

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

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

Surveyed school nurses to assess if children are being weighed, measured and referred, as appropriate.

Two state staff attended the 2012 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

Population Based Services

Participated in the development of a targeted media campaign aimed at reducing sugary drinks in the diet of tweens in Shawnee County.

Approximately 270 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2012. The conference featured a keynote presentation on "Healthy People 2020."

Enabling Services

Participated on the Kansas Governor's Council on Fitness.

Participated in planning and promotion of the 2012 Statewide Obesity Summit.

Worked with the Bureau of Health Promotion (BHP) to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was held on May 4, 2012.

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

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

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities

Infrastructure Building

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

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

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

University of California Davis Human Lactation Center Baby Behavior train-the-trainer was attended by 2 State and 2 LHD staff. This program discourages overfeeding and future overweight.

Collaborate with federally funded nutrition programs to identify opportunities for coordination to meet overall maternal and child health nutrition goals by participating in NuPAC.

Survey school nurses to assess if children are being weighed, measured and referred, as appropriate.

Population Based Services

Work with BHP to develop food procurement standards.

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

Enabling Services:

Participate on Kansas Governor's Council on Fitness

Work with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was scheduled for May 3, 2013.

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

c. Plan for the Coming Year

Infrastructure Building

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

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

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

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

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

Survey school nurses to assess if school-aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters and referring to the health care provider will be covered in newsletters and trainings.

Develop and implement a Kansas Baby Behavior staff training based on the University of California Davis Human Lactation Center model.

Population Based Services

Work with the BHP and other stakeholders to design and promote consistent and culturally appropriate nutrition and physical activity messages.

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

Enabling Services

Participate on the Kansas Governor's Council on Fitness.

Model health education and physical activity for 3rd grade students in Kansas, by working with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

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

State Performance Measure 9: *The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				84	84
Annual Indicator			84	83.5	83.5
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005/2006	National Survey of CSHCN, 2009/2010	National Survey of CSHCN, 2009/2010
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	85	85	86	86	87

Notes - 2012
DATA SOURCE:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

Notes - 2011
DATA SOURCE:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

Notes - 2010
DATA SOURCE:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2005/06. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 52.7% of Kansas youth with special health care needs (YSHCN), 12-17 years, received the services necessary to make appropriate transitions to adult health care, work

and independence and 83.5% reported that their doctors or other health care providers usually or always encouraged them to take responsibility for their health care needs, such as taking medication, understanding their diagnosis, or following medical advice.

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

ES: Staff with the KS Family-to-Family Health Information Center (F2F) assists families with the development and use of a personal healthcare notebook, the CareING notebooks. The Family Advisory Council developed a series of transition checklists for parents of children 0-6, pre-teens and teenagers age 7-13, and youth and young adults ages 14-19. These booklets cover a variety of topics, including health, education, employment, community living, and more. The appropriate booklet in the series is included in each CareING notebook provided to the families.

PBS: Through a partnership with Families Together, transition-related issues were embedded into regional and statewide conferences for parents/families, educators, community and health providers, and other interested parties. A strong focus on engaging youth early and providing resources to parents prior to the formal transition period was evident.

IBS: The D-70 ICS grant shifted from addressing transition and medical home as separate activities to a focus on transition within the medical home. This includes how youth, families and providers can be effective partners in this model. This model incorporates a variety of components to support capacity and infrastructure building in Kansas, including: the Parent Support Navigator project; the JumpStart project; a self-determination curriculum; partnership with the Heartland Genetics Collaborative; and individualized healthcare plans.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the KS F2F program to disseminate information about transition through the CARing Medical Notebooks.		X	X	
2. Work with CYSHCN Family Advisory Council members to develop and disseminate transition resources and information to families and providers.		X	X	X
3. Develop and disseminate tools and resources that can support youth transition and engaging children and youth early in their transition planning.		X		
4. Dissemination of the Kansas Health Care Transition Model to providers and other stakeholders.			X	X
5. Continue collaborations with the Center for Child Health and Development to maintain up-to-date and valuable information about transition resources on the Building a Life Kansas Transition website.				X
6. Partner with the Kansas Youth Empowerment Academy to transition the Youth Advisory Council to a Youth Leadership program.		X	X	X
7.				

8.				
9.				
10.				

b. Current Activities
Continue previous year activities.

PBS: The Kansas Transition website was launched. This website is dedicated to families to navigating transition. The website includes resources, tools and stories to aid families in supporting youth transition related to the following six transition-related topics: Life in the Community; Your Home; Work; School; Health; and Circle of Support. The website is housed at the University of Kansas Medical Center, Center for Child Health and Development for ongoing technical support and sustainability.

IBS: The CYSHCN Youth Advisory Council underwent a transition with a stronger focus on youth leadership. The group shifted to a youth leadership committee, Leaders Advocating for Youth Resource and Supports (LAYRS) in which they were responsible for developing a structure for the committee and planning additional youth-outreach activities across the state to empower other youth and support leadership and growth through coordinating multiple community-wide youth outreach activities. These additional activities were to be planned, coordinated, and hosted by LAYRS, with support and assistance from KYEA and KDHE.

c. Plan for the Coming Year
Continue previous year activities.

ES: Continued focus on dissemination of FAC transition materials. Additionally, the FAC is writing a white paper to share with medical professionals, specifically medical school students, related to raising a child with special health care needs. This paper will touch on a variety of subjects, transition being a central focus and how medical providers can support youth in a stronger way, providing anticipatory guidance, and support to youth and their families in independent living and community-based services. The paper will be disseminated to a wide range of providers (both medical and community), advocates, students, and consumer. Strategies for distribution include word of mouth, social media, assigned reading for medical professionals in school, continuing education, series of webinars, and other methods.

IBS: The Kansas Youth Empowerment Academy and KDHE will work together to determine a new program to support youth leadership development. It is identified that the existing format of the council was no longer cost-effective. However, a continued desire to support youth transition, leadership development, and self-advocacy skill building is evident in Kansas. Over the next year, the program and partners will review several leadership programs -- including existing youth, adult and public health professional programs -- to identify a blended format that can be developed in Kansas. This would build on initiatives and efforts youth may experience through the Youth Leadership Forum already supported by KYEA. This new leadership program will be available to youth of all disabilities and all ages. It is expected that internship opportunities will be identified and pursued in the development of this program, to promote employment upon completion of the program.

State Performance Measure 11: *The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.*

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator			46.6	65.1	49.5
Numerator			41	41	45
Denominator			88	63	91
Data Source			SoundBeginning, 2010	SoundBeginning, 2011	SoundBeginning, 2012
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	66	66	68	68	70

Notes - 2012
Data Source: SoundBeginnings Program data, 2012
Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
Denominator = Number of infants identified with PCHL

Notes - 2011
Data Source: SoundBeginnings Program data, 2011
Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
Denominator = Number of infants identified with PCHL

Notes - 2010
Data Source: SoundBeginnings Program data, 2010
Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
Denominator = Number of infants identified with PCHL

a. Last Year's Accomplishments
Hearing loss is the most common congenital anomaly found in newborns and 2-3 in 1,000 births will be diagnosed with some degree of hearing loss each year. 90-95 % of babies with hearing loss are born to parents who have normal hearing. Any degree of hearing loss can be educationally handicapping for children. In 2011, 66 babies were identified through the newborn hearing screening program as having some degree of hearing loss. All children residing in Kansas, birth to three years of age, identified with any type or degree of hearing loss are eligible for Early Intervention services. 3 Infants were not eligible for services because they did not reside in Kansas. 40 of the 63 (63%) babies that were identified with hearing loss were enrolled in early intervention services before the recommended Joint Committee on Infant Hearing (JCIH) guidelines of 6 months of age. 76% of the 63 babies identified, with age not factored, were enrolled in early intervention services receiving the appropriate services for the normal development of speech and language. Enrollment in Early Intervention before 6 months of age increased at a rate of 13% than that in 2010 and is 13% higher than the national average for 2011. The first three years of life is the most critical period in the development of speech and language. Research indicates if early identification before 3 months and intervention before 6 months of age, children with hearing loss have language development that is comparable to their age peers when they are three to eight years old. Great measures have been implemented throughout the past several years that have proven to be indicators in reducing the LFU/LTD.

SoundBeginnings (SB) continues to provide Infant-Toddler programs with ongoing technical

assistance in the use of the equipment, reporting, referrals, and providing any information to the program that will assist in increasing their rates of children identified with hearing loss enrolled before 6 months of age. It is felt that this collaboration was a large asset to the decrease in the percentage of those infants lost to follow-up and documentation.

ES: Collaborated and provided direct referrals to local tiny-k early intervention networks when a child is identified with hearing loss. Family Support Consultant calls from parents of previously identified children to newly identified parents for support and assistance with resources and to emphasize the importance of early intervention on the child's speech and language development. Continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization.

PBS: Infants identified with hearing loss, residing in Kansas, were referred into Infant Toddler Early Intervention programs.

IBS: SoundBeginnings staff continues to focus on maintaining the national JCIH goals for Early Intervention and improve the understanding of the benefits of early intervention to all professionals touching the lives of our children and to improve the health and quality of life for children with hearing loss and their families in Kansas. The staff attends the annual Early Hearing Detection and Intervention Conference each year to be a part of an amazing collaboration of health care and early intervention service providers, families, and state and national representatives who join forces to exchange best practices, discuss program improvement and raise awareness of successful strategies for improving the early hearing detection and intervention process at state and local levels.

SB-EHDI Advisory Committee meets quarterly to review, endorse, provide guidance and promote elements of the state EHDI program. The members of the advisory committee representing a varied group of early interventionists including the State Part C Coordinator, an Early Intervention Network Coordinator, a Deaf Educator, an Early Childhood Teacher of the Deaf and Hard of Hearing, a representative of Kansas Special Education Services, the Birth to Three Coordinator for the Kansas School for the Deaf, the Kansas Deaf/Blind Project Coordinator, a Birth to Three Speech Language Pathologist, a Pediatric Audiologist, several Mothers of Deaf and Hard of Hearing Children, and a Pediatrician and Chapter Champion representative for the American Academy of Pediatrics. Continued collaboration with these state agencies ensures and endorses the EHDI mission, goals, and objectives.

Table 4b, State Performance Measures Summary Sheet

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

families at first contact.				
9. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations.				X
10. Continued attendance at EHDI, parent support and deaf education focused meetings				X

b. Current Activities
Continued previous year activities.

ES: Collaboration with Pediatric Audiologists, Kansas Infant-Toddler Services (Local tiny-k programs), Kansas School for the Deaf, Hartley Family Center, Parents As Teachers, Early Head Start and family support organizations.

PBS: Early Intervention referral services are implemented at the local level by birthing facilities, SoundBeginnings, and Medical Home providers for any child birth to three years of age with a diagnosed hearing loss.

IBS: Support through grants is ongoing for reducing loss to follow-up and loss to documentation and tracking, surveillance and integration. SoundBeginnings Advisory Committee meets quarterly to incorporate, collaborate and disseminate education materials to professionals and parents.

Support to Early Intervention programs through educational OAE Hearing Screening trainings, technical assistance and presentations.

c. Plan for the Coming Year
ES: Continued assistance with the Kansas Hands and Voices Chapter family support organization groups specifically for families of children who are deaf or hard of hearing to promote Parent-to-Parent program services to families, assist with family support activities and assist parent consultants. Continue collaboration with Pediatric Audiologists, Kansas Infant-Toddler Services (Local tiny-k programs), the Kansas School for the Deaf, Hartley Family Center, Parents As Teachers, Early Head Start and family support organizations. Provide resources to parents upon child being newly identified with hearing loss regarding resources state and nationwide. Distribute letters to parents if their child has not been enrolled in services before 6 months of age to seek explanation as to why the child is not receiving early intervention services or if the child is receiving services through a private sector. Provide Pediatric Audiologists with packets of early intervention services to give the parents upon diagnosis.

PBS: Maintain and continue to make improvements to ensuring that children identified with hearing loss receive early intervention services before 6 months of age through the statewide data management tracking and surveillance system.

IBS: Continued referrals to Infant-Toddler Services and accept the required Healthy People 2020 data fields including race, ethnicity, language spoken in the home, and birth defects.

Collaborate with the Kansas School for the Deaf, Infant Toddler Services, University of Kansas Deaf Education program, tiny-k networks, WIC, Healthy Start Home Visit programs, Hartley Family Center, and Sound Start to provide assistance and training for personnel at tiny-k networks working with families of children identified with hearing loss and develop a regional program to assist in first contacts with families.

SoundBeginnings Newborn Hearing Screening Program Advisory Committee will continue to meet quarterly. The committee has established goals for the Advisory year which begins in

January including parent communication and family concerns; focus on education to all members involved in early intervention and including the focus of the family perspective. Staff, parents, and Pediatric Audiologists will continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	7.2	7.3	7.1	7.2	7.2
Numerator	3014	3021	2867	2867	2867
Denominator	41804	41378	40429	39628	39628
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

Notes - 2011
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Narrative:
Reducing births with low birth weight (LBW) is a Kansas maternal and child health (MCH) priority in the MCH2015, the 5-year state MCH needs assessment (2011-2015). In Kansas, the percent of LBW increased slightly in 2011 to 7.2% from 7.1% in 2010. Kansas' low birth weight percentage has been slightly lower than the national average (7.2% and 8.1% (preliminary), respectively, in 2011). This remains/is below the Healthy People (HP) 2020 goal of 7.8%.

Regardless of maternal race and ethnicity, LBW is associated with a small percentage of live births but a disproportionate large percentage of infant deaths. In 2011, among the infant deaths where birth weight was known, 64.9% (157) of infants who died were LBW. This compares to 7.2% for all live births at LBW. Non-Hispanic black women are more likely than non-Hispanic white women to give birth to a LBW infant (13.5% and 6.7%, respectively, in 2011). In 2011, 78.9% of infants who died who were born to non-Hispanic black mothers were LBW, compared with 63.0% of infants of non-Hispanic white mothers.

Due to the high mortality (and morbidity) among infants born too small, LBW is a very important issue in Kansas as noted above. Access to care in the rural areas is another important concern. In 2011, the population density of Kansas was 35.1 persons per square mile compared with 88.2 persons per square mile for the U.S. The county population density ranged from 1,168.2 persons per square mile in Johnson County in eastern Kansas, Kansas City area, to less than six persons per square mile in western Kansas counties. Low birthweight and access to care in rural areas are important public health concerns in Kansas.

The risk of delivering a LBW infant is greater among non-Hispanic black mothers compared to non-Hispanic white mothers and differs by maternal age, with the highest risk for infants born to the youngest and oldest mothers regardless of race in Kansas.

