Maternal and Child Health Services Title V Block Grant

Kansas

Created on 7/20/2015 at 12:51 PM

Table of Contents

I. General Requirements 4

I.A. Letter of Transmittal 4

I.B. Face Sheet 5

I.C. Assurances and Certifications 5

I.D. Table of Contents 5

I.E. Application/Annual Report Executive Summary 5

II. Components of the Application/Annual Report 10

II.A. Overview of the State 10

II.B. Five Year Needs Assessment Summary 18

II.B.1. Process 18

II.B.2. Findings 20

II.B.2.a. MCH Population Needs 20

II.B.2.b Title V Program Capacity 25

II.B.2.b.i. Organizational Structure 25

II.B.2.b.ii. Agency Capacity 27

II.B.2.b.iii. MCH Workforce Development and Capacity 30

II.B.2.c. Partnerships, Collaboration, and Coordination 31

II.C. State Selected Priorities 36

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures 40

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures 48

II.F. Five Year State Action Plan 49

II.F.1 State Action Plan and Strategies by MCH Population Domain 49

Women/Maternal Health 51

Perinatal/Infant Health 63

Child Health 77

Adolescent Health 89

Children with Special Health Care Needs 98

Cross-Cutting/Life Course 115

Other Programmatic Activities 118

II.F.2 MCH Workforce Development and Capacity 122

II.F.3. Family Consumer Partnership 126

II.F.4. Health Reform 128

II.F.5. Emerging Issues 130

II.F.6. Public Input 130

II.F.7. Technical Assistance 135

III. Budget Narrative **137**

III.A. Expenditures 138

III.B. Budget 139

IV. Title V-Medicaid IAA/MOU **141**

V. Supporting Documents **142**

VI. Appendix **143**

Form 2 MCH Budget/Expenditure Details 144

Form 3a Budget and Expenditure Details by Types of Individuals Served 149

Form 3b Budget and Expenditure Details by Types of Services 151

Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated 154

Form 5a Unduplicated Count of Individuals Served under Title V 157

Form 5b Total Recipient Count of Individuals Served by Title V 159

Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX 161

Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data 164

Form 8 State MCH and CSHCN Directors Contact Information 166

Form 9 List of MCH Priority Needs 168

Form 10a National Outcome Measures (NOMs) 170

Form 10a National Performance Measures (NPMs) 195

Form 10b State Performance/Outcome Measure Detail Sheet 198

Form 10c Evidence-Based or Informed Strategy Measure Detail Sheet 199

Form 10d National Performance Measures (NPMs) (Reporting Year 2014 & 2015) 200

Form 10d State Performance Measures (SPMs) (Reporting Year 2014 & 2015) 221

Form 11 Other State Data 232

State Action Plan Table 233

I. General Requirements

I.A. Letter of Transmittal

Bureau of Family Health
Curtis State Office Building
1000 SW Jackson, Suite 220
Topeka, KS 66612

Kansas

Phone: 785-291-3368
Fax: 785-296-6553
www.kdheks.gov/bfh

Susan Mosier, MD, Secretary | Department of Health & Environment | Sam Brownback, Governor

July 15, 2015

HRSA Grants Application Center
ATTN: MCH Block Grant
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

Dear Sirs:

Attached to this letter of transmittal is a signed Application for Federal Assistance Standard Form 424 for Kansas' web-based submission of the FFY 2016 Maternal and Child Health Services Block Grant Application and FFY 2014 Annual Report. Kansas is not requesting a waiver of the 30 percent allotment.

If you have questions concerning this application, please contact Rachel Sisson at 785-296-1310 or rsisson@kdheks.gov. Thank you for your consideration.

Sincerely,

Susan K. Mosier

Susan Mosier, MD, MBA
Secretary and State Health Officer
Kansas Department of Health and Environment

Enc
RM/rs

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

I.E. Application/Annual Report Executive Summary

The purpose of this summary is to orient the reader to the Title V Maternal & Child Health (MCH) Services Block Grant, highlight key programmatic themes and data points, and provide specific examples of MCH program activities. The Block Grant is administered by the Kansas Department of Health and Environment, Bureau of Family Health.

What is Title V?
Title V of the Social Security Act is the longest-standing public health legislation in American history. Enacted in 1935, Title V is a federal-state partnership that promotes and improves MCH. According to each state's unique needs, Title V supports a spectrum of services, from infrastructure-building services like quality assurance and policy development, to gap-filling direct health care for children and youth with special health care needs. Title V resources are directed towards MCH priority populations: pregnant women, mothers, infants, women of reproductive years, children and adolescents, and children and youth with special health care needs.

How does the MCH Block Grant Program meet the unique needs of Kansas families?
Kansas is required to complete a statewide needs assessment every five years. This process identifies Kansas MCH program priorities and determines a plan of action to address those priorities. The most recent Kansas needs assessment, referred to as *MCH 2020*, identified eight MCH program priorities for the time period 2016-2020.

MCH 2020 (2016-2020) Kansas MCH Program Priorities

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

- NPM1: Well-woman visit (Percent of women with a past year preventive medical visit)
- NPM4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)

- NPM6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- NPM7: Child injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through9 and adolescents ages 10 through 19)
- NPM9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)
- NPM10: Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)
- NPM11: Medical home (Percent of children with and without special health care needs having a medical home)
- NPM14: Smoking during pregnancy and household smoking (A. Percent of women who smoke during pregnancy and B. Percent of children who live in households where someone smokes)

Activities & Program Highlights

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

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

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

Women/Maternal Health and Perinatal/Infant Health

Infant Mortality Collaborative Innovation and Improvement Network (CoIIN): The Kansas Department of Health & Environment (KDHE) along with several partners and organizations including the March of Dimes and the Kansas Infant Death and SIDS Network is actively engaged in the Infant Mortality CoIIN, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. Each participating state selected two to three strategies to focus on as part of the national platform. Kansas' selections include: 1) Smoking cessation (before, during and after pregnancy) and 2) Early term and preterm birth.

Perinatal Community Collaboratives/Birth Disparities Programs: The Kansas MCH Program, in collaboration with local communities and the broader network of local health care and community service providers, are involved in an on-going process of developing grassroots perinatal care collaboratives using the March of Dimes, "Becoming A Mom/Comenzando Bien" as a consistent and proven prenatal care education curriculum. The March of Dimes began development of these community collaboratives in 2010, bringing prenatal education and clinical prenatal care together to create the comprehensive Healthy Babies are Worth the Wait/Becoming a Mom (BAM) program. There are currently seven established sites in Kansas. Preliminary birth outcome data shows statistically significant improvements including fewer preterm births and fewer low-birth weight babies. Sites are reporting increases in breastfeeding initiation rates and lowered infant mortality rates.

Communities Supporting Breastfeeding: The long-term goal of the Communities Supporting Breastfeeding (CSB) project is to improve exclusive breastfeeding rates for infants at three and six months of age in Kansas. The objective of this project is to assist communities with achieving the CSB designation by the Kansas Breastfeeding Coalition (KBC) as defined by the following six criteria needed to provide multifaceted breastfeeding support across several sectors: 1) A local breastfeeding coalition with a page on the KBC website listing local breastfeeding resources; 2) Peer breastfeeding support group(s) such as La Leche League or similar mother-to-mother group; 3) One or more community hospitals participating in High 5 for Mom & Baby or Baby Friendly ® USA; 4) One business for every 1000 community citizens* or 25 (whichever is less) participate in the "Breastfeeding Welcome Here" program; 5) One business for every 5000 community citizens or 10 (whichever is less) receive a Breastfeeding Employee Support Award from Kansas Business Case for Breastfeeding; and 6) A minimum of 20 child care providers completing How to Support the Breastfeeding Mother and Family course as provided by an approved training organization. *Number of community citizens defined by 2010 census.

Delivering Change: Delivering Change is a comprehensive approach to eliminating disparities in perinatal health in Geary County, Kansas, that focuses on individual/family level health, evidence-based practices, standardized approaches, and quality improvement. KDHE as the lead agency is aligning Delivering Change with Title V and Kansas MCH programs and services to directly support individual participants. Program models include: OB Navigator; Becoming a Mom; Period of PURPLE Crying; Triple P-Positive Parenting Program; Parents as Teachers. Key partners in delivering programs include the Geary Community Hospital, Geary County Health Department, and Flint Hills OBGYN.

Critical Congenital Heart Defect Newborn Screening (CCHD): The Kansas Newborn Screening (NBS) program launched a comprehensive public health quality initiative in November 2013. The initiative was launched in partnership with birthing facilities in response to recommendations referred to the KDHE Secretary from the Newborn Screening Advisory Council. Recommendations addressed the need for all newborns to be screened for CCHD; assurance of prompt care; connection to resources; short- and long-term follow-up; systems to support hospital-based data collection, management, evaluation and quality assurance; and improvement of overall health outcomes for infants with CCHD. The successful initiative has resulted in Kansas hospitals and birthing facilities screening infants for CCHD prior to discharge.

Child Health and Adolescent Health

The KDHE Bureau of Family Health, 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 priorities identified as part of the five year needs assessment (2010-2015): 1) all children and youth receive health care through medical homes; 2) reduce child and adolescent risk behaviors with an emphasis on alcohol reduction and deterring tobacco use among teens; and 3) all children and youth achieve and maintain healthy weight through activity and healthy eating. In an effort to address the identified needs and priorities for children and adolescents, a number of initiatives involving state and local programs have been launched. The most recent Maternal and Child Health five-year needs assessment is complete and new priorities and objectives have been identified. As part of the comprehensive statewide needs assessment, the MCH Program partnered with Kansas State University, Research and Extension to conduct an adolescent health assessment and a state adolescent health plan.

Children and Youth with Special Health Care Needs

A strategic planning process began mid-2013 in an effort to enhance and improve services provided to families through the KS-SHCN program. New priorities have been selected by families, providers, community partners, and other key stakeholders. These five priorities are: cross-system care coordination, behavioral health integration, addressing family caregiver health, direct health services and supports, and training and education. The new priorities align closely in many ways with the 2010-2015 objectives, however, have provided a new direction for the

program. The KS-SHCN program was accepted into Cohort 2 of the Association of Maternal and Child Health Programs (AMCHP) Workforce Development Center (WDC) to address the needs of families of CYSHCN through collaboration, systems integration, and increased capacity for telemedicine/telehealth. The target population includes Kansas CYSHCN and their families in rural communities. The primary objective of this project is to increase capacity for utilization of utilization of telemedicine in rural communities. We will support health transformation through improved access to care and systems integration. Utilizing quality improvement and evaluation, we strive for sustainable and systemic changes for the CYSHCN population. To better meet the unique challenges of CYSHCN and their families, this project will build partnerships and engage key stakeholders to increase capacity for integration, collaboration, and systems change. The leadership team of this project consists of the state Title V CYSHCN Director and KS-SHCN Program Manager as co-leads and includes representation from Medicaid/Kancare, a community hospital partner, and coordinator for the HRSA Regional Telehealth Resource Center.

Cross-Cutting/Life Course

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

MCH Block Grant Budget Overview

(Source: Title V MCH Services Block Grant 2016 Application/2014 Annual Report, Forms 2, 3a and 3b) (SGF: State General Fund; CIF: Children’s Initiative Fund)

Federal-State Title V Block Grant Partnership

$12.6 Million

State Match: $3,567,032; **Local Match:** $4,401,548

For every $4 of Federal funds, at least $3 must be matched by state and local funds.

Aid to Local*
$4,385,468
Title V: $2,226,006; **SGF:** $1,921,548; **CIF:** $237,914
*Grants to local health departments, contracts, special health services

Where do I fit into the Title V Block Grant?

Whether you are a parent, government official, advocate, service provider, or member of the general public, the MCH Block Grant likely touches your life. Its success lies in the strength of partnerships and collaborations. The program collects input related to existing services, population needs, and emerging issues throughout the year. Your input is needed to assure that the MCH Program is guided by the needs of Kansas families. To provide feedback, please

visit our website and refer to the “Public Input” section: http://www.kdheks.gov/c-f/mch.htm.

Where can I learn more? Review the full-length MCH Block Grant at: http://www.kdheks.gov/c-f/mch.htm. The Title V Information System (TVIS) website also allows you to compare Kansas to other states: https://mchdata.hrsa.gov/TVISReports/.

II. Components of the Application/Annual Report

II.A. Overview of the State

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

Geography/Demography

Kansas, spanning 81,759 sq. miles, is divided into 105 counties with 628 cities. The U.S. Census Bureau estimates there are approximately 2,893,957 residents living in the state of Kansas (2013). The state of Kansas has a unique geographic layout that ranges from urban to frontier counties. Within each of the regions throughout the state there are few populous cities intermixed with multiple rural areas. For example, within the South Central regions lays Wichita with a population of 386,552. Within that same region also lays Pratt with a population of 6,986. This is a good example of the diversity of the Kansas population where rural communities are influenced by mid-sized cities and mid-sized cities are therefore influenced by rural communities. This provides challenges to service delivery, but also an opportunity for sharing resources among the populations.

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

The population density of Kansas was 35.4 inhabitants per square mile in 2013, a 14.2% increase from 31.2 persons per square mile in 1994. For comparison, the population density of the U.S. increased from 69.8 to 89.4 persons per square mile from 1994 to 2013, a 28.1% increase. In 2013, 36 of the state's 105 counties had population densities of less than 6.0 persons per square mile. The most sparsely populated counties were Greeley and Wallace, with a density of 1.7 persons per square mile. The most densely populated county was Johnson, with 1,197.6 persons per square mile. Several Kansas counties were re-categorized from one population-density peer group to another, to reflect population shifts indicated by the 2010 U.S. Census. As a result of these changes, the frontier, densely-settled rural, and urban peer groups had increases in population 2009-2013 of 32.1%, 12.2%, and 8.3%, respectively, while the semi-urban and rural peer groups had decreases in population of 16.7% and 12.5%, respectively.[1]

Population Growth/Change

The percent increase in the Kansas total population from 1994-2013 was 13.3%, including a 14.8% increase for Kansas males and an 11.9% increase for Kansas females. Kansas increased in population from 2,885,905 residents in 2012 to 2,893,957 residents in 2013, a 0.3% increase. Geary, Pottawatomie, and Stevens Counties had the largest relative increases in population from 2009 to 2013 with percent changes of 17.7, 13.5, and 13.4 respectively. Finney, Elk, and Kearny Counties had the largest relative decreases in population, with changes of 11.8%, 11.5% and 5.9% respectively.[1]

In 2013, there were an estimated 39,597 infants living in Kansas or about 1.4% of the total Kansas population (2,893,957). Women of reproductive age 15-44 accounted for 19.3% (558,538) of the Kansas population. The race and ethnicity composition for this group was estimated at 73.8% non-Hispanic white, 6.3% non-Hispanic black, 1.0% non-Hispanic Native American or Alaska Native, 3.7% non-Hispanic Asian and Pacific Islander, 2.4% non-Hispanic multiple race, and 12.8% Hispanic (any race).

In 2013, there were 902,980 children and adolescents aged 1 to 22 years living in Kansas, which represents 31.2% of the Kansas population. The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. About three-in-ten Kansas children and adolescents belong to a racial or ethnic minority. Across the age groups, three-in-ten young children (1 to 5 years) are part of a racial/ethnic minority versus two-in-ten young adults (20 to 22 years). About 14.3% of Kansans age 15 to 22 are Hispanic, compared to 19.1% of young children. Among families with children under 18, 29.1% are single-parent families versus married-couple families (70.5%).

According to the 2011/12 National Survey of Children's Health, 19.4% of Kansas children aged 0 to 17 (est. 139,623 children) had special health care needs. These rates represent an increase from the percentage reported in 2009/10 (17.3%) for Kansas. The reasons for this increase are not fully understood. While it is possible that the number of children and youth with special health care needs (CYSHCN) is actually increasing, it is also possible that children's conditions are more likely to be diagnosed, due to increased access to medical care or growing awareness of these conditions on the part of parents and physicians.[2]

Age

The median age of Kansans in 2013 was 36.0 years, a 5.6 percent increase from the median age of 34.1 in 1994. The median ages of Kansas males and females in 2013 were 34.6 and 37.4 respectively. Shifts in the Kansas population distribution by age from 1994 to 2013 included a decrease in the 35-44 age group of 14.6 percent. An increase of 35.3 percent in residents 45-54 years of age and 75.9 percent in residents 55-64 reflected the aging of the baby boomers. Furthermore, there were 8.7, 2.5, 16.7, 2.4 and 16.0 percent increases in the 0-4, 5-14, 15-24, 25-34 and 65-74 age-groups respectively, and a decrease of 4.8 percent in the 75 and over age-group.[1]

The prevalence of special health care needs within the child population increases with age. Older children in Kansas were twice as likely as younger children to have a special health care need. In Kansas, preschool children (aged 0-5 years) have the lowest prevalence of special health care needs (10.2%), followed by children aged 6-11 years (23.9%). Adolescents (aged 12-17 years) have the highest prevalence of special health care needs (24.3%). The higher prevalence of special health care needs among older children is likely attributable to conditions that are not diagnosed or that do not develop until later in childhood.[2]

Race/Ethnicity

According to the 2013 Census Bureau estimates, 77.1 percent of Kansans were non-Hispanic white and 5.9 percent were non- Hispanic black. Hispanics made up 11.2 percent of Kansas' population.[1] The prevalence of special health care needs varies by the child's race and ethnicity. Kansas Hispanic children (15.2%) were least likely to have a special health care need compared to non-Hispanic white children (19.6%) and non-Hispanic black children (22.3%).[2]

Diversity/Languages

According to the 2011-2013 American Community Survey, in Kansas, 2.4% of the households met the definition of being linguistically isolated compared to 4.5% of U.S. households. In Kansas, the prevalence of linguistic isolation in households varies by language spoken at home. Linguistic isolation among households speaking Spanish was 23.5%, other Indo-European languages 8.9%, Asian and Pacific Island languages 28.0%, and other languages 13.7%.[3]

Ninety-three percent (93.2%) of the people living in Kansas in 2011-2013 were native residents of the United States. About 59.2% of these residents were living in the state in which they were born. Seven percent (6.8%) of the people living in Kansas in 2011-2013 were foreign born. Of the foreign born population, 34.7% were naturalized U.S.

citizens, and 90.3% entered the country before the year 2010. About 9.7% of the foreign born entered the country in 2010 or later. Foreign born residents of Kansas come from different parts of the world.[4]

Among people at least five years old living in Kansas in 2011-2013, 11.1% spoke a language other than English at home. Of those speaking a language other than English at home, 66.4% spoke Spanish and 33.6 % spoke some other language; 39.7% reported that they did not speak English "very well." Notable is a change in Spanish speaking population in Kansas, which has been steadily increasing. The increase mirrors similar trends at the national level.[4]

Education

Kansas compares favorably with the U.S. average in terms of educational attainment with an 89.8% high school graduation rate compared with 86.0% for the U.S. Thirty percent (30.3%) of Kansans have a bachelor's degree or higher compared with 28.8% for the U.S.[5]

Income/Poverty

For 2013, the federal poverty level is $23,550 for a family of four. Children living in families with incomes below the federal poverty level are referred to as poor. Research suggests that, on average, families need an income of about twice the federal poverty level to meet their basic needs.[6]

In 2013, compared to the U.S. population, a lower percentage of Kansans lived in households with incomes below the federal poverty level (13.2% vs. 14.5% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (18.1% vs. 19.9% for the U.S.). While a decreasing trend was observed during 2010-2013, overall the 10 year period (2004-2013), Kansas experienced an increase in the poverty rate for children under age 18. Similar trends were seen in the United States.[7]

In 2013, 131,251 Kansas children under 18 years of age were living in poverty. Most of these children live within four population centers: Sedgwick County (Wichita), Wyandotte and Johnson Counties (KansasCity metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). Five counties accounted for over half of all Kansas children (72,206 children; 55.0%) in poverty: Sedgwick (29,273), Wyandotte (17,136), Johnson (10,079), Shawnee (9,513), and Douglas (3,249). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty.[8]

In 2013, the percent of Kansas' families living at or below the federal poverty level (8.6%) is lower than the U.S. (11.2%). Poverty is more common in Kansas families headed by single females and those with children in the household, regardless of race or ethnicity. In 2013, the Kansas percent of female headed households living below 100% federal poverty level (31.5%) was below the U.S. percent (41.3%). However, for the years 2004-2012, the percent of Kansas female headed households living in poverty increased and exceeded the U.S. rate.[7]

The prevalence of special health care needs varies by income group in Kansas. CYSHCN prevalence among low income families, 0-99% of the federal poverty level (FPL), was the highest group (26.4%).[2]

Health Insurance Coverage

Data from the U.S. Census Current Population Survey (CPS) show that the percentage of Kansas children under 18 years old without health insurance decreased from 9.4 in 2011 to 6.1 in 2012, a 35.1% decrease. The U.S. percentage also decreased from 9.4 in 2011 to 8.9 in 2012.

In Kansas, based on the 3-year average CPS estimates (2010-2012), 7.7% of children were uninsured. With an uninsured rate of 8.9%, children in poverty were more likely to be uninsured than children not in poverty (7.4%). About one-third of children (37.6%) were publicly insured by sources such as Medicare, Medicaid, military health care, and

the State Children's Health Insurance Program (CHIP). About 10.3% of Hispanic children did not have any health insurance, compared with 8.1% for non-Hispanic white children and 7.8% for non-Hispanic black children. Non-Hispanic white children had high rates of private health insurance coverage (64.9%) compared to non-Hispanic black and Hispanic children (41.0% and 31.8%, respectively). Non-Hispanic black and Hispanic children were the most likely to have public coverage (62.8% and 61.1%, respectively).

As family income increases, rates of private coverage increase and rates of public coverage and no coverage decrease. Children with family incomes below 100% of the poverty level were the most likely to have public coverage (77.1%) or be uninsured (8.9%). The majority (94.3%) of children with family incomes of 400% or more of the poverty level were privately insured. The CPS results indicate that a child's insurance status is related to a wide range of child and family characteristics. Socioeconomic characteristics and parental employment were found to have an especially strong relationship with a child's insurance status.

Nearly half (49.8%) of all uninsured Kansas children under age 19 live in the four largest population centers: Sedgwick County (Wichita), Johnson and Wyandotte counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). However, in the southwestern part of the state has many counties with high concentrations of uninsured children under age 19, a largely Hispanic populated area and presumably many are not KanCare (Medicaid or CHIP) eligible. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with high concentrations of children in poverty, as stated above, but the children are less likely to be uninsured than those in the southwestern part of the state.[9]

In Kansas, 89.3% of CYSHCN were reported to have been insured for all of the previous 12 months, while the remaining 10.7% were uninsured for all or some part of the year. Overall, almost 96% of CYSHCN were reported to have some type of insurance at the time of the interview: about two-thirds (64.2%) had private coverage, 25.1% had public coverage, 6.2% had both, and 4.6% had no insurance.[2]

Primary Care Access/Workforce

KDHE recognizes that while there are needs across the state, there are also unique needs in different areas of the state. Access to care has been recognized as a challenge for the maternal and child health population living in both geographic domains for different reasons. For example, women in rural areas face barriers accessing transportation and getting to providers who may be unavailable in their area. Whereas, women in more densely populated areas, have a wider availability of services yet may not have time off work or the insurance needed to receive services. Overall, KDHE has recognized that programs and providers are an important part of the landscape and the unique needs of the Kansas MCH population are being addressed throughout the state. The Bureau has been and will continue to be committed to working with local partners to address those unique needs, and to build on the successes at the local and regional levels in improving maternal and child health.

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

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

Infant Mortality Collaborative Innovation and Improvement Network (CoIIN): The Kansas Department of Health & Environment (KDHE) along with several partners and organizations including the March of Dimes (MOD) and the Kansas Infant Death and SIDS Network is actively engaged in the Infant Mortality Collaborative Improvement & Innovation Network (CoIIN) initiative, launched by the U.S. Department of Health & Human Services (DHHS) in 2012 and expanded in 2014 to include Kansas and other Region VII states. The National Institute for Children's Health

Quality (NICHQ) is leading the work. Cross-state and region collaborative work involves learning networks/sessions for six identified CoIIN strategies. Each participating state selected three strategies to focus on as part of the national platform. Kansas' selections include:

1. Smoking cessation (before, during and after pregnancy);
2. Early term and preterm birth; and
3. Preconception and inter-conception care.

The Kansas CoIIN initiative is the overarching state initiative ("Blueprint") with other state and community infant mortality activities advancing the work to drive change, increase coordination, and enhance/improve services.

Perinatal Community Collaboratives/Birth Disparities Programs: The Kansas MCH Program and the March of Dimes, Kansas Chapter in collaboration with local communities and the broader network of local health care and community service providers are involved in an on-going process of developing grassroots perinatal care collaboratives using the March of Dimes, "Becoming A Mom/Comenzando Bien" (BAM) as a consistent and proven prenatal care education curriculum. The March of Dimes Kansas Chapter began development of these community collaboratives in 2010, bringing prenatal education and clinical prenatal care together to create the comprehensive Healthy Babies are Worth the Wait (HBWW)/Becoming a Mom (BAM) program. There are currently seven established sites in Kansas. BAM partnerships have formed with the Kansas Department of Health and Environment, University of Kansas School of Medicine-Wichita, county health departments, federally qualified health centers, private obstetric practices and hospitals serving women with demonstrated high birth disparities. Preliminary birth outcome data shows statistically significant improvements including fewer preterm births and fewer low-birth weight babies. Sites are reporting increases in breastfeeding initiation rates and lowered infant mortality rates.