F. Other Program Activities

State MCH program activities have considerable breadth. Many fall outside the parameters of priority needs and National and State performance measures. Some make significant contributions to the health and well-being of mothers and infants, children, and CYSHCN.

/2014/ Kansas Perinatal Quality Collaborative (KPQC): KPQC was formed as the result of a coordinated effort by the Greater Kansas Chapter of the March of Dimes and various Kansas perinatal health care stakeholders. The KPQC's goal is to improve service quality and access to care for women and babies in Kansas. This is to be achieved by assuring quality perinatal care using data-driven, evidenced-based practices and quality improvement processes.

Kansas Blue Ribbon Panel on Infant Mortality (Panel): The Panel consists of 22 representatives from state, local, and private organizations who have a broad range of expertise in maternal child health. It was originally formed in 2009 in response to Kansas' ranking of 40 out of the 50 states in infant mortality and its ranking of 50 out of the 50 states in black infant mortality. The Panel continued to make strides in its quest to decrease the rate of infant mortality in Kansas in 2012 as evidenced by the Healthy Babies are Worth the Wait awareness campaign, the formation of the KPQC and the establishment and continued work of various community collaboratives focused on the reduction of infant mortality.

Center for Healthy Equity (CHE): CHE and KIDS Network, Inc. coordinate multi-year statewide health promotion campaign on infant mortality. The campaign has a preconception health focus that is important for all women of reproductive age in order to promote awareness of steps that can be taken to support better health and better health outcomes which ties to the theme from the national Office of Minority Health campaign - "A Healthy Baby Begins With You" for which Tonya Lee Lewis (wife of film director Spike Lee) is the celebrity spokesperson. Within the universe of women, however, we want to make sure that we direct campaign messages through the Blue Ribbon Panel on Infant Mortality partners who are connected to women regardless of race or ethnicity who are under 24 years of age, single, with less than high school education - the population that is at higher risk for infant mortality.

High 5 for Mom&Baby Project: High 5 for Mom&Baby Project was initiated through efforts of KDHE and the Kansas Breastfeeding Coalition, Inc. and is funded by the private foundation United Methodist Health Ministry Fund. The project is designed to help Kansas hospitals develop and implement policies and procedures that help mothers successfully initiate and continue to breastfeed after leaving the facility. Hospital staff receives training

on five evidence based practices that improve breastfeeding success. Staff can also receive scholarships to become International Board Certified Lactation Consultants. Twenty hospitals are in the process of being trained and developing policies and procedures to implement High 5.

The Kansas Breastfeeding Coalition, Inc. (KBC) works to improve the health of children and mothers by increasing breastfeeding rates in Kansas. MCH collaborates with the KBC on a variety of projects. Projects include the Business Case for Breastfeeding -- workshops around Kansas train interested persons to assist employers in setting up lactation support for their employees who are breastfeeding. The KBC promotes, enhances and supports this project through free workshops, promotion of the project, employer grants, and employer recognition. The KBC encourages businesses throughout Kansas to support breastfeeding customers through the Breastfeeding Welcome Here Campaign. Stickers on store windows or doors let customers know that the business welcomes them. Additional projects help develop and support local (city/regional) breastfeeding coalitions through coalition building trainings and seed projects; provide education to child care providers about breastfeeding support through Child Care Provider train-the-trainer and on-line education, a joint project with KDHE Child Care Licensing, Child Care Aware and the Kansas Childcare Training Organization; and support of the largest delivering hospital in Kansas which is working toward Baby Friendly status with a Continuity of Care prenatal education and breastfeeding support project.

Kansas Nutrition Council is a statewide non-profit organization of nutrition professionals that supports improved nutrition for Kansans. The Kansas WIC program collaborates with the Kansas Nutrition Council (KNC) by providing financial support to bring recognized experts in the field of maternal and child health to speak at KNC's annual conference. In 2012 a joint conference was held with KNC and the Kansas Dietetic Association. Kansas WIC supported a speaker on breastfeeding. All of the state WIC nutritionists are KNC members and past or current Board members. KNC also provides mini-grant support for member nutrition projects, based on a grant application process. Many funded projects have centered on maternal and child health.

Special Health Services Take Spanish Class: All 13 staff in the Special Health Services (SHS) within the Bureau completed a Spanish in the Workplace - Command Spanish, course to learn basic Spanish phrases and words that would allow non-Spanish speaking staff to better communicate with our always expanding Spanish speaking population. The SHS section includes the Children and Youth with Special Health Care Needs, Metabolic Newborn Screening Follow-up, Newborn Hearing Screening, and Birth Defects Registry programs.

Heartland Regional Genetics & Newborn Screening Collaborative (Heartland) IHP Project: A new partnership between Heartland and KDHE emerged this past year with a Subcontract of the Heartland HRSA Grant # H46MC24089. Heartland Advocate Work Group identified the individualized health care plan (IHP) as an area of interest and need. At the present time the IHP is not mandated by law, however the National School Nurse Association recommends an IHP is developed for any student that requires medical attention during the school day. Previous work in Kansas found vast discrepancies across schools regarding IHP processes and protocols. The school nurse was often the sole person responsible for developing the plan and families were generally not involved in the process. Through the Kansas Integrated Community Systems (HRSA D-70) grant, an IHP template was developed with the input of families, nurses, and medical providers to assist school nurses in developing IHPs for students with health needs. Examples include children who take medications during the school day, require health monitoring, are at risk for medical crisis and require a crisis care plan, use special medical equipment while at school, or require frequent health care procedures. Heartland's efforts build on this previous work in Kansas. To date, the template was reviewed by Heartland Advocates for

use for children with genetic conditions. A webinar was held December 19, 2012 to promote the project and identify stakeholders. Currently, learning teams are being identified and will meet April 22-23, 2013 for the kickoff of the Heartland IHP Learning Collaborative. The learning collaborative process will not only support local implementation of the IHP but also inform the development of a train-the-trainer curriculum and provide data as a resource for policy change.

NEMOURS: KDHE will work as a partner with NEMOURS. Nemours and its partners will create a new resource, the National ECE Technical Assistance and Support Center for Quality Improvement (National TA Center) to provide targeted support to the learning collaboratives and participating programs and support quality improvement capacity within state ECE systems to promote additional spread and sustainability. Nemours has been an innovator in using a structured approach to training ECE providers adapted from the Institute for Healthcare Improvement's Breakthrough Series (BTS) model. The organization will build on this approach to expand the reach to ECE programs and impact on children birth to age five nationwide. The overall objective of this project is to assist licensed providers in adopting nutrition, breastfeeding support, physical activity, and screen time policies and practices through a collaborative method. Ultimately, the goal is to spread impactful, sustainable program-level policy and practice changes to transform ECE programs. This project provides an opportunity to change provider's behaviors and the understanding and acceptance of future regulation changes that promote a healthy lifestyle for Kansas children. //2014//

G. Technical Assistance

Infant Mortality Reduction

In 2009, Kansas requested and received technical assistance on infant mortality reduction with an emphasis on black infant mortality. Rosemary Fournier, from Michigan FIMR, presented to the Kansas Blue Ribbon Panel on Infant Mortality, a subcommittee of the Governor's Child Health Advisory Committee. She provided an overview of how data from PRAMS and FIMR have guided Michigan with good examples from Detroit. Then she facilitated a discussion with panelists about next steps. The panel adopted a number of recommendations which are posted on this website -- http://www.datacounts.net/infant_mortality/

During the 2010 session, they focused on changing the Vital statutes that have prohibited use of birth certificates for "follow-back" that is, for PRAMS and FIMR. The result is this law http://www.kslegislature.org/bills/2010/2454.pdf Hooray for our Panel members (especially Kansas Action for Children and March of Dimes). They worked hard to get this bill through the legislature. And there were many ups and downs. We are very grateful to them and for the technical assistance that helped moved this process along.

Birth Defects Information System

For the coming year, Kansas is requesting technical assistance from CDC. Senate Bill 418 passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects surveillance system. The statutory language is similar to that of model statutes for the State of Ohio. BCYF submitted an application to the CDC for funding of a birth defects surveillance system. The application was approved but not funded. Resources are not available to establish a surveillance system at this time. Some very limited components of a system such as a database are maintained using MCH federal funds. BFH needs CDC technical assistance to review current efforts and to make recommendations about next steps. /2012/ Two consultants from CDC visited Kansas. They reviewed existing systems with staff and senior management. They have provided Kansas with a document that outlines the steps needed to achieve a quality system for Kansas. Within funding constraints, Kansas MCH is implementing recommended steps. //2012//

/2012/ MCH/Medicaid Intragency Coordination/Collaboration

As indicated earlier in this document, ERO 38 introduced in the 2011 Legislative Session, mandates the merger of the KDHE (Title V MCH State Agency) and the Kansas Health Policy Authority (The State Medicaid Agency). Consultation with a national expert is needed to take advantage of the opportunities and to meet new challenges to MCH posed by this merger. No specific consultant has been suggested. //2012//

/2013/ Technical Assistance is requested from CDC to evaluate our current birth defects information system and to make recommendations: Vital Statistics was reengineered and we are analyzing our birth defects database and staffing needs for data collection and reporting.

Technical Assistance is requested from CDC to evaluate our current MCH/NBS information system and to make recommendations: Database and staffing needs for data collection and reporting. //2013//

/2014/ Technical assistance is requested from peer states and a national expert (no specific consultant) to develop and apply an Aid To Local (ATL) funding formula for annual grants awarded to local health departments for MCH service delivery. [Current program information and contractor requirements are online at: http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html. The allocations by county were set years ago (no formula/criteria), and awards have not changed based on population, MCH services, needs assessments, etc.]
Objective 1: Develop applicable and organized process(es) to evaluate and update ATL funding formula.
Objective 2: Apply strategic process(es) to evaluate and update ATL funding formula.
Objective 3: Finalize implementation plan for updating current ATL funding formula.
Objective 4: Discuss implications in updating current ATL funding formula (change in awards, impact, etc).
Objective 5: Provide examples of other states similar to Kansas undergoing an ATL funding formula revision. //2014//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4710420	3951063	4670131		4670131	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	3972344	3564172	3972344		3722188	
4. Local MCH Funds *(Line4, Form 2)*	4710220	4712166	4190160		4740394	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	13392984	12227401	12832635		13132713	
8. Other Federal Funds *(Line10, Form 2)*	70032836	74057661	70032836		80287199	
9. Total *(Line11, Form 2)*	83425820	86285062	82865471		93419912	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2674119	2535298	2550360		2743042	
b. Infants < 1 year old	2674120	2535298	2550360		2743042	
c. Children 1 to 22 years old	5375059	5360537	5076243		5339541	
d. Children with	2329686	1791268	2320672		2057088	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	340000	5000	335000		250000	
g. SUBTOTAL	13392984	12227401	12832635		13132713	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	97260		97260		0	
c. CISS	135813		135813		0	
d. Abstinence Education	359879		359879		359879	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	60000000		60000000		67338600	
h. AIDS	0		0		0	
i. CDC	100000		100000		0	
j. Education	4030759		4030759		4010088	
k. Home Visiting	0		0		0	
k. Other						
Family Planning	2300000		2300000		2471250	
Medicaid TPTCM					338846	
MIECHV					4172802	
NB Hearing Screening					207000	
Other-ICC,SC,SB,KRG					138000	
Project LAUNCH					850000	
WIC BF Peer Ed					400734	
Other	3009125		3009125			

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		**FY 2013**		**FY 2014**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1180342	909586	1179092		1271992	
II. Enabling Services	7258507	6594688	6929242		6780384	
III. Population-Based Services	3827857	3904743	3629085		3963147	
IV. Infrastructure Building Services	1126278	818384	1095216		1117190	
V. Federal-State Title V Block Grant Partnership Total	13392984	12227401	12832635		13132713	

A. Expenditures

/2012/ Form 3 - SFY 10 Block Grant partnership expenditures were as follows: $4,164,028 federal; $3,880,903 state; and $4,598,337 local. In comparison, for FFY 09, Block Grant partnership expenditures were: $4,718,608 federal; $4,512,530 state; and $4,782,085 local match. So, from SFY 09 to SFY 10 there were decreases in all three expenditures categories.

In SFY 10, Kansas spent federal dollars within the amount available and also compatible with the priority needs identified in the State Needs Assessment.

In SFY 10, federal MCH funding to support MCH/CYSHCN initiatives was expended within the department as follows: Office of Health Assessment $23,085; Office of Local and Rural Health $39,999; Child Care Licensing and Registration $146,775. Within the Bureau of Family Health (the MCH unit within KDHE) $475,784 in federal MCH funds was spent for staff and operating costs working in programs for Pregnant Women & Infants, and for Children & Adolescents. Staff, operating costs, and CYSHCN contracts and supplies were $1,001,064. Nutrition consultation through the WIC program was $1,800. Aid to Local agencies and contracts with providers for MCH services totaled $1,806,306.

Newborn screening follow-up expenditures (2 salaries) were $90,868. Salary and operating for one epidemiologist, the director and assistant were $203,366 while indirect costs totaled $334,907.

Federal MCH dollars have declined over the past 17 years from $5,004,067 in FFY 94 to $4,710,420 in FY 10. While this decline appears small, taking into account inflation, the Kansas federal MCH grant has lost almost half of its spending value. What cost $5 million in FFY 94, would cost $7.4 million today. To a great extent increased costs for MCH/CYSHCN have shifted to state and local governments. MCH dollars have been directed towards priority work with accountability for work performed.

For FY 10, no State dollars were expended for Pregnancy Maintenance Initiative. This funding accounts for much of the variability from year to year in state expenditures. It is routinely cut by executive branch and then some or all is restored by the legislature or vice versa. This is also the case for Teen Pregnancy Prevention.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements. However, most provide a dollar for dollar match or greater. A very few local health departments have had difficulties meeting minimal local matching requirements. We continue to monitor this situation as local budgets tighten.

Form 4 - Two other items relating to expenditures should be noted here: 1) When considering federal MCH funds only, the state meets its federal obligation of 30-30 that is, equity in funding for each of the three population groups. When considering all Block Grant partnership expenditures, the Children and Adolescent (C&A) services funding is three times the funding for CYSHCN, and 2.5 times that for Pregnant Women & Infants (P&I). The reason for this is twofold. First, CYSHCN contracts require no local matching dollars. Second, MCH grants to local communities do not require services for CYSHCN. Various solutions to address this have been proposed such as requiring CYSHCN contractors to provide a match, or require that local MCH agencies serve children with special health care needs, and/or a combination of these. Such changes are not likely to take place in the near future.

Another item worth noting is that the funding paradigm has shifted in the MCH grants to local agencies. Previously, services were weighted towards pregnant women and infants through such programs as M&I and Healthy Start Home Visitor. After consolidation of these two grants with the Child Health grants to make one MCH grant, the instruction to local agencies was to allocate resources 50% to pregnant women and infants, and 50% to children and adolescents. Since there were already other aid to local grants focusing on youth services (e.g., teen pregnancy, disparity, school health) the effect of this change was a slight over-allocation of resources to the C&A population group.