Communities Supporting Breastfeeding: The long-term goal of the Communities Supporting Breastfeeding (CSB) project is to improve exclusive breastfeeding rates for infants at three and six months of age in Kansas. The objective of this project is to assist six communities (Great Bend, Liberal, Hays, Parsons, Salina and Cowley County) to achieve the CSB designation by the Kansas Breastfeeding Coalition (KBC) to provide multifaceted breastfeeding support across several sectors in the community, as defined by the following six criteria:

1. A local breastfeeding coalition with a page on the KBC website listing local breastfeeding resources;
2. Peer breastfeeding support group(s) such as La Leche League or similar mother-to-mother group;
3. One or more community hospitals participating in High 5 for Mom & Baby or Baby Friendly ® USA;
4. One business for every 1000 community citizens* or 25 (whichever is lesser) participate in the "Breastfeeding Welcome Here" program;
5. One business for every 5000 community citizens or 10 (whichever is lesser) receive a Breastfeeding Employee Support Award from Kansas Business Case for Breastfeeding; and
6. A minimum of 20 child care providers in the community completing the KBC's How to Support the Breastfeeding Mother and Family course as provided by an approved training organization.

*Number of community citizens defined by 2010 census.

Healthy Start/Delivering Change: Healthy Moms, Healthy Babies: Delivering Change is a comprehensive approach

to eliminating disparities in perinatal health in Geary County, Kansas, that focuses on individual/family level health, evidence-based practices, standardized approaches, and quality improvement. The Kansas Department of Health and Environment (KDHE) as the lead agency, is aligning Delivering Change with Title V and Kansas MCH programs and services to directly support individual participants. Delivering Change expands on existing work of the Geary County Perinatal Coalition to integrate a comprehensive array of services and maximizes the resources in Geary County through a system of mutually reinforcing activities that provide appropriate, high quality services to meet the needs of women, infants, and families. Key program models include: OB Navigator; Becoming a Mom/Comenzando bien©; Period of PURPLE Crying; Triple P – Positive Parenting Program; and Parents as Teachers. Key partners in delivering these programs include the Geary Community Hospital, the Geary County Health Department and Flint Hills OB/GYN. Delivering Change uses a Collective Impact approach that will support achieving the three project goals: 1) Develop a comprehensive, coordinated perinatal system that leads to improved women's health; 2) Improve the quality of services available to pregnant women and new mothers; and 3) Develop a system of programs, services and partnerships that strengthen family resilience. A comprehensive process and outcome evaluation will ensure accountability through quality improvement and performance monitoring.

Critical Congenital Heart Defect (CCHD): The Kansas Newborn Screening (NBS) program launched a comprehensive public health quality initiative in November 2013. The initiative was launched in partnership with birthing facilities in response to recommendations referred to the KDHE Secretary from the Newborn Screening Advisory Council. Recommendations addressed the need for all newborns to be screened for CCHD; assurance of prompt care; connection to resources; short- and long-term follow-up; systems to support hospital-based data collection, management, evaluation and quality assurance; and improvement of overall health outcomes for infants with CCHD. The successful initiative has resulted in 98.6% of Kansas hospitals and birthing facilities committed to screening infants for CCHD prior to discharge.

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV): KDHE is the lead agency for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, a federal initiative to improve health and development outcomes for at-risk children through evidence-based home visiting programs offered on a voluntary basis to pregnant women and children birth to age five. The MIECHV Program is designed to strengthen and improve Title V MCH programs and activities, improve coordination of services for at-risk communities, and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. In the at-risk Kansas communities targeted for implementation - Wyandotte County (urban Kansas City, Kansas) and Montgomery, Labette, and Cherokee counties (rural southeast Kansas) - Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs and, in Wyandotte County specifically, a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants Endangered by Substance Abuse (TIES) Program, have scaled up. Since the launch of MIECHV program services in January 2012 through December 2014, 781 enrolled pregnant women and families with infants and young children received home visiting services. A coordinated outreach and referral system has been established in the southeast Kansas counties and an established screening and referral system in Wyandotte County has expanded. An in-home intervention for mothers identified with depression was initiated with Wyandotte County MIECHV program sites. Front line and supervisory staff from local implementing agencies have received enhanced training and consultation on a variety of topics. Rigorous process and impact evaluations are being conducted. A cross-program performance management and data system has been developed and implemented to collect and report data including 35 required indicators in the six MIECHV benchmark areas:

1. maternal & newborn health;
2. child injuries, child abuse & neglect, emergency visits;
3. school readiness & achievement;

4. domestic violence;
5. family economic self-sufficiency; and
6. coordination and referrals for other community resources and supports.

Kansas data reported through September 2014 showed improvements in 29 of the 35 identified indicators across each of the benchmarks.

Early Childhood Comprehensive Systems: Building Health Through Integration: In August 2013, KDHE was awarded a three-year Early Childhood Comprehensive Systems: Building Health Through Integration (ECCS) grant. Named the Kansas Initiative of Developmental Ongoing Screening (KIDOS), the project goal is to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers (birth to age three) across early childhood support systems at the state and local levels including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs and families. A state work group chaired by a pediatrician was convened to provide expertise and guidance for the KIDOS project. The Collective Impact approach is woven throughout the initiative. A comprehensive Community Toolkit has been developed to provide resources, tools, and guidance to communities coordinating comprehensive developmental screening systems. Technical assistance will be provided to community implementation teams. Another key objective is to build statewide capacity for quality training on the Ages and Stages Questionnaires (ASQ-3™ and ASQ: Social-Emotional). The KIDOS project will also enhance data collection systems for developmental screenings and referrals, and evaluate system and quality improvements.

Adolescent Health Assessment and Plan: As part of KDHE's development of the Maternal and Child Health State Plan for the period 2016-2020, Kansas State University Research and Extension conducted an assessment of adolescent health in Kansas. The results will inform the priorities, measures, and activities over the next year and beyond as well as yield new partnerships and projects. The priority health needs of adolescents, service gaps, access barriers and program recommendations were revealed through a comprehensive approach involving review of state-level population data, online surveys, and focus groups.

Healthy Smiles: This collaboration involves MCH, Child Care, Oral Health, Oral Health Kansas, and other partners such as Child Care Aware of Kansas (CCA). The focus is on changing behavior and practices in child care settings to include providing nutritious meals and snacks, tooth brushing after meals, and toothbrush replacement to reduce untreated decay prior to school entry.

Pregnancy Risk Assessment Monitoring System (PRAMS) Pilot (2014-2015): Kansas is not a PRAMS state, so the Title V program is leading a pilot (target area is three Healthy Start zip codes in Sedgwick County) to demonstrate capacity to implement PRAMS and follow CDC protocol. This population-based risk factor surveillance system is needed to identify and monitor maternal behaviors and experiences that occur before, during, and shortly after pregnancy.

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

SHCN Strategic Planning: During the 5-Year MCH Statewide Needs Assessment (2011-2015), the Kansas Special Health Care Needs (KS-SHCN) Program adopted the objectives of ensuring children and families have access to a medical home, are supported in transition to adulthood in all aspects of adult life, and services minimize the financial impact for families of children and youth with special health care needs (CYSHCN). While these objectives remain a

priority through 2015, a strategic planning process began mid-2013 in an effort to enhance and improve services provided to families through the KS-SHCN program. New priorities have been selected by families, providers, community partners, and other key stakeholders. These five priorities are:

1. cross-system care coordination,
2. behavioral health integration,
3. addressing family caregiver health,
4. direct health services and supports, and
5. training and education.

The new priorities align closely in many ways with the 2010-2015 objectives; however have provided a new direction for the program. The 2016-2020 Needs Assessment completes the strategic planning process, with the selection of measurable objectives and key strategies. Next steps include program policy changes to support improved services for families.

Building on these successes, the Title V Needs Assessment for 2016-2020 aligns with KDHE's goals, the Governor's Roadmap, MCH 3.0, and *Healthy Kansas 2020* to inform work over the next five years for women, infants, children, children with special health care needs, adolescents, and life course.

References:

1. Oakley D, Crawford G, Moyer C, Zornes R. Kansas Annual Summary of Vital Statistics, 2013. Topeka, KS: Kansas Department of Health and Environment, 2014. www.kdheks.gov/hci/annsumm.html
2. National Survey of Children's Health, 2011/12. www.childhealthdata.org
3. U.S. Census Bureau. 2011-2013 American Community Survey. Table S1602. Linguistic Isolation. http://factfinder2.census.gov
4. U.S. Census Bureau. 2011-2013 American Community Survey. Table DP02. Selected Social Characteristics in the United States. http://factfinder2.census.gov
5. U.S. Census Bureau. Kansas Quick Facts. http://quickfacts.census.gov/qfd/states/20000.html
6. Columbia University. National Center for Children in Poverty. Kansas: Demographics of Poor Children. http://www.nccp.org/profiles/KS_profile_7.html
7. U.S. Census Bureau, Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. Pov46. Poverty Status by State (weighted). http://www.census.gov/hhes/www/poverty/data/incpovhlth/index.html.
8. U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), Kansas, Under Age 18 in Poverty, 2013. http://www.census.gov/did/www/sahie
9. U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE), 2013. http://www.census.gov/cgi-bin/saipe/saipe.cgi

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Goals, Framework, and Methodology

With a goal to maximize the input of internal and external partners, the Kansas Title V 2020 Needs Assessment utilized a mixed methods approach relying on continuous input from a diverse team of key informants and partners, as well as broad public input. The MCH team approached the Needs Assessment as an opportunity to engage stakeholders and form partnerships through interactive regional meetings and surveys, in addition to reviews of national and state data, resulting in capturing a wide range of input and conscious decision making based on stakeholder, partner, and community knowledge. The meetings expanded beyond a listening tour model–providing a setting where community voices mattered and were heard–as the six MCH population health domain needs emerged and were defined as priorities. KDHE continuously assesses the needs of Kansas MCH populations. This is and will be an ongoing Needs Assessment that stretches beyond the 5 year vision.

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

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

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

1. *While serving as the lead agency for Title V, KDHE is not alone in this work.* There are many complimentary and supporting efforts across state agencies that, in conjunction with Title V, can lead to improved MCH population outcomes. Partnerships will be key to achieving the goals of the Title V work over the next 5 years.
2. *Not all populations are addressed by other initiatives at the same level of intensity.* Significant attention has been given to women, infants, and life course issues, likely as a result of infant mortality work that has been done. KDHE appears to lead in assuring that CYSHCN, child, and adolescent needs are identified and addressed.
3. *The cross-cutting/life course domain has particular significance in coordinating across initiatives and moving the needle on health across MCH domains.* Research indicates the importance of multi-generational approaches to individual and community well-being. The role of life course priorities and strategies has not fully been explored in Kansas; however, the Alignment of Key Frameworks indicated the importance of doing so through the Needs Assessment process.

Stakeholder Involvement and Input

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

Care Organizations and Medicaid.

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

Partner	**Role**	**Domain(s) addressed**
EnVisage Consulting, Inc. Connie Satzler	Facilitator, MCH Council & SHCN Strategic Planning Process/Meetings	Women, Infants, Children, CYSHCN
Kansas State University Research & Extension Dr. Elaine Johannes	Contractor, Adolescent Health Needs Assessment & Report	Adolescents
University of Kansas Dr. Rebecca Gillam	Contractor, Overall Title V Needs Assessment Comprehensive Process & Final Report	Women, Infants, Children, Cross-cutting and Life Course

While the Kansas Title V Priorities reflect the overall needs of the state, the Needs Assessment process incorporated a regional approach, based on the Bureau's recognition of the unique needs of local communities. For nearly a year, the needs assessment team covered 6 regions of the state in person, conducting and facilitating MCH regional meetings, attended, facilitated, or presented at 3 MCH council meetings, the Blue Ribbon Panel on Infant Mortality, and various strategic planning meetings with MCH staff and stakeholders. The broad approach continued with three large scale surveys distributed over 9 months. The Public Input Section provides a detailed breakdown of the data collection process, input methods and level of response.

Process Strengths/Weaknesses

Overall, the process accomplished what it was designed to do:

1. initiate/gather broad stakeholder input; and
2. ensure that all population domains were given adequate time and attention.

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

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

Guiding Principles

This process highlighted the importance of recognizing and understanding the connections between priorities across MCH population domains. Four overarching themes were identified as guiding principles that impact Title V work in Kansas. It is important to note that these guiding principles do not stand alone yet build upon and complement each other, further exemplifying the collaborative approach KDHE envisioned throughout the process. The guiding principles are:

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

Data Sources:

- KDHE Bureau of Epidemiology & Public Health Informatics, Annual Summary of Vital Statistics, Kansas Hospital Discharge Data; Bureau of Disease Control and Prevention, STD Program; Bureau of Family Health, Newborn Screening Programs
- National Center for Health Statistics (NCHS), National Vital Statistics Reports
- National Center for Health Statistics, VitalStats
- CDC, WISQARS (Web-based Injury Statistics Query & Reporting System)
- US Census Bureau, American Community Survey
- National Immunization Survey
- Kansas Medical Assistance Program Reporting System, KAN-Be-Healthy annual participation report & Well Child for HW21 report
- Behavioral Risk Factor Surveillance System, Centers for Disease Control & Prevention, Bureau of Health Promotion, KDHE
- Youth Risk Behavior Surveillance System
- National Survey of Children with Special Health Care Needs
- National Survey of Children's Health

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health

Women's health consistently was voiced as a priority. Access to care is a need that was expressed as overarching not only for the specific community, but providers, programs and families throughout the state; yet was so broad that

many other priorities began to emerge as objectives that fit within the need. As stated by one of many stakeholders during community meetings, “What is really needed is a [system] where women can get all the services they need and providers work together and know what each other are doing.” This exemplifies the idea there is not necessarily a need for new or additional services, but rather better coordination among existing services. This provides the foundation for the state priority for the women/maternal health domain: *“Women have access to and received coordinated, comprehensive care and services before, during and after pregnancy.”*

In 2013, more than 20% of pregnant women in Kansas did not access prenatal care in the first trimester, supporting the need for better coordination and access to care for all women. Recent NOMs data describe the health status of pregnant women in Kansas:

- 79.4% of pregnant women received prenatal care beginning in the first trimester, a 7.3% increase over the past 5 years;
- the maternal mortality rate per 100,000 live births (5 year rolling average) was 16.5, a 21.3% increase over the past 5 years; and,
- 12.5% of pregnant women smoked during pregnancy, a 17.2% decrease over the past 5 years.

Early prenatal care (i.e., care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.

KDHE has successful programs, resources and services in place to continue striving for more coordination around care and services. The message shared throughout the Needs Assessment process positions KDHE for more engagement with community partners, building on existing programs to address needs. Continuation of, or enhancements to, existing programs and partnerships are likely to impact populations through: improved Healthy Babies are Worth the Wait-HBWW/Becoming a Mom Program-BAM) outcomes; collaborative home visiting; uniform screenings; reduction of smoking in the home; increased breastfeeding; improved access to care (including well woman visits); increased health insurance coverage; better coordination; and increased access to transportation.

NPMs addressed through this domain include NPM 01: Well-woman visits and NPM 14-A: smoking during pregnancy.

Perinatal/Infant Health

The perinatal mortality rate has not changed since the previous Needs Assessment, and Sudden Unexplained Infant Death (SUID) mortality has substantially decreased. The rates of deliveries of infants who were preterm or low birth rate have also remained constant, while the rate of non-medically indicated early term deliveries has significantly decreased. Therefore, the strengths and needs of the perinatal/infant population in Kansas is the same or improved from the time period during which the previous Needs Assessment occurred. The related state priority crosses many population domains, *“Families are empowered to make educated choices about nutrition and physical activity."* This is supported by NPM 04, the proportion of infants who were ever breastfed. In Kansas, a 6% increase (up to 84.2%) in the previous 5 years has been experienced in this area, however input throughout the Needs Assessment identified a continued need for the existing work around this population health need. The focus was for both infant health, and mother health - one of many priorities crossing MCH domains. Public input also outlined many other areas of focus for the perinatal/infant population, addressed through alignment with other priorities and strategies across domains.

Recent NOMs and NPMs data describe perinatal/infant health in Kansas, during the previous 5 years, has:

- remained relatively constant at 7.0% of deliveries were infants with low birth weight (<2,500 grams);
- slightly increased by 3.3% from 9.2% to 8.9% of births were preterm (<37 weeks);
- decreased by 27.1%, down to 29.3% of non-medically indicated early term deliveries (37-38 weeks) among singleton term deliveries (37-41 weeks);
- remained relatively constant with the perinatal mortality rate of 6.5 per 1,000 live birth, plus fetal deaths.

To address continued risks associated with negative outcomes for this population, strategies that will be employed include: uniformly screening and monitoring for high-risk conditions; ensuring that more than 90% of at-risk women receive 17-P; refer high-risk deliveries to facilities that provide the appropriate level of care; and expand HBWW/BAM program model, targeting areas with disparities and poor birth outcomes.

Child Health

Healthy development for children was a strong theme, addressing many needs identified in each community. A strong focus was on assuring children were provided opportunities through age-appropriate services, leading to the state priority for this domain – "*Developmentally appropriate care and services are provided across the lifespan"* – directly linked to NPM 06 on developmental screening.

Many identified needs for the child health domain carried over into adolescence and were connected by a common thread: injury and safety. Injury prevention efforts, addressing safety concerns in the home and reducing risk, and selection of safe childcare settings are all areas of interest, focused on reducing non-fatal injury hospitalizations (NPM 07). Statistics indicate the number of Kansas children "excellent or very good" health is slightly higher (86.8%) than the national average (84.2%)[4] and Kansas children receive a preventive medical visit at a rate consistent with the national average. Data, from OSD and NOMs, related to the health status of Kansas children show:

- the rate of death in children aged 1 through 9 per 100,000 was 23.8, a 9.7% increase over the previous 5 years;
- 6.7% of children were without health insurance, a 18.3% decrease;
- 7.6% of school age children were victims of bullying[2];
- 7.2% of school age children were bullies[2];
- 59.1% of all children received comprehensive, coordinated care from a medical home, which was higher than the national average of 54.4%[4]; and
- 79.4%% of children received a preventive dental visit in the previous year, which was slightly higher than the national rate of 77.2%.[4]

Stakeholders provided useful and innovative ideas to improve upon while expanding current initiatives, many of which are already in the scope of work for Title V. KDHE can further strengthen the guiding principle of collaboration at state and community levels, and create community change by building from existing successes of programs like Safe Kids Kansas, and increasing the number of MCH grantees that serve as a lead agency for local Safe Kids Coalitions. Other identified needs absorbed into the priority of developmentally appropriate care are focused on: safety and education opportunities; safe sleep initiatives; access to childhood immunizations; and oral health education and developmental screenings. Combined, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course.

Children & Youth With Special Health Care Needs

As with other population domains, the CYSHCN domain priority need identified was care coordination. From all sources of input throughout the Needs Assessment, promoting and providing services for optimal mental and behavioral health was a critical issue to a healthy family and overall community well-being. In the regional meetings,

and particularly in the “Communities for Kids” meetings, it became apparent that family support was emerging as a high need for this population, and that those supports include a need for access to care. In particular, participants mentioned a lack of transportation, particularly in rural communities, and the limited availability of specialists, again, particularly in rural areas. As the assessment progressed, family support also expanded into the need for social-emotional support and respite for caregivers. These issues lead Title V to identify a high need for more coordinated care across systems, reducing duplication of services and providing opportunity for stronger family engagement - the foundation for which led to the state priority, *“Services are comprehensive and coordinated across systems and providers,”* and will be measured through medical home indicators (NPM 12).

Data, from OSD and NPMs, related to medical home indicators for Kansas CYSHCN show:

- 49.4% receive care within a medical home, compared to 43.0% nationally;[3]
- 45.7% receive effective care coordination, when needed;[3]
- 33.1% experience difficulties or delays in getting services for their child because the services needed were not available in their area;
- 32.7% report their current insurance coverage is inadequate; and
- among families caring for CYSHCN, lack of receiving care within a medical home was associated with 1.7 times increased odds of reporting of financial burden.

Having a medical home is essential to coordinated systems of care. Families are better supported, experience less frustration when accessing services, fewer delays in services, and children tend to be healthier. Medical homes are also critical in successful transition to adult living. Kansas is above the national average of children 10 months to 5 years who received a standardized screening for developmental or behavioral problems (37% in Kansas versus 30.8% nationally).[4] Care coordination efforts, within a medical home or not, can assist in identifying children with potential developmental delays allowing for earlier intervention than for those without this support.

Through the KS-SHCN Strategic Planning, four additional priorities emerged: family caregiver health; behavioral health; training and education; and direct health services. Enhanced services that could be provided by KS-SHCN include increased access to family-centered medical homes through support by KDHE through existing structures, as well as through: assisting families to navigate service systems; engaging MCO’s and primary care providers; parent leadership development, increasing community and statewide partnerships, assuring children receive developmentally appropriate assessments and behavioral health screenings, implementing tele-medicine strategies, and professional development training.

Adolescent Health

Central to the discussion was a holistic approach to adolescent well-being, focusing on positive youth development and providing opportunity for young people to thrive. Adolescence is an important developmental stage filled with opportunities as well as health risks, which can be magnified by transitions between systems of care, especially for CYSHCN. Regardless of geographic location, adolescents face common barriers and risks such as bullying, risk taking, poverty, boredom leading to negative choices, lack of skills, and perhaps even the responsibility of attending to other family members. Many youth cope with chronic health conditions and many live in neighborhoods and families that pose health risks. However, with positive supports and opportunities, youth can learn to build their abilities, and develop into contributing adults, leading to the state priority, *“Communities and providers support physical, social, and emotional health.”* Bullying (NPM 09) is a key focus within this domain, as is NPM 10: Adolescent well-visit.

The following data describe the health status of Kansas adolescents:

- the death rate ages 10-19 per 100,000 was 31.9, a 21.0% decrease over the past 5 years;

- the rate of suicide deaths ages 15 through 19 per 100,000 (3 year rolling average) was 13.2, a 45.1% increase over the past 5 years;
- 84.6% of adolescents, ages 13-17, have received at least one dose of the Tdap vaccine, a 33.0% increase over the past 5 years; and
- 55.9% of adolescents, ages 13-17, have received at least one dose of the meningococcal conjugate vaccine, a 46.0% increase over the past 5 years.

KDHE desires to address the needs of this population through promoting wellness and addressing serious and pervasive issues that adolescents face such as bullying, suicide, and mental/social health issues. Life skills development is an important objective under this priority. There is a need to promote positive coping mechanisms and assure youth receive annual physical and mental health screenings to promote overall health and social emotional health. Trained adults and mentors can help adolescents navigate life skills and set goals (high school completion, employment, youth development). Adolescents have a natural desire to become active in society and community, this priority will promote community partnerships and engagement, reinforce protective factors, and promote prevention of risky behaviors. Opportunity for partnerships and community collaboration is a key point for this domain.

Cross-Cutting/Life Course

Seeking appropriate care for the MCH population is critical to the continued support required to ensure that this populations needs are met. For quality care to be delivered, it is important that the professionals interfacing with this population are properly trained to provide this care. This is an area that impacts all MCH populations. This priority will focus on workforce development and capacity, promoting diversity, inclusion, and integrated supports for all, and supporting providers to address the social-emotional development of children. This includes concerted efforts to support health literacy for MCH consumers. Participants stated that understanding the importance of personal health, how to find services, and how to navigate the health care system promote lifelong habits for well-being can lead to the reduction of or prevention of many of the health issues discussed throughout the process. In addition, professionals need not only training (including training about cultural competency), but also to effectively coordinate care.

Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains. When asked what could improve services within the community, responses included, “having trained professionals who take the time and listen to our needs.” Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and the health impact that it may have on this population. In particular, children and youth with special needs was identified as a population that needed improved support from professionals. This led to a broad state priority, *“Professionals have the knowledge and skills to address the needs of the maternal and child health population.”*

Insurance coverage continuity entails continuous insurance coverage throughout the previous year. In 2011-2012, 11.3% of Kansas residents lacked continuous insurance coverage, which is congruent with the national percentage of 11.3% (The Health & Well Being of Children, 2014). Inconsistent health insurance coverage may keep children and families from receiving the necessary medical care required to maintain a good health status. If health problems go undetected, this may result in more significant health problems at a later date that require longer, intensive, and more costly health services.