Form 5 - Direct health care expenditures are approximately 8% of the total MCH budget. Enabling

services are 50% of the overall budget with population-based at 31% and core public health at 10% each. Over the past five years of this program, there has been a shift away from expenditures for direct services towards other levels of the pyramid.

With State expenditures of $3,880,903 in FY 10, the State of Kansas is well within its required maintenance of effort requirement of $2,352,511.

Kansas meets its 75% matching requirement through use of State funds. The increase in state and local fiscal responsibility for the program has continued over the past several years.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet. //2012//

/2013/ Form 3. SFY 11 Block Grant partnership expenditures were: $3,637,101 federal; $3,408,049 state, and $3,854,940 local. There were decreases in all 3 expenditure areas from SFY 10 to SFY 11.

In SFY 11, federal spending to support MCH/CYSHCN initiatives expended within the department were: $22, 595 Office of Health Assessment, $28,534 Office of Local and Rural Health, $156,112 Office of Child Care Licensing and Registration. Within the Bureau of Family Health (MCH Section) $392,790 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $975,801. Aid to Local agencies and contracts with providers for MCH services totaled $1,675,505.

Newborn screening follow-up expenditures (2 salaries) were $77,395. Salary and operating for one epidemiologist, director and assistant were $86,309. Indirect costs totaled $203,009.

Federal MCH dollars have declined over the past 18 years. To an increasing extent, costs for MCH/CYSHCN have shifted to state and local governments. This shift is increasingly more difficult to sustain.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements. We continue to monitor this as local budgets tighten.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Including all Block Grant partnership expenditures, the Children & Adolescent services funding is 3 times the funding for CYSHCN and 2.5 times the funding for Pregnant Women & Infants. CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 51% of the overall budget. Population based services are 31%, and core public health at 10%. The shift of expenditures from direct services toward other pyramid levels continues.

The State Kansas is well within its required maintenance of effort of $2,352,311 with expenditures of $3,408,049 in SFY 11.

Kansas meets its matching requirement of $3 state/$4 federal through the use of State funds. Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached spreadsheet. //2013//

/2014/

2011 Expenditures Updated:

Form 3. SFY11 Block Grant partnership expenditures were updated as part of this application: $4,670,131 federal; $3,695,620 state; and $5,093,392 local. Total MCH expenditures are $13,459,143. During SFY11, federal spending to support MCH/CYSHCN initiatives within the department included: $31,977 Office of Health Assessment/Vital Statistics, $33,905 Local and Rural Health/Public Health Program, $197,127 Child Care Licensing Program. Within the Bureau of Family Health (MCH Section) $455,452 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $1,102,982, and WIC Nutrition consultation costs totaled $5,371. Aid to Local agencies and contracts with providers for MCH services totaled $2,266,882. Newborn screening follow-up expenditures (2 salaries) were $99,766. Salary and operating for two epidemiologists, director, assistant, and fiscal were $156,898. Indirect costs totaled $319,770.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Including all Block Grant partnership expenditures: Pregnant Women & Infants 40%, Children & Adolescent services 45%, CYSHCN 15%. The CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 52% of the overall budget. Population based services are 31%, and core public health is approximately 9%.

2012 Expenditures:

Form 3. According to fiscal reports at the time of submission, SFY12 Block Grant partnership expenditures were: $3,951,063 federal; $3,564,172 state; and $4,712,166 local. Total MCH expenditures are $12,227,401. During SFY12, federal spending to support MCH/CYSHCN initiatives within the department included: $22,459 Office of Health Assessment/Vital Statistics; $56,659 Local and Rural Health/Public Health Program; $106,489 Child Care Licensing Program; and $5,000 Center for Health Equity (partnership to support preconception peer educator community events). Within the Bureau of Family Health (MCH Section) $322,919 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $1,271,964. Aid to Local agencies and contracts with providers for MCH services totaled $1,955,079. Newborn screening follow-up expenditures (2 salaries) were $89,871. Salary and operating for two epidemiologists, director, assistant and fiscal were $115,622. Indirect costs totaled $5,000 at the time of this application.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Local match bolsters total expenditures for pregnant women/infants and children/adolescents due to the local match. More than $5,000,000 was reported in expenditures by local MCH grantees. CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 7% of the total MCH budget. Enabling services are 54% of the overall budget. Population based services are 32%, and core public health is approximately 7%. The shift of expenditures from direct services toward other pyramid levels continues.

The State Kansas is well within its required maintenance of effort of $2,352,311 with expenditures of $3,564,172 in SFY12. Kansas meets its matching requirement of $3 state/$4 federal through the use of State funds.

//2014//

B. Budget
/2012/

Form 2 - The Kansas budget for MCH federal dollars is $4,710,420. This is the full amount of the anticipated federal Title V award. There is an additional $70 million other federal dollars budgeted and $6.3 million other state dollars.

For FFY 12, the Block Grant partnership budget is: $4,710,420 federal; $3,880,903 state match; and $4,598,337 local. Overall Kansas Maternal and Child Health Services' funding is about one-third federal, one-third state, and one-third local. Kansas meets the 75% match for the federal dollars. Local agencies who receive MCH funds report all local funds used for MCH services.

Comparing the budgeted amounts of MCH dollars for FFY 11 and FFY 12 there is a small reduction in funds for Child Care Licensing ($8,188) that corresponds to the estimated amount of the federal reduction at the time of the submission. Child Care Licensing has gone to a fee-funded operation due to passage of Lexie's Law.

Form 2 - Amounts of funding allocated to children and adolescents and CYSHCN meet the 30-30 allocation requirement with $1,539,884 (33%) of the federal grant allocated to children and adolescents and $1,491,017 (32%) allocated to children with special health care needs.

Form 3 - Kansas' budget for FFY 12 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of 75% is achieved through projected State matching funds of $3,972,344. Kansas also anticipates local reporting of expenditures of $4,710,220.

Form 4 - Of its overall MCH budget (fed, state and local), Kansas allocates about $2.7 million to services for pregnant women and $2.7 for infants. Another $5.4 million is allocated to children and adolescents and $2.3 million for CYSHCN.

Form 5 - Considering the overall MCH budget, about $1.2 million (9%) is allocated to direct services, $7.3 million (54%) to enabling services such as case management and transportation. $3.8 million and $1.2 million are allocated respectively to population-based services and to core public health infrastructure services.

The indirect cost rate for KDHE is 21%. For Kansas, administrative costs are defined as indirect costs charged to the MCH Title V grant. As such they are within the 10% limit set forth in federal Title V law.

At this time, Kansas is in compliance with all requirements of the law.

Detailed information about the FFY 12 budget is provided in the attached Excel spreadsheets.

The State of Kansas assures that the MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, into the state budget, and into the process of prioritizing programs for MCH resources based on the State MCH needs assessment.

The Children & Families Section administers MCH grant funding for local agencies relating to: perinatal and reproductive health services, and child and adolescent health services. The contracts for this section include: MCH-- 85 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 58 contracts with local health departments and other local agencies for coverage of all counties. In addition there are contracts with providers of teen pregnancy case management services, pregnancy maintenance initiative services, SIDS outreach and education.

Following is the list of MCH contracts with local agencies for SFY 12 -- totaling $4,095,403

Barber Co Health Dept $4,413
Barton Co Health Dept (multi county) $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $76,997
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept B $3,115
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept - $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,303
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK (multi county) $92,645
Nemaha Co Health Dept $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874

Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,629
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK (multi county) $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Dept $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
CHC of SE Kansas $54,571
Hays Area Children's Center $18,156
Mercy Hospital $63,245

Teen Pregnancy Case Management Contracts for SFY 12 -- $338,846 (plus Medicaid match)

School-Public Health Nurse Collaboratives -- not funded in SFY 12

Pregnancy Maintenance Initiative for SFY 12 -- funding restored to $338,846

SIDS Network of Kansas contract for SFY 12 -- reduction from $75,000 in SFY 11 to $71,374 in SFY 12

Women's Right to Know budget for SFY 12 --no budget

//2012//

/2013/

Form 2. The Kansas federal budget for MCH dollars is $4,670,131. There is an additional $70 million other federal dollars budgeted and $6.3 million other state dollars.

The SFY 13 Block Grant parntership is: $4,670,131 federal; $3,972,344 state match; and $4,190,150 local. Overall, Kansas' MCH Services funding is approximately 36% federal, 31% state, and 33% local.

The amounts of funding allocated to Children and Adolescents (C&A) and CYSHCN meet the 30-30 allocation requirement. Children and Adolescents (C&A) with $1,527,101 (33%) and CYSHCN with $1,482,002 (32%).

Form 3. The Kansas budget for SFY 13 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of $3 state/$4 federal is achieved through projected State matching funds of $3,972,344. Kansas anticipates local match of $4,190,160.

Form 4. Kansas allocates approximately $2.5 million to services for pregnant women and $2.5 million for infants. An additional approximate $5.1 mlllion is allocated to C&A and $2.3 million for CYSHCN.

Form 5. Approximately $1.1 million (9%) is allocated to Direct Health services. Approximately $6.8 million (53%) is allocated to Enabling services. Approximately $3.5 million (28%) is allocated to Population Based services. Approximately $1.1 million (9%) is allocated to Core Public Health/Infrastructure services.

The indirect cost rate for KDHE is 21.4%. Administrative costs are indirect costs charged to the MCH Title V Grant. They are within the 10% limit set forth in federal Title V law.

Kansas is in compliance with all requirements of the law.

Kansas MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based upon the State MCH Needs Assessment.

Following is the list of MCH contracts with local agencies for SFY 13 -- totaling $4,095,403.00

Barber Co Health Dept $4,413
Barton Co Health Dept $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $77,000
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept $3,115
Grant Co Health Dept $8,549
Gray Co Health Dept $5,016
Greeley Co Health Dept $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363

Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,300
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK Multi- Co Health Dept $92,645
Neosho Co Health Dept $18,925
Nemaha Co Health Services $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,629
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK Multi-Co Health Dept $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Agency $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
Community Health Center $54,571
Hays Area Children's Center $18,156
Mercy Health System of KS $63,245

//2013//

/2014/ Kansas MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based upon the State MCH Needs Assessment.

Form 2. The Kansas total MCH budget is $93,419,912. The federal budget for MCH dollars is $4,670,131, the final authorized amount for FFY13. State match is budgeted at $3,722,188 and local match totals $4,740,394 (estimated based on total SFY13 match reported by local grantees). Overall, Kansas' MCH federal-state partnership total funding is $13,132,713. There is an additional $80 million other federal dollars budgeted, including $3 million for the MIECHV development grant, and $6.4 million other state dollars.

The amounts of Title V funding allocated to Children and Adolescents (C&A) and CYSHCN meet the 30-30 allocation requirement: Children and Adolescents (C&A) $1,550,312 (33%); CYSHCN $1,444,782 (31%).

Form 3. The Kansas budget for SFY14 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of $3 state for every $4 federal is achieved through projected State matching funds of $3,722,188. Kansas anticipates local match of $4,740,394, which is approximate and based on the SFY13 match reported by local grantees and calculated at the time of this application.

Form 4. Kansas allocates approximately $2.8 million to services for pregnant women and $2.8 million for infants. An additional approximate $5.5 million is allocated to C&A and $2.1 million for CYSHCN.

Form 5. Approximately $1.3 million (10%) is allocated to Direct Health services. Approximately $6.9 million (52%) is allocated to Enabling services. Approximately $4.1 million (30%) is allocated to Population Based services. Approximately $1.1 million (8%) is allocated to Core Public Health/Infrastructure.

The current indirect cost rate for KDHE is 17.9%. Administrative costs charged to the block grant are indirect costs within the 10% limited set forth in federal Title V law. For this budget period, $250,000 is budgeted (5.35%).

Following is the list of MCH contracts with local agencies for SFY14 totaling $4,088,872. The Title V portion allocted for the contracts this budget period is $1,935,940.

Barber Co Health Dept $4,413
Barton Co Health Dept $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,099
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $77,000
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194

Finney Co Health Dept $130,068
Ford Co Health Dept $66,442
Franklin Co Health Dept $22,356
Geary Co Health Dept $98,173
Gove Co Health Dept $3,115
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,300
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK Multi- Co Health Dept $92,645
Neosho Co Health Dept $18,925
Nemaha Co Health Services $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,603
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK Multi-Co Health Dept $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Agency $454,592

Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
Community Health Center $54,571
Hays Area Children's Center $18,156
Mercy Health System of KS $63,245

//2014//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Title V Block Grant Application Forms (2-21)
State: KS
Application Year: 2014

- Form 2 - MCH Budget Details
- Form 3 - State MCH Funding Profile
- Form 4 - Budget Details By Types of Individuals Served and Sources of Federal Funds
- Form 5 - State Title V Program Budget and Expenditures by Types of Services
- Form 6 - Number and Percentage of Newborn and Others Screened, Case Confirmed, and Treated
- Form 7 - Number of Individuals Served (Unduplicated) Under Title V
- Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX
- Form 9 - State MCH Toll-Free Telephone Line Data
- Form 10 - Title V Maternal and Child Health Services Block Grant State Profile for FY 2013
- Form 11 - National and State Performance Measures
- Form 12 - National and State Outcome Measures
- Form 13 - Characteristics Documenting Family Participation in Children with Special Health Care Needs
- Form 14 - List of MCH Priority Needs
- Form 15 - Technical Assistance (TA) Request and tracking
- Form 16 - State Performance/Outcome Measure Detail Sheets
- Form 17 - Health System Capacity Indicators (01 through 04,07,08) - Multi-year Data
- Form 18
  - Medicaid and Non-Medicaid comparison
  - Medicaid Eligibility Level (HSCI 06)
  - SCHIP Eligibility Level (HSCI 06)
- Form 19
  - General MCH Data Capacity (HSCI 09A)
  - Adolescent Tobacco Use Data Capacity (HSCI 09B)
- Form 20 - Health Status Indicators 01-05 - Multi-year Data
- Form 21
  - Population Demographics Data (HSI 06)
  - Live Birth Demographics Data (HSI 07)
  - Infant and Children Mortality Data (HSI 08)
  - Miscellaneous Demographics Data (HSI 09)
  - Geographic Living Area Demographic Data (HSI 10)
  - Poverty Level Demographic Data (HSI 11)
  - Poverty Level for Children Demographics Data (HSI 12)

Form 2

MCH Budget Details for FY 2014

[Secs. 504 (d) and 505(a)(3)(4)]

State: KS

1. Federal Allocation
(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:
$ 4,670,131

A.Preventive and primary care for children:
$ 1,550,312 (33.2 %)

B.Children with special health care needs:
$ 1,444,782 (30.94 %)
(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:
$ 250,000 (5.35 %)
(The above figure cannot be more than 10%)[Sec. 504(d)]

2. Unobligated Balance (Item 15b of SF 424) $ 0

3. State MCH Funds (Item 15c of the SF 424) $ 3,722,188

4. Local MCH Funds (Item 15d of SF 424) $ 4,740,394

5. Other Funds (Item 15e of SF 424) $ 0

6. Program Income (Item 15f of SF 424) $ 0

7. Total State Match (Lines 3 through 6) $ 8,462,582
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 2,352,511

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 13,132,713
(Total lines 1 through 6. Same as line 15g of SF 424)

9. Other Federal Funds
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 0
c. CISS:	$ 0
d. Abstinence Education:	$ 359,879
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 67,338,600
h. AIDS:	$ 0
i. CDC:	$ 0
j. Education:	$ 4,010,088
k. Home Visiting:	$ 0
l. Other:	
Family Planning	$ 2,471,250
Medicaid TPTCM	$ 338,846
MIECHV	$ 4,172,802
NB Hearing Screening	$ 207,000
Other-ICC,SC,SB,KRG	$ 138,000
Project LAUNCH	$ 850,000
WIC BF Peer Ed	$ 400,734

10. Other Federal Funds (SUBTOTAL of all Funds under item 9) $ 80,287,199

11. STATE MCH BUDGET TOTAL $ 93,419,912
(Partnership subtotal + Other Federal MCH Funds subtotal)

Form Notes for Form 2

None

Field Level Notes

1. **Section Number:** Form2_Main
   Field Name: OtherFedFundsOtherFund
   Row Name: Other Federal Funds - Other Funds
   Column Name:
   Year: 2014
   Field Note:
   Maternal, Infant & Early Childhood Home Visiting: Formula Funds $1,172,802; Development Grant $3,000,000

Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: KS

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 4,700,774	$ 4,718,608	$ 4,719,246	$ 4,164,028	$ 4,718,608	$ 4,670,131
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
3. State Funds *(Line3, Form 2)*	$ 4,659,442	$ 4,512,530	$ 4,079,395	$ 3,880,903	$ 4,462,639	$ 3,695,620
4. Local MCH Funds *(Line4, Form 2)*	$ 4,261,972	$ 4,782,085	$ 5,475,000	$ 4,598,337	$ 4,374,000	$ 5,093,392
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
7. Subtotal	$ 13,622,188	$ 14,013,223	$ 14,273,641	$ 12,643,268	$ 13,555,247	$ 13,459,143
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 62,362,445	$ 72,448,016	$ 70,812,887	$ 70,812,887	$ 72,444,016	$ 70,032,836
9. Total *(Line11, Form 2)*	$ 75,984,633	$ 86,461,239	$ 85,086,528	$ 83,456,155	$ 85,999,263	$ 83,491,979
	(STATE MCH BUDGET TOTAL)					

Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: KS

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 4,710,420	$ 3,951,063	$ 4,670,131	$	$ 4,670,131	$
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
3. State Funds *(Line3, Form 2)*	$ 3,972,344	$ 3,564,172	$ 3,972,344	$	$ 3,722,188	$
4. Local MCH Funds *(Line4, Form 2)*	$ 4,710,220	$ 4,712,166	$ 4,190,160	$	$ 4,740,394	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
7. Subtotal	$ 13,392,984	$ 12,227,401	$ 12,832,635	$ 0	$ 13,132,713	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 70,032,836	$ 74,057,661	$ 70,032,836	$	$ 80,287,199	$
9. Total *(Line11, Form 2)*	$ 83,425,820	$ 86,285,062	$ 82,865,471	$ 0	$ 93,419,912	$ 0
	(STATE MCH BUDGET TOTAL)					

Form Notes for Form 3

None

Field Level Notes

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2012
   Field Note:
   Positions not filled have resulted in unspent funds. Projects under review to be funded with Title V dollars before year end include perinatal quality collaborative initiatives.
2. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2011
   Field Note:
   Total expended less than budgeted due authorized amount
3. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   Overestimated state match figured for FFY12 budget; required amount of state match still met.
4. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
5. **Section Number:** Form3_Main
   Field Name: LocalMCHFundsExpended
   Row Name: Local MCH Funds
   Column Name: Expended
   Year: 2011
   Field Note:
   total expended updated; final reports and actual expenditures provided July 2013; information updated for previous year

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: KS

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 2,559,173	$ 2,788,564	$ 2,800,492	$ 2,431,175	$ 2,774,634	$ 2,608,527
b. Infants < 1 year old	$ 2,559,174	$ 2,788,564	$ 2,800,492	$ 2,431,176	$ 2,774,635	$ 2,608,527
c. Children 1 to 22 years old	$ 5,423,785	$ 6,132,606	$ 5,868,371	$ 5,569,489	$ 5,456,728	$ 5,954,256
d. Children with Special Healthcare Needs	$ 2,594,476	$ 1,937,112	$ 2,415,786	$ 1,876,521	$ 2,179,250	$ 1,968,063
e. Others	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
f. Administration	$ 485,580	$ 366,377	$ 388,500	$ 334,907	$ 370,000	$ 319,770
g. SUBTOTAL	$ 13,622,188	$ 14,013,223	$ 14,273,641	$ 12,643,268	$ 13,555,247	$ 13,459,143
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 94,644		$ 94,644		$ 94,644	
c. CISS	$ 140,000		$ 140,000		$ 132,000	
d. Abstinence Education	$ 337,112		$ 0		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 54,889,700		$ 61,543,000		$ 62,000,000	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 100,000		$ 100,000		$ 100,000	
j. Education	$ 3,887,531		$ 5,851,667		$ 4,030,759	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Family Planning	$ 2,379,479		$ 2,482,320		$ 2,300,000	
Other	$		$		$ 3,786,613	
NBHS, BF, XIX, SRS	$		$ 601,256		$	
NBHS, BF, XIX, SRS	$ 533,979		$		$	
III. TOTAL	$ 62,362,445		$ 70,812,887		$ 72,444,016	

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: KS

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	$ 2,674,119	$ 2,535,298	$ 2,550,360	$	$ 2,743,042	$
b. Infants < 1 year old	$ 2,674,120	$ 2,535,298	$ 2,550,360	$	$ 2,743,042	$
c. Children 1 to 22 years old	$ 5,375,059	$ 5,360,537	$ 5,076,243	$	$ 5,339,541	$
d. Children with Special Healthcare Needs	$ 2,329,686	$ 1,791,268	$ 2,320,672	$	$ 2,057,088	$
e. Others	$ 0	$ 0	$ 0	$	$ 0	$
f. Administration	$ 340,000	$ 5,000	$ 335,000	$	$ 250,000	$
g. SUBTOTAL	$ 13,392,984	$ 12,227,401	$ 12,832,635	$ 0	$ 13,132,713	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 97,260		$ 97,260		$ 0	
c. CISS	$ 135,813		$ 135,813		$ 0	
d. Abstinence Education	$ 359,879		$ 359,879		$ 359,879	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 60,000,000		$ 60,000,000		$ 67,338,600	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 100,000		$ 100,000		$ 0	
j. Education	$ 4,030,759		$ 4,030,759		$ 4,010,088	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Family Planning	$ 2,300,000		$ 2,300,000		$ 2,471,250	
Medicaid TPTCM	$		$		$ 338,846	
MIECHV	$		$		$ 4,172,802	
NB Hearing Screening	$		$		$ 207,000	
Other-ICC,SC,SB,KRG	$		$		$ 138,000	
Project LAUNCH	$		$		$ 850,000	
WIC BF Peer Ed	$		$		$ 400,734	
Other	$ 3,009,125		$ 3,009,125		$	
III. TOTAL	$ 70,032,836		$ 70,032,836		$ 80,287,199	

Form Notes for Form 4

None

Field Level Notes

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Budgeted
   Row Name: Children 1 to 22 years old
   Column Name: Budgeted
   Year: 2011
   Field Note:
   This is a slight reduction from FFY 08 due to los of ATL funds
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Expended
   Row Name: Children 1 to 22 years old
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2012
   Field Note:
   funds obligated for SFY13 CYSHCN contracts not fully expended at the time of the expense reports provided from Fiscal/SMART system
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AllOthersExpended
   Row Name: All Others
   Column Name: Expended
   Year: 2011
   Field Note:
   Items 1 - 5 reflect a migration to a different payment processing system and period of time. We are establishing an expenditures reported process that is different from past periods. This process will be used in to report expenditues for this application and forward.
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2012
   Field Note:
   administration costs expended at the time of submission
9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: KS

Type of Service	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 5,304,203	$ 4,666,526	$ 4,877,888	$ 1,042,866	$ 1,086,334	$ 1,103,996
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 6,101,176	$ 6,951,535	$ 7,570,830	$ 6,360,872	$ 6,901,877	$ 7,003,638
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 1,115,094	$ 1,227,408	$ 566,913	$ 3,975,450	$ 4,254,786	$ 4,111,664
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 1,101,715	$ 1,167,754	$ 1,258,010	$ 1,264,080	$ 1,312,250	$ 1,239,845
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 13,622,188	$ 14,013,223	$ 14,273,641	$ 12,643,268	$ 13,555,247	$ 13,459,143

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: KS

Type of Service	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 1,180,342	$ 909,586	$ 1,179,092	$	$ 1,271,992	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 7,258,507	$ 6,594,688	$ 6,929,242	$	$ 6,780,384	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,827,857	$ 3,904,743	$ 3,629,085	$	$ 3,963,147	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 1,126,278	$ 818,384	$ 1,095,216	$	$ 1,117,190	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 13,392,984	$ 12,227,401	$ 12,832,635	$ 0	$ 13,132,713	$ 0

Form Notes for Form 5

None

Field Level Notes

1. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2012
   Field Note:
   funds yet to be expended for SFY13 and SFY14 contracts for CYSHCN
2. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
3. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
4. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year
5. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2012
   Field Note:
   vacant positions have allowed remaining funds
6. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2011
   Field Note:
   Final reports and actual expenditures provided July 2013; information updated for previous year

Form 6

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

Sect. 506(a)(2)(B)(iii)

State: KS

Total Births by Occurrence: 40,467 | **Reporting Year: 2011**

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	40,233	99.4	9	3	3	100
Congenital Hypothyroidism	40,233	99.4	114	39	39	100
Galactosemia	40,233	99.4	4	0	0	
Sickle Cell Disease	40,233	99.4	10	10	10	100
Other Screening (Specify)						
Biotinidase Deficiency	40,233	99.4	2	1	1	100
Cystic Fibrosis	40,233	99.4	66	11	11	100
Homocystinuria	40,233	99.4	44	0	0	
Maple Syrup Urine Disease	40,233	99.4	16	0	0	
Tyrosinemia Type I	40,233	99.4	21	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	40,233	99.4	6	1	1	100
Isovaleric Acidemia	40,233	99.4	5	0	0	
Carnitine Uptake Defect	40,233	99.4	9	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	40,233	99.4	20	2	2	100
Methylmalonic acidemia (Cbl A,B)	40,233	99.4	8	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	40,233	99.4	6	2	2	100
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	40,233	99.4	8	2	2	100
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

Form Notes for Form 6

None

Field Level Notes

1. **Section Number:** Form6_Main
   Field Name: SickleCellDisease_Confirmed
   Row Name: SickleCellDisease
   Column Name: Confirmed Cases
   Year: 2014
   Field Note:
   All presumptive positive cases were confirmed.

FORM 7

Number of Individuals Served (Unduplicated) under Title V
(By Class of Individuals and Percent of Health Coverage)

[Sec. 506(a)(2)(A)(i-ii)]

State: KS

Number of Individuals Served - Historical Data by Annual Report Year					
Types of Individuals Served	**2007**	**2008**	**2009**	**2010**	**2011**
Pregnant Women	8,464	7,158	9,912	9,675	9,011
Infants < 1 year old	40,686	41,951	42,566	42,511	41,580
Children 1 to 22 years old	45,963	50,523	60,110	81,070	64,935
Children with Special Healthcare Needs	7,124	4,005	4,716	3,210	3,847
Others	10,783	9,043	7,290	5,140	4,353
Total	113,020	112,680	124,594	141,606	123,726

Reporting Year: 2011

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	**(A) Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private/Other %**	**(E) None %**	**(F) Unknown %**
Pregnant Women	8,958	20.3	12.6	14.8	48.4	4.0
Infants < 1 year old	40,467	33.4	0.0	59.1	7.1	0.4
Children 1 to 22 years old	66,258	20.9	25.5	23.4	26.5	3.7
Children with Special Healthcare Needs	2,688	28.0	5.3	21.3	41.3	4.0
Others	4,147	23.8	21.9	28.1	22.0	4.2
TOTAL	122,518					

Form Notes for Form 7

None

Field Level Notes

1. **Section Number:** Form7_Main
   Field Name: CSHCN_TS
   Row Name: Children with Special Health Care Needs
   Column Name: Title V Total Served
   Year: 2014
   Field Note:
   The total number served includes those who receive specialty medical care services through the CYSHCN program as well as through outreach in the CYSHCN multi-disciplinary clinics. Due to reporting inconsistencies and insufficiencies, the insurance source breakdown is based upon data from the CYSHCN data management system for those who receive specialty medical care services through the CYSHCN program only. Modifications to clinic reporting requirements will be made beginning July 1 for data submitted to ensure this information is captured.

FORM 8
Deliveries and Infants Served By Title V and Entitled to Benefits Under Title XIX
(By Race and Ethnicity)
[Sec. 506(a)(2)(C-D)]
State: KS

Reporting Year: 2011

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
Deliveries								
Total Deliveries in State	40,657	33,516	2,993	242	1,123	58	767	1,958
Title V Served	8,958	7,981	449	73	117	11	229	98
Eligible for Title XIX	13,916	10,870	1,720	297	315	16	0	698
Infants								
Total Infants in State	40,467	33,367	2,970	240	1,118	58	761	1,953
Title V Served	40,467	33,367	2,970	240	1,118	58	761	1,953
Eligible for Title XIX	18,285	13,934	2,502	428	463	24	0	934

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
Deliveries								
Total Deliveries in State	34,226	6,386	45	4,610	28	125	434	1,189
Title V Served	6,692	2,266	0	1,777	12	22	93	362
Eligible for Title XIX	10,296	3,619	1					
Infants								
Total Infants in State	34,081	6,344	42	4,574	26	125	432	1,187
Title V Served	34,081	6,344	42	4,574	26	125	432	1,187
Eligible for Title XIX	13,491	4,794	0					

Form Notes for Form 8

None

Field Level Notes

1. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_TotalHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Hispanic or Latino
   Year: 2014
   Field Note:
   Hispanic sub-categories were not collected in CY2011.
2. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: InfantsTitleXIX_TotalHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Hispanic or Latino
   Year: 2014
   Field Note:
   Hispanic sub-categories were not collected in CY2011.