References

1. Kansas Health Matters. (2015). http://www.kansashealthmatters.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=17326490
2. High, Brenda. (2000). Estimates of Children Involved in Bullying State by

State. http://www.bullypolice.org/BullyingNumbers.pdf
3. NS-CSHCN Chartbook (2009-2010). http://mchb.hrsa.gov/cshcn0910/state/pages/ks.html
4. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, The Health and Well-Being of Children: A Portrait of States and the Nation, 2011-2012. Rockville, Maryland: U.S. Department of Health and Human Services, 2014.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

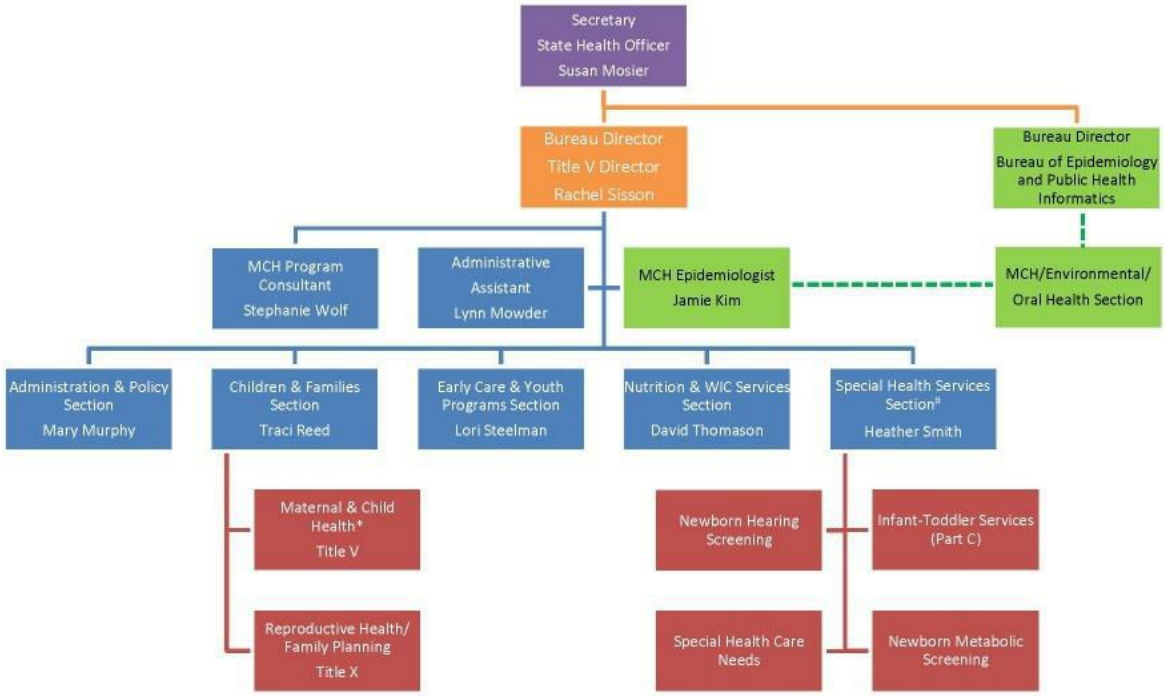
The Kansas Department of Health and Environment (KDHE) is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. The Secretary of KDHE is appointed by the Governor and serves on the Governor's Cabinet. The agency Secretary, State Health Officer, and Division of Public Health Director is Susan Mosier, MD. As the State's public health agency, KDHE's mission is to promote and protect health and prevent disease and injury among the people of Kansas. The agency is composed of three divisions: Public Health, Health Care Finance, and Environment. The Division of Public Health has six bureaus: Family Health; Disease Control and Prevention; Community Health Systems; Health Promotion; Oral Health; and Epidemiology and Public Health Informatics.

The Title V Maternal and Child Health (MCH) Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH has three goals: (1) Improve access to comprehensive health, developmental and nutritional services for women and children including children with special health care needs; (2) Improve the health of women and children in the State through prevention/wellness activities, a focus on social determinants of health, adopting a life-course perspective and addressing health equity; and (3) Strengthen Kansas' MCH infrastructure and systems to eliminate barriers to care and to reduce health disparities. The BFH has five sections*: Children & Families; Special Health Services; Nutrition and WIC Services; Early Care & Youth Programs; and Administration & Policy. **Foster care was a part of the KDHE BFH until June 21, 2015, at which time the program was transferred to the Department for Children and Families as authorized by Executive Reorganization Order 43.*

The BFH programs partially funded by the federal-state Title V Block Grant include MCH, CYSHCN, and Child Care. Within the Division of Public Health, other Bureaus that receive support include the Bureau of Epidemiology and Public Health Informatics (Vital records data sharing, analysis, and reporting); the Bureau of Community Health Systems (workforce development, training, capacity building, systems development); and the Bureau of Health Promotion (PRAMS pilot telephone survey support).

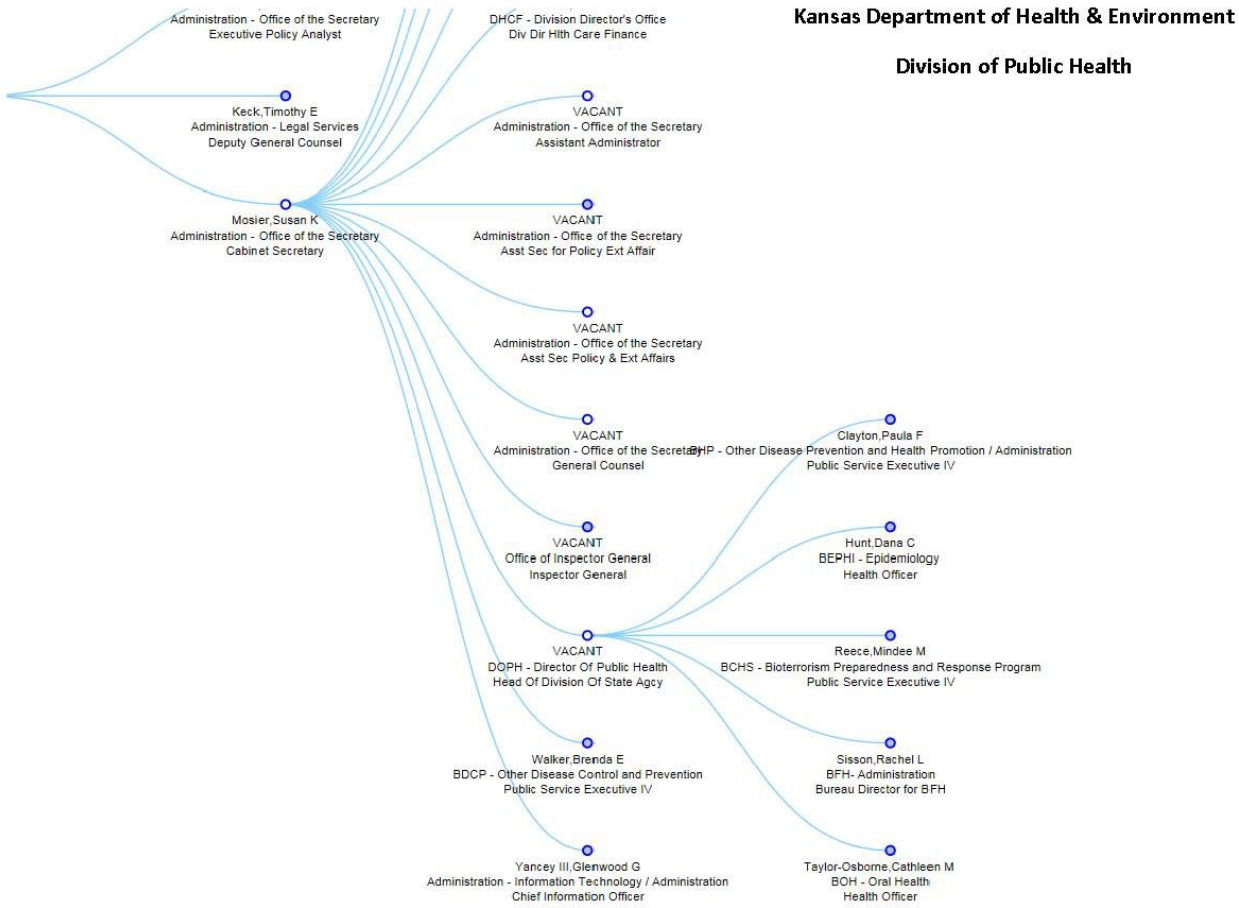
Organizational charts are attached to this section as images.

Kansas Department of Health & Environment
Division of Public Health
Bureau of Family Health



*Includes Aid to Local Programs/Grant Projects: Title V MCH, Pregnancy Maintenance Initiative (PMI), Teen Pregnancy Targeted Case Management (TPTCM), Healthy Families, Home Visiting, MIECHV, Project LAUNCH, Early Childhood Comprehensive Systems (ECCS); Abstinence Education; Healthy Start; staffing for Woman's Right to Know (WRTK materials), Blue Ribbon Panel on Infant Mortality, and KS MCH Council

#Includes staffing for Kansas Resource Guide, Birth Defects/Registry, Newborn Screening and Hearing Screening Councils



II.B.2.b.ii. Agency Capacity

Capacity to provide services by population health domain: The Bureau of Family Health has experienced significant vacancies and staff turnover at the state level during the past year, which has provided ongoing challenges. At the same time, it has created an opportunity to build partnerships and increase/enhance community capacity in each of the population health domains. Recognizing the staff on the MCH team are key to building partnerships at the state level and providing support at the local levels, the new structure has led to improved state-local coordination and alignment with vision. The current Title V staff (with expertise by domain) are listed below:

- Women/Maternal: Stephanie Wolf, MCH Program Consultant; Carrie Akin, MCH Administrative Consultant; Kay White, MCH Administrative Consultant
- Perinatal/Infant: Stephanie Wolf, MCH Program Consultant; Carrie Akin, MCH Administrative Consultant; Kay White, MCH Administrative Consultant
- Child: Stephanie Wolf, MCH Program Consultant; Debbie Richardson, Home Visiting Program Manager; Traci Reed, Children & Families Director; Vacant, MCH Child & Adolescent Health Consultant; Lori Steelman, Child Care Licensing Program Director; Mary Murphy, Administration & Policy Director
- CYSHCN: Heather Smith, Special Health Services Director; Kayzy Bigler, SHCN Program Manager; Jentry

Sprang, Michelle Black, Geno Fernandez, and Portia Taylor, SHCN Program Staff; Kelly Blake, SHS Payment and Contracting Specialist

- Adolescent: Traci Reed, Director, Children & Families Section; Vacant, MCH Child & Adolescent Health Consultant; Lori Steelman, Child Care Licensing Program Director; Mary Murphy, Administration & Policy Director
- Cross-cutting or Life Course: MCH team, led by Rachel Sisson, Bureau Director; Jamie Kim, MCH Epidemiologist

State program collaboration with other state agencies and private organizations: The table below identifies the key partnerships with other state agencies and private organizations, essential to addressing the needs and emerging issues of MCH populations.

Collaboration Partner	Type	Purpose
Kansas Department for Children & Families	Public State Agency	Coordination between child care licensing and subsidy; state level coordination of Maternal Infant and Early Childhood Home Visiting program
Kansas Department on Aging & Disability Services	Public State Agency	Access to behavioral health services
Kansas State Department of Education	Public State Agency	State level coordination of Maternal Infant & Early Childhood Home Visiting (MIECHV) program
Kansas Children's Cabinet & Trust Fund	Legislatively Created Entity	Early childhood programs and services; Children's Initiative Funds
Maternal Child Health Council	Public-Private Collaboration	Advisory council for MCH team
March of Dimes Kansas Chapter	Private	Initiatives related to preterm/early term birth, early elective deliveries, prematurity, etc. (Ex: ASTHO Challenge); implementation and expansion of the Healthy Babies are Worth the Wait/Becoming a Mom programs
Kansas Chapter of the American Academy of Pediatrics	Private	Systems development for child, school and adolescent health care; convene and facilitates the state MCH Council
Kansas Breastfeeding Coalition, Inc.	Private	Breastfeeding education, training, and community support projects
Geary County Community Healthcare Foundation	Private	Healthy Start project/grant partner and Becoming a Mom Lead

University of Kansas Medical Center (Kansas City) and School of Medicine (Wichita)	Public	Medical specialty care and related services for children and youth with special health care needs.

State support for communities: The majority of programs funded by the Block Grant are delivered by local county or multi-county health departments. Since health departments are positioned to provide many core public health services in addition to MCH, this delivery system has the advantages of convenience and comprehensive care. The programs and services delivered by local agencies are designed to address ongoing needs and those identified as part of the most recent needs assessment. When funds are allocated to 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. Services are to be in compliance with Title V legislation and in accordance with the Kansas MCH Services Manual (http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf). The contractual process with local agencies begins with the development of Grant Application Guidance/Reporting Materials by MCH program staff annually in December. These materials are available by mid-January to local agencies currently receiving funds as well as any other eligible agency wishing to apply for Title V funding as part of the KDHE aid to local funding process. The review process which informs funding recommendations involves external reviewers applying guidance and a scoring matrix, funding formula based on poverty and population by county/target area, and willingness/ability to comply with grant requirements. The grant application review process takes place between March and May with awards announced by June prior to the start of the State Fiscal Year (July 1 - June 30). Detailed client encounter/service data is required to be collected, aggregate reports are required quarterly, affidavits of expenditures are required quarterly, and site visits are conducted to verify compliance with funding requirements and progress toward priorities, goals, objectives, and measures. More information about the MCH Aid to Local Program (http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html) including program guidance requirements is available online. Aid to Local contract documents and the list of local 2016 MCH grantees statewide are attached as supporting documents.

Additionally, the BFH provides funding and technical assistance to assist local communities to improve health outcomes for pregnant women, infants, children, adolescents, and CYSHCN; systems of care and grants to communities to support the health of women in their reproductive years and the CYSHCN population; and other grants and initiatives targeted to specific populations and needs including the administration of the Early Childhood Comprehensive Systems grant, the MIECHV Program, Project LAUNCH, and SHCN regional office and multi-disciplinary specialty clinics. Through public health regional meetings (focused on birth outcomes/AMCHP Birth Outcomes Compendium as key document), the BFH renewed its commitment to working in partnership with local communities to support their MCH work. Based on feedback from meeting participants, the BFH will provide training and technical assistance to further support for local systems development.

Coordination with health components of community-based systems: The BFH has partnerships at the state and local levels to ensure coordination of health components of the MCH system. Through the MCH council, Blue Ribbon Panel on Infant Mortality, and regular communication with local health departments, the state MCH team provides expertise, gathers feedback, and makes connections to maximize the effectiveness of the MCH system. As an example of this work, the BFH has facilitated coordination of a Long Acting Reversible Contraceptive (LARC) program between the local health department, Title X, and private OB/GYN practice in one rural community. The BFH acted as a convener of the conversation and drafted the partnership agreement to be modified and adopted by the local partners. This process highlights the role that the BFH has taken as not only a leader of MCH coordination, but a key partner in the process.

Coordination of health services with other services at the community level: The public health regional meetings at the community level are evidence of the BFH's commitment to a broad view of health and well-being that incorporates health services and other community partners. Approximately 20% of participants at the five regional meetings were representing other services at the community level. The BFH recognizes that MCH requires a systemic approach that provides health and other services to meet the needs of the community. Key partners identified through the regional meetings included schools and local elected officials (county commissions). The SHCN program has strengthened partnerships and developed new partnerships and will support a hospital to home coordination program through a state-wide home health entity and a new youth leadership program in the coming year; in addition to expansion of outreach, care coordination, supporting the University of Kansas Department of Pediatrics Medical Home, and a new initiative with the MCOs to support identification of children ages 0-5 born with Medicaid that have not received any documented follow-up care.

II.B.2.b.iii. MCH Workforce Development and Capacity

Effective June 2015, the Bureau of Family Health (BFH) has 81.2 full-time equivalent (FTEs) positions. Two FTEs including the Title V Director and an Assistant are located in administration. Special Health Services has 20 FTEs including a Director (MPH) and program staff including: 6 Special Health Care Needs (SHCN); 3 Newborn Metabolic Screening; 6 Infant Toddler Services; 4 Newborn Hearing Screening (one audiologist). Children & Families has 12 FTEs including a Director (LMSW) and RN. Nutrition & WIC Services has a total of 15 FTEs including 3 nutritionists. Child Care Licensing has 20.2 FTEs including a Director and 5 Coordinator of Children's Services staff located in KDHE District Offices across the state with responsibility for supporting regulatory services at the community level. Administration & Policy has 12 FTEs including a Director, 4 Healthy Homes positions and 7 administrative and support staff. MCH Block Grant funds provide salaries for approximately 18% of the staffing in the Bureau, supporting administration, SHCN, and MCH. MCH funding also supports part-time staff in the Bureau of Community Health Systems' Local Public Health Program for (workforce development, capacity building, and training) and the Office of Vital Statistics. Additionally, funding supports two full time epidemiologists within the Bureau of Epidemiology and Public Health Informatics (one position is vacant). The epidemiologists interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. Both epidemiologists coordinate all data analyses for the MCH/CYSHCN 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.

Descriptions for senior level management serving in lead MCH-related positions, including staff who contribute to planning and data analysis follow.

Rachel Sisson (formerly Berroth) was appointed as the Bureau Director and Title V Director in 2012. She has 15 years of experience related to workforce development and 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. She holds a Master's degree in Early Childhood Education and Bachelor's degree in Family Studies and Human Services from Kansas State University.

Heather Smith serves as the Special Health Services Section Director and Kansas Special Health Care Needs (SHCN) Director. 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.

Traci Reed serves as the Children and Families Section Director and Interim Family Planning Director. She is primarily responsible for management and oversight of the Title X Family Planning and Maternal and Child Health Aid to Local programs. She also has responsibility for additional Aid to Local programs including Healthy Families, Teen Pregnancy Targeted Case Management, and Pregnancy Maintenance Initiative. Prior to her current position Traci worked in State child welfare programs for 19 years. She was employed at the Department for Children and Families as an Assessment and Prevention Administrator where she was responsible for management of regional child abuse/neglect investigation and family services programs. She has a Master of Social Work degree from Wichita State University.

Stephanie Wolf, RN, BSN, serves as the Maternal & Child Health (MCH) Program Consultant (effective March 30, 2015). She also serves as the perinatal consultant for the Federal Healthy Start project and lead for the development and expansion of the Healthy Babies are Worth the Wait/Becoming a Mom programs across the state. Stephanie was previously the MCH Program Coordinator for the Salina-Saline County (Local) Health Department.

Kayzy Bigler is the SHCN Program Manager. She is primarily responsible for overseeing program activities, family and youth engagement opportunities within the Bureau, care coordination development and assisting with the strategic planning. Kayzy previously worked as a Parent Information Specialist and a Parent to Parent Coordinator. Past experience includes co-ownership of a private Interactive Metronome Therapy business. Prior to that she worked for a local school district for 15 years doing Applied Behavioral Analysis (ABA) therapy, speech therapy and assisting with occupational and physical therapies and classroom education for children with special health care needs. Kayzy obtained her AA in Pre-Social Work from Allen County Community College in 2006. She is a Registered Interactive Metronome Certified Therapist and has obtained over 500 in-services hours through the local school district and the State of Kansas.

Jamie Kim has served as a maternal and child health epidemiologist since 2003 and also serves as the State Systems Development Initiative (SSDI) project director. She provides epidemiological support for MCH and affiliated programming. Her priority job assignments focus on pregnant women and infants (infant mortality, Perinatal Periods of Risk approach (PPOR), maternal mortality and morbidity, teen pregnancy, family planning), CYSHCN (birth defects surveillance, newborn screening, and health disparities in children due to disability status), and WIC. She earned a Master of Public Health (in association with the University of Kansas) and Bachelor of Science in Chemistry from Wichita State University.

II.B.2.c. Partnerships, Collaboration, and Coordination

A major focus of all the Title V and Family Health policy and program initiatives is collaborative partnerships, so calling on partners, providers and consumers/families to be engaged in the needs assessment was highly successful. Through existing forums, Title V engaged stakeholders through the State MCH Council, State Agencies Early Learning Coordinating Council, Newborn Screening Advisory Council, Family Advisory Council, Blue Ribbon Panel on Infant Mortality, Kansas Breastfeeding Coalition, among others. The Bureau and Title V programs demonstrate strong commitment to coordinating and collaborating to address the emerging and ongoing needs of all MCH populations.

Other MCHB Investments: BFH staff is exploring ways to better coordinate and integrate the Kansas Maternal, Infant and Early Childhood Home Visiting (MIECHV) and Early Childhood Comprehensive Systems (ECCS) program activities with other programs, and strong linkages have been identified between the MIECHV, ECCS, and

Title V MCH needs assessment priorities, goals, and strategies. The Kansas MIECHV Program continue with both annual formula and competitive development grant funds administered by BFH. The at-risk communities targeted for implementation are Wyandotte County (urban Kansas City), Montgomery, Labette, and Cherokee counties (rural southeast Kansas). Evidence-based home visiting programs include Early Head Start, Healthy Families America, and Parents as Teachers. Wyandotte County has implemented a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants Endangered by Substance Abuse (TIES) Program. A state level Home Visiting Workgroup, composed of representatives from multiple state agencies, organizations, and programs including MCH, child care, and Part C, developed a strategic plan. In August 2013, KDHE BFH was awarded a new three-year ECCS grant focused on strategy two with the goal to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers across early childhood systems including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs. The project has been named the Kansas Initiative of Developmental Ongoing Screening (KIDOS). KDHE contracts with the University of Kansas Center for Public Partnerships and Research to coordinate and evaluate various aspects of both programs, the same organization that led the Title V statewide needs assessment and development of the five year action plan.

Other Federal Investments and State Health Department Programs: The WIC, Title X/Family Planning, and Abstinence Education programs are managed in the BFH, supporting joint planning, increased communication and coordination, and aligned priorities and efforts for greater impact. The Title V MCH and Title X Family Planning programs have been strategically planning and meeting as a larger team since 2014 to set priorities, goals, objectives, and identify linkages between MCH and Reproductive Health/Family Planning. Joint meetings and open communication continues, and both the Title V and Title X State Action Plans include targeted work across programs at both the state and local levels. MCH works directly with WIC on an ongoing basis and the State WIC director is part of the MCH Coordination team; joint initiatives for the next five years are related to CoIIN, home visiting, pre/early term birth, smoking cessation, breastfeeding, and oral health. Title V engaged the Injury Prevention program throughout the needs assessment process and received direct input related to the state's injury prevention plan; the MCH action plan reflects shared priorities and strategies. The MCH Perinatal Consultant and MCH epidemiologist work directly and in partnership with the Director of Vital Statistics Data Analysis and maintain an on-going collaboration with local health departments to assist with data needs, including assisting with regular and ad hoc data requests, Perinatal Periods of Risk (PPOR) Analysis presentations, Fetal and Infant Mortality Review (FIMR) support, local public health system assessment, Pregnancy Risk Assessment Monitoring System (PRAMS) pilot project, State Health Assessment Report (Maternal, Infant, and Child Health Focus Area), etc. The Title V Director met with Medicaid Director and Informatics staff in 2014 to discuss the MCH data snapshot, specifically disparities between the Medicaid/non-Medicaid populations. Detailed information related to Title V, legislation, and programming relevant to the Title V-Medicaid partnership, was shared; discussion continues and has resulted in a stronger partnership and coordination related to the Infant Mortality CoIIN initiative. Focus has been on the Medicaid MCH data/linked data set and areas where measures and programming align--disparities in prenatal care and birth outcomes (including preterm birth and infant mortality) is feasible and will have the greatest impact on health and costs. Joint projects identified with Medicaid include: Collaborate with state Medicaid staff and managed care organizations to ensure consistent reporting of low birth weight, understand current and planned initiatives to improve birth weight, and identify potential performance improvement interventions to improve birth weight for members using KanCare services. Examine the impact of maternal diabetes and pre-diabetes on birth weight, and identify potential performance improvement interventions to improve birth weight for members using KanCare services. Assist Medicaid to identify and address reporting and program requirements related to CMS Abstraction and Reporting Tool related to children's services issues, including childhood immunization status, live birth weight, well child visits, and chlamydia screening.

State and Local Programs: The Title V Program provides funding directly to local health departments, health

centers, clinics, and other community based organizations to provide local services for legislatively mandated populations. Partnerships were strengthened and networks expanded through the needs assessment process. The primary focus was on collaboration at the state and local levels, assessing what's working and what's not, and utilizing existing resources to guide the process. Using a collective impact framework, KDHE partnered with the March of Dimes Greater Kansas Chapter (MOD) and AMCHP to engage more than 200 partners across the state between May 2014 and February 2015, to focus on forging partnerships to collectively and comprehensively address issues families face in the context of their communities throughout the course of life. The MOD delivered a special presentation during each of the regional meetings to describe the Title V-MOD partnership related to establishing and expanding the Kansas Healthy Babies are Worth the Wait/Becoming a Mom program. Since the meetings ended in February 2015, an additional 12 communities have identified an interest to launch the program through support from Title V and MOD.

Other State Departments/Agencies: Several KDHE BFH staff representing MCH/MIECHV/ECCS, Part C, and Child Care, are active members of the State Early Childhood Leadership Team. The team is a formalized group representing early childhood programs within state agencies including KDHE, Department for Children and Families (DCF), Department of Education (KSDE), and the Children's Cabinet and Trust Fund (KCCTF). It was created to represent state agencies as a collective voice on early childhood programs and services for children and families from birth to after kindergarten entry, and to plan and initiate cross-agency unified efforts and outreach directed toward development of a comprehensive early childhood system. The team meets monthly to conduct strategic planning, identify priorities, and implement communication and coordination activities, including MCH. BFH worked directly with the team to promote the Kansas School Readiness Framework, and identified the following priorities: developmental screening including the system for referral and follow up; family engagement practices and standards; use of the Kansas Early Learning Standards; and early childhood professional development system. The Bureau maintains a strong partnership with the KCCTF with primary focus on the Home Visiting program and alignment with the Cabinet's *Blueprint for Early Childhood*.

Kansas Tribes: The Kansas Department of Health and Environment has been working over the last three years to develop a working relationship with the four Kansas tribes (Iowa Tribe of Kansas and Nebraska, Prairie Band Potawatomi Nation, Sac & Fox Tribe, and Kickapoo Tribe). As a result of improved communication and established trust with KDHE, the first Kansas Tribal Health Summit was held in 2013. The purpose of the annual Summit is to bring together Kansas Tribes and leadership from KDHE. The partnership grew in 2014 when the Summit involved more KDHE programs and staff including MCH and focused on the status/future plans of each of the tribes community health assessments (following the Healthy Kansans 2020 model/process). The 2015 Summit is scheduled for August and will be a time to align the state MCH priorities for legislatively mandated populations and the Tribes findings as a result of their individual assessments and plans.

Family/consumer partnership and leadership programs: Family/consumer partnership throughout the needs assessment focused on input and what is working well within their community, as well as gaps and barriers to accessing services. Primary activities geared toward family and youth engagement included the Communities for Kids (C4K) meetings, the SHCN strategic planning, and the adolescent health assessment. These initiatives focused heavily on families and consumers, with the intent to gain meaningful input and feedback regarding MCH services to support positive outcomes across the lifespan.