Form 9
State MCH Toll-Free Telephone Line Data Form (Optional)
[Secs. 505(a)(E) and 509(a)(8)]
State: KS

	FY 2014	FY 2013	FY 2012	FY 2011	FY 2010
1. State MCH Toll-Free "Hotline" Telephone Number	1-888-744-4825			(888) 744-4825	
2. State MCH Toll-Free "Hotline" Name	Women's Right To Know			Effective Fiscal Year 2008 WRTK calls are included in MADIN call	
3. Name of Contact Person for State MCH "Hotline"	Genoveva Fernandez			Daniel Gibbons	
4. Contact Person's Telephone Number	785-296-1317			785-296-1317	
5. Contact Person's Email	gfernandez@kdheks.gov			dgibbons@kdheks.gov	
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	32	0	0

Form 9
State MCH Toll-Free Telephone Line Data Form
[Secs. 505(a)(E) and 509(a)(8)]
State: KS

	FY 2014	FY 2013	FY 2012	FY 2011	FY 2010
1. State MCH Toll-Free "Hotline" Telephone Number	800-332-6262	800-332-6262	800-332-6262	(800)-332-6262	(800)-332-6262
2. State MCH Toll-Free "Hotline" Name	Kansas Resource Guide	Kansas Resource Guide	Kansas Resource Guide	Make a Difference Information Network (MADIN)	Make a Difference Information Network (MADIN)
3. Name of Contact Person for State MCH "Hotline"	Genoveva (Geno) Fernandez	Daniel Gibbons	Daniel Gibbons	Daniel Gibbons	Norma Hinton
4. Contact Person's Telephone Number	785-296-1317	785-296-1317	785-296-1317	785-296-1317	(785)-296-1317
5. Contact Person's Email	gfernandez@kdheks.gov	dgibbons@kdheks.gov	dgibbons@kdheks.gov	dgibbons@kdheks.gov	nhinton@kdheks.gov
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	1732	1932	2927

Form Notes for Form 9

None

Field Level Notes

None

Form 10
Title V Maternal & Child Health Services Block Grant
State Profile for FY 2014
[Sec. 506(a)(1)]
State: KS

1. State MCH Administration:
(max 2500 characters)

The Bureau of Family Health in the Kansas Department of Health and Environment administers the Maternal and Child Health Services Block Grant program. The mission of the bureau is to provide leadership to enhance the health of Kansas women and children through partnerships with families and communities. Core functions include assessment, policy development, and assurance. The bureau engages in the ten essential public health services to promote the health of all Kansas mothers and children: assess and monitor MCH health status; diagnose and investigate health problems; inform and educate the public and families about MCH issues; mobilize community partnershps; engage in priority setting, planning and policy development; enforce legal requirements to protect the health and safety of mothers and children; link mothers and children to services; assure a competent workforce; evaluate services and conduct research to improve MCH.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 4,670,131
3. Unobligated balance (Line 2, Form 2)	$ 0
4. State Funds (Line 3, Form 2)	$ 3,722,188
5. Local MCH Funds (Line 4, Form 2)	$ 4,740,394
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 0
8. Total Federal-State Partnership (Line 8, Form 2)	$ 13,132,713

9. Most significant providers receiving MCH funds:

- Local County Public Health Departments
- Medical Specialty Service Providers
- Community Based Organizations
- Early Childhood Service Providers

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	8,958
b. Infants < 1 year old	40,467
c. Children 1 to 22 years old	66,258
d. CSHCN	2,688
e. Others	4,147

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

CSHCN provides case management services to families to assure access to appropriate services. Financial aqssistance may be provided when health care for the children's conditions pose a financial hardship for the family and there is no other source of assistance. MCH staff in local health departments provide care coordination to pregnant women and link them with local providers and community services.

b. Population-Based Services:
(max 2500 characters)

Kansas newborns receive screening for all but one (SCID) of the conditions recommended by a national panel. This includes screening for metabolic conditions and hearing loss. Out-of-range-findings are reported to a nurse or audiologist who notifies the provider and/or family of the need for further testing. Families are linked with appropriate services and in some cases may receive financial assistance.

c. Infrastructure Building Services:
(max 2500 characters)

Kansas MCH/CSHCN staff assume leadership roles in a number of state initiatives to represent the needs of mothers and children and to provide data as appropriate. Initiatives include: Blue Ribbon Panel on Infant Mortality; School Readiness Task Force; KS Perinatal Quality Collaborative; State Developmental Disabilities Council; KS MCH Council, and others.

12. The primary Title V Program contact person:

Name	Rachel Berroth
Title	Bureau of Family Health Director

13. The children with special health care needs (CSHCN) contact person:

Name	Heather Smith
Title	Special Health Services Section Director

Address	1000 SW Jackson Street, Ste 220	Address	1000 SW Jackson Street, Ste 220
City	Topeka	City	Topeka
State	KS	State	KS
Zip	66612	Zip	66612
Phone	785-296-1310	Phone	785-296-1316
Fax	785-296-8616	Fax	785-296-8616
Email	rberroth@kdheks.gov	Email	hsmith@kdheks.gov
Web	www.kdheks.gov/bfh	Web	www.kdheks.gov/bfh

Form Notes for Form 10

None

Field Level Notes

None

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 11

None

Performance Measure # 01

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	61	57	59	71	67
Denominator	61	57	59	71	67
Data Source	Kansas Newborn Screening data	Kansas Newborn Screening data, 2009	Kansas Newborn Screening data, 2010	Kansas Newborn Screening data, 2011	Kansas Newborn Screening data, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATASOURCE:
   *NOTE: Data for 2010 is not available at the time of this application. 2009 data was used to pre-populate this peformance measure. Data will be available by 1 September 2011.

Performance Measure # 02

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	70	70	67	66	73
Annual Indicator	65.6	65.6	65.6	72.6	72.6
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	73	74	74	75	75
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

   Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

Performance Measure # 03

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	60	60	50
Annual Indicator	55.3	55.3	55.3	49.4	49.4
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	51	52	53	54	54
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM#03.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

Performance Measure # 04

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	64	64	64	65	61
Annual Indicator	62.9	62.9	62.9	60	60
Numerator					
Denominator					
Data Source	National CSCHN 2005-2006. Estimate KS	National CSCHN 2005-2006. KS Estimate.	National CSCHN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	61	62	62	63	63
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

   Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

Performance Measure # 05

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	99	93	67
Annual Indicator	92.5	92.5	92.5	66.8	66.8
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	68	68	69	69	69
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM#05.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

*The Annual Performance Objective of 99 is unrealistic and should be revised to 93 for 2010.

Performance Measure # 06

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	53	53	55	53	53
Annual Indicator	50.3	50.3	50.3	52.7	52.7
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	54	54	55	55	55
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2010
   Field Note:

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM#06 and the 2005-2006 may be considered baseline data.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

* The 2010 Annual Performance Objective of 55 is unrealistic and should be revised to 53.

Performance Measure # 07

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	79	79	83
Annual Indicator	78.2	77.5	80.1	83.6	83.6
Numerator					
Denominator					
Data Source	CDC National Immunization Survey 2008, KS	CDC National Immunization Survey 2009, KS	CDC National Immunization Survey 2010	CDC National Immunization Survey 2011	CDC National Immunization Survey 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	85	85	87	87	89
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2011 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2011. Adhoc report.

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

3. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2010
   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, 2010. Adhoc report.

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

Performance Measure # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	18	20	20	20	18
Annual Indicator	22.0	20.6	19.1	15.5	15.5
Numerator	1,261	1,162	1,106	896	896
Denominator	57,321	56,277	57,952	57,687	57,687
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	15	14	14	13	13
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2011 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The 2011 column is populated with 2010 data. 2010 data will be available Fall 2012.

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source:
   Numerator = Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census; 2010 data are actual Census counts, not estimates.

Performance Measure # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	40	40	40	40	41
Annual Indicator	38.2	38.2	38.2	35.7	35.7
Numerator	13,176	13,176	13,176		
Denominator	34,506	34,506	34,506		
Data Source	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	38	38	40	40	42
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

3. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: KDHE. Office of Oral Health. Smiles Across Kansas: 2007 Update - unpublished weighted data.

   Data for 2010 is not available. 2007 data was used to pre-populate this performance measure. A report of 2009 data will be released in September 2011.

Performance Measure # 10

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	3.8	3.6	3.6	2.5	3.6
Annual Indicator	3.6	2.7	4.0	2.8	2.8
Numerator	21	16	24	17	17
Denominator	582,572	588,523	606,823	605,120	605,120
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	2.6	2.6	2.4	2.4	2.2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census; 2011 estimates.

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census; 2010 data are actual Census counts, not estimates.

Performance Measure # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	24	45	45	50	42
Annual Indicator	43.8	47.4	41	45.1	45.1
Numerator					
Denominator					
Data Source	National Immunization Survey, 2006 birth cohort	National Immunization Survey, 2007 birth cohort	National Immunization Survey, 2008 births	National Immunization Survey, 2009 births	National Immunization Survey, 2009 births
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	47	47	49	49	50
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data (provisional data, 2009 births). Data will be available in 2014.

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

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

3. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

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

Performance Measure # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	98	98	98.2	98.2	99
Annual Indicator	89.5	98.0	98.5	98.7	98.7
Numerator	37,661	41,645	40,962	39,908	40,631
Denominator	42,060	42,515	41,593	40,452	41,175
Data Source	KDHE. Kansas Newborn Screening program, 2008	KDHE. Kansas Newborn Screening program, 2009	KDHE. Kansas Newborn Screening program, 2010	KDHE. Kansas Newborn Screening program, 2011	KDHE. Kansas Newborn Screening program, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	99	99	99	99	99
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 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.

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2011.
   Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

3. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2010.
   Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

Performance Measure # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	7	7	10.5	8	7.5
Annual Indicator	10.4	7.3	7.5	9.4	9.4
Numerator					
Denominator					
Data Source	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	9.2	9.2	9	9	8.8
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm

   Data for 2012 is not available. 2011 data was used to pre-populate this performance measure. Data for 2012 will be available in fall, 2013.

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm

   Data for 2011 is not available. 2010 data was used to pre-populate this performance measure. Data for 2011 will be available October 2012.

3. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm

Performance Measure # 14

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	29	29	28	28	28
Annual Indicator	30.0	29.8	28.7	28.4	28.4
Numerator	10,306	11,013	10,860	10,657	10,657
Denominator	34,352	36,956	37,838	37,524	37,524
Data Source	Kansas PedNSS, 2008	Kansas PedNSS, 2009	Kansas PedNSS, 2010	Kansas PedNSS, 2011	Kansas PedNSS, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	27	27	27	26	26
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2011 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2011(Kansas WIC database).

3. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2010 (Kansas WIC database).

Performance Measure # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	13.5	13	13	12.5	12.5
Annual Indicator	13.8	12.7	12.7	12.2	12.2
Numerator	5,720	5,246	5,005	4,795	4,795
Denominator	41,570	41,210	39,409	39,441	39,441
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	12	12	11.8	11.8	11.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

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

Performance Measure # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	9.4	9.3	11	9	10
Annual Indicator	11.1	9.1	10.1	10.5	10.5
Numerator	67	55	61	64	64
Denominator	604,131	602,256	604,262	608,906	608,906
Data Source	Kansas Vital Statistics, 2006-2008	Kansas Vital Statistics, 2007-2009	Kansas Vital Statistics, 2008-2010	Kansas Vital Statistics, 2009-2011	Kansas Vital Statistics, 2009-2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	10	9.8	9.8	9.6	9.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2009-2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0.

   Denominator =U.S. Bureau of the Census
   2009-2011 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2008-2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0.

   Denominator =U.S. Bureau of the Census
   2008-2009 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

Performance Measure # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	85	86	86	87	87
Annual Indicator	78.9	80.8	82.3	86.6	86.6
Numerator	412	437	377	425	425
Denominator	522	541	458	491	491
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	88	88	89	89	90
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident instate births) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).

3. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident instate births) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   Kansas's level III hospitals are 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), Via Christi-St Joseph and Wesley Medical Center (Wichita).

Performance Measure # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	78	79	79	80	80
Annual Indicator	73.1	74.1	75.1	77.3	77.3
Numerator	29,089	29,244	29,552	29,618	29,618
Denominator	39,776	39,481	39,362	38,296	38,296
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	80	80	80	80	80
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 11

None

State Performance Measure # 2 - Reporting Year

The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective				14.4	13.5
Annual Indicator	12.7	14.5	14	17.7	17.7
Numerator					
Denominator					
Data Source	Kansas BRFSS, 2008	Kansas BRFSS, 2009	Kansas BRFSS, 2010	Kansas BRFSS, 2011	Kansas BRFSS, 2011
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	13	12.5	12	11.5	11
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas BRFSS 2011
   Note: The 2011 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

3. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas BRFSS 2010

State Performance Measure # 3 - Reporting Year

The percent of live births that are born preterm less than 37 weeks of gestation.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective				9.1	8.6
Annual Indicator	9.3	9.2	8.8	9.1	9.1
Numerator	3,873	3,804	3,534	3,598	3,598
Denominator	41,747	41,313	40,381	39,593	39,593
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	8.6	8.4	8.4	8.2	8.2
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The 2010 column is populated with 2009 data. 2010 data will be available Fall 2011.

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

State Performance Measure # 5 - Reporting Year

The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective				63	63
Annual Indicator	61.3	61.3	61.3	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2011/2012	National Survey Of Children's Health, 2011/2012
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	62	62	64	64	66
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   National Survey of Children's Health. NSCH 2011/2012. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   National Survey of Children's Health. NSCH 2011/2012. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

3. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE:
   National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

   Data for 2010 is not availabe so 2007 data was used to pre-populate this field.

State Performance Measure # 6 - Reporting Year

The percent of high school students who had at least one drink of alcohol during the past 30 days.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective				37	37
Annual Indicator			38.7	32.6	32.6
Numerator					
Denominator					
Data Source			YRBS, 2009	YRBS, 2011	YRBS, 2011
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	30	30	28	28	26
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2012
   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.

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2011. http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.

3. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE:
   CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2009. http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS

State Performance Measure # 7 - Reporting Year

The Percent of children who are obese.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective				13.1	12.6
Annual Indicator	13.3	13.2	13.0	12.8	12.8
Numerator		4,878	4,919	4,803	4,803
Denominator		36,956	37,838	37,523	37,523
Data Source	Kansas PeNSS, 2008	Kansas PeNSS, 2009	Kansas PeNSS, 2010	Kansas PeNSS, 2011	Kansas PeNSS, 2011
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	12.4	12.2	12	12	11.8
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2012(Kansas WIC database).

3. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2010(Kansas WIC database).

State Performance Measure # 9 - Reporting Year

The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective				84	84
Annual Indicator			84	83.5	83.5
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005/2006	National Survey of CSHCN, 2009/2010	National Survey of CSHCN, 2009/2010
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	85	85	86	86	87
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

2. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

3. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE:
   National Survey of Children with Special Health Care Needs. NS-CSHCN 2005/06. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

State Performance Measure # 11 - Reporting Year

The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator			46.6	65.1	49.5
Numerator			41	41	45
Denominator			88	63	91
Data Source			SoundBeginning, 2010	SoundBeginning, 2011	SoundBeginning, 2012
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	66	66	68	68	70

Annual Indicator
Numerator
Denominator

Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: SoundBeginnings Program data, 2012
   Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
   Denominator = Number of infants identified with PCHL

2. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: SoundBeginnings Program data, 2011
   Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
   Denominator = Number of infants identified with PCHL

3. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: SoundBeginnings Program data, 2010
   Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
   Denominator = Number of infants identified with PCHL

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 12

None

Outcome Measure # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	6.3	6.1	6.1	6.1	6.1
Annual Indicator	7.2	7.0	6.3	6.2	6.2
Numerator	303	290	253	247	247
Denominator	41,815	41,388	40,439	39,628	39,628
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	6.1	6.1	6	6	5.9
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2011
   Denominator = Birth certificate (resident) data, 2011

3. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2010
   Denominator = Birth certificate (resident) data, 2010

Outcome Measure # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	1.7	1.7	1.6	1.6	1.6
Annual Indicator	2.1	2.6	2.4	2.4	2.4
Numerator	13.3	15.5	11.9	12.9	12.9
Denominator	6.2	6	4.9	5.3	5.3
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	2.2	2.2	2	2	1.8
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   For 2011, race and ethnicity is reported out an white non-Hispanic and black Non-Hispanic to more accuratly reflect population numbers.

3. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   For 2010, race and ethnicity is reported out an white non-Hispanic and black Non-Hispanic to more accuratly reflect population numbers.

Outcome Measure # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	4.2	4.1	4.1	4	4
Annual Indicator	4.6	4.3	4.2	4.0	4.0
Numerator	193	176	170	157	157
Denominator	41,815	41,388	40,439	39,628	39,628
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	3.8	3.8	3.6	3.6	3.4
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2011
   Denominator = Birth certificate (resident) data, 2011

3. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2010
   Denominator = Birth certificate (resident) data, 2010

Outcome Measure # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	1.9	1.9	1.8	1.8	1.8
Annual Indicator	2.6	2.8	2.3	2.3	2.3
Numerator	110	114	93	90	90
Denominator	41,815	41,388	40,439	39,628	39,628
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	2.1	2.1	1.9	1.9	1.7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2011
   Denominator = Birth certificate (resident) data, 2011

3. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2010
   Denominator = Birth certificate (resident) data, 2010

Outcome Measure # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	5.7	5.7	5.6	5.6	5.6
Annual Indicator	6.6	6.6	6.2	5.9	5.9
Numerator	278	275	250	234	234
Denominator	41,933	41,519	40,546	39,741	39,741
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	5.6	5.6	5.6	5.6	5.6
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death and stillbirth certificate (resident) data, 2011
   Denominator = Live birth and stillbirth certificate (resident) data, 2011

3. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death and stillbirth certificate (resident) data, 2010
   Denominator = Live birth and stillbirth certificate (resident) data, 2010

Outcome Measure # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	22	18	18	17	17
Annual Indicator	21.3	21.4	22.3	19.1	19.1
Numerator	115	117	126	108	108
Denominator	540,147	547,017	566,037	565,128	565,128
Data Source	Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	17	17	17	17	17
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

2. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 12

None

Form 13
Characteristics Documenting Family Participation in CSHCN Programs
State: KS

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

3

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

3

4. Family members are involved in service training of CSHCN staff and providers.

2

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

3

6. Family members of diverse cultures are involved in all of the above activities.

2

Total Score: 16

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Form Notes for Form 13

As a component of the D-70 Integrated Community Systems for Youth with Special Health Care Needs grant and now a commitment of the CYSHCN program, we have coordinated a Youth Advisory Council (YAC) since 2010. This council has experienced significant reduction in engagement and attendance at quarterly meetings. This group is facilitated by the Kansas Youth Empowerment Academy (KYEA).

This past year, the YAC transition and decided to change their name to Leaders Advocating for Youth Resources and Supports (LAYRS). This past year, an attempt was made to shift to a stronger focus on youth leadership. Based upon youth responses to planning session, it was determined that the group will transition to a youth leadership committee, ad be responsible for developing a structure for the committee and planning additional youth-outreach activities across the state to empower other youth and support leadership and growth.

Due to youth health complications, KYEA staff turn-over and a decline in interest from the youth, it has been decided that the YAC (or LAYRS) will no longer continue into the coming state fiscal year. However, a contract with the KYEA will still be issued to identify and research potential youth leadership programs, such as a youth version of the Colorado Parent Leadership Training Institute or the existing Kansas Partners in Policymaking programs. These caliber of programs can build youth leaders in the state, while supporting self-determination and building independence. The CYSHCN program is dedicated to supporting youth development and building youth leaders. . It is expected that by Spring 2014, the program and KYEA will identify a future direction or youth engagement.

Field Level Notes

1. **Section Number:** Form13_Main
   Field Name: Question1
   Row Name: #1. Family members participate on advisory committee or task forces...
   Column Name:
   Year: 2014
   Field Note:
   There are currently 9 consumer parent/family consultants and 4 professional parent consultants on the CYSHCN Family Advisory Council (FAC). There are currently 6 openings for the FAC and member recruitment is ongoing. The FAC meets in-person four times each year. In between each in-person meeting, a 2 hour teleconference is held.

   The FAC Executive Committee was established in 2012 and continues to support FAC meeting planning and logistics by providing input in developing agendas, recommending changes to the by-laws and council objectives, and addressing concerns of the general member population. There is currently 1 vacant position on this committee due to turnover on the overall council. We are currently accepting new applications for this position.

   In recent past, the FAC has been instrumental in developing products and materials related to the CYSHCN Program Priority Objectives. Additionally, the family members support additional projects that directly relate to other programmatic needs or gaps in service for families of CYSHCN.

   Parent and youth consultants were supported in attending the 2013 AMCHP conference in Washington, D.C. Additionally the FAC was highlighted at the annual conference and the FAC parent-professional facilitator and another family member presented about the Kansas FAC to conference attendees. This session was recorded and is available through the AMCHP session archives.

2. **Section Number:** Form13_Main
   Field Name: Question2
   Row Name: #2. Financial support (...) is offered for parent activities or parent groups.
   Column Name:
   Year: 2014
   Field Note:
   Consumer parent consultants on the CYSHCN Family Advisory Council are provided a stipend for their participation on the council as well as travel and child care costs.

   The Bureau of Family Health contracts with Families Together, Inc., the KS Family Voices organization, in a variety of ways. Primarily, the KDHE/Families Together partnership provides services, programs, and training to parents of CYSHCN across Kansas. Specifically, the CYSHCN program contracts with them to facilitate the CYSHCN Family Advisory Council; connect families to resources and services (including financial supports and insurance options); conduct conferences for families and youth; and support families and youth in transition and identifying/initiating access to a medical home.

   Through these contracts, Families Together also provides resources and trainings to service providers on working with and supporting CYSHCN and their families.

3. **Section Number:** Form13_Main
   Field Name: Question3
   Row Name: #3. Family members are involved in the Children with Special Health Care Needs...
   Column Name:
   Year: 2014
   Field Note:
   In previous years, parent partners have been invited to provide feedback through the development of the needs assessment and MCH Block Grant. Previous years have resulted in only parent-professional feedback on the MCH Block Grant. The changes to the public input period for this year's application is allowing for more engaged and valuable feedback from parents and families. These changes were presented to the FAC members who expressed excitement and interest in providing feedback through our public input survey.

   Additionally, FAC members have and continue to provide valuable feedback to CYSHCN staff throughout the year on needed services or potential project activities. In August 2013, a strategic planning session will be held with the FAC to identify possible changes to the CYSHCN program in coming years. It is understood and expected that changes within the Affordable Care Act, Kansas Managed Care initiatives, and other MCH efforts will likely cause a shift in the provision of CYSHCN services. It is imperative that our family partners be engaged from the beginning in conversations related to potential changes in services, delivery of services, and appropriate supports for families. There will be a minimum of three strategic planning sessions and each will engage families.

4. **Section Number:** Form13_Main
   Field Name: Question4

Row Name: #4. Family members are involved in service training of CSHCN staff and providers.
Column Name:
Year: 2014
Field Note:
The Parent Support Navigator program continues to be supported through MCH and external funds. This project is undergoing a transition as the primary funding source, the HRSA D-70 grant, has come to an end and Families Together, the Kansas affiliate of Family Voices, has identified potential expansion opportunities by shifting from specialty care clinics to primary care medical homes or federally qualified health centers. Current efforts are underway to determine the future of this project and the parent navigators. It is anticipated that a formal expansion plan be established in the fall of 2013 for continued support.

Title V contracts with Families Together to train parents, youth and providers on many different topics including medical home and health care transition. Families Together conducts outreach to a variety of providers, including health and education, to educate about the needs of the CYSHCN population and their families. Additionally, family members are eligible to apply to become a Families Together trainer and conduct trainings for other families.

5. **Section Number:** Form13_Main
Field Name: Question5
Row Name: #5. Family members hired as paid staff or consultants to the State CSHCN program...
Column Name:
Year: 2014
Field Note:
Through the project described in Question 4 (see note), parent consultants were hired as the Parent Support Navigators(s) in a care coordination pilot project. This model will be utilized in any expansion efforts. Additionally, stipends and supports for parent consultants are provided through the CYSHCN Family Advisory Council. CYSHCN and contracts provide Families Together partial funding for multiple staff positions within their organization.

6. **Section Number:** Form13_Main
Field Name: Question6
Row Name: #6. Family members of diverse cultures are involved in all of the above activities
Column Name:
Year: 2014
Field Note:
Through the CYSHCN Family Advisory Council, an active effort is made to ensure families from the various cultural and geographical areas of KS are represented. Approximately 10% of the CYSHCN Family Advisory Council members represent the Hispanic population and 30% represent rural geographic areas throughout Kansas. FAC member recruitment is ongoing to ensure diversity. Recently, a bilingual parent-professional was invited to participate in the interview team for a new CYSHCN staff person to ensure the candidate was able to meet the needs of the Spanish speaking families as well as express the compassion necessary to effectively work with families in our state.

Form 14
List of MCH Priority Needs

[Sec. 505(a)(5)]

State: KS FY: 2014

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Kansas women need early and comprehensive health care before, during and after pregnancy.
2. The mental health and behavioral health needs of pregnant women and new mothers should be addressed.
3. Kansas preterm births, LBW and infant mortality should be reduced.
4. Kansas women need support to increase initiation, duration, and exclusivity of breastfeeding.
5. All Kansas children and youth should receive health care through medical homes.
6. Child and adolescent risk behaviors relating to alcohol, tobacco and other drugs should be reduced.
7. Kansas children and youth need to achieve and maintain healthy weight
8. All CYSHCN should receive coordinated, comprehensive care within a medical home.
9. Kansas CYSHCN need early transition planning and services necessary to achieve maximum potential in all aspects of adult life, including health care, work and independence.
10. Financing for CYSHCN services should minimize financial hardship for their families

Form Notes for Form 14

None

Field Level Notes

None

Form 15
Technical Assistance(TA) Request

STATE: KS

APPLICATION YEAR: 2014

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Develop and apply a funding formula for grants awarded to local health departments for MCH service delivery.	Allocations by county were set years ago (no formula/criteria); awards haven't changed based on population, services, needs assessments.	Expert, peer states with similar structure (Missouri) or others of similar size
2.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
3.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National			

	Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

Form Notes for Form 15

None

Field Level Notes

None

Form 16
State Performance and Outcome Measure Detail Sheet
State: KS

SP() # 2

Performance Measure:	The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.
Status:	Active
Goal	Improve mental health and behavioral health of pregnant women and new mothers.
Definition	N/A **Numerator:** The estimated number of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days. **Denominator:** The estimated number of women in their reproductive years(18-44 years) during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	MICH-11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women. MICH-11.1 Alcohol Target: 98.3 percent MICH-11.2 Binge drinking Target: 100 percent
Data Sources and Data Issues	Kansas Behavioral Risk Factor Surveillance System (BRFSS)
Significance	The use of alcohol, tobacco, and illegal substances during pregnancy is a major risk factor for low birth weight and other poor infant outcomes. Alcohol use is linked to fetal death, LBW, growth abnormalities, mental retardation, and fetal alcohol syndrome (FAS). Overall rates of alcohol use during pregnancy have increased during the 1990s, and the proportion of pregnant women using alcohol at higher and more hazardous levels has increased substantially. (Reference: HP2010)

SP() # 3

Performance Measure:	The percent of live births that are born preterm less than 37 weeks of gestation.
Status:	Active
Goal	Reduce preterm and low birthweight births, and infant mortality.
Definition	Preterm births are defined as live births that occurred before the 37th week of pregnancy. **Numerator:** The Number of resident live births born preterm less than 37 weeks of gestation during the reporting period. **Denominator:** The Number of resident live births during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	MICH-9: Reduce preterm births MICH-9.1 Total preterm births Target: 11.4 percent MICH-9.2 Late preterm or live births at 34 to 36 weeks of gestation Target: 8.1 percent MICH-9.3 Live births at 32 to 33 weeks of gestation Target: 1.4 percent MICH-9.4 Very preterm or live births at less than 32 weeks of gestation Target: 1.8 percent
Data Sources and Data Issues	Kansas certificate of live birth
Significance	Perterm birth is a major determinant of infant mortality and morbidity and is the leading cause of death among newborns during the first month of life in the U.S. Infants born before 37 weeks gestation are at higher risk than infants born full-term for neurodevelopmental, respiratory, gastrointestinal, immune system, central nervous system, hearing and vision problems. Infants born preterm have longer hospital stys than full-term infants. Nationally, newborns with no complications stay an average of 1.5 days in the hospital, compared with an average of 13 days for preterm infants. Preschool and school-age children who are born preterm can also experience learning difficulties, and more behavioral problems later in life. Infants born very preterm (<32 weeks gestation) are at highest risk for death and life-long disability. (Reference: 2010 Rhode Island Kids Count Factbook.) Kansas baseline for 2002 was 8.7% of live births born preterm less than 37 weeks of gestation.