There were a total of 253 participants across all meetings, and 21.5% self-identified on the sign-in sheet as a parent or parent of a child with special health care needs. Family and consumer partners of all backgrounds, education levels, and ethnicities were invited to participate in the C4K meetings. Specific demographic data regarding race or ethnicity was not collected. The meetings provided an opportunity for participants to register in advance and notify meeting organizers of needed language or disability accommodations; no meeting participants required or requested these accommodations. It stands to reason that everyone in attendance could be counted from a family/consumer partner perspective; however, many were there in a professional capacity. Parents, siblings, and

other family members were engaged in public forum discussions, in both large and small groups. It was clear that those in attendance were extremely passionate about improving the health of children and youth. Many participants were in attendance to support both personal and professional interests; however, they often identified which "hat" they were wearing during the discussions, and most often the "parent hat" was more prominent than the "business hat." Approximately 10 participants were identified as having interest in the Special Health Services Family Advisory Council (FAC), 2 of which who have already joined and attended their first meeting. Families associated with the FAC receive valuable training on Title V and MCH core competencies. The input obtained was key in discussions for selecting priorities and objectives for the five year plan. Topics addressed through these meetings that were also adopted as part of the State Action Plan include: engaged and empowered families, family supports and peer groups, developmental screenings and follow-up, immunizations, motor vehicle safety, oral health, healthy foods and physical activity for children of all ages, bullying, emotional health and well-being, behavioral health services, training for parents and teachers on child behaviors, care coordination, telemedicine, difficulty accessing services in rural communities, health literacy and system navigation. Additionally, based upon feedback received through these meetings, specific strategies were developed to increase leadership and advocacy among families and consumers, expanding on training of Title V and MCH provided to FAC members. Further description of youth and parent leadership initiatives is outlined in the State Action Plan narrative.

The primary cohort of family/consumer partners engaged within the KS-SHCN strategic planning process included those on the FAC. Family members of all backgrounds, education levels, and ethnicities are invited to participate in the FAC. The family leaders who participated in the strategic planning process represent a wide variety of diverse backgrounds related to their family member's age, disability, and geographic location of the state. Program staff are constantly working towards recruiting FAC members of more diverse ethnic backgrounds. The engagement of the FAC in the KS-SHCN strategic planning supported the program to develop priorities related to care coordination, family caregiver health, behavioral health, training and education, and direct health care services. The strategies developed were based on input from the FAC, including final approval of the FAC as trusted advisors. The FAC will continue to be involved in the implementation of the KS-SHCN Strategic Plan and will assist in identifying areas of improvement or potential changes throughout the five years, to assure the program remains relevant and a valuable resource to families.

The Adolescent Health Needs Assessment consisted of an online survey and in-person focus groups. The statewide online survey received 854 respondents, representing 85 counties. Of the respondents, a large percentage (86.49) were female. Respondents ranged from age 11 to 82 with an average age of 49. The majority of the respondents identified themselves as White (90%), while 2.36% identified themselves as African-American, 3.07% Hispanic, 1.42% Asian/Pacific Islander, 1.53% Other. The majority of respondents were married (70.21%), had completed a college degree (84.43%), in the upper-middle class of household income (66.28%) and lived in suburban, small town or rural areas (14.61% lived in urban areas). While the survey did not specifically ask respondents if they were parents, in response to the question, "How many children under 16 years old live in your household?" 60% indicated none, 18% indicated 1, 13% indicated 2, 6% indicated 3, and 3% indicated 4 or more. There were 26 focus groups held in 5 communities: Chanute, Dodge City, Great Bend, Hoisington, Kansas City, with a total of 401 participants (324 adolescents, ages 12-18 years). There was a concerted effort to obtain the participation of adolescents in the focus groups due to high adult response rate of the survey. Focus groups were held in schools during classes, study hall, early-release time and were conducted with a 4-H group and an afterschool group known as "Young Women on the Move." More females (60%) participated in the focus group than males. The participant breakdown by race was 63% White, 17% Hispanic, 7% African American, 2% mixed race, and <1% Asian, American Indian, and Other. Of the 77 participants over the age of 18, 50 identified themselves as parents. There was no identified need to provide incentives or compensation for youth participation due to location and attendance. The selected sites allowed representation from urban and rural communities, and for a Spanish focus group to be available in Dodge City. The primary recommendation of the adolescent health assessment was to "Address the highest priority adolescent health issues." In order of priority, based on all information obtained/reviewed, those issues are: mental health, substance

abuse, reproductive/sexual health, nutrition and physical activity, and injury prevention. Youth participants in the focus groups indicated the need for trusted, supportive adult/mentors in their lives. As a result, a specific strategy to establish networks of adult and peer mentors was incorporated. Youth participants of the focus groups shared that they appreciated being asked for their input. Ongoing engagement of youth with Title V programs is desired and will be integrated into future work. It is believed that including adolescents and parents in assessment and planning processes provides Title V a clearer understanding of the issues the key issues – leading to more identification of solutions that will be effective and accepted.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	New	
2	Services and supports promote healthy family functioning.	New	
3	Developmentally appropriate care and services are provided across the lifespan.	New	
4	Families are empowered to make educated choices about nutrition and physical activity.	New	
5	Communities and providers support physical, social, and emotional health.	New	
6	Professionals have the knowledge and skills to address the needs of maternal and child health populations.	New	
7	Services are comprehensive and coordinated across systems and providers.	New	
8	Information is available to support informed health decisions and choices.	New	

To develop the priorities and create an intended plan of action, the needs assessment process consisted of a mixed methods approach that relied on the input of key informants, partners, and community members. For more than a year, the Title V Needs Assessment team (and partners) covered regions of the state conducting and facilitating eight Public Health Regional Meetings (focused on improving birth outcomes using the AMCHP Compendium as a key resource for planning), three MCH Council meetings, 17 Communities for Kids meetings (focused on the health needs of children, adolescents including children and youth with special health care needs), focus groups centered on adolescent health with 350 participating adolescents, and strategic planning meetings with MCH staff and stakeholders. Additional, supporting processes and methods that resulted in rich input included online input surveys, presence at the Kansas Parent Leadership Conference, and a Child Care Licensing Program Tour to hear more about child care issues related to availability, access, and quality from local inspectors, providers, parents, and the public. This comprehensive process and broad approach assisted with identifying key priorities to ensure an

intended plan of action to effectively improve and address maternal and child health. With a better understanding of the needs of Kansas MCH populations, the needs assessment team was able to develop a series of questions to be used in initial and follow up conversations with partners, program directors, community service providers, and parents.

Over time, common issues across populations showed repeated connections that exemplified the interconnectedness of the priorities. This led to some original priorities not being a focus when it was realized that they were eventually naturally connected to other priorities, eventually becoming key goals or strategies in the action plan, assuring that a number of needs were actually covered within a priority and could be measured over time. It was also realized that the emerging needs that stood out and are now the final priorities, could be measured over time and support the principal of KDHE to continue its role in building partnerships.

The state priorities that emerged as well as the selection/decision-making process, are summarized below. Criteria used in final selection and categorization of priorities and elements of the plan included:

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

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

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

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

From all sources of input throughout the needs assessment, promoting and providing services for optimal mental and behavioral health was a critical issue to a healthy family and overall community well-being. During data collection, follow up questions to determine 1) the nature of mental and behavioral health needs and 2) the role of MCH in mental and behavioral health helped to inform a broader priority that addressed mental and behavioral health as a component of family functioning. Parents and providers indicated that family functioning was contributing to stressors across all population domains. Lack of services were an issue, but the bigger issue was lack of knowledge of services and stigma. Teachers expressed feeling overwhelmed with young children's behavioral issues which then connected to a stressful home environment because of potential factors of overworked parents, poor nutrition due to lack of time and money, domestic violence, and unhealthy sleep habits. These factors were pointed out as interconnected and expressed in the child's behavior. This systemic issue suggests the need for resources to manage adult relationships in a healthy way to address the needs of women, and to interrupt the frequency of stressors to promote the child's health all the way from pre natal care into infancy and beyond. Parent education through home visiting, opportunities for community engagement, and life skills classes such as cooking, budgeting

and job trainings could be addressed. Participants shared: *"If something could be written in the state plan around the research of ACES and trauma informed care and how these experiences are a health issue, behavioral and mental health will be in the priorities somehow. Social emotional health needs to be addressed." "We need to address stress." "[We need to] teach teens and families how to manage life skills and empower them."*

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

The priority of healthy development for children was a strong theme that addressed many needs in every community that could really stand on their own as priorities. These needs were connected to a common goal of the health of children on many levels and span into the adolescent years: injury prevention efforts, safety concerns in the home, and selection of safe childcare. What is unique is that these needs provide KDHE with the opportunity to focus on cross cutting goals in programs and practices. By strengthening existing successes of programs like Safe Kids Kansas as well as increase the number of MCH grantees that serve as a lead agency for local safe kids coalitions, KDHE can continue to strengthen the guiding principle of collaboration and creating community change. Additional needs that were absorbed into the priority of developmentally appropriate care focused on essential health, safety and education opportunities by providing prevention practices for parents and providers: safe sleep initiatives, access to childhood immunizations, oral health education and developmental screenings. Taken together, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course. Participants and staff in the meetings provided useful and innovative ideas that KDHE will look forward to implementing and continue to improve upon while expanding current programs. Many of the suggestions and ideas are already in the scope of KDHE's work and will further promote collaboration at state and community levels.

Priority 4: Families are empowered to make educated choices about nutrition & physical activity (Perinatal/Infant)

Discussions during the needs assessment regularly focused on the need to address obesity across population domains. While there was targeted discussion about children, specifically related to school lunches, there was a shift to a broader view of the systemic nature of nutrition and physical activity. Specifically, a change in terminology and definition began to emerge and the priority was reframed. Providing access to healthy food choices was an issue of both availability and knowledge. The need to educate parents and children on what a healthy food choice actually is was clearly reflected in the data. At the same time, the real challenge caused by food deserts in Kansas was discussed. Some families rely on a small grocery or convenience store due to transportation barriers and/or locale, thus connecting other daily issues (poverty, work schedules, children home alone) to unhealthy food choices. Participants and staff suggested the importance of aligning with existing programs including home visiting programs, in schools, and through community campaigns, to promote nutrition education and physical activity.

Priority 5: Communities, providers, and systems of care support <u>physical, social and emotional health</u> (Adolescents)

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

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

Seeking the appropriate care for the maternal and child health care population is critical to the continued support required to ensure that this populations needs are being met. For quality care to be delivered it's important that the professionals interfacing with this population are properly trained to provide this care. This is an area which impacts not only maternal and child health, but also children, perinatal/infant, adolescents and the children with special needs population. Ensuring professionals, serving MCH populations, have adequate training can impact individuals at birth and continues throughout adulthood. Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains. When asked what could improve services within the community, responses included "*having trained professionals who take the time and listen to our needs*." Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and the health impact that it may have on this population. In particular children and youth with special needs was identified as a population that needed improved support from professionals. Strategies suggested included incorporating evidence-based trainings and mid-level trainings for home based practitioners. Additionally, it was reported that not only an increase in training occur amongst professionals, but coordination of care also increase to enhance delivery of services. Through agencies collaborating with one another, resources are then shared within an interconnected environment that can help the MCH population be more aware of services and provide the appropriate linkage. This area has been recognized as one of importance. Objectives include: developing a trained, qualified workforce; providing training to providers to promote diversity, inclusion, and supports; and incorporating the support of early childhood service providers.

Priority 7: Services are <u>comprehensive and coordinated</u> across systems and providers (CYSHCN)

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

Priority 8: Information is available to support <u>informed health decisions and choices</u> (Cross-cutting)

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

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

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	79.9	80.4	81.0	81.5	81.9

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	21.7	24.7	28.1	31.9	36.3

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	151.4	142.1	133.4	125.1	117.4

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	7.9	5.6	4.0	2.8	2.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.2	89.0	91.9	95.0	98.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	58.7	64.0	69.9	76.2	83.1

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.8	10.3	9.8	9.3	8.9

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.5	21.8	20.2	18.8	17.4

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

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

Corresponding NPMs:

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

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

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

Priority Two: Services and supports promote healthy family functioning.

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

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

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

Corresponding NPMs:

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

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

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

Priority Four: Families are empowered to make educated choices about nutrition & physical activity. (Perinatal/Infant)

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

NPM 4 was selected because of widespread support by meeting participants for breastfeeding resources. ESMs for this priority will strengthen existing infant feeding education for mothers and communities. Efforts related to this priority will also be expanded to improve access to nutrition and increase physical activity.

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

Corresponding NPMs:

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

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

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

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

There is no corresponding NPM for this priority. A State Performance Measures will be developed. This issue was identified as the continued success of maternal and child health services in Kansas. Participants throughout Kansas voiced a need for trained, qualified professionals who could deliver services across domains. Strategies are focused on developing innovative methods for training the provider workforce.

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

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

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

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

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

FFY2016 TITLE V MCH SERVICES BLOCK GRANT NEEDS ASSESSMENT (MCH 2020)

STATE PRIORITIES: 2016-2020 (state performance measures to be developed)

Priority 1: Women have access to and receive coordinated, comprehensive care and services <u>before, during and after pregnancy</u>
Domain(s): Women/Maternal; Cross-cutting
National Measures:
- NPM1: Well-woman visit (Percent of women with a past year preventive medical visit)
- NPM14: Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy)

Priority 2: Services and supports promote healthy <u>family functioning</u>
Domain(s): Cross-cutting
National Measure(s):
- NPM14: Smoking during Pregnancy and Household Smoking (B. Percent of children who live in households where someone smokes)

Priority 3: <u>Developmentally appropriate care and services</u> are provided across the lifespan
Domain(s): Children
National Measure(s):
- NPM6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- NPM7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9/dolescents ages 10 through 19)

Priority 4: Families are empowered to make educated choices about <u>nutrition and physical activity</u>
Domain(s): Perinatal/Infant
National Measure(s):
- NPM4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)

Priority 5: Communities and providers support <u>physical, social, and emotional health</u>
Domain(s): Adolescents
National Measure(s):
- NPM9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)
- NPM10: Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)

Priority 6: <u>Professionals have the knowledge and skills</u> to address the needs of maternal and child

health populations *Domain(s):* Cross-cutting *National Performance Measures(s):* None. State Performance Measure to be developed.
Priority 7: Services are comprehensive and coordinated across systems and providers *Domain(s):* Children & Youth with Special Health Care Needs *National Measures(s):* • NPM11: Medical home (Percent of children with and without special health care needs having a medical home)
Priority 8: Information is available to support informed health decisions and choices *Domain(s):* Cross-cutting *National Measures(s):* None. State Performance Measure to be developed.

NPM	National Performance Measure	Associated Outcome Measures
1	Well-woman visit (Percent of women with a past year preventive medical visit)	Severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Low birth weight rate (%) Very low birth weight rate (%) Moderately low birth weight rate (%) Preterm birth rate (%) Early preterm birth rate (%) Late preterm birth rate (%) Early term birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Postneonatal mortality rate per 1,000 live births Preterm-related mortality per 100,000 live births
4	Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)	Infant mortality rate per 1,000 live births Postneonatal mortality rate per 1,000 live births Sleep-related SUID per 100,000 live births
6	Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)	Percent of children in excellent or very good health Percent of children meeting the criteria developed for school readiness
7	Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9/adolescents	Child mortality ages 1 through 9 per 100,000 Adolescent mortality ages 10 through 19 per 100,000 Adolescent motor vehicle mortality ages 15 through 19 per 100,000 Adolescent suicide ages 15 through 19 per 100,000

	ages 10 through 19	
9	Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)	Adolescent mortality ages 10 through 19 per 100,000 Adolescent suicide ages 15 through 19 per 100,000
10	Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)	Percent of children in excellent or very good health Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine Adolescent mortality ages 10 through 19 per 100,000 Adolescent motor vehicle mortality ages 15 through 19 per 100,000 Adolescent suicide ages 15 through 19 per 100,000 Percent of children with mental/behavioral health condition who receive treatment or counseling Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile) Severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Low birth weight rate (%) Very low birth weight rate (%) Moderately low birth weight rate (%) Preterm birth rate (%) Early preterm birth rate (%) Late preterm birth rate (%) Early term birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Postneonatal mortality rate per 1,000 live births Preterm-related mortality per 100,000 live births
11	Medical home (Percent of children with and without special health care needs having a medical home)	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

		Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
14	Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy and B. Percent of children who live in households where someone smokes)	Severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Low birth weight rate (%) Very low birth weight rate (%) Moderately low birth weight rate (%) Preterm birth rate (%) Early preterm birth rate (%) Late preterm birth rate (%) Early term birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Preterm-related mortality per 100,000 live births Post neonatal mortality per 1,000 live births Sleep-related SUID per 100,000 live births Percent of children in excellent or very good health

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

NOTE: States are not required to develop and submit the 3 to 5 State Performance Measures (SPMs) until the FFY 2017 Application. State measures will be developed as necessary and appropriate to address selected priorities during the next year and submitted as part of the FFY 2017 MCH Block Grant Application/2015 Annual Report.

II.F. Five Year State Action Plan

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

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

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

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	1.1 All women of reproductive age who access Title V services receive prenatal risk assessments and education at least annually to improve birth outcomes. 1.2 Women are connected to the services and supports that they need to promote their	1.1.1 Obtain consensus among providers on standards of care and practice guidelines related to prenatal risk assessment 1.1.2 Expand the HBWW/BAM program model, targeting areas with disparities and poor birth	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	emotional well-being through 100% screening and/or referral rates at every visit. 1.3 Communities have the capacity and resources to promote education, screening, referral, and treatment for women and families.	outcomes 1.2.1 Integrate behavioral health education into community, clinic, and home settings 1.2.2 Implement a standard screening protocol and utilization of standard tool for maternal risk and depression 1.3.1 Promote and collaborate with family planning and Title X to improve women's health 1.3.2 Increase community capacity through asset mapping and forging partnerships to address MCH population health needs	(<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live			

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

Elimination of health risks and comprehensive management of disease prior to pregnancy increases the likelihood of a pregnant woman delivering a healthy infant. The Title V priority, objectives, and strategies for Women/Maternal Health underscore the importance. The primary programmatic efforts and activities to address the priority and carry out strategies are discussed.
Priority: Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy

Strategies/Activities:

- Obtain consensus among providers on standards of care and practice guidelines related to prenatal risk assessment
  - *Develop protocol and guidelines including utilization of progesterone to prevent preterm birth*
  - *Engage perinatal obstetricians to provide educational materials on recommended immunizations for women.*
- Expand the HBWW/BAM program model, targeting areas with disparities and poor birth outcomes
  - *Replicate the model in at least five new communities*
  - *Integrate evidence-based tobacco cessation interventions, including the Quitline, into community-based service models*
  - *Link smoking during pregnancy/in the home to increased risk for infant mortality, especially SUID and SIDS*
  - *Decrease wait time for Medicaid coverage and access to prenatal care through referral to the outstation workers*
  - *Promote compliance with recommended immunizations for women and pregnant women*
- Integrate behavioral health education into community, clinic, and home settings
  - *Promote the ongoing participation in Medicaid Health Homes for serious mental illness or other chronic conditions/chronic illness*
  - *Establish home visiting protocol that supports adequate referral and follow up for behavioral health screening and treatment*
- Implement a standard screening protocol and utilization of standard tool for maternal risk and depression
  - *Local HDs utilize when appropriate*
  - *Coordinate among community partner*
- Promote and collaborate with family planning and Title X to improve women's health
  - *Well woman visits*
  - *Reproductive health and family planning*
  - *Interconception care and spacing of children*
  - *Cervical/breast cancer screening*

    - *Methods of contraception including Long Acting Reversible Contraceptive (LARC)*
- Increase community capacity through asset mapping and forging partnerships to address MCH population health needs
    - *Increase the number of public health departments with certified application counselors on site to support women in selecting appropriate health plans*
    - *Promote value-added services offered by KanCare Managed Care Organizations at the provider and community level*

Programs/Initiatives:

Healthy Babies are Worth the Wait/Becoming a Mom (HBWW/BAM): The Kansas Department of Health and Environment (KDHE) Title V Program is committed to providing support and infrastructure to continue the high level of innovative and collaborative initiatives that are currently in process across our state. Partnerships with the March of Dimes Greater Kansas Chapter (MOD), Managed Care Organizations (MCO), Kansas Chapter of the American Academy of Pediatrics (KAAP), as well as with other Bureaus across KDHE, are advancing MCH work at the state and local levels, resulting in collective impact through the alignment of shared priorities and joint initiatives. Healthy Babies are Worth the Wait/Becoming a Mom (HBWW/BAM), the Community Collaborative Prenatal Education Model in our state, is in its sixth year of implementation and embarking on a third phase of expansion across the state. Now an official HBWW state, Kansas BAM sites are being provided additional resources, technical assistance and networking from March of Dimes National, bringing an additional investment to enhance program implementation. Recent partnership and investment by MCO Amerigroup (WellPoint), one of Kansas' three managed care organizations that covers the state's Medicaid prenatal care expenses, is also helping with site expansion, website development, and expansion of the program's evaluation system in the upcoming year. Kansas Title V Director has allocated funds to the expansion of HBWW/BAM to launch up to five new sites across the state in the next year, specifically targeting those areas that are more rural/frontier and have higher rates of disparities and poor birth outcomes. HBWW/BAM sites are also concentrating outreach efforts and partnership expansion to include faith based organizations, primarily those serving targeted racial/ethnic populations. Commitment has also been made to the funding and creation of a comprehensive online database and evaluation system. A vital part of the program's progress is to expand the shared measurement and evaluation process to better demonstrate the program's efficacy, aiding in the establishment of "Becoming a Mom" as an evidence-based prenatal education model. With this, program sites will be moving to a more comprehensive and sustainable tool for data entry into an online database (DAISEY*), also making evaluation more manageable for the statewide expansion. This will improve the quality and accuracy of data entry, generating timely data reports for the sites' use in furthering their collaborative efforts at the local level. Additionally, KDHE Bureau of Family Health (BFH) has committed MCH staff to the *integration* of state services with the HBWW/BAM program. This plan specifically targets the integration of state entities such as the Kansas Tobacco Quitline (KanQuit), WIC, Kansas Breastfeeding Coalition, Inc., Title X Family Planning, and the Kansas Infant Death and SIDS Network. Future evaluation is expected to reveal an increase in program participation at both state and local maternal child health programs (e.g. Medicaid, CHIP, WIC, Title X), through enhanced outreach, education and public awareness and an increase in health information and referral services available to the program's participants who use tobacco and other substances, as well as those who are eligible for WIC and Title X Family Planning Services. An example of this integration is to cross-train WIC and MCH staff and to develop a system for the electronic scheduling of WIC participants into BAM prenatal education sessions, and BAM participants into WIC certification appointments. Both programs will incentivize participation in the other programs, and will deliver consistent messaging and support around breastfeeding, nutrition, oral health, smoking cessation, and more. Other integration work will include the incorporation of local Title X Family Planning staff or other local providers to present on family planning options, including LARC, during the BAM session on postpartum care, as well as a standardized screening and referral process for mental health during and after pregnancy. A major component of *expansion*, *integration,* and evaluation efforts is to develop and implement solid referral and follow-up processes within programs/agencies and across community partners. Additionally, extensive

efforts will take place to integrate HBWW/BAM program enrollment as a direct referral service provided by all case managers of pregnant women across all three MCOs in the state.

Healthy Start: Eliminating Disparities in Perinatal Health: With support and guidance from KDHE Title V as the lead agency for the newly funded Healthy Start Initiative in Geary County, the *Delivering Change* model now has sufficient support to implement such previously described initiatives around women's health and prenatal care on a broader scale. In addition to having funds available to scholarship early prenatal care for a greater number of women without insurance coverage, Geary County Health Department and Flint Hills OB/GYN Practice will be expanding their partnership to make LARC and other family planning services more readily available to the area's women who are most at-risk. Located adjacent to Fort Riley, Geary County's low-income population is compounded with risks related to the transient nature of the military based population. Although extremely high rates of short-interval pregnancies in this area have made this partnership an immediate necessity, KDHE plans to take this model and replicate it across the state in other areas of high need. Another component of the *Delivering Change* model that has been attained through additional Healthy Start funding is the "OB Navigator" position. The OB Navigator will be a primary mechanism in addressing *improved women's health*, as it builds on the existing infrastructure and partnerships in the community, adding much-needed coordination and referral services through targeted case-management. This position will be a central connecting point among collaborative partners between meetings and formal communications, as well as assuring comprehensive care and wrap-around services are attained by individuals of this most at-risk population. KDHE MCH staff plan to assist local health department MCH programs around the state to better utilize their current professional staff, consisting of licensed nurses and/or social workers, to incorporate this "OB Navigator" concept in improved marketing of services to local physicians and community partners, who often underutilize them as such a valuable resource in the community. Two of the three project goals and planned activities for the coming year focus on women/maternal health: 1) Develop a comprehensive, coordinated perinatal system in Geary County that leads to improved women's health; and 2) Improve the quality of services available to pregnant women and new mothers in Geary County.

Infant Mortality Collaborative Improvement & Innovation Network (CoIIN): KDHE along with several partners and organizations including the March of Dimes and Kansas Infant Death and SIDS Network is actively engaged in the infant mortality CoIIN initiative, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. The original Kansas team that was convened traveled to the launch/expansion summit in July 2014. Since that time the project has progressed, and work related to the Kansas Blueprint for Change and selected learning networks has advanced. The second national learning session for states will be held in person in Boston, MA, July 27-28; six Kansas team members including the Title V Director, MCH epidemiologist, and Family Delegate plan to attend. CoIIN is the overarching state initiative ("Blueprint") with other state and community infant mortality activities advancing the work to drive change, increase coordination, and enhance/improve services. During the next 6-12 months, action plans, change ideas, and interventions will be tested and implemented in pilot sites and replicated across the state. Targeted pilot sites are local health departments and clinics in Crawford, Geary, Saline, and Sedgwick counties. Goals, objectives, and change ideas for the Kansas priorities/selections follow:

<u>SMOKING CESSATION</u> (primary focus: reduce smoking before, during and/or after pregnancy)
Goal: By July 2016, we will reduce the rate of smoking in women in their reproductive years by 10% with emphasis on before, during, and after pregnancy.

- Increase the percentage of women who stop smoking during pregnancy by 10%
- Increase the percentage of women who maintain cessation after delivery by 10%
- Increase the number of women enrolled in Quitline in reproductive years (15-44 years of age) by 10%
- Increase the number of providers trained on the 5A's of tobacco cessation by 10%, implementing a provider

reminder system and the KS Quitline fax referral system
- In pilot sites: increase the percentage of smoking women who are referred to smoking cessation counseling and programs like Quitline to 95% or higher

Change Ideas:

Providers and support personnel refer women to evidence-based programs like Quitline

- Screen for smoking at every visit and make referrals at the time of screening
  - Cessation counseling
  - Evidence-based interventions (Quitline, Baby and Me-Tobacco Free, SCRIPT--Smoking Cessation and Reduction in Pregnancy Treatment--Programs)
- Follow up with women referred to stop smoking, inquire and refer again with advice
- Refer college age women and adolescents to evidence based support services like Quitline

Women in child bearing years avoid smoking or stop and stay quit

- Use media, social media, texting, videos, peer to peer mentoring
- Consistent, repeat messages about tobacco and nicotine across all systems
- Use of 5As and motivational interviewing techniques to help women commit to stop and stay quit

Providers recognize role in coaching and supporting women to stop and stay quit

- Providers trained in smoking interventions and aware of resources/interventions
- Put toolkits (screening, referral, resources, programs) in the hands of providers
- Enlist support of pediatricians to inquire about smoking, counseling, referrals postpartum

PREVENTION OF PRETERM AND EARLY TERM BIRTHS (primary focus: increase appropriate utilization of progesterone and/or reduce early elective deliveries EED)
Goal: By July 2016, reduce prevalence of preterm and early term singleton births by 10 %.

- Decrease non-medically indicated births between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5%
- Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40%
- Achieve or maintain equity in utilization of progesterone by race/ethnicity
- Increase the number of *Healthy Babies are Worth the Wait/Becoming a Mom* sites by at least 5

Change Ideas:

Timely, reliable and effective screening, identification and prevention of pre-term birth

- Universal practice protocol and tool to screen women for history of preterm birth and short cervix
- Establish universal process for early access to care
- Use claims data and data linkages to increase # of women prescribed progesterone

Increase patient, family and community understanding of progesterone and full term births

- EED and progesterone education/materials for HBWW/BAM
- Integrate screening and referral to BAM into WIC—intake, appointment interviews, data collected
- Utilize existing blogs, websites and text messaging, such as Healthy Mom and Baby, March of Dimes Share Your Story and CineMama, and Text4Baby to provide information on progesterone

Build capacity of and support for hospitals and providers to reduce EED

- Standard forms for scheduling that collect gestational age and indication for delivery (to determine medically indicated)

- Standard tool, process, reporting system for EED
- Standard protocol and/or policies (hard stop, scheduling process/form, informed consent, flow charts, etc.

MCH Healthy Start Home Visitor Program: During the coming year, MCH will complete review and redesign of the program. The goal is to clearly define the program within the context of other state home visiting programs. As a universal program, the role is to ensure collaboration and partnership with other home visiting programs as well as other health/educational programs for families statewide. Specific tasks will include updating the manual to be consistent with transformation and improvement and revising tools/assessments/forms utilized by home visitors to capture data in order to measure progress toward outcomes as required by MCH and as outlined in the logic model. KDHE will ensure that programs are able to report aggregate data through a web-based data management system (DAISEY) in order to present a clear picture of the impact of the program. Revisions related to data will include changes to the tools home visitors use to record encounters, the collection of data elements as specified, the ability to easily separate the HSHV data from other MCH services, and processes for providers reporting the data to KDHE.

Breastfeeding Promotion and Education - MCH/WIC/Kansas Breastfeeding Coalition Partnership: The Bureau of Family Health (BFH) and the Kansas Breastfeeding Coalition, Inc. (KBC) continue to work on several projects that support breastfeeding families and build community support. These organizations have partnered on the Communities Supporting Breastfeeding project. The CSB project incorporates six separate Kansas breastfeeding support projects: 1)The Kansas High 5 for Mom and Babies project educates and works with hospitals to implement five evidence based practice steps from the Baby Friendly designation. 2) Supporting and Developing Local Breastfeeding Coalitions. The number of local breastfeeding coalitions has grown from 3 to 18 in the last 3 years with local coalitions implementing actions that assist their community. 3) Business Case for Breastfeeding, a KBC project – employers are educated about lactation support and can be recognized for their efforts. 4) Breastfeeding Welcome Here, a KBC program which encourages local businesses to welcome breastfeeding customers. 5) Kansas Child Care Training – child care providers enroll in a *How to Support the Breastfeeding Mother and Family* course, this is a joint project of the BFH Child Care Licensing Program, Child Care Aware © of Kansas and the KBC. 6) Peer support – communities must have a peer support group such as a La Leche League, Health Department WIC/MCH support group or similar. BFH in collaboration with the KBC applied for and recently was awarded funding to continue the work and assist ten additional communities with reaching the designation in the next two years. Title V is supporting a contract with the KBC to develop the *Infant Feeding Session* of the Becoming a Mom class to be implemented in 2015. The session content and materials will promote, include and be consistent with the Kansas *Baby Behavior* training, KIDS Network of Kansas safe sleep practices, and “High 5 for Mom & Baby” maternity care practices.

Child Care Licensing Outreach to Improve Providers' Health: Many child care providers in Kansas do not have adequate health insurance or qualify for mammogram and pap screens based on income eligibility. KDHE Child Care Licensing will be collaborating with KDHE Health Promotions to educate child care providers on the availability of free mammograms and pap screenings. An information card will be added to each initial application response by mail, and a link will be provided to all renewal emails as well as to the program website. Based on facility and staff counts, more than 6,000 women of reproductive age will receive this essential health screening information. The program intends to follow up periodically with a survey to targeted child care providers to inquire as to action taken in response to receiving the information, such as utilizing the services.

Kansas Pregnancy Risk Assessment Monitoring System Pilot: When the birth file becomes available in 2015, data will be weighted by a statistician. This will provide data on health indicators, such as prematurity, low birthweight, infant mortality, late prenatal care, and pregnancy intent for the target area that are not collected by other surveillance systems. The data will also be used to investigate emerging maternal and child health issues, provide data to plan and review policies focused on improving MCH, provide data for grant applications, identify emerging issues that could affect maternal and child health program planning, and evaluate health disparities.

Maternal, Infant, Early Childhood Home Visiting Program (MIECHV): The MIECHV Program collects and reports data for the Maternal and Newborn Health Benchmark construct, Preconception Care, as follows: Percent of non-pregnant mothers enrolled in home visiting who receive one or more routine primary care visits after birth of index child and before a subsequent pregnancy. Evidence-based and promising approach home visiting programs involved with the MIECHV Program provide their enrolled pregnant women and mothers with information, referrals, and support addressing multiple health areas including prenatal care, preconception care, inter-birth intervals, and maternal health insurance coverage. Screenings of alcohol, tobacco and drug use, maternal depression, and domestic violence are also conducted which identify needs for additional information, support, and referrals. Data is collected on each of these Benchmark constructs.

*At this time, data collection, reporting, and analysis is still cumbersome for BAM sites and state and local MCH programs. There is concern about the integrity and consistency of the data collected/compiled on an ongoing basis. To address this critical area and barrier, we are working with the University of Kansas Center for Public Partnerships and Research to design, develop, and implement a web-based data system, DAISEY, (Data Applications and Integrated Solutions for the Early Years) to ensure accuracy in data collection and reporting related to types of individuals served and services provided. This system will allow us to 1) pull data from grant partners' existing databases; and 2) use DAISEY as a database for grant partners that don't have an existing database. We do not want to require grant partners to duplicate data entry or use a project specific database. The system is tentatively set to be piloted, first with BAM sites then with all other MCH programs, beginning in July 2015. CoIIN measures for smoking and pre/early term birth will also be incorporated into DAISEY to support state and local (pilot site) data collection and reporting.

Women/Maternal Health - Annual Report

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

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

Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) Pilot: PRAMS is a population-based health surveillance system. PRAMS utilizes mixed mode system consisting of mail and telephone surveys to collect data. Kansas is not a CDC funded PRAMS state. However, KDHE Title V launched a pilot in April 2015. The PRAMS pilot follows model surveillance protocol for CDC funded states and includes an adapted questionnaire modeled from the state of Iowa. The pilot project is funded and conducted in collaboration with the Sedgwick County Health Department and the Behavioral Risk Factor Surveillance System (BRFSS) Section of the KDHE Bureau of Health Promotion. The purposes of the pilot project are to: 1) demonstrate that Kansas has the capacity to follow the protocol and carry out PRAMS, which will position Kansas for the next funding opportunity; and 2) quantify risk factors for poor perinatal outcomes among infants born to resident mothers in three Sedgwick County Federal Healthy Start zip codes. The survey distribution has been conducted over a period of one year (mothers giving birth in April 2014 – March 2015). The samples were derived from the live birth certificate files and are generated to include mothers who gave birth 3 to 4 months prior to sample selection. A 100% sample was drawn from each monthly sampling frame in the three zip code area. As of May 2015, approximately 80-100 mothers are selected each month to participate in the survey and only 40-50% of participants responded.

Use of clinical preventive services for women of reproductive age before, during, and after pregnancy serves as an indicator of access to health care services. Access to health services including preventive, primary care, and tertiary

care often depends on whether a person has health insurance. According to the BRFSS4, approximately 25.3% of Kansas women ages 18 to 44 years lacked health care coverage in 2013, which is above the national average of 22.4%. Non-Hispanic black women were nearly twice as likely as non-Hispanic white women to be uninsured, and Hispanic women were more than two and half times as likely. Women with family incomes under 100% of the federal poverty level (FPL) were more likely to report that hospital outpatient departments and emergency departments were the places they usually go when sick, and were more likely to have no usual source of care than those with higher incomes. (MCH 2014 Biennial Summary)

When Kansas Family Medical (Medicaid and CHIP) programs separated from the State welfare (TANF and SNAP) agency (Department for Children and Families) in 2012, the Kansas Department of Health and Environment (KDHE) developed efforts to expedite applications for assistance for children, families and pregnant women by centralizing eligibility determination. Recognizing many families need more one-on-one assistance with the Medicaid application process, 12 Out Stationed Eligibility Worker positions were created. These workers are located across Kansas in Federally Qualified Health Care Centers and hospitals, where families without insurance may seek medical care. These eligibility workers determine eligibility for Medicaid and CHIP programs, as well as providing information and outreach to communities, local health departments, clinics and hospitals, explaining eligibility requirements, trouble-shooting payment problems, and encouraging families and pregnant women to apply. While local health department staff across MCH, WIC, and Family Planning programs work to identify uninsured pregnant women and refer them to local Outstation Workers for expedited eligibility determination, Outstation Workers work collaboratively within communities and agency partners to make referrals for prenatal and parenting support and education programs as well as medical prenatal care. Outstation Workers participated alongside local health department MCH staff, mental health providers, birth centers, Early Head Start programs, and many other local agencies during the State hosted AMCHP Compendium Regional Public Health Meetings. State supported efforts have been ongoing throughout the past year to engage local grantees in improving coordination efforts among MCH, Family Planning, WIC, and Medicaid. Many of these efforts are expanded upon in this section and throughout this document.

In relationship to access, early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes. Most recent data (2013) reveals 79.4% of infants were born to pregnant women receiving prenatal care in the first trimester, a slight increase from 2012 (78.8%). The U.S. data for 2013 on this measure was 74.2%; Kansas exceeded the U.S. on this measure by 7.0% in 2013 and above the Healthy People 2020 goal of 77.9%. Kansas 2013 data shows that Hispanic and non-Hispanic black mothers are most likely to enter prenatal care late. In general, women in rural areas are less likely to get prenatal care. (2014 Kansas MCH Biennial Summary)

Local health departments, Federally Qualified Health Centers, hospitals, and local obstetrical and perinatal health care providers comprise the comprehensive prenatal care coordination system in Kansas. Local MCH agencies use care coordination and case management models to provide comprehensive prenatal services. Family Planning, WIC and MCH programs coordinate prenatal care outreach and assist clients in navigating the health care system and KanCare (Medicaid/SCHIP). Kansas Title V funds and supports outreach and case management services such as Healthy Start Home Visitors (HSHVs) and other programs to improve engagement in early prenatal care. Evidence-based and promising approach home visiting programs funded by the MIECHV Program served 516 enrolled pregnant women and families with children birth to five from October 2013-September 2014. These programs provided information, referrals, and support addressing multiple health areas including prenatal care, preconception care (i.e., well-woman preventive care visits), inter-birth spacing, and maternal health insurance

coverage. Screenings of alcohol, tobacco and drug use, maternal depression, and domestic violence were also conducted which identify needs for additional information, support, and referrals.

KDHE participated in a workgroup to plan and implement the Kansas Breastfeeding Summit which took place September 2014. Strategies for Kansas, based on the *CDC Guide to Strategies to Support Breastfeeding Mothers and Babies,* were developed as a roadmap for future breastfeeding promotion and support grant funding and activities. 550 WIC staff and other interested health professionals completed *Baby Behavior* training in 2014 which research shows improves exclusive breastfeeding rates. Additionally, WIC provided financial support to the Kansas LaLeche League 2014 spring conference and supported a Certified Lactation Educator (CLE) training fall 2014. WIC will provide financial support for a CLE course fall 2015 in the western frontier portion of the state. The one-half day course "Breastfeeding 101" developed by the KBC will be offered by WIC and the KBC for WIC staff and interested healthcare professionals in nine to ten communities around the state this year. This course enhances care of breastfeeding mothers and infants.
Local efforts towards improving the health of women and infants include the Geary County *Delivering Change* project. *Delivering Change* is a non-profit project of the local Geary County Perinatal Coalition, made up of individuals and organizations that impact the health of mothers and their infants in Geary County. This project was created in 2010 in response to a growing need for improved health of women of childbearing age, and improved outcomes for the infants born in the community. *Delivering Change* has created a community-wide collaborative that aims to increase or improve the tools necessary for improving maternal health and decreasing infant morbidity and mortality. Priority areas include: Maternal Health; Public Awareness; Prenatal Care: Access/Education; Infant Health; Breastfeeding; Scholarship; and Fetal and Infant Mortality Review (FIMR). The *Delivering Change* model takes a collective impact approach to achieve three project goals: (1) develop a comprehensive, coordinated perinatal system that leads to **improved women's health**; (2) improve the quality of services available to pregnant women and new mothers; and (3) develop a system of programs, services and partnerships that strengthen family resilience. In the approach, it is recognized that personal finances and lack of health insurance can be a barrier to getting early and consistent prenatal care, a vital step in having healthy babies. Outreach and enrollment in health coverage programs is a priority of the *Delivering Change* program. A scholarship fund has been established to cover prenatal care and delivery for residents of Geary County who are uninsured, or while awaiting approval for Medicaid coverage. Media partners advertise this service and urge pregnant women to seek care. As a result of these initiatives, Vital Statistics rates for the "Quality of Prenatal Care" as "Adequate/Adequate Plus" have steadily and significantly improved from 66% in 2010 to 76.4% in 2013. Women's health being inclusive of mental and behavioral health services, an established medical home, and reproductive life planning, are all priorities of the Collaborative. These initiatives and high level of community collaboration perfectly positioned Geary County to be a candidate for federal Healthy Start funds. KDHE applied for Healthy Start funds, in partnership with Geary County Delivering Change, and in August 2014 was awarded a five year 3.5 million dollar grant from the U.S. Department of Health and Human Services (HHS).

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

birth outcomes. This innovative model was replicated in Junction City (Geary County), Kansas in 2012 with the similar preliminary successes of the pilot program. With two effective sites implementing the model, program evaluation tools were refined and standardized in 2013 in partnership with evaluators from the University of Kansas School of Medicine-Wichita and Wichita State University. Preliminary data reports showed improvements in participant's knowledge, behaviors, and growth of community partnerships and shared resources. Three additional sites, in Reno, Riley, and Wyandotte counties, were added. In 2014 KDHE committed to partner with the March of Dimes with a financial investment of $277,034 over a three year period for further expansion of the model across the state. In the expansions' first year work plan, two additional sites, Crawford County and Lyon County, were added. The second year of the expansion plan in 2015, adds five more sites. During the AMCHP Compendium Regional Public Health Meetings, interested sites were solicited to incorporate into their MCH Aid-to-Local application, a plan for implementing the HBWW/BaM collaborative model in their community, particularly in the southeast and western parts of the state where greater disparities and fewer resources exist in these largely rural areas. Statewide expansion in the second year also includes an additional investment of $20,000 from KANCARE Amerigroup (WellPoint), one of Kansas' three managed care organizations that covers the state's Medicaid prenatal care expenses. Investments by these three organizations are providing the opportunity for site expansion, website development, and expansion of the program's evaluation system. The HBWW/BaM curriculum comes from National March of Dimes and consists of six, two-hour group prenatal education and support sessions, delivered in both English and Spanish languages. Participants are scheduled into these sessions during their prenatal visit with their medical provider. Partnerships at the local level leverage funds and other resources to support the inclusion of incentives, childcare and transportation, in an attempt to reduce barriers and encourage program completion. Attendance by support people is also encouraged and incentivized. Curriculum content covers topics such as: importance of early and continuous prenatal care; risks associated with smoking, use of drugs, environmental exposures, stress, etc.; pregnancy health and nutrition; preterm labor risks and signs/symptoms; preparation for labor and delivery; infant care and feeding; postpartum recovery and interconception health. The curriculum includes an extensive support component that incorporates guest presenters from area agencies, as well as highlighting other applicable community resources. Most program coordinators and group facilitators are local health department MCH staff, as the program is intertwined with other MCH services such as individual case management and healthy start home visitor services.

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 tend to weigh less than other infants, and low birthweight (<2,500 grams) is a key predictor for infant mortality.1 (MCH 2014 Biennial Summary) In 2013, the percentage of pregnant Kansas women reporting smoking during pregnancy was 12.5%, a decrease from 2012 (13.7%).5 Over the nine year period (2005-2013), there was a significant decreasing trend detected. The smoking rate was highest for non-Hispanic Native American women, at 31.3%, followed by non-Hispanic white women, 14.4%, and non-Hispanic black women, 13.3%. Rates for Hispanic (4.0%) and non-Hispanic Asianwomen (1.8%) were substantially lower. Teenagers 18-19 years and women in their early twenties had the highest smoking rates (17.8% and 19.1%, respectively). Smoking rates for women in their thirties and older were sharply lower, around 7%. Overall, in 2013, Medicaid paid for the delivery of 13,151 (33.9%) Kansas live births. Among women who reported smoking during pregnancy, 65.6% had births reimbursed by Medicaid, according to Medicaid claims data. This was a slight increase from 2012 (65.3%). In 2013, 10.5% of Kansas women reported smoking during the last three months of pregnancy, decreased from 2012 (11.5%). Among women who reported smoking during the last three months of pregnancy, 67.6% had births reimbursed by Medicaid, according to Medicaid claims data. This was an increase from 2012 (66.9%). (MCH 2014 Biennial Summary)

Local grantee staff have continued to utilize the Kansas Tobacco Quitline as a referral resource for pregnant women to encourage them to quit smoking, as well as local tobacco cessation resources. MCH grantees are provided education on use of the Quitline and web resources through the March of Dimes and CDC and are encouraged to

promote smokefree.org, Txt2stop, and other web resources to assist women to quit smoking. Training in the 5 A's method of tobacco cessation counseling is encouraged for grantee staff. Through the Bureau of Health Promotion at KDHE, an online training course on *Brief Tobacco Interventions* was developed, offering 1.0 CEU credits free of charge to all providers across the state. MCH grantees trained in the 5 A's counseling method of smoking cessation provide brief interventions to pregnant women. Local grantee Healthy Start Home Visitors link pregnant women to smoking cessation resources, make referrals to the Quitline, and provide education and supportive services. Training of local grantees and interested partners continues through efforts by Kansas TUPP and MCH staff. Coalition building efforts continue with a focus towards involving more businesses, hospitals and local health care providers. Perinatal collaboratives such as HBWW/BaM, located in multiple communities across the state, are screening for tobacco use and providing education and resources to women served in these settings as part of a comprehensive prenatal education approach. (MCH Title V Block Grant Application/Report 2015/2013)

State data showing higher rates of smoking among young reproductive aged women and the Medicaid population has led to Kansas selecting *smoking cessation* as one of the national learning strategies/networks to participate in as part of the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). Kansas joined CoIIN in July 2014 and is committed to advancing the national CoIIN agenda and Blueprint for Change to address state priorities. State selected strategic priorities around smoking cessation include *building community capacity to promote education, screening, referral, and treatment for women.* The Kansas CoIIN Team has identified “change ideas” and tasks related to this priority and have recently identified pilot sites in three locations in the state. Two pilots will be implemented through HBWW/BaM sites in Crawford and Saline Counties. The third pilot will be in the Sedgwick County WIC program. Currently all sites are in their first PDSA cycle including tasks around assessment of current screening processes in place and inventory of local resources, evidence-based programs/services/interventions.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Families are empowered to make educated choices about nutrition and physical activity.	2.1 Infants, children and adolescents ages 0-17 years of age and older have access to healthy foods and increased knowledge of opportunities for physical activity in order to adhere to and achieve optimum lifelong health	2.1.1 Increase the availability of healthy food and beverages in sufficient supply in schools 2.1.2 Increase opportunities for students to participate in regular physical activity both in and out of school (e.g., non-competitive sports leagues,	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	2.2 Parents have access to information and resources on infant nutrition and feeding education in a multifaceted way using existing programs starting in the prenatal period, initiated during the first trimester	intramural)				
		2.1.3 Promote and implement “brain breaks” in schools including recess and designated time between classes and activities				
		2.2.1 Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including home visiting and WIC				
	2.3 Increased opportunities for regular physical activity for families are provided through structured environments and improved accessibility to facilities that support physical activity	2.2.2 Support breastfeeding mothers and babies by creating communities in Kansas that provide a multifaceted approach to breastfeeding support across sectors				
		2.2.3 Develop prenatal education				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		content to support an accurate, consistent message for women related to optimal infant feeding				
		2.3.1 Explore opportunities to engage local businesses in health and wellness activities				
		2.3.2 Provide resources and educational materials to child care and home visiting programs focused on healthy eating and physical activity in early childhood to decrease risk of obesity in childhood and adolescence				
		2.3.3 Support local health departments and or community centers in local initiatives to promote				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		physical activity and utilization of walking and biking trails				

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

Newborn Screening Follow-Up (NBS-FU): Significant shifts in available providers, services, and delivery systems support a revision of the 2010 State Genetics Plan. The NBS-FU Program will lead this initiative, with support from the NBS Advisory Committee and the Special Health Care Needs (SHCN) program, which provides family supports and assistance around genetics services and medical needs. The recent addition of a shared position between the NBS-FU and SHCN programs will allow for opportunities to expand NBS-FU community supports around family and parent education initiatives and family-centered care coordination around needed resources and services. This collaborative partnership among two state programs will be critical to the development and adoption of a long-term follow-up program in the coming years.

During FY16, NBS-FU will continue to provide training and education on Critical Congenital Heart Disease (CCHD) screening for any birthing facilities requesting technical assistance. NBS-FU will expand outreach and education by providing parent educational materials to obstetricians, primary care providers, and maternity care/nursery staff. In partnership with the Newborn Hearing Screening (NBHS) program, NBS-FU will provide training, education, and resources to midwives in order to ensure all midwives are screening for CCHD. Only midwives associated with a licensed birthing center were part of the initial training efforts. NBS-FU staff will continue to collaborate to ensure that the Kansas Electronic Birth Certificate changes are implemented and all birthing facilities are informed and trained on the new CCHD reporting. Monitoring of reporting and screening efforts will take place in the coming year.

In the coming year, NBS-FU and Kansas Health & Environment Laboratories (KHEL) will be working together on the implementation of SCID screening. KHEL will be the lead on the majority of SCID activities this next year since activities are primarily focused on lab equipment and training protocols. NBS-FU will participate when appropriate, especially in regard to planned site visits. NBS-FU and KHEL staff will receive consultation regarding equipment purchase, workflow processes and protocols, and how to incorporate the new equipment into the existing lab structure. KHEL will assure validation of the equipment and a pilot study, using samples received for the metabolic screening. This will assure validity and reliability of the new equipment and provide quality improvement data to KHEL and NBS-FU on timing and need to modify work processes. The SCID Subcommittee will continue to meet to assist in the development the NBS-FU algorithm and flow-cytometry specimen collection protocols, parent and provider education materials, and provide recommendations on lab collection needs for Kansas communities.