SP() # 5

Performance Measure:	The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home.
Status:	Active
Goal	All children and youth receive health care through medical homes.
Definition	Medical Home as defined by AAP is derived from 19 questions asked in five core areas. These core areas ask parents whether the child has 1) personal doctor or nurse, 2) usual source for sick and well care, 3) family-centered care, 4) no problems getting needed referrals, and 5) effective care coordination when needed (including translation services). A child was defined to have a medical home if they answered yes to first core key areas and if needed answered yes to core areas 4 and 5. **Numerator:** The estimated number of children who receive care that meets the (AAP) definition of medical home during the reporting period. **Denominator:** The estimated number of children during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	MICH–30: Increase the proportion of children who have access to a medical home. Target: 63.3 percent. Baseline: 57.5 percent of children under age 18 years had access to a medical home in 2007.
Data Sources and Data Issues	National Survey of Children's Health
Significance	Providing primary care to children and youth in a "medical home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

SP() # 6

Performance Measure:	The percent of high school students who had at least one drink of alcohol during the past 30 days.
Status:	Active
Goal	Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs.
Definition	N/A **Numerator:** The estimated number of students who had at least one drink of alcohol on at least 1 day during the previous 30 days. **Denominator:** The estimated number of students during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	SA–14.4 Reduce the proportion of adolescents engaging in binge drinking during the past month Target: 8.5 percent. Baseline: 9.4 percent of adolescents aged 12 to 17 years reported that they engaged in binge drinking during the past month in 2008. Target setting method: 10 percent improvement. SA–14.1 Reduce the proportion of high school seniors engaging in binge drinking in the past 2 weeks Target: 22.7 percent. Baseline: 25.2 percent of high school seniors reported that they engaged in binge drinking during the past 2 weeks in 2009. Target: 10 percent improvement.
Data Sources and Data Issues	Youth Risk Behavior Survey (YRBS).
Significance	Adolescent alcohol use remains a continuing problem for Kansas and the U.S. Young people between the ages of 12 and 20 are more likely to use alcohol than use tobacco or illicit drugs and drink considerably more on average per occasion, 5 drinks, than adults. The consequences of underage drinking include higher rates of risk sexual behaviors, injury (including car crashes), crime (including homicide, physical and sexual assaults), suicide, and death from alcohol poisoning. The baseline rate in 2009 for Kansas was 42.4% of youth drank alcohol in the past month since the survey.

SP() # 7

Performance Measure:	The Percent of children who are obese.
Status:	Active
Goal	Help all children and youth achieve and maintain healthy weight.
Definition	Obese is defined as children with BMI-for-age >= 95th percentile. **Numerator:** The number of WIC participant children ages 2-<5 at >= 95 percentile during the reporting period(unduplicated). **Denominator:** The number of WIC participant children ages 2-<5 during the reporting period (unduplicated). **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	NWS-10 Reduce the proportion of children and adolescents who are considered obese NWS–10.1 Children aged 2 to 5 years. Target: 9.6 percent. Baseline: 10.7 percent of children aged 2 to 5 years were considered obese in 2005–08. NWS–10.2 Children aged 6 to 11 years. Target: 15.7 percent. Baseline: 17.4 percent of children aged 6 to 11 years were considered obese in 2005–08. NWS–10.3 Adolescents aged 12 to 19 years. Target: 16.1 percent. Baseline: 17.9 percent of adolescents aged 12 to 19 years were considered obese in 2005–08. NWS–11.4 (Developmental) Prevent inappropriate weight gain in children and adolescents aged 2 to 19
Data Sources and Data Issues	Pediatric Nutrition Surveillance System (PedNSS),CDC, Kansas WIC Program - Table 2C, Summary of Health Indicators Children ages 2-<5. The PedNSS data will be used as a proxy measure.
Significance	Maintenance of healthy weight is a major goal to reduce the burden of illness and its consequent reduction in quality of life and life expectancy. Patterns of healthful eating behavior need to begin in childhood and be maintained throughout adulthood. Overweight and obesity acquired during childhood or adolescence may persist into adulthood and increase the risk for some chronic diseases later in life. Kansas baseline for 2003 was 28.6%.

SP() # 9

Performance Measure:	The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.
Status:	Active
Goal	YSHCN receive services necessary to make transitions to all aspects of adult life, including health care, work, and independence.
Definition	This SPM was chosen to specifically measure the transition to medical care age 13 to 25. The Kansas CSHCN program serves children through age 21. NPM 6 looks at the broad definition of transition (health care, work and independence) for children 0-18. **Numerator:** The estimated number of YSHCN that the doctor or other health care providers usually or always encourage the youth to take responsibility for their health care needs. **Denominator:** The estimated number of YSHCN (ages 12-17). **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	DH–5: Increase the proportion of YSHCN whose health care provider has discussed transition planning Target: 45.3 percent. Baseline: 41.2 percent of youth with special health care needs had health care providers who discussed transition planning from pediatric to adult health care in 2005–06.
Data Sources and Data Issues	National Survey of Children with Special Health Care Needs
Significance	The transition of youth to adulthood remains a priority to fulfill the vision contained in President George W. Bush's "New Freedom Initiative: Delivering on the Promise" (March 2002). Over 90% of CSHCN now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. The baseline rate for CYSHCN in Kansas with a medical home is 50.7%.

SP() # 11

Performance Measure:	The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.
Status:	Active
Goal	To increase the proportion of newborns who are enrolled in appropriate intervention services no later than age 6 months.
Definition	N/A **Numerator:** The number of infants with PCHL enrolled in Early Intervention by 6 months of age. **Denominator:** The number of infants identified with PCHL. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	Related to Hearing and Other Sensory or Communication Disorders Objective 1.3: Enrollment of infants with confirmed hearing loss for intervention services no later than age 6 months.
Data Sources and Data Issues	SoundBeginning Program - State based Early Hearing Detection and Intervention (EHDI) Program
Significance	The advantages of early intervention of hearing impairments are indisputable and include necessary follow-up of free and appropriate enrollment in habilitation and education programs

Form Notes for Form 16

None

Field Level Notes

None

Form 17
Health Systems Capacity Indicators
Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data
State: KS

Form Level Notes for Form 17

None

Health Systems Capacity #01

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	26.9	24.8	23.0	20.3	20.3
Numerator	545	509	472	414	414
Denominator	202,529	205,385	205,492	203,655	203,655
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Summer 2014.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Hospital Association. Kansas hospital discharge data, 2011. Accessed through the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

3. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas hospital discharge data, 2010, Kansas Hospital Association. Accessed through the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

Health Systems Capacity #02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	89.4	71.5	87.0	82.0	93.6
Numerator	17,295	14,043	17,165	14,808	14,311
Denominator	19,351	19,638	19,732	18,063	15,297
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2011-09/30/2012 (FY 2012).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2010-09/30/2011 (FY 2011).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

3. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2009-09/30/2010 (FY 2010).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

Health Systems Capacity #03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	66.0	58.8	77.9	65.7	70.9
Numerator	268	231	233	326	378
Denominator	406	393	299	496	533
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2011-09/30/2012 (FFY 2012).
   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2010-09/30/2011 (FFY 2011).
   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

3. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2009-09/30/2010 (FFY 2010).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

Health Systems Capacity #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	77.6	79.0	79.8	81.8	81.8
Numerator	30,573	30,713	30,914	30,852	30,852
Denominator	39,423	38,861	38,730	37,702	37,702
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
   Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

3. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
   Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	81.0	85.0	78.4	95.1	97.6
Numerator	202,289	218,523	234,284	304,163	322,152
Denominator	249,763	257,147	298,994	319,926	329,923
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

   Data Source: Medicaid paid claims data file, Division of Health Care Finance, Kansas Department of Health and Environment (calendar year 2012).

   Numerator = # of unduplicated consumers =329,923
   Denominator = # of unduplicated Medicaid beneficiaries = 322,152
   Percent = 102.4%

   Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2010 can be paid in 2011, and services in 2011 can be paid in 2012. Therefore, consumer counts are higher than beneficiary counts.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

   Data Source: Medicaid paid claims data file, Division of Health Care Finance, Kansas Department of Health and Environment (calendar year 2011).

   Numerator = # of unduplicated consumers =319,926
   Denominator = # of unduplicated Medicaid beneficiaries = 304,163
   Percent = 105.2%

   Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2009 can be paid in 2010, and services in 2010 can be paid in 2011. Therefore, consumer counts are higher than beneficiary counts.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

   Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2010).

   Numerator = # of unduplicated consumers =298,994
   Denominator = # of unduplicated Medicaid beneficiaries = 234,284
   Percent = 127.6%

   Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2008 can be paid in 2009, and services in 2009 can be paid in 2010. Therefore, consumer counts are higher than beneficiary counts.

Health Systems Capacity #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	56.3	58.1	58.6	60.8	54.7
Numerator	24,094	26,380	28,634	31,618	31,189
Denominator	42,826	45,409	48,875	52,007	57,031
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2011-09/30/2012 (FFY 2012)
   Numerator=Number of eligible receiving any dental services.
   Denominator=Number of individuals eligible for Kan Be Healthy.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2010-09/30/2011 (FFY 2011)
   Numerator=Number of eligible receiving any dental services.
   Denominator=Number of individuals eligible for Kan Be Healthy.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2009-09/30/2010 (FFY 2010)

   Numerator=Number of eligible receiving any dental services.
   Denominator=Number of individuals eligible for Kan Be Healthy.

Health Systems Capacity #08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	6,822	7,287	7,721	8,034	8,388
Denominator	6,822	7,287	7,721	8,034	8,388
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: http://www.childhealthdata.org/browse/titlev/state-ssi-data

   Numerator=Number of children under age 16 receiving federally administered SSI payments
   Denominator= Number of children under age 16 receiving federally administered SSI payments

   Due to SSA requirements, the CYSHCN program no longer receives monthly printouts or disability determination forms for those clients in Kansas receiving SSI benefits. In Kansas, all children receiving SSI are eligible for Medicaid and therefore have access to needed rehabilitation services through Medicaid coverage.

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: http://www.childhealthdata.org/browse/titlev/state-ssi-data

   Numerator=Number of children under age 16 receiving federally administered SSI payments
   Denominator= Number of children under age 16 receiving federally administered SSI payments

   Due to SSA requirements, the CYSHCN program no longer receives monthly printouts or disability determination forms for those clients in Kansas receiving SSI benefits. In Kansas, all children receiving SSI are eligible for Medicaid and therefore have access to needed rehabilitation services through Medicaid coverage.

3. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: http://www.childhealthdata.org/browse/titlev/state-ssi-data

   Numerator=Number of children under age 16 receiving federally administered SSI payments
   Denominator= Number of children under age 16 receiving federally administered SSI payments

   Due to SSA requirements, the CYSHCN program no longer receives monthly printouts or disability determination forms for those clients in Kansas receiving SSI benefits. In Kansas, all children receiving SSI are eligible for Medicaid and therefore have access to needed rehabilitation services through Medicaid coverage.

Form 18
Health Systems Capacity Indicator #05
(Medicaid and Non-Medicaid Comparison)
State: KS

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
a) *Percent of low birth weight (< 2,500 grams)*	2011	Payment source from birth certificate	8.9	6.4	7.2
b) *Infant deaths per 1,000 live births*	2011	Matching data files	7.3	5.5	6.2
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2011	Payment source from birth certificate	63.7	84.4	77.3
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2011	Payment source from birth certificate	72.5	86.8	81.8

Form 18
Health Systems Capacity Indicator #06(Medicaid eligibility level)
State: KS

INDICATOR #06 *The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)
a) *Infants (0 to 1)*	2012	150
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2012	133 100
c) *Pregnant Women*	2012	150

Form 18
Health Systems Capacity Indicator #06(SCHIP eligibility level)
State: KS

INDICATOR #06 *The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL SCHIP
a) *Infants (0 to 1)*	2012	150
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2012	150 150
c) *Pregnant Women*	2012	150

Form Notes for Form 18

None

Field Level Notes

1. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Infant
   Row Name: Infants
   Column Name:
   Year: 2014
   Field Note:
   CHIP eligibility for infants (0-1): 133-150%

2. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Children
   Row Name: SCHIP Children
   Column Name:
   Year: 2014
   Field Note:
   CHIP eligibility for
   young children (1-5): 133-150%
   older children (6-18): 100-150%

3. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2014
   Field Note:
   CHIP eligibility for pregnant women: Over 150% (if they are in CHIP and pregnant - but that is a rare occurrence)

4. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2014
   Field Note:
   Data source: Live birth certificate (resident) data, 2011. Bureau of Epidemiology and Public Health Informatics, KDHE.

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

   Medicaid population - includes live births records that checked as "Medicaid"
   Non-Medicaid population - includes live birth records that checked as "private/Employer Ins., selfpay, Indian Health Service, CHAMPUS/TRICARE, other government, and other".
   All population - includes all live birth records regardless of "principal source of payment for this delivery" status.
   Live birth records with unknown/missing values for birth weight were excluded from analysis.

5. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2014
   Field Note:
   Data source:
   Numerator: Linked death and birth file, 2011 death cohort. Bureau of Epidemiology and Public Health Informatics, KDHE.
   Denominator: Live birth certificate (resident) data, 2011. Bureau of Epidemiology and Public Health Informatics, KDHE.

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

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

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

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

6. **Section Number:** Form18_Indicator 05
   Field Name: CareFirstTrimester
   Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   Column Name:
   Year: 2014

Field Note:
Data source: Live birth certificate (resident) data, 2011. Bureau of Epidemiology and Public Health Informatics, KDHE.

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

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

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

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

Records (i.e., live births) with unknown/missing values for start date for prenatal care were excluded from analysis.

7. **Section Number:** Form18_Indicator 05
Field Name: AdequateCare
Row Name: Percent of pregnant women with adequate prenatal care
Column Name:
Year: 2014
Field Note:
Data source: Live birth certificate (resident) data, 2011. Bureau of Epidemiology and Public Health Informatics, KDHE.

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

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

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

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

Records (i.e., live births) with unknown/missing values for prenatal care were excluded from analysis.