Newborn Hearing Screening - Sound Beginnings (NBHS/SB): Sound Beginnings staff will continue to participate in activities or initiatives to strive to resolve issues that lead to the reduction of Kansas' overall loss to follow-up rate. Staff will focus on maintaining the national JCIH goals for EHDI, improving understanding of the hearing screening process and the benefits to professionals touching the lives of our children, and improving the

health and quality of life for children with hearing loss and their families in Kansas. SB staff will continue to participate in activities or initiatives to strive to resolve issues that lead to the reduction of Kansas' overall loss to follow-up rate. Staff will focus on maintaining the national JCIH goals for EHDI, improving understanding of the hearing screening process and the benefits to professionals touching the lives of our children, and improving the health and quality of life for children with hearing loss and their families in Kansas. Over the next fiscal year, SB will work with the Kansas Commission for the Deaf and Hard of Hearing, Sound START, and the Kansas School for the Deaf on developing a statewide Deaf Mentoring program, a Family Network Support system, and a Deaf/Hard of Hearing Liaison" program to ensure that families receive unbiased comprehensive information and support to promote early access to language.

Healthy Babies are Worth the Wait/Becoming a Mom (HBWW/BAM) Perinatal Community Collaboratives: Through the work of the HBWW/BaM *Integration* Pilot, Kansas Title V Director has allocated funding to contract with the Kansas Breastfeeding Coalition for the development of a two-hour evidence-based breastfeeding curriculum. This evidence-based curriculum will replace the existing two-hour session that is currently part of the HBWW/BaM program. Primary focus will be on breastfeeding, but will also include information on safe/healthy bottle feeding practices where messaging will be consistent with WIC initiatives such as *Baby Behavior*. Focus will continue to be on getting breastfeeding off to a solid start, partner support, and successful transition back to work, all of which have a great impact on rates of continuation. All HBWW/BAM site staff will be trained on the implementation of the curriculum and a comprehensive support and follow-up system, modeled after the Saline County site, in the fall of 2015. The curriculum will also be made available to WIC/MCH programs in counties across the state where HBWW/BaM sites are not in place. HBWW/BaM sites will be required to include plans for targeted outreach to disparate populations. With the improved evaluation and data collection system, DAISEY, that will be implemented across HBWW/BAM sites beginning fall of 2015, sites will be expected to compare participant demographic data to identified high-need/risk groups in their individual counties to assess if the target market is being appropriately served. This in turn will hopefully have an improved effect on breastfeeding rates among the teen and non-hispanic black populations.

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

Plans for expansion of the HBWW/BAM program during the 2016 state fiscal year, will include five new sites across the state, specifically targeting those areas of the state that are more rural/frontier and have higher rates of disparities and poor birth outcomes. KDHE MCH staff are committed to assisting counties in the development of a regional model in locations where birth numbers are too small to justify a full scale independent HBWW/BAM program. By increasing access to such comprehensive prenatal education and support services, where local MCH program staff serve as the lead or are at least a primary partner, and other Home Visiting and MCH case management services are intertwined, we look forward to an infrastructure that leads to a greater collective impact on the improvement of birth outcomes in Kansas.

Safe Sleep & Injury Prevention: The Kansas Infant Death and SIDS Network in partnership with Title V will focus on a multi-sector (individual, health care/social service provider, community, organization) approach to reduce SIDS and SUID. Strategies include:

- Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need
- Launch a campaign on safe sleep practices targeted to relative caregivers and those providing family-friend- and neighbor care
- Establish safe sleep standard of care for clinical providers, birthing facilities, and home visitors
- Inventory existing safe sleep initiatives and activities to determine what services are needed and areas to target education, training, and materials
- Identify a safe sleep expert in every region of the state and ensure availability of core health and safety training related to safe sleep policies and practices

Breastfeeding Support & Promotion: Title V State Action Plan strategies related to breastfeeding include:

- Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including home visiting and WIC
- Support breastfeeding mothers and babies by creating communities in Kansas that provide a multifaceted approach to breastfeeding support across sectors
- Expand the Communities Supporting Breastfeeding model to at least five more Kansas communities
- Develop prenatal education content to support an accurate, consistent message for women related to optimal infant feeding

Title V and the Kansas Breastfeeding Coalition (KBC) partnered on development of a breastfeeding proposal that was funded by the Kansas Health Foundation and United Methodist Health Ministry Fund. Organizations funded are expected to implement CDC Recommended Strategies to promote and support breastfeeding mothers and infants. This initiative will support KDHE and KBC in further developing and implementing breastfeeding initiatives in coordination with health care systems, health care providers, public health professionals and communities. The funding supports continued work related to the existing efforts, specifically the *Communities Supporting Breastfeeding* (CSB) project/designation to recognize communities in Kansas who are creating a culture of breastfeeding support through a variety of community level strategies. During the next three years, focus will be on expanding work within the six criteria:

- CSB Criteria #1: NEW Activities to support local breastfeeding coalitions
  - Train 2-3 regional consultants from within the KBC to provide technical assistance in-person (project and governance ideas, community engagement tools, start-up meeting facilitation)
  - Annual coalitions conference for in-person sharing of ideas and strategies
- CSB Criteria #2: NEW activity to help families locate local peer support groups (and all breastfeeding resources in their community)
  - Local resource directory (need identified from the Breastfeeding Summit): Converting it to an app for increased access and staff time to populate, maintain and promote. Directory would also contain "Breastfeeding Welcome Here" participating businesses, and "Breastfeeding Friendly" physician offices
- CSB Criteria #3: NEW activities to support hospitals with High 5 for Mom and Baby
  - Continuity of Care & Consistent Messaging: Providing training and materials to ensure community partners (physicians, clinics, public health/MCH-WIC, hospital, etc.) provide the same information to families about breastfeeding and insuring a "warm handoff" in the early days and weeks postpartum
- Kansas Chapter American Academy of Pediatrics (KAAP) to create a physician office designation for "breastfeeding friendly" that includes physician and staff education and tool kits for outpatient care. Focus will be on pediatricians and family practice with whom the KAAP has existing relationships. It will be a 1-5 star system. Work will include connecting physicians' offices with local breastfeeding resources such as WIC and

local coalitions/staff.

- Other project partners to assist with CSB criteria:
  - WorkWell Kansas (in conversation, not definite) for CSB Criteria #5: Business Case for Breastfeeding Employer Awards
  - KS Child Care Training Opportunities for CSB Criteria #6: Child Care Provider Education (online trainings)
  - Child Care Aware of KS (CCAKS) for CSB Criteria #6 – Child Care Provider Education (center designation)

Child Care Licensing is focusing on increasing the number of breastfeeding friendly environments through educating child care providers regarding breastfeeding friendly environments and increasing the number of mothers that continue to breastfeed at six months and while the infant is in out of home care. Details of that work will be determined as discussions continue with KBC, CCAKS and Nemours. The Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program collects and reports data for the Maternal and Newborn Health Benchmark construct, Breastfeeding, as follows: Mean number of weeks that mothers enrolled in home visiting breastfeed their index child. Evidence-based and promising approach home visiting programs involved with the MIECHV Program provide their enrolled pregnant women and mothers with information, referrals, and support to promote breastfeeding. Programs address multiple areas related to infant health such as well-child visits, parenting behaviors and parent-infant interaction, infant development, developmental screenings, child health insurance coverage, and injury prevention. Data is collected on each of these constructs.

Infant Mortality Collaborative Improvement & Innovation Network (CoIIN): During the next 6-12 months, CoIIN action plans, change ideas, and interventions will be tested and implemented in pilot sites and replicated across the state in an effort to reduce infant mortality and improve birth outcomes. Targeted pilot sites are local health departments and clinics in Crawford, Geary, Saline, and Sedgwick counties. Goals, objectives, and change ideas for the Kansas priorities/selections follow:

SMOKING CESSATION *(primary focus: reduce smoking before, during and/or after pregnancy)*
Goal: By July 2016, we will reduce the rate of smoking in women in their reproductive years by 10% with emphasis on before, during, and after pregnancy.

- Increase the percentage of women who stop smoking during pregnancy by 10%
- Increase the percentage of women who maintain cessation after delivery by 10%
- Increase the number of women enrolled in Quitline in reproductive years (15-44 years of age) by 10%
- Increase the number of providers trained on the 5A's of tobacco cessation by 10%, implementing a provider reminder system and the KS Quitline fax referral system
- In pilot sites: increase the percentage of smoking women who are referred to smoking cessation counseling and programs like Quitline to 95% or higher

Change Ideas:

- Providers and support personnel refer women to evidence-based programs like Quitline
- Women in child bearing years avoid smoking or stop and stay quit
- Providers recognize role in coaching and supporting women to stop and stay quit

PREVENTION OF PRETERM AND EARLY TERM BIRTHS *(primary focus: increase appropriate utilization of progesterone and/or reduce early elective deliveries EED)*
Goal: By July 2016, reduce prevalence of preterm and early term singleton births by 10 %.

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

- Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40%
- Achieve or maintain equity in utilization of progesterone by race/ethnicity
- Increase the number of *Healthy Babies are Worth the Wait/Becoming a Mom* sites by at least 5

Change Ideas:

- Timely, reliable and effective screening, identification and prevention of pre-term birth
- Increase patient, family and community understanding of progesterone and full term births
- Build capacity of and support for hospitals and providers to reduce EED

Healthy Start *Delivering Change* Geary County: A comprehensive approach to eliminating disparities in perinatal health in Geary County will continue to be strengthened and expanded upon in the upcoming year. KDHE, as lead agency, will continue to align *Delivering Change* with Title V and Kansas MCH programs and services. In addition to inclusion of the above mentioned HBWW/BAM *Integration* components, plans are also in place to incorporate a standardized screening and referral process at the Geary County Hospital Birth Center, in collaboration with the *Delivering Change* OB Navigator and Geary County Health Department's Healthy Start Home Visitor and Healthy Families Case Management programs. Modeled after a successful long-time process and partnership in place in Saline County, state MCH staff will be assisting Geary County and other counties with the implementation of this standardized process. It includes consent and screening forms along with a referral process adapted from Healthy Families America, to assure postpartum women and new infants are scheduled with a post-discharge in-home visit from a Healthy Start Home Visitor and referred into on-going family support and early childhood services in the community, to assure direct connection to a tight-knit web of safety-net services. New in the coming year is also a Title X - MCH/Healthy Start partnership aimed at increasing the availability of Title X services, specifically Long Acting Reversible Contraceptives (LARC). The local clinic, health department, and coalition entered into an agreement to support cross referral and linking Healthy Start participants with needed services based on maternal risk.

Perinatal/Infant Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	79.9	80.4	81.0	81.5	81.9

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	21.7	24.7	28.1	31.9	36.3

Comprehensive Birth Outcomes Initiative: Using a collective impact framework, KDHE partnered with the March of Dimes Greater Kansas Chapter (MOD) and AMCHP to engage more than 200 stakeholders across the state between May 2014 and February 2015. This effort was not exclusively about health care, but instead focused on

forging partnerships to collectively and comprehensively address issues families face in the context of their communities throughout the course of life. The primary goal has been to develop collaboration at the state and local levels, assessing what's working and what's not, and utilizing existing resources to guide the process. Conversations kicked off in Southeast Kansas, a region that experiences the worst rates of preterm birth and smoking during pregnancy and has higher infant mortality than the state overall. Tools created for the initiative included an online inventory(conducted in advance of services, assets, priorities, and partnerships; facilitated day-long meeting with networking and interactive exercises for public health professionals and partners including managed care organizations, early intervention and behavioral health providers, and hospitals; a pre and post assessment; meeting evaluation; and, follow up materials and resources. Group exercises engaged participants in interpreting data, identifying partnership opportunities, reflecting on services in relation to the Health Impact Pyramid, and thinking about promising MCH practices. The AMCHP birth outcomes compendium, *Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality*, was a key resource used to frame the type of information collected on the inventory; shape the small group exercises; and, provide an opportunity to familiarize local partners with an important tool to help guide decision-making around MCH priorities and services. The compendium continues to be referenced for actionable strategies, and effective, coordinated efforts to reduce disparities and improve outcomes. Participant feedback and pre/post assessment results indicate the initiative was successful. There was a positive change in every area measured. Partners reported increased awareness, feeling part of a "shared" agenda to improve birth outcomes, confidence in partnerships to address population health needs, and ability to impact change. Participants commented, "I learned so much about where Kansas health care is heading...I love your 'why not' belief on how we can really make some changes to benefit every Kansan's health and wellbeing." (*South Central Participant)* "Very appreciative of the State going out to communities & listening to agencies/people that live there. Really feel that opinions & needs & concerns were heard!" (*Northeast Participant)* The project was highlighted in the May 2015 AMCHP *Pulse* and State and National conferences.

Pregnancy Risk Assessment Monitoring (PRAMS) Pilot: The Kansas pilot project aims to: 1) demonstrate Kansas has the capacity to follow the CDC protocol and carry out PRAMS positioning Kansas for a future funding opportunity; and 2) quantify risk factors for poor perinatal outcomes among infants born to resident mothers in three Sedgwick County Healthy Start zip codes (67213, 67214, 67218). The overall goal of PRAMS is to reduce infant morbidity and mortality and to promote maternal health by influencing maternal and child health programs, policies, and maternal behaviors during pregnancy and early infancy. PRAMS is a population-based risk factor surveillance system (survey) designed to identify and monitor selected maternal behaviors and experiences that occur before, during, and shortly after pregnancy. Data is used by policy makers and health care groups across the state to develop prevention and control measures, plan research and policies to improve the health of women, infants and families, as well as evaluate current programs and policies (http://www.cdc.gov/prams/index.htm). Pilot protocol includes a pre-letter sent to the mother three months postpartum with an explanation of the survey to follow and option for incentive upon completing and returning the survey. The Sedgwick County Health Department is committed to working with Title V/KDHE in support of the pilot project. The local health department, Healthy Babies Program, communicates with partners, providers and hospitals to promote the survey and increase local engagement prior to delivery. In addition, Sedgwick County provides marketing, media support, and incentives for the participants. Marketing materials include postcards mailed to mothers and distributed locally through WIC clinics and Healthy Babies providers (focused in targeted zip codes). Sedgwick County continues to work with local retailers and community partners to secure funding and donations for incentives for PRAMS project participants. The Steering Committee, Blue Ribbon Panel on Infant Mortality, advises PRAMS staff in the development and selection of state-specific questions and on the use, dissemination, and application of findings. The Committee may also use 2014 PRAMS findings to guide recommendations for developing or modifying intervention programs or for securing resources for local and state program changes.

Newborn Metabolic Screening: In 2014, the Kansas Newborn Screening Follow-Up (NBS-FU) program monitors

the number of reported newborn metabolic screens and provides immediate and short-term follow-up on infants who screen positive for 28 metabolic conditions. NBS-FU works collaboratively with the Kansas Health and Environmental Laboratories (KHEL). The system is an integrated database with the Newborn Hearing Screening (NBHS) program, SoundBeginnings. The NBS data system consists of a direct link to the vital statistics record. This link will allow NBS-FU to obtain accurate data on the number of infants with a reported screen and match those with the data shared from KHEL, providing a more accurate account of possible infants who may not have received a NBS, for whatever reason. This past year, the NBS Advisory Committee recommended that NBS-FU begin efforts around expanding screening to include critical congenital heart defects (CCHD) and severe combined immune deficiency (SCID).

An intensive Quality Initiative (QI) to increase rates of screening for Critical Congenital Heart Defects (CCHD) began May 2014. HHS added CCHD to the Newborn Screening Recommended Uniform Screening Panel in September of 2011 and the QI was recommended by the NBS Advisory Committee in November 2013. The QI included the development of a CCHD subcommittee, including Pediatric Cardiologists, Pediatric Cardiothoracic Surgeons, March of Dimes, Kansas Hospital Association, the American Heart Association, other vested providers, and parent advocates. The project focused on training with birthing facilities and the development of a reporting mechanism. Prior to the start of the QI, approximately 78% of babies were being screened in Kansas and 31% of birthing facilities in Kansas were screening for CCHD. To date, data show 99.6% of babies born in Kansas are being screened for CCHD and 98.6% of birthing facilities are completing the screen prior to discharge. While Kansas chose to implement this critical point of care screening without a state mandate, this did not deter facilities from participating. NBS and the Office of Vital Statistics (OVS) are working together to assure a long-term reporting mechanism is in place to support facilities in their efforts. Long-term success of this initiative rests on the ability for the NBS program to assure screenings are provided and results are received. NBS and OVS have submitted a request for modifications to the Kansas Electronic Birth Certificate to allow birthing facilities to report the CCHD screen results in the same manner they report NBS and hearing screens. This is expected to be completed Fall 2015. In the meantime, a secure web-based reporting method has been utilized to capture results. Of the facilities who have agreed to report through this interim method, 41 (83.5%) have submitted a completed screen report. The remaining facilities who have not agreed to report yet (16.5%) have agreed to do so when it is on the birth certificate.

The NBS Advisory Committee formed a SCID subcommittee with specialists, providers, and stakeholders to gather data and information to present for a formal recommendation. This was obtained by the Committee and the subcommittee is now focused on the NBS-FU protocols and procedures, while KHEL works on the lab screening protocols and procedures. In 2014, NBS-FU and KHEL applied for, and received, a grant from the Association of Public Health Laboratories (APHL) to assist Kansas with the implementation of SCID. This grant will assist with the purchasing of necessary testing equipment and provide technical assistance on training, messaging and communication efforts for consumers and providers, and other areas of need to fully implement this screening. Lab piloting of screening is anticipated in 2015 with full implementation of SCID screening soon after.

Newborn Hearing Screening: SoundBeginnings (SB), strives to improve the health and quality of life of children with hearing loss and their families in Kansas. Program goals include: (1) screen all babies before one month of age; (2) identify permanent hearing loss before three months of age; and (3) receive the appropriate services for normal development of speech and language, for those identified with hearing loss. Screening is implemented at the local level by hospitals, birthing centers or other licensed obstetrical/newborn facilities. SB administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance. Screening and diagnostic evaluation results received through direct database input, fax, mail and email. Follow-up was completed on missed, NICU, and failed screens by staff and by EHDI Coordinator for confirmed hearing loss to medical home providers, Part C local networks and families. Collaboration with Birthing Hospitals, Midwives, WIC and Local Health ha contributed to success towards improvements in program goals with 99% of

babies receiving a hearing screen before one month. Of those infants that failed the hearing screen, 73% received a diagnosis before 3 months, which could include receiving a diagnosis of normal hearing or some level of hearing loss. Lastly, 73% of the infants who were identified with hearing loss received early intervention services before 6 months. The SB Advisory Committee continues to meet quarterly to provide guidance and promote elements of the state EHDI program. The members include parents and family members of deaf and hard of hearing children, community and medical providers. The Committee has established goals including parent communication and family concerns; education to all members involved in early intervention, including a focus on the family perspective; and information sharing of legislative issues or advocacy.

Safe Haven for Newborns: Kansas law, KSA 38-2282 Newborn Infant Protection Act, was amended July 1, 2014, to expand the list of locations where an infant can be surrendered to include police stations, sheriff's office and law enforcement centers. A Safe Haven for Newborns in Kansas public awareness campaign was launched across the state. The United Way 2-1-1 Call Center in Kansas City and Wichita were there to answer questions. A Safe Haven for Newborns® sign has been presented to all 105 county health departments. Collaboration with the Safe Haven for Newborns Coalition of Greater Kansas City, KDHE Bureau of Family Health and United Way of the Plains, Wichita, provided the safe haven for newborns message across Kansas. The goal was to raise community awareness about the Safe Haven laws and at the same time, prevent a tragedy.

Breastfeeding: In 2013, Kansas birth certificate data showed that mothers initiated breastfeeding in 84.2% of resident live births. This was an increase from the 81.7% reported in 2012 and exceeded the Healthy People 2020 goal of an 81.9% breastfeeding initiation rate. According to the most recent National Immunization Survey, Kansas initiation rate was 77.4% (children born in 2011). Although this was a decrease from the 76.1% (children born in 2010), during the three birth year period (2009-2011), a slightly upward trend was observed. While initiation rates made a good progress, exclusive breastfeeding at six months for Kansas showed an 11.4% duration rate. Healthy People 2020 goal is 25.5%. Working together collaboratively across WIC, MCH, and HBWW/BaM, as well as with community partners such as local hospitals and birthing centers, breastfeeding coalitions, and La Leche League groups, much progress is being made to improve breastfeeding initiation and continuation rates in Kansas. Healthy Start Home Visitors are working alongside WIC Breastfeeding Peer Counselors (BPC) to provide breastfeeding support to individuals in their homes and clinic settings in both the prenatal and postpartum periods. Sites have expanded the breastfeeding curriculum from the original March of Dimes curriculum, to provide for more extensive and comprehensive education around breastfeeding, with a specific focus on effects of labor and delivery practices, getting off to a good start, and the importance of partner support. In isolated sites around the state, such as Saline County, initiation rates are significantly higher among HBWW/BaM participants in comparison to county level data. This is likely related to the cohesive breastfeeding support system in the community and extensive support that is provided to HBWW/BaM participants by MCH staff who coordinate the program and facilitate the sessions. Aggregate data for all sites, however, shows initiation rates slightly lower than county averages. This may in part be related to the nature of typically lower breastfeeding rates among the high-risk population that is being targeted for participation. HBWW/BaM sites and local MCH programs around the state have also acknowledged a lack of a structured follow-up process or system for data collection related to continuation rates. KDHE MCH staff has committed to assisting local health departments and sites with the development of a comprehensive follow-up and data collection system. For the first time, Title V Aid-to-Local grantees are required to submit a specific plan for targeted follow-up efforts in their MCH application, and will be required to report outcomes related to this throughout the next year. Child Care encourages child care providers to complete "How to Support the Breastfeeding Mother and Family" course. A total of 1,113 licensed day care providers and staff completed the face to face and online training.

Safe Sleep: Title V/KDHE partners with the Kansas Infant Death and SIDS (KIDS) Network to conduct safe sleep

education and bereavement services statewide. The KIDS Network serves individuals or organizations who strive to reduce the risk of infant death or Sudden Infant Death Syndrome by providing supportive services, community education, professional training and supporting associated research. The KIDS Network program initiatives include: Becoming a Mom collaborations with March of Dimes; Safe sleep community baby showers (expanded to obstetrical/pediatric clinics); Cribs for Kids (expanded from home visitors to hospitals and clinics); Physician Safe Sleep Toolkit (expanded from pediatrics to family practice and obstetrics); Safe sleep training for nurses, physicians, allied health, healthy start home visitors and child care providers; and Bereavement support, grief and loss. The number of providers who received safe sleep or professional development by the KIDS Network in 2014 was 2,893.The number of children provided direct services by the KIDS Network in each age range during 2014 follows.

Age of Children Receiving Services	#
Prenatal to 2 years	447
2-5 years	11
5-12 years	10
12-18 years	10
18 years and older	2,222

Safe sleep and breastfeeding training were provided at six sites across Kansas as part of the Fall Regional Training for home visitors. Christy Shunn, KIDS Network Director/content expert in safe sleep, and Brenda Bandy, Kansas Breastfeeding Coalition Program Director/content expert in breastfeeding, collaborated and delivered the join training to ensure a singular message regarding safe nighttime breastfeeding practices and other times when mom or baby may get sleepy. A total of 89 home visitors, RNs and local health department administrators participated in the trainings and completed a survey regarding their safe sleep practices and information sharing with families. Participants reported sharing safe sleep information with 94% of the families they visit either at home or in other settings. They also reported that the biggest barriers to teaching families safe sleep practices were family friends and relatives providing conflicting information. In addition, home visitors reported supporting breastfeeding efforts statewide through distribution of educational materials and coordinating individual breastfeeding consultations for the women and infants they visit.

Perinatal Community Collaboratives (prenatal education/clinical care): As premature birth and low birth weight continue to be the primary cause for infant mortality, the Kansas Blue Ribbon Panel on Infant Mortality (est. 2009) recommendations included the March of Dimes Healthy Babies are Worth the Wait (HBWW)/Becoming a Mom (BaM) Birth Disparities Program as an initiative to address these issues. Implementation of the HBWW/BaM prenatal curriculum and community collaborative model is currently in place in seven locations in the state. By the nature of the community collaborative work around access to care and comprehensive prenatal education that is inclusive of social support services within the community during the perinatal period, it is a driving force behind improving birth outcomes in our state. The primary target of the curriculum is to address risk factors related to preterm births, improving knowledge and effectively influencing behaviors of the participants. Topics included in the curriculum, spanning six two-hour sessions, include: importance of early, regular, and continued prenatal care; effects of harmful exposures (ranging from smoking and drugs, to diet, to stress and environmental exposures); signs and symptoms of preterm labor and what to do; delivery at appropriate level of NICU; labor and delivery, including risks related to early elective deliveries; infant feeding, with emphasis on breastfeeding; infant care, immunizations, safe infant care seat installation, “Period of Purple Crying”, “Happiest Baby on the Block”, safe sleep and SIDS risk reduction; postpartum care (physical and emotional), interconception health, ideal pregnancy spacing and family planning options. Statistical significance was shown in an improvement from 48% (pre-survey) to 60% (post-survey) of women who strongly agreed with the statement “A woman who gets prenatal care as soon as she finds out she is

pregnant will have a healthier pregnancy." All six questions related to preterm labor signs had statistically significant improvements from pre to post surveys. Participants reported greater knowledge in recommended gestational age (92% to 98%), back to sleep (78% to 99%), and healthy pregnancy spacing (75% to 93%). The reported preterm birth rate (<37 weeks) was 6% for program participants compared to 9.9% for all women in Geary and Saline Counties in 2013.The low birth weight was also lower than county comparisons at 3% for program participants compared to 8.2%. In addition to HBWW/BaM as a key component of the Healthy Start/*Delivering Change* model in Geary County, Geary Community Hospital has been the only hospital in the state to be participating in the March of Dimes 39 Week Early Induction Project. These initiatives are undoubtedly contributing to the steady decline in infant mortality rates (IMR) that have been observed in both Geary and Saline counties since the onset of such extensive community collaborative efforts in 2010. Saline County has witnessed a decline in IMR from 9.0/1000 (2005-2009) to 6.3/1000 (2009-2013) and Geary County from 11.9/1000 (2005-2009) to 7.5/1000 (2009-2013).

Infant Mortality Collaborative Improvement & Innovation Network (CoIIN): Title V/KDHE and partners including the March of Dimes and KIDS Network are actively engaged in the initiative, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas (Region VII). The Kansas team attended the national summit/expansion kickoff in July 2014 and compiled the state's *Blueprint for Change,* identifying four priorities including comprehensive care for women before during, and after pregnancy; multi-sector approaches to address SIDS/SUID; and community collaboration to align efforts related to screening, smoking, breastfeeding messages and activities. Kansas is engaged in two of six strategies as part of the national CoIIN platform: Smoking Cessation and Pre & Early Term Birth.

Kansas Infant Mortality CoIIN *State* Team:

- KDHE: Susan Mosier, MD, Secretary/State Health Officer; Aaron Dunkel, Deputy Secretary; Rachel Sisson, Title V Director; Stephanie Wolf, Perinatal Consultant; Jamie Kim, Epidemiologist;Greg Crawford, Vital Statistics
- Christy Schunn, Director, KIDS Network
- Dennis Cooley, MD, Kansas MCH Council Chair
- Shalae Harris, March of Dimes Greater Kansas Chapter
- Jill Nelson, Healthy Start Program Director
- Donna Yadrich, Patient/Family Advocate, Kansas Family Delegate

Additional Workgroup/Learning Network Members

- KDHE: David Thomason, Nutrition & WIC; Debbie Richardson, Home Visiting Program; Jennifer Church, Carol Cramer & Matthew Schrock, Tobacco Cessation Program
- Kim Neufeld, Kansas Academy of Family Physicians
- Taneisha Scheuermann, University of KS Medical Center (Kansas City)
- Sharla Smith, University of Kansas Medical Center (Wichita)
- Randall Morgan, MD, Associates in Women's Health (OBGYN)
- Diane Daldrup, Community Volunteer

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Developmentally appropriate care and services are provided across the lifespan.	3.1 Infants, children and adolescents are in environments where there are safeguards against preventable injury and harm. 3.2 Children receive immunizations according to the recommended schedule 3.3 Multi-sector (individual, health care/social service provider, community, organization) approaches are in place to reduce SIDS and SUID rates 3.4 Oral health care and preventive services are integrated into programs and services for MCH	3.1.1 Assure appropriate motor vehicle safety education is provided for all individuals transporting infants and children 3.1.2 Establish prevention activities focused on reducing motor vehicle crash injuries and deaths to adolescents due to distracted or impaired driving (SAFE) 3.1.3 Engage home visiting in evaluating safety concerns in the home and provide education regarding prevention and risk 3.1.4 Increase the number of MCH grantees that serve as	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	populations in order to promote overall good health and desirable outcomes	the home agency for local Safe Kids Coalitions 3.1.5 Provide education and support to assist parents with selecting a child care setting that meets health and safety requirements 3.2.1 Improve access to childhood immunizations for families by reducing barriers and improving delivery processes 3.2.2 Support medical and early intervention providers through appropriate tools and resources to encourage parents resistant of immunizing their child(ren)				

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		3.3.1 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need				
		3.3.2 Launch a campaign on safe sleep practices targeted to relative caregivers and those providing family-friend- and neighbor care				
		3.3.3 Inventory existing safe sleep initiatives and activities to determine what services are needed and areas to target education, training, and materials				
		3.4.1 Integrate oral health education into prenatal and infant health				

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		education 3.4.2 Promote oral health in all programs targeted towards CYSHCN through care coordination activities 3.4.3 Implement collaborative oral health initiatives to expand oral health screening and education targeted to infants and children				
Developmentally appropriate care and services are provided across the lifespan.	3.5 All children receive an age-appropriate developmental screening at least annually with a valid and reliable tool	3.5.1 Build MCH capacity for screening follow-up through complete referrals to providers and community-based 3.5.2 Conduct statewide campaign to coordination among	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		providers who screen for developmental delays, including recommended protocols for information sharing. 3.5.3 Develop a standard and consistent message to communicate importance of developmental screening among home visiting and child care programs				

Child Health

Child Health - Plan for the Application Year

The priority of healthy development for children was a strong theme that addressed many needs in every community that could really stand on their own as priorities. These needs were again, connected to a common goal of the health of children on many levels and span into the adolescent years as well. They include injury prevention efforts, safety concerns in the home, and selection of safe childcare settings. What is unique is that these needs provide KDHE with the opportunity to focus on life span and cross cutting goals in programs and practices. The KDHE Injury Prevention Program and Sake Kids Kansas stand ready to work in partnership with the Title V program and the Bureau of Family Health to implement the action plan. Safe Kids has 24 local coalitions serving 28 counties, covering 75% of the states 0-19 population being served by a local Safe Kids Coalition. Additionally, Bullying Prevention programs are established in at least 15 local schools (implementing the Committee for Children curriculum). By strengthening existing successes of programs like Safe Kids Kansas as well as increase the number of MCH grantees that serve as a lead agency for local safe kids coalitions, KDHE can continue to strengthen the guiding principle of collaboration and creating community change. The priorities that emerged which address the needs for this domain, specifically priorities three and four, focus on parent education through home visiting, opportunities for community engagement, increasing life skills, and more.

State priority three aims to ensure ***developmentally appropriate care and services are provided across the lifespan***, with special emphasis on Child Health. Objectives for this priority are focused on:

- injury prevention including safe and healthy child care;
- receiving immunizations according to the recommended schedule;
- annual child well visits and preventive services/care;
- developmental screening (standard protocol and valid, reliable tools); and
- Oral health education, preventive services, and care.

Taken together, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course. Participants and staff in the needs assessment/stakeholder meetings provided useful and innovative ideas that KDHE will look forward to implementing and continue to improve upon while expanding their current programs. Many of the suggestions and ideas are already in the scope of KDHEs work and will further promote collaboration at state and community levels. Below are just a few examples and greater detail is provided as strategies incorporated into the State Action Plan.

Participant suggestions:

- Training classes for early childhood professionals including child care providers
- Media campaigns to promote oral health
- Develop a standardized message to communicate the importance of screening
- Increase the availability of healthy food in schools
- Partner with schools to identify safe biking and walking routes

KDHE existing services and potential expansion:

- Partner with existing community collaboratives such as *Becoming a Mom* programs
- Promote immunization program through WIC and MCH clinics
- Provide essential supplies like sleep sacks to at risk/in need families
- Implement collaborative oral health initiatives
- Improve coordination of referral services among providers
- Provide child care programs with oral care supplies

Discussions during the needs assessment also focused on the need to address obesity across population domains. There was targeted discussion about children, specifically as related to school lunches, but then came a shift to a broader view of the systemic nature of nutrition and physical activity. Specifically, a change in terminology and definition began to emerge and the priority was reframed. Providing access to healthy food choices was an issue of both availability and knowledge. The need to educate parents and children on what a healthy food choice actually is was clearly reflected in the data. At the same time, the real challenge caused by food deserts in Kansas was discussed. Some families rely on a small grocery or convenience store due to transportation barriers and/or locale, thus connecting other daily issues (poverty, work schedules, children home alone) to unhealthy food choices. Participants and staff suggested the importance of aligning with existing programs--specifically home visiting programs, in schools, and through community campaigns--to nutrition education and promote physical activity.

Priority 4 addresses the need for ***families to make educated choices about nutrition & physical activity.*** Objectives related to this priority include access to healthy foods and opportunities for physical activity. Suggested activities are cross-cutting but especially considered for Child Health.

Home Visiting:

- Promote breastfeeding initiation and duration
- Engage and support WIC

- Align programs to deliver consistent message on breastfeeding and child nutrition

Schools:

- Offer healthy food choices throughout the day to reduce quick lunch
- Promotion of longer or more frequent outdoor time
- Provide resources and educational materials to child cares and schools focused on healthy eating and physical activity

Community Campaigns:

- Support local health departments and or community centers to promote physical activity and utilization of walking and biking trails
- Provide walking and biking trails
- Promote YMCA and other community recreation centers

Adults interacting with children on a daily basis, including parents and teachers, expressed concerns and feelings of being overwhelmed with young children's behavioral issues. These issues connected to a stressful home environment due to potential factors of overworked parents, competing home and work priorities, poor nutrition due to lack of time and money, domestic violence, and unhealthy sleep habits. These factors were pointed out as interconnected and expressed in the child's behavior. This systemic issue suggests the need for resources to manage and even interrupt the frequency of stressors to promote the child's health all the way from prenatal care into infancy and beyond.

Participants shared:

- "If something could be written in the state plan around the research of ACES and trauma informed care and how these experiences are a health issue, behavioral and mental health will be in the priorities somehow. Social emotional health needs to be addressed."
- "We need to address stress."
- "[We need to] teach [children] teens and families how to manage life skills and empower them."

These identified needs and issues are reflected in the State Action Plan in part under Priorities five and six. Objectives include:

- Educated and empowered adults, children, and adolescents to possess protective factors to reduce the impact of bullying through decreased annual rates;
- Early childhood service providers support the social-emotional development of children; and
- Efforts and services assist children and adolescents with building coping skills and managing stress to prevent suicide to reduce the annual rates of bullying.

Program Plans/Activities/Initiatives:

Maternal, Infant, Early Childhood Home Visiting (MIECHV): The MIECHV Program collects and reports data for the School Readiness and Achievement Benchmark constructs as follows: Percent of index children who are screened for developmentally-appropriate communication skills, general cognitive skills, positive approach to learning, social behavior and emotional well-being, physical health and development. Also, data is collected and reported for the Benchmark, Prevention of Child Injuries, Child Maltreatment, and Reduction of Emergency Department Visits, as follows: Information provided or training of home visiting participants on prevention of child

injuries, and Incidence of index child injuries requiring medical treatment. Evidence-based home visiting programs involved with the MIECHV Program perform developmental screenings with enrolled parents and their infants and young children using the Ages and Stages Questionnaires (ASQ-3; ASQ-SE). Additionally, the MIECHV Program local implementing agencies provide information, support, and referrals on multiple areas related to early childhood health such as well-child visits, parenting behaviors and parent-child interaction (e.g., learning and development; knowledge of child development; demonstration of responsive and accepting behaviors), child development, and child health insurance coverage. Data is collected on each of these constructs.

Early Childhood Comprehensive Systems (ECCS): The ECCS project, referred to as the Kansas Initiative for Ongoing Developmental Screenings (KIDOS), focuses on state and local systems improvements to effectively coordinate, improve, and track developmental screenings and referrals for infants and toddlers across Kansas early childhood support systems, i.e., home visiting, early education, pediatricians and medical homes, intervention services, child care programs, and families. Benchmark data is being collected using the ASQ Enterprise online system to report the percentage of children who received developmental screening and did not need follow up or a referral (Birth-age 5).
Kansas Special Health Care Needs (KS-SHCN): The KS-SHCN program, plans to expand the diagnostic clinics to more communities, assuring stronger partnership with early intervention providers through the Part C/Infant-Toddler networks. Community education around these clinics will be enhanced in the coming year to support more community referrals including from the local health department, primary care providers, hospitals, and child care providers. Currently, the primary referral source for these clinics are through the school systems early intervention program. Implementation of the Safe Kids Kansas and KS-SHCN smoke and carbon monoxide detectors project will begin in SFY16 and continue until funding runs out. It is the hope of both programs that other funding sources will be located to continue the program in the future. However, even if funding is not available to continue to provide free detectors KS-SHCN program will continue to share safety tips with families per the Safe Kids Kansas recommendations. Both programs are committed to working together to keep all Kansas children safe and healthy. The SHCN program and Safe Kids Kansas will continue to collaborate on additional safety measures for all children.

Child Care Licensing Program: The Child Care program has been very proactive during the last year to effectively allocate and utilize MCH funds to support collaborative projects that cut across domains, especially infant and child health, and ultimately impact behavior change. Increased coordination and efforts to align and leverage will continue during the next year. An example of the program's successful approach and partnerships is the *Healthy Smiles* oral health initiative. This is a collaborative project led by the Child Care Licensing in partnership with Title V MCH, Oral Health Kansas, Bureau of Oral Health, Child Care Aware of Kansas (CCAKS), Kansas Child Care Training Opportunities (KCCTO), Local Health Departments, and more. The focus is on improved oral heath care and tooth brushing routines in regulated child care facilities, with efforts mainly targeted to day care homes since regulations already require tooth brushing in child care centers/preschools. The project launched in May 2015 with training and tool kits for child care providers. Over the next year, KCCTO will offer 200 oral health trainings for licensed providers and facility staff in between July and August 2015. CCAKS will conduct two face-to-face trainings in western Kansas for 50 participants (highest untreated decay for children under five years)--dates to be determined. All trainings will be offered free of charge to providers. Other activities planned by the Child Care Program to improve the health and well-being of children include:

- General Regulation Revision/Update: The program is in the preliminary stages of review and revision of the general regulations (K.A. R. 28-4-122 through K.A.R. 28-4-132) pertaining to day care homes, group day care homes, child care centers and preschools. These regulations address parental access and permission, background checks, health of individuals residing or working in the facility, emergency preparedness and safety, swimming/wading activities, transportation, pets, diapering and other child care practices.
- Illegal Care Campaign: The program will launch a campaign to educate the public and County Attorneys

regarding illegal child care (misdemeanor in Kansas) to include face to face meetings and publications on the program's website.

- Automated Complaint Inspections: The program will complete the complaint module the licensing database (CLARIS) in order to make findings available to the public through the Online Information Dissemination System (OIDS). The intent is to provide easy access to compliance information in order to assist parents/guardians with making informed decisions regarding the care of their children.
- Consumer Education Initiative: The program will continue the work to establish a parent page on the agency website. The page will promote involvement by parents and family members in the development of their children in child care settings.

Local Maternal & Child Health Grantees/Programs: According to 2016 proposals and plans, local programs will continue to provide immunizations, well child checks and MCH services on a sliding fee scale (down to zero) for families that are unable to pay for services. Services are provided regardless of insurance or ability to pay. Local MCH programs including Healthy Start Home Visitors (HSHV) will screen and assist families with enrollment for KanCare (Medicaid). Local MCH Programs will work with state/local partners to assist families in accessing insurance coverage. HSHVs will provide health education and make referrals as needed. Local MCH programs serve as a gap-filling provider for families served through the Medicaid program. Local MCH continues to support and promote outreach/enrollment activities in local agencies and schools for Medicaid-eligible women/children encouraging health services in a medical home or safety net clinic. MCH continues to work with KanCare managed care organizations/health plan providers to link them to potential clients. Additionally, MCH utilizes federal technical assistance resources related to the implications and implementation of the Affordable Care Act to inform local MCH agencies and determine needs, roles, and strategies for MCH services/programs. MCH staff (clerical and/or nursing) obtain height/weight and calculate BMI data on children at agency visits, unless client declines. Information regarding healthy eating and physical activity from Bright Futures is provided as well as a copy of the height/weight/BMI data. Information and resource materials are provided as appropriate. The majority of Well Child exams include use of Ages and Stages Questionnaire (ASQ), height and weight measurements, and hearing and vision screening. Referrals are made as needed.

Child Health - Annual Report

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	151.4	142.1	133.4	125.1	117.4

Home Visiting: The Maternal, Infant, Early Childhood Home Visiting (MIECHV) evidence-based and promising

approach home visiting programs served 516 enrolled pregnant women and families with children birth to five from October 2013-September 2014. These programs provided enrolled families information, support, and referrals on multiple areas related to early childhood health such as well-child visits, parenting behaviors and parent-child interaction, child development, and child health insurance coverage, and conducted developmental screenings using the ASQ-3 and ASQ-SE.

Healthy Start Home Visitors (HSHV) conducted a total of 4,149 visits in 2014. HSHVs are employed by local health departments and partnering agencies with primary responsibility for conducting outreach to provide education and information, initiating referrals, and offering other supports for pregnant women and families. A HSHV works with professional nursing and/or social work staff as part of the constellation of maternal and child health promotion and prevention services to support healthy pregnancies, improve birth outcomes, and promote healthy infant development. The program is part of the MCH Aid to Local program and universal in approach, available to all without additional eligibility limitations. HSHV services are short-term, providing just one to a few visits, and are distinct from other longer-term, intensive home visiting programs such as Parents as Teachers and Early Head Start. The HSHV services are intended to increase knowledge, change beliefs, and alter behaviors by increasing the number of women accessing early and comprehensive health care before, during and after pregnancy. A HSHV provides education on health and safety promotion, parenting, and preventive programs relevant to the prenatal and postnatal periods and infancy. They provide assistance to families in linking them to resources and in navigating access to community systems of care. Orientation of new home visitors consists of six components: 1) training and review of relevant agency/local policies and procedures including child abuse and neglect reporting and Confidentiality/ HIPPA regulations; 2) consultation with the nurse or social work supervisor or other designated professional staff regarding public health services in Kansas; 3) review of the Maternal and Child Health Services Manual; 4) review of the Aid to Local Grant/Contract Application and Reporting Guidelines for the state fiscal year with supervisor; 5) Orientation to all programs and staff in the local health department/agency and 6) orientation to referral resources in the local community and county. Newly hired HSHVs complete the Kansas Basic Home Visitation Training provided by the Kansas Head Start Association within the first six months of employment. The training consists of both online modules and in-person components. As a requirement of the state's MCH Grant, all HSHVs also attend the fall regional HSHV training hosted by KDHE MCH staff. In addition, HSHVs are to engage in continuing education activities and complete a professional development plan annually. They are required to attend one additional statewide conference per year, are registered and have access to online training through KS-TRAIN and can also access the MCH Navigator online learning portal for MCH professionals.

In the past year, KDHE has embarked on a thorough review process that will result in a redesign of the Healthy Start Home Visiting program. A new position was created in 2014, Maternal/Family and Early Childhood Health Consultant, with primary responsibility for refining HSHV program criteria, expectations, outcomes, and processes. The program manager is a member of the state's Home Visiting Leadership group to ensure that the role of HSHVs is aligned with other home visiting programs including MIECHV, Parents as Teachers, Head Start and Early Head Start and Part C. Initial tasks completed include the compilation and analysis of HSHV information gathered directly from home visitors across the state. The survey results and analysis were shared with home visitors during the 2014 Fall Regional Trainings to obtain feedback and gather input on initial program changes. The survey included an assessment of the current HSHV workforce including educational background, experience, and supervisory structure; practices and tools most commonly used by HSHVs; the range of frequency, duration, and method of service provision by HSHVs; and priorities for training needs. Results of the survey were used to update the program manual to more clearly define the unique role of the HSHV, the services provided through HSHV, and the timelines and settings of service provision. In addition, the training needs information was used to determine topics for the HSHV track of the 2015 Governor's Conference on Public Health.

Developmental Screening: The Early Childhood Comprehensive Systems (ECCS)/KIDOS project hosted an ASQ

Training of Trainers seminar in March 2015 and was attended by 22 professionals from across Kansas. This will expand the capacity to provide quality training for communities on the ASQ screening process. A community toolkit was constructed to provide tools and guidance for community systems improvements. Training on the ASQ and ASQ-SE was provided at the Governor's Public Health Conference in April-May 2015.

Special Health Care Needs: The Kansas Special Health Care Needs (KS-SHCN) program in partnership with the Kansas State Department of Education and the Kansas University Medical Center – Center for Child Health and Development (KU-CCHD), supports specialty clinics designed to assist in the assessment and diagnosis of development delay. These outreach clinics are held in multiple areas of the state where the child and family meets with a multi-disciplinary team of professionals, including (but not limited to) a developmental pediatrician, early intervention and childhood providers, speech/physical/occupational therapy, and others in the child's community who may support the child and family after diagnosis. KS-SHCN has focuses on developing partnerships among programs statewide. Since children with special health care needs are children first, it is important that they learn the same safety skills as other children. Therefore, KS-SHCN expanded their partnership with Safe Kids Kansas to provide free smoke and carbon monoxide detectors in homes of families of children with special needs. Safe Kids Kansas will provide the detectors and the specialized community partners to install the devices in the family's home and review safety tips with parents. KS-SHCN will provide funding to cover the cost of any detectors that need to be customized due to the special health care need of the child or family. KS-SHCN program will offer this service to families identified as not having a smoke or carbon monoxide detector through care coordination. Care coordinators will share safety tips with families per Safe Kids Kansas recommendations located on their website. Protocols and procedures have been developed and implementation will begin Summer 2015. A log will be kept of all smoke and carbon monoxide detectors given out.

Access to Health Insurance/Care: Data from the U.S. Census Current Population Survey (CPS)3 show that the percentage of Kansas children under 18 years old without health insurance decreased from 9.4 in 2011 to 6.1 in 2012, a 35.1% decrease. The U.S. percentage also decreased from 9.4 in 2011 to 8.9 in 2012 (2014 MCH Biennial Summary). In Kansas, based on the 3-year average CPS estimates (2010-2012), 7.7% children were uninsured. With an uninsured rate of 8.9%, children in poverty were more likely to be uninsured than children not in poverty (7.4%). About one-third of children (37.6%) were publicly insured by sources such as Medicare, Medicaid, military health care, and the State Children's Health Insurance Program (CHIP). About 10.3% of Hispanic children did not have any health insurance, compared with 8.1% for non- Hispanic white children and 7.8% for non-Hispanic black children. Non-Hispanic white children had high rates of private health insurance coverage (64.9%) compared to non-Hispanic black and Hispanic children (41.0% and 31.8%, respectively). Non- Hispanic black and Hispanic children were the most likely to have public coverage (62.8% and 61.1%, respectively) (MCH 2014 Biennial Summary). State MCH staff have been instrumental in linking local grantees to health care navigators located across Kansas. As grantees become more aware of the resources that health care navigation staff provides, more grantees are referring their clients to them for assistance. As reported under the Women/Maternal Health section, Kansas Department of Health and Environment (KDHE) created 12 Out Stationed Eligibility Worker positions in recognition that families may need one-on-one assistance with the completion of Medicaid applications. These workers are located across Kansas in Federally Qualified Health Care Centers and hospitals, where families without insurance may seek medical care. These eligibility workers determine eligibility for Medicaid and CHIP programs, as well as providing information and outreach to communities, local health departments, clinics and hospitals, explaining eligibility requirements, trouble-shooting payment problems, and encouraging families to apply. While local health department staff across MCH, WIC, and Family Planning programs work to identify families with uninsured children and refer them to local Outstation Workers for expedited eligibility determination, Outstation Workers work collaboratively within communities and agency partners to make referrals for parenting support and education programs as well as medical care. Local health department staff, alongside Outstation Workers, mental health

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

Child Care (healthy, safe, quality): The Child Care Licensing Program implemented the Kansas Licensing Indicator System (KLIS) in March 2014 for thousands of child care facilities across the state (Licensed and Group Day Care Homes, Child Care Centers, and Preschools). KLIS is a tool that measures compliance with a small number of regulations that statistically predict compliance with the entire set of requirements. KLIS provides a measure of compliance with regulations in a fair and equitable manner and increases consistency, allowing licensing programs to achieve maximum protection by balancing available resources/capacity (time, staff, funding, etc.). Implementation across the state allows more time for technical assistance and consultation to support noncompliant facilities with reaching and maintaining compliance, improving the health and safety of out of home care settings. Approximately 67% of all facilities with a pending annual inspection qualify for the KLIS survey. KLIS allows surveyors to spend more time providing technical assistance to support facilities with reaching and maintaining compliance; and conducting full inspections and monitoring noncompliant providers.
The Child Care Licensing program conducted Complaint investigation training in June 2015. Surveyors conducting complaint investigations received extensive training on how to appropriately cite noncompliance with statutes and regulations and complete a complaint investigation for licensed home and center based facilities and complaints with alleged illegal care. This directly impacts the health and safety of children in care as regulations are intended to ensure the health safety and wellbeing of children in out of home care.

Child Care Licensing collaborated with KDHE Bureau of Oral Health, Oral Health of Kansas, Kansas Child Care Training Opportunity (KCCTO), and Child Care Aware of Kansas (CCAKS) to launch the *Healthy Smiles* initiative. Southwest Kansas was targeted due to the data that revealed the highest number of children entering kindergarten with untreated decay are from that public health region. The focus of the initiate is on changing behavior and practices to include providing nutritious meals and snacks, tooth brushing after meals, and toothbrush replacement in licensed and group day care homes, ultimately reducing the rate of untreated decay upon school entry, specifically to:

- Increase the number of day care home and group day care home child care facilities that provide daily tooth brushing for children in care;
- Increase the number of child care providers trained on the topic of oral health; and
- increase the number of child care providers with policies/practices related to tooth brushing and oral health care.

In order to participate, child care providers were required to complete a two hour oral health training conducted by KCCTO and included nutrition and tooth brushing topic areas. A kick off was held on Saturday May 2, 2015, (Baby Days) in Dodge City and free screenings were provided to children 0-11 years of age. Area Child Care Centers were invited to attend and received an educational tub that included oral health supplies. A total of 105 children in 17 Licensed and Group Day Care Homes received education and screenings by a dental hygienist between May 4-8, 2015. Parents received screening results and referrals, in addition to oral health literature. Screening results revealed 6 children had untreated decay [5 required early dental care; 1 had urgent needs due to multiple decayed teeth and an abscess children had treated decay (some form of filling/crown)] and 60 children had never been to the

dentist (6 of these children were less than 1 year of age). Home and Center providers received a kit upon completion of the training/screening which included:

- Toothbrushes
- Toothbrush holder w/mesh cover
- Sand timers
- Digital timers
- Toddler and preschool books
- Magnet board or puppet
- Dental wipes (infant care)

Child Care Licensing purchased an additional 200 oral health online trainings from KCCTO that were offered in June 2015 to providers free of charge. As means of gathering data regarding oral health practices in day care homes an initiative question regarding tooth brushing practices was added to annual and initial inspections for all Licensed and Group Day Care Homes to promote the discussion related to oral health routines and practices. The data obtained may guide future regulation changes and training. In addition, surveyors provide a consultation regarding the oral health benefits of nutritious foods, tooth brushing and toothbrush replacement.