Form 19
Health Systems Capacity Indicator - Reporting and Tracking Form
State: KS

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

Form 19
Health Systems Capacity Indicator - Reporting And Tracking Form
State: KS

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Other: Kansas Youth Tobacco Survey	3	Yes

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

Form Notes for Form 19

None

Field Level Notes

None

Form 20
Health Status Indicators #01-#05
Multi-Year Data
State: KS

Form Level Notes for Form 20

None

Health Status Indicator #01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	7.2	7.3	7.1	7.2	7.2
Numerator	3,014	3,021	2,867	2,867	2,867
Denominator	41,804	41,378	40,429	39,628	39,628
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

3. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Health Status Indicator #01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	5.7	5.6	5.5	5.6	5.6
Numerator	2,302	2,258	2,167	2,146	2,146
Denominator	40,537	40,055	39,194	38,329	38,329
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Health Status Indicator #02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	1.4	1.4	1.2	1.3	1.3
Numerator	574	577	491	527	527
Denominator	41,804	41,378	40,429	39,628	39,628
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages

3. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Health Status Indicator #02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	1.0	1.1	0.9	1.0	1.0
Numerator	420	430	368	374	374
Denominator	40,537	40,055	39,194	38,329	38,329
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Health Status Indicator #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	9.3	10.2	10.9	9.9	9.9
Numerator	54	60	66	60	60
Denominator	582,572	588,523	606,823	605,120	605,120
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas 2011 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiolgoy and Public Health Informatics, Kansas Department of Health and Environment.

   Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, Y85-Y86, Y88) for children (residents) aged 14 years and younger for the reporting period.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Kansas 2010 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiolgoy and Public Health Informatics, Kansas Department of Health and Environment.

   Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, Y40-Y86, Y88) for children (residents) aged 14 years and younger for the reporting period.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. 2010 US Census

Health Status Indicator #03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	3.6	2.7	4.0	2.8	2.8
Numerator	21	16	24	17	17
Denominator	582,572	588,523	606,823	605,120	605,120
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2011 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2010 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: 2010 US Census

Health Status Indicator #03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	26.0	21.9	27.9	19.4	19.4
Numerator	107	93	114	80	80
Denominator	411,027	423,712	408,275	411,997	411,997
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Fall 2013.

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2011 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2010 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: 2010 US Census

Health Status Indicator #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	242.4	242.6	215.4	190.4	190.4
Numerator	1,412	1,428	1,307	1,152	1,152
Denominator	582,572	588,523	606,823	605,120	605,120
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Summer 2014.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: 2010 US Census.

Health Status Indicator #04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	13.4	13.8	14.2	12.6	12.6
Numerator	78	81	86	76	76
Denominator	582,572	588,523	606,823	605,120	605,120
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available Summer 2014.

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Health Status Indicator #04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	93.7	87.6	84.5	75.7	75.7
Numerator	385	371	345	312	312
Denominator	411,027	423,712	408,275	411,997	411,997
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 column is populated with 2011 data. 2012 data will be available in Summer 2014.

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Health Status Indicator #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	28.4	30.9	27.2	29.4	31.0
Numerator	2,742	2,981	2,682	2,905	3,062
Denominator	96,531	96,536	98,459	98,702	98,702
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2012
   Denominator= U.S. Census, 2011

2. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2011
   Denominator= U.S. Census, 2011

3. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE:

   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2010
   Denominator= U.S. Census, 2010

Health Status Indicator #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2008	2009	2010	2011	2012
Annual Indicator	9.9	11.2	10.2	11.2	12.3
Numerator	4,508	5,126	4,657	5,129	5,612
Denominator	456,950	457,444	456,125	457,880	457,880
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2012.
   Denominator= U.S. Census, 2011

2. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2011.
   Denominator= U.S. Census, 2011

3. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   DATA SOURCE:

   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2010
   Denominator= U.S. Census, 2010

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HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	39,992	33,489	4,258	845	1,400	0	0	0
Children 1 through 4	163,663	138,685	16,721	2,970	5,287	0	0	0
Children 5 through 9	201,906	173,053	18,654	3,684	6,515	0	0	0
Children 10 through 14	199,559	172,334	17,666	3,762	5,797	0	0	0
Children 15 through 19	204,502	176,618	18,282	4,028	5,574	0	0	0
Children 20 through 24	207,495	177,602	18,042	3,700	8,151	0	0	0
Children 0 through 24	1,017,117	871,781	93,623	18,989	32,724	0	0	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	32,733	7,259	0
Children 1 through 4	131,798	31,865	0
Children 5 through 9	165,486	36,420	0
Children 10 through 14	167,452	32,107	0
Children 15 through 19	175,817	28,685	0
Children 20 through 24	180,694	26,801	0
Children 0 through 24	853,980	163,137	0

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HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	52	36	11	0	2	0	1	2
Women 15 through 17	896	633	94	7	13	2	46	101
Women 18 through 19	2,597	1,960	305	28	20	5	104	175
Women 20 through 34	31,858	26,615	2,168	218	843	46	550	1,418
Women 35 or older	4,222	3,494	189	13	232	5	50	239
Women of all ages	39,625	32,738	2,767	266	1,110	58	751	1,935

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	35	16	1
Women 15 through 17	583	313	0
Women 18 through 19	1,950	645	2
Women 20 through 34	27,196	4,629	33
Women 35 or older	3,529	690	3
Women of all ages	33,293	6,293	39

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HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	247	171	38	7	5	0	9	17
Children 1 through 4	46	33	3	0	1	0	2	7
Children 5 through 9	35	28	3	0	0	0	2	2
Children 10 through 14	27	16	6	2	0	0	2	1
Children 15 through 19	104	84	8	0	1	0	3	8
Children 20 through 24	193	152	20	1	3	0	6	11
Children 0 through 24	652	484	78	10	10	0	24	46

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	168	58	21
Children 1 through 4	28	18	0
Children 5 through 9	24	10	1
Children 10 through 14	17	10	0
Children 15 through 19	75	25	4
Children 20 through 24	162	28	3
Children 0 through 24	474	149	29

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HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Final

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	809,622	694,179	75,581	15,289	24,573	0	0	0	2011
Percent in household headed by single parent	21.5	19.0	53.8	33.5	18.3	19.5	38.6	31.8	2010
Percent in TANF (Grant) families	5.9	4.5	14.0	5.4	4.0	0.0	0.0	0.0	2011
Number enrolled in Medicaid	256,325	190,282	39,974	5,082	5,567	384	0	15,036	2011
Number enrolled in SCHIP	61,343	48,753	5,778	826	1,501	92	0	4,393	2011
Number living in foster home care	8,264	6,497	1,603	110	40	8	0	6	2011
Number enrolled in food stamp program	196,413	140,857	32,566	3,015	3,827	280	6,004	9,864	2011
Number enrolled in WIC	97,048	74,127	10,662	3,131	1,735	217	7,176	0	2011
Rate (per 100,000) of juvenile crime arrests	861.0	755.9	2,078.3	336.2	669.0	0.0	0.0	0.0	2011
Percentage of high school drop-outs (grade 9 through 12)	2.1	1.7	3.7	4.4	1.7	0.0	2.6	0.0	2011

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	673,286	136,336	0	2011
Percent in household headed by single parent	0.0	31.8	0.0	2010
Percent in TANF (Grant) families	5.7	6.9	0.0	2011
Number enrolled in Medicaid	192,208	64,115	2	2011
Number enrolled in SCHIP	45,334	16,007	2	2011
Number living in foster home care	7,314	913	37	2011
Number enrolled in food stamp program	153,027	43,386	0	2011
Number enrolled in WIC	64,512	32,524	0	2011
Rate (per 100,000) of juvenile crime arrests	825.3	1,007.8	0.0	2011

Percentage of high school drop-outs (grade 9 through 12)	0.0	2.8	0.0	2011

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HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	495,726
Living in urban areas	579,559
Living in rural areas	201,573
Living in frontier areas	28,490
Total - all children 0 through 19	809,622

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

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HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	2,871,238
Percent Below: 50% of poverty	5.7
100% of poverty	13.6
200% of poverty	32.7

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HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	809,622
Percent Below: 50% of poverty	7.4
100% of poverty	18.4
200% of poverty	41.8

Form Notes for Form 21

None

Field Level Notes

1. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2014
   Field Note:
   DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2011, United States resident population from the Vintage 2010 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau.

   Note-- Asian and Pacific Islander racial categories have been combined.
2. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2014
   Field Note:
   DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2011, United States resident population from the Vintage 2010 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau.

   Note-- Asian and Pacific Islander racial categories have been combined.
3. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2014
   Field Note:
   Source: U.S. Census Bureau, Asian = Asian and Native Hawaiian/Other Pacific Islander
4. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2014
   Field Note:
   Source: U.S. Census Bureau, American Community Survey - B11003: Family type by presence and age of own children under 18 years, 2006-2010.

   "Total NOT Hispanic or Latino" information is not available.
5. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2014
   Field Note:
   Source: Kansas Department for Children and Families, ages 0 through 18 that received TANF (Cash) assistance benefits during calender year 2011.
6. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_MedicaidNo
   Row Name: Number enrolled in Medicaid
   Column Name:
   Year: 2014
   Field Note:
   Source: Kansas Department of Health Environment, Division of Health Care Finance, 2011
7. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SCHIPNo
   Row Name: Number enrolled in SCHIP
   Column Name:
   Year: 2014
   Field Note:
   Source: Kansas Department of Health Environment, Division of Health Care Finance, 2011
8. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_FoodStampNo
   Row Name: Number enrolled in food stamp program
   Column Name:
   Year: 2014
   Field Note:
   Source: Kansas Department for Children and Families, ages 0 through 18 that received SNAP (food) assistance benefits during calender year 2011.
9. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_WICNo

Row Name: Number enrolled in WIC
Column Name:
Year: 2014
Field Note:
Source: Kansas Department of Health Environment, Nutrition and WIC Services, KWIC, 2011.

10. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2014
Field Note:
Source: Kansas Bureau of Investigation, 2011. Rates are arrests of persons ages 10-17 per 100,000 persons ages 10-17 in the resident population.

11. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2014
Field Note:
Source: Kansas Department of Education, 2011-2012 school year,
http://svapp15586.ksde.org/k12/state_reports.aspx

"Total NOT Hispanic or Latino" information is not available.

12. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2014
Field Note:
Source: U.S. Census Bureau, American Community Survey - B11003: Family type by presence and age of own children under 18 years, 2006-2010.

"Total NOT Hispanic or Latino" information is not available.

13. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2014
Field Note:
Source: Kansas Department of Education, 2011-2012 school year,
http://svapp15586.ksde.org/k12/state_reports.aspx

"Total NOT Hispanic or Latino" information is not available.

14. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U. S. Census Bureau. Bridged Race Population, 2011.
Metropolitan areas are defined as Butler, Douglas, Harvey, Johnson, Leavenworth, Miami, Sedgwick, Shawnee, Sumner, and Wyandotte.

15. **Section Number:** Form21_Indicator 10
Field Name: Urban
Row Name: Living in urban areas
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U. S. Census Bureau. Bridged Race Population, 2011.

Kansas Vital records definition of urban and semi-urban counties were used in this analysis. Counties were included if they had population densities of 40 or more persons per square mile. These Kansas counties are: Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, Wyandotte, Butler, Crawford, Franklin, Geary, Harvey, Miami, Montgomery, Reno, Riley, and Saline.

16. **Section Number:** Form21_Indicator 10
Field Name: Rural
Row Name: Living in rural areas
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U. S. Census Bureau. Bridged Race Population, 2011.

Kansas Vital records definition of rural and densely-settled rural counties were used in this analysis. Counties included had population densities between 6 and 39 persons per square mile. These counties are: Allen, Atchison, Barton, Bourbon, Cherokee, Cowley, Dickinson, Doniphan, Ellis, Finney, Ford, Jackson, Jefferson, Labette, Lyon, McPherson, Neosho, Osage, Pottawatomie, Seward, Sumner, Anderson, Brown, Clay, Cloud, Coffey, Ellsworth, Grant, Gray, Harper, Haskell, Kingman, Linn, Marion, Marshall, Mitchell, Morris, Nemaha, Norton, Ottawa, Pawnee, Philips, Pratt, Republic, Rice, Russell, Scott, Stevens, Thomas,

Wabaunesse, Washington, Wilson, and Woodson.

17. **Section Number:** Form21_Indicator 10
Field Name: Frontier
Row Name: Living in frontier areas
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U. S. Census Bureau. Bridged Race Population, 2011.

Kansas Vital records definition of frontier counties was used in this analysis. Counties included had population densities that had fewer than 6 persons per square mile. These counties are: Barber, Chase, Chautauqua, Cheyenne, Clark, Comanche, Decatur, Edwards, Elk, Gove, Graham, Greeley, Greenwood, Hamilton, Hodgeman, Jewell, Kearny, Kiowa, Lane, Lincoln, Logan, Meade, Morton, Ness, Osborne, Rawlins, Rooks, Rush, Sheridan, Sherman, Smith, Stafford, Stanton, Trego, Wallace, and Wichita.

18. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U. S. Census Bureau. Bridged Race Population, 2011.

19. **Section Number:** Form21_Indicator 11
Field Name: S11_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2014
Field Note:
DATA SOURCE:
U.S. Census Bureau. 2009-2011 American Community Survey 3-Year Estimates. B17002: Ratio of Income to poverty level in the past 12 months.
http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866279838

20. **Section Number:** Form21_Indicator 11
Field Name: S11_100percent
Row Name: 100% of poverty
Column Name:
Year: 2014
Field Note:
DATA SOURCE:
U.S. Census Bureau. 2009-2011 American Community Survey 3-Year Estimates. B17002: Ratio of Income to poverty level in the past 12 months.
http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866279838

21. **Section Number:** Form21_Indicator 11
Field Name: S11_200percent
Row Name: 200% of poverty
Column Name:
Year: 2014
Field Note:
DATA SOURCE:
U.S. Census Bureau. 2009-2011 American Community Survey 3-Year Estimates. B17002: Ratio of Income to poverty level in the past 12 months.
http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866279838

22. **Section Number:** Form21_Indicator 12
Field Name: S12_Children
Row Name: Children 0 through 19 years old
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U. S. Census Bureau. Bridged Race Population, 2011. Children 0-19 years.

23. **Section Number:** Form21_Indicator 12
Field Name: S12_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U.S. Census Bureau. 2009-2011 American Community Survey 3-Year Estimates. C17024: Age by ratio of income to poverty level in the past 12 months. Children under 18 years.

http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866118279

24. **Section Number:** Form21_Indicator 12
Field Name: S12_100percent
Row Name: 100% of poverty
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U.S. Census Bureau. 2009-2011 American Community Survey 3-Year Estimates. C17024: Age by ratio of income to poverty level in the past 12

months. Children under 18 years.

http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866118279

25. **Section Number:** Form21_Indicator 12
Field Name: S12_200percent
Row Name: 200% of poverty
Column Name:
Year: 2014
Field Note:
DATA SOURCE: U.S. Census Bureau. 2009-2011 American Community Survey 3-Year Estimates. C17024: Age by ratio of income to poverty level in the past 12 months. Children under 18 years.

http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866118279

26. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2014
Field Note:
Source: Kansas Department for Children and Families, Prevention and Protection Services, Children in Out of Home Placement, Family and Child Tracking System (FACTS), SFY 2011.