Childhood Nutrition/Obesity/WIC BMIs: Analysis of WIC data for overweight and obesity levels for children from 2004 through 2014 found overweight and obesity rates have decreased significantly from 2010 through 2014. A total of 550 Kansas WIC staff and other interested health professionals completed a Baby Behavior day long training in 2014 which research shows reduces overfeeding and overweight in infants at 6 months of age. WIC staff will continue to teach parents about overfeeding to prevent future overweight. All new employees receive Baby Behavior training through on-line training.

Several local WIC clinics organize physical fitness events annually to educate parents about the importance of activity for their children. The WIC Newsletter published six times per year provides staff articles about nutrition. All WIC clinics received the Ellyn Satter books Child of Mine Feeding with Love and Good Sense and How to Get Your Kid to Eat But Not Too Much for staff education in 2014. The Kansas WIC Conference planned for Spring 2016 will provide education on nutrition and the feeding of children. In addition, NWS staff continues to work to increase the number of well-trained MCH staff who plan, facilitate, deliver and evaluate healthy eating and physical activity messages, by sponsoring and promoting training opportunities. State nutritionists participate on the Association of State Public Health Nutritionists committees with an emphasis on healthy eating and physical activity. Some Kansas WIC clinics sponsor a Farmers Market in the health department parking lot or participate in nutrition booths at a Farmers Market.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Communities and providers support physical, social,	4.1 All children and adolescents receive comprehensive	4.1.1 Promote annual well-child visits through adolescence	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17, with a		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
and emotional health.	preventive health care that addresses social and emotional aspects of health at annual child and adolescent well visits, promoted through a developed cross system partnership (schools, community partners, Health Department)	into adulthood. 4.1.2 Engage school nurses to identify and refer children with an Individualized Healthcare Plan who have not had a well-child visit in the past year 4.1.3 Promote incorporation of behavioral health/behavioral health screening into annual child and adolescent well visits	Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents,	preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			
Communities and providers support physical, social, and emotional health.	4.2 Adults, children, and adolescents are aware of and have access to prevention and intervention programs that educate and empower them to practice protective factors to reduce the impact of bullying through MCH community	4.2.1 Increase awareness of options for educat¬ing and reporting unsafe digital content 4.2.2 Bullying and Cyberbullying intervention and prevention 4.2.3 Make connections among schools, families, communities	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	and school trainings provided annually	and health providers through programs such as Communities in Schools (CIS) and school-based clinics				
Communities and providers support physical, social, and emotional health.	4.3 All youth are provided with the support, relationships, and resources they need in order to build and improve coping skills and manage stress through measurable, positive youth development interventions and the implementation of evidence-based practices to prevent suicide	4.3.1 Partner with community partners to connect children and adolescents with supports that promote protective factors. 4.3.2 Implement evidence-based/evidence-informed practices to support healthy behaviors and choices and the development of positive coping mechanisms among adolescents. 4.3.3 Provide services that support reducing the impact of Adverse Childhood Experiences (ACEs) on	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		children and adolescents.				

Adolescent Health

Adolescent Health - Plan for the Application Year

The unique health needs of adolescents came to the surface during the Five Year Needs Assessment as well as the stand-alone Adolescent Health Needs Assessment, even in settings that were not focused on adolescent health. There was a push to look holistically at adolescent well-being, focusing on positive youth development and providing opportunity for young people to thrive.

Some adolescents live in rural communities and some in larger cities or counties but many face common barriers and risks such as bullying, risk taking, poverty, boredom leading to negative choices, lack of skills, and perhaps even the responsibility of attending to other family members. Many youth cope with chronic health conditions and many live in neighborhoods and families that pose health risks. However, with positive supports and opportunities, youth can learn to build their abilities, and develop into contributing adults. KDHE has recognized the potential to address the specific needs of this population and promote wellness over the next year while also addressing serious and pervasive issues that adolescents face such as bullying, suicide, and mental and social health issues. Life skills development such as budgeting, cooking, job training and healthy recreation (in partnership with communities and schools) are also important objectives under this priority. The need to promote positive coping mechanisms can be accomplished with yearly mental health screenings (suicide prevention, addressing bullying/bullies). Well visits for adolescents can promote overall health (immunizations, healthy eating, and oral health), and social emotional health can enhanced by providing trained adults and mentors to help adolescents navigate life skills and set goals (high school completion, employment, youth development). Given that adolescents have a natural desire to become active agents in society and community, this priority can be promoted through community partnerships and engagement, and can reinforce protective factors and promote prevention of risky behaviors. KDHE can support schools and faith based organizations to provide the whole family with education and public awareness campaigns, and implementation of policy and procedures can be explored to promote suicide prevention and address bullying.

State Priority 5 is focused on ***communities providers, and systems of care supporting physical, social and emotional health***, especially for adolescents. Related objectives and efforts include:

- promoting health through adolescent well visits;
- ensuring services to assist adolescents with building coping skills and managing stress to prevent suicide and reduce the rates of bullying; and
- educating and empowering adults and adolescents to reduce the impact of bullying.

The Title V program will remain focused on employing the strategies related to these objectives during the next year and beyond to advance efforts related to the priorities for adolescents.

- Promote annual well-child visits through adolescence into adulthood
- Engage school nurses to identify and refer children with an Individualized Healthcare Plan who have not had a

well-child visit in the past year
- Promote incorporation of behavioral health/behavioral health screening into annual adolescent well visits
- Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received
- Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment
- Partner with community providers to connect children and adolescents with supports that promote protective factors
- Implement evidence-based/evidence-informed practices to support healthy behaviors and choices and the development of positive coping mechanisms among adolescents
- Promote the Yellow Ribbon* initiative and accessible crisis services through school and out-of-school activities
- Provide services that support reducing the impact of Adverse Childhood Experiences (ACEs) on children and adolescents
- Increase awareness of options for educating and reporting unsafe digital content Bullying and Cyberbullying intervention and prevention
- Make connections among schools, families, communities and health providers through programs such as Communities in Schools (CIS) and school-based clinics

*Yellow Ribbon is a grass-roots, community based, volunteer organization developed to serve youth and the communities that surround them, and to address youth/teen suicide through public awareness, education and training to help communities build new and/or strengthen existing programs. Two Kansas Chapters are located in Wichita.

The Title V team, namely the Child and Adolescent Health consultant, local grantees, and other partners will also focus on the recommendations resulting from the adolescent health needs assessment, prioritizing the recommendations based on the Title V State Action Plan priority needs and related objectives and strategies. The Adolescent State Health Report includes the following recommended strategies and planned activities.

RECOMMENDATION 1: Address the highest priority adolescent health issues.

Mental Health:

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

Substance Abuse:

- Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

Sexual and Reproductive Health:

- Make accurate information on responsible sexual behavior, including the benefits of abstinence, more easily

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

Nutrition and Physical Activity:

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

Injury Prevention:

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

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

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

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

- Emphasize social emotional as well as academic competence in the school setting.
- Increase the availability of skill-based health information for youth.
- Support schools to establish and sustain health access points and health services on-site during the school day.

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

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

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

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

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

The data collected on needs of adolescents between ages 10 and 22 is in alignment with the research about the importance of this age as a 'critical period of development for establishing habits with lifelong implications and is an important time for caring adults and communities to intervene as well as help youth establish positive health behaviors' (Call, Ridel, Hein, Mcleod, Peterson & Kipke, 2002). Adolescence is an important developmental stage filled with opportunities as well as health risks, and can be magnified by transitions between systems of care, especially for CYSHCN. To address this population's special health care needs, the Kansas Special Health Care Needs (KS-SHCN) program will expand transition resources and services through care coordination. Youth of a certain developmental age will begin working with the care coordinator and identified community members to work towards an effective health care transition, utilizing tools and resources developed through a previous HRSA Integrated Community Systems grant. These tools include a youth self-assessment to determine where the youth feels most confident in their skills needed to accomplish their goals. Additionally, the care coordinators will address the importance of receiving preventive care in an adolescent will visit, regardless of how frequently care is received by a specialist. The dissemination of the "Plan It – Live It" website to promote youth independence and provide opportunities for skill-building, self-determination and support in becoming an empowered patient will occur this coming year. This online curriculum will support youth to 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. 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. After a few years of setbacks and technology challenges, this project has been identified as viable and a youth-led review is being pursued to finalize the update for dissemination.

KS-SHCN, in partnership with the Kansas Youth Empowerment Academy (KYEA), will implement Faces of Change with up to twelve youth participants in September 2015. Evaluations will be completed throughout and after the program, including a youth-completed pre/post self-efficacy and leadership assessment. Additionally, the evaluation plan includes long-term initiatives at one and three years after completion of the program. KS-SHCN will offer an internship in Summer 2016 to at least one youth leader who successfully completes the program. Additionally, there is interest in future expansion of the program (based upon year 1 evaluation data) to include youth without disabilities

Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	151.4	142.1	133.4	125.1	117.4

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	7.9	5.6	4	2.8	2

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.2	89	91.9	95	98.1

Adolescent Health Needs Assessment and State Plan: In Spring of 2014 KDHE contracted with Kansas State University Research and Extension to conduct a statewide assessment of adolescent health needs and develop a state adolescent health plan. The Adolescent Health Needs Assessment provided state-specific information regarding the adolescent population that was not previously available, including identification of issues of particular interest to adolescents themselves. The assessment process consisted of a review of existing health data, an online community input survey, community focus groups, and gathering of input from key stakeholder. The review of data revealed areas of improvement, including decreasing rates for teen pregnancy, tobacco use, and unintentional injury and increased levels of physical activity. However, negatives trends were noted in the areas of increased behavioral/mental health needs and intentional injury (e.g., suicide attempts, bullying) and obesity.

Following the review of population data, an open access, electronic survey was made available for anyone in Kansas over the age of 13 to complete. The survey was disseminated to more than 50 organizational lists, points of contact, and electronic newsletters via email, flyers with URLs and QR codes, and sample copies delivered at conferences, meetings, and public gatherings. A link to the survey was also posted on Facebook and Twitter. The online survey resulted in 854 responses representing 83 of the 105 Kansas counties. Respondents ranged from age 11 to 82 with an average age of 49. In response to the question asking which 2 health issues impact adolescents in their area the most the top 8 issues identified were substance abuse (56.2%), mental health (35%), Obesity/overweight (30.1%), adolescent pregnancy and parenting (22.2%), sexual health (17.6%, positive health development (17%), adolescent injury (8.7%, and healthcare services (8.5%). In narrative sections of the survey respondents emphasized concerns about their communities' capacity to diagnose and treat substance abuse issues due to lack of available and accessible services and cited a lack of adolescent substance abuse prevention programs. Many respondents cited mental health care issues such as transition to adulthood, life stressors impacting families, stress management, and suicide. The lack of education about healthy development was an issue raised by multiple respondents with specific reference to the need for education related to injury and violence prevention, substance abuse prevention, obesity and physical education, sexual/reproductive health, and teen pregnancy. Barriers to services for adolescents identified in the survey included lack of accessible and affordable transportation or lack of awareness about available transportation options, insufficient marketing of services provided in communities, and a lack of doctors or other providers who are trained on and/or address the specific needs of adolescents. Additional information was gathered in 26 focus groups held in 5 communities across Kansas. The 5 communities were strategically selected to obtain information from areas of the state that were not well represented in the online survey responses. Of the 401 focus group participants, 324 were youth ages 12-18. There was an intentional effort to gather the input of adolescents in the focus groups to complement the majority of survey responses received from adults. Participating youth identified the following issues as having great impact on the adolescent population: drug and alcohol use, teen pregnancy, lack of adequate sexual education, bullying, self-inflicted physical harm, depression, dealing with stress and high expectations of adults, and obesity. The participants indicated the need for "real" information about sexuality, sexually transmitted diseases, and life-altering consequences of teen pregnancy. They expressed needing supportive, non-judgmental adults to confide in and provide guidance.

The Adolescent Health Needs Assessment resulted in specific recommendations and strategies to address the needs of adolescents in Kansas. Recommendations were grouped in 5 categories:

1. Address the highest priority heath issues (mental health, substance abuse, reproductive/sexual health, nutrition and physical activity, and injury prevention);
2. Help families support the health and well-being of their adolescents;
3. Provide educational environments that prepare youth for healthy adulthood;
4. Encourage collaborations and increase community support for those working for and with youth; and
5. Improve the responsiveness, availability, and access of health care to youth.

Specific strategies recommended to address high priority health issues include school-based access to screening, referral, and treatment; establishment of networks of skilled, supportive adult mentors in safe, accessible environments; provision of confidential, youth-friendly reproductive health services; increased availability of healthy foods and beverages in schools; implementation of an awareness campaign to reduce sedentary time and increase physical activity; development of policies and prevention activities to reduce motor vehicle crash injuries and deaths. To help families support the health of children, identified strategies target increased availability of information and supports to parents and family members about normative adolescent development and risk and protective factors for youth and increased opportunities for parents to improve their skills in seeking quality health-related information and services. Strategies for providing educational environments that prepare youth for healthy adulthood include establishment of health access points and services on-site during the school day and increased availability of skill-based health information for youth. To encourage collaborations and increase community support for adolescents,

strategies such as effective afterschool and out-of-school programs, increased youth-related continuing education opportunities for professionals and paraprofessionals, and interdisciplinary conferences and workshops were recommended. To address the need for improved responsiveness, availability, and access to health care identified strategies include education and outreach to inform youth and parents about healthcare options and providers who specialize in serving adolescents, work with health insurers to widen the concept of well-child visits through adolescence (up to age 24), and create avenues for youth to be involved in discovering and utilizing healthcare systems that meet their needs. Results and recommendations included in the assessment are being used to help guide decisions about MCH programming and services for youth in Kansas.

Abstinence Education Program: KDHE continued the Kansas Abstinence Education Program (KAEP) funded by the US Department of Health and Human Services, Administration for Children & Families. KDHE contracts with the Children's Alliance of Kansas to deliver the program targeted to at-risk foster care youth. The Children's Alliance coordinated abstinence education training to foster/adoptive/kinship parents and children/youth in foster care and residential care as well as some general population school children. Trained foster care providers conducted All Starts, Choices, Healthy Relationships trainings and programs reaching 754 youth ages 10-19 and 143 parents for the period of October 2013 to September 2014.

Special Health Care Needs: The Kansas Special Health Care Needs (KS-SHCN) program supports multi-disciplinary clinics in Kansas City and Wichita, which include activities around transition to adulthood. Clinic teams and coordinators work with patients and families to assist and assure services are identified and obtained prior to aging out of the program. Transition services will be expanding in the coming year with the implementation of the KS-SHCN care coordination program. KS-SHCN, in partnership with the Kansas Youth Empowerment Academy (KYEA), is developing a youth leadership program called Faces of Change. Faces of Change is focused on leadership development through civic engagement for youth ages 16-22 with disabilities. The program is seven months long, with monthly sessions focusing on an area contributing to effective leadership, such as: what it means to be a true leader, authentic leadership, effective communication, and team motivation. Youth participants will be using the new leadership qualities that they are learning throughout the program through a Community Change Project, which will be created and led by the youth. This program was developed to address risk factors for youth with disabilities and special healthcare needs. It is believe that this program will decrease the following risk factors for youth with disabilities: low self-esteem and self-efficacy, high unemployment, and bullying. During the stage of young adulthood, youth need to find abilities within and connect with others. This program will have a strong emphasis on civic engagement, this provides participants the opportunity to explore abilities and realize their worth to society by giving back to others. The rate of unemployment for youth with disabilities ages 16-19 is more than twice the number of youth without disabilities. Youth participants will have enhanced employability skills such as communication, active listening, team work, time management and dress attire, and more. Lastly, youth with disabilities are more likely to be bullied compared with their nondisabled peers; contributing to secondary mental health conditions and increased risk for depression and suicide. These youth are not only victims of bullying by their peers, but also experience intimidation from medical professionals, family members and school faculty. Building communication and assertiveness skills, developing problem solving skills, and creating a network of peers and adults are intended outcomes of this program and will lead to positive outlets and create resiliency. Our belief is that by enhancing leadership skills, youth with disabilities and special healthcare needs will demonstrate increased self-efficacy, self-determination, and feel connected on a social and civic level to their community.

HPV Kansas Vaccination Project: Training entitled *Working Together to Protect Our Youth* was provided with Title V support. The training shares information about Kansas HPV Vaccination project activities, the importance of the HPV vaccine recommendations, and available resources. Training is focused on the key steps to improving Human Papillomavirus (HPV) vaccination and ways to communicate with parents about the HPV vaccine.

Teen Pregnancy: Although the rate of teen pregnancy in the United States dropped by more than 25% during the 1990s, more than 800,000 U.S. teens still become pregnant each year, and eight in 10 of these pregnancies are

unintended. [1] Close to half of unintended pregnancies (45 percent) end in abortion. [2] Women whose pregnancies are unintended are less likely to adopt healthy behaviors and to start prenatal care early in the pregnancy. [3] Infant mortality rates are highest among teenage mothers. [4] Teenagers are at a higher risk of delivering a low birth weight live birth. Studies suggest that the higher mortality risk for infants of younger mothers may be related to socioeconomic factors as well as biologic immaturity. Also, young maternal age may be a marker for poverty. [3] The Bureau of Family Health's Teen Pregnancy Targeted Case Management (TPTCM) program intends to address this risks and needs. TPTCM is to provide comprehensive case management services to KanCare (Medicaid) eligible pregnant and/or parenting adolescents in Kansas communities, with priority given to communities with greater numbers of adolescent Medicaid recipients. The project's goals are: to reduce negative consequences of teenage pregnancy for KanCare-enrolled teens and their children; to increase levels of self-sufficiency and goal-directedness relating to their own futures and that of their children; and to delay subsequent childbearing until completion of goals related to basic education/training; or they reach 21 years of age. KDHE receives state general funds to support Teen Pregnancy Targeted Case Management (TPTCM) programs. In SFY 2014, 10 local programs received funding and the number of teens served dropped to 886. In SFY 2015, we continued to provide funding to 10 local programs. In the last year the program manager has updated the TPTCM manual, more clearly defining the supports and services provided at the local level. The SFY 2016 application process was enhanced with questions added to more clearly understand local partnerships, program management, service delivery and community outreach efforts. A total of 11 programs are funded and projected to enroll more than 440 new teens over the coming year. Program reporting has continued to evolve in response to our desire to further understand the impact of our services and to provide standardization across programs.

References

[1] Guttmacher Institute. National Day to Prevent Teen Pregnancy (May 3, 2006). www.guttmacher.org/media/inthenews/2006/05/03/index.html

[2] Henshaw, SK. Unintended pregnancy in the United States. Family Planning Perspective. 1998;30(1): Table 1.

[3] O'Brien J, Benzyl B, Gilbert BC, et al. PRAMS and Unintended Pregnancy (n.d.). www.cdc.gov/ PRAMS/UP.htm

[4] Mathews TJ, MacDorman MF. Infant mortality statistics from the 2006 period linked birth/infant death data set. National vital statistics reports; vol 58 no 17. Hyattsville, Maryland: National Center for Health Statistics. 2010.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Services are comprehensive and coordinated across systems and providers.	5.1 Improve communication and outreach among service providers, individuals, and families to help with coordination of	5.1.1 Support implementation of family-centered medical homes through increased awareness, professional development, and collaboration	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	Percent of children with and without special health care needs having a medical home		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	care. 5.2 Systems that support age and developmentally appropriate, universal behavioral health are integrated, increasing collaboration between systems of care 5.3 Assist and empower individuals and families to navigate systems for optimal health outcomes throughout the life course	5.1.2 Implement communication and referral protocols for SHCN Care Coordinators and providers 5.1.3 Expand KS-SHCN to have care coordinators located in all regions 5.2.1 Explore partnerships with and support existing structures that promote behavior health services 5.2.2 Promote collaboration between primary care and behavioral health providers 5.2.3 Integrate behavioral health assessment results in the KS-SHCN action plan resources/referrals 5.3.1 Develop, monitor and evaluate a patient-centered care coordination action plan for all	Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents,			

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		SHCN clients 5.3.2 Complete the online navigational tool kit to provide resources and services 5.3.3 Increase access to primary and specialty care in underserved areas	ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Children with Special Health Care Needs

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

The Kansas Special Health Care Needs (KS-SHCN) Program promotes the functional skills of persons, who have or are at risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction. KS-SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions. Additionally, the program provides services to persons of all ages with metabolic or genetic conditions screened through the Newborn Screening. Services may include diagnostic evaluations, treatment services or care coordination.

This program assured that medical specialty services were accessible through a contractual system and provided diagnostic evaluation, case management, treatment services, and financial assistance to more than 5,000 individuals with qualifying conditions and income, and their families, across the state. This is done with support of six regional offices (RO): 3 RO's are located in local health departments (Crawford, Ellis, and Saline counties); 2 RO's are located within hospital systems (Wyandotte and Sedgwick counties); and the administrative office serves as the North Central RO and is located at KDHE (Shawnee county). There is a current vacancy in the Southwest region of the state where a local health department partner was unable to continue providing services as the KS-SHCN Regional Office. A new partner will be identified in that area of the state to serve as a RO in the coming year.

The RO's serve as the entry-point into KS-SHCN, working directly with families throughout the application process, and assisting them with their application, and answering questions. The RO's are being assessed for capacity and staffing needs to expand their role to include care coordination services in the coming year. Services provided through the KS-SHCN program are based upon recommendations from the Special Health Services (SHS) – Family Advisory Council (FAC). Family engagement and family partnership are a critical components to moving program services in the right direction. Families can provide firsthand knowledge and insight to areas that state program staff may not have considered, as well as suggestions on how to make positive changes for the CYSHCN population. To

support opportunities for family engagement, the Title V Block Grant input survey is promoted to families across the state to share their thoughts and ideas for ways to improve the system. The survey includes a place to put personal comments and ideas to be integrated into block grant applications and annual reports.

Since July 2013, KS-SHCN has undergone a comprehensive strategic planning process and developed a robust action plan to address the changes based upon the new five priorities identified through the strategic plan and Title V needs assessment. To conclude this process, KS-SHCN developed a five-year plan, with 5 new priorities and a total of 14 objectives and 31 total strategies. During the Title V needs assessment planning, the CYSHCN domain was integrated into the work around the other population health domains, to assure a cohesive approach to data and input collection. The Title V CYSHCN Director and KS-SHCN Program Manager led 17 community meetings to assess child and adolescent health needs for the Title V needs assessment, integrating input opportunities for Title V and KS-SHCN priorities.

The KS-SHCN five year plan focuses on the five priorities as follows: (1) Care Coordination focuses on empowering families, improving communication among providers and systems, and stronger cross-system collaboration; (2) Family Caregiver Health focuses on promoting health and wellness among family caregivers, increasing awareness of and access to respite services, and family leadership and peer supports; (3) Behavioral Health focuses on collaboration to support integrated care, community education and referrals, and screening and assessments for KS-SHCN families; (4) Training and Education focuses on advocacy, youth leadership and self-determination, and training for professional in integrated care of people with disabilities; and (5) Direct Health Services is focused on gap-filling services such as oral health, access to adequate insurance coverage, and telehealth.

For each of the KS-SHCN priorities, objectives and strategies have been developed. Priorities were identified and selected in Phase 1 of the strategic planning and defined in Phase 2. Objectives were developed in Phase 3 of the strategic planning process with broad stakeholder input. Strategies were developed by KS-SHCN staff, in partnership with the SHS-FAC. SHS-FAC members approved and recommending KS-SHCN adopt these as the first strategies towards working towards overall objectives and priorities. These strategies will be re-assessed each year by the SHS-FAC to monitor progress and make recommendation for changes, as needed.

Priority 1: All children and youth with special health care needs (CYSHCN) receive family-centered, coordinated care.

Objective	Strategy
1.1. Assist and empower individuals and families to navigate systems for optimal health outcomes throughout the life course. (Title V Action Plan Objective 7.4)	1.1.1. Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients. (Title V Action Plan Objective 7.4) 1.1.2. Complete the online navigational tool kit to provide resources and services (Title V Action Plan Objective 7.4)
1.2. Improve communication and outreach among service providers, individuals, and families to help with coordination of care. (Title V Action Plan Objective 7.1)	1.2.1. Implement communication and referral protocols for SHCN Care Coordinators and providers. (Title V Action Plan Objective 7.1) 1.2.2. Expand KS-SHCN to have care coordinators located in all regions. (Title V Action Plan Objective 7.1)
1.3. Increase collaboration between the KS-SHCN and other systems of care to support change.	1.3.1. Engage MCO's and primary care providers in collaborative coordination for SHCN clients. (Title V Action Plan Objective 7.3) 1.3.2. Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care. (Title V Action Plan Objective 7.3)

Priority 2: Support optimal health and well-being for family caregivers of CYSHCN.

Objective	Strategy
2.1. Support activities and initiatives to educate family caregivers on the importance of taking care of their own health needs and the impact of their health on those they care for.	2.1.1. Utilize KS-SHCN "Family Caregiver Assessment" to identify needs and resources for family members of KS-SHCN clients. (Title V Action Plan Objective 2.1) 2.1.2. Provide education about how the role as a caregiver can impact their health and the ability to care for their loved one. (Title V Action Plan Objective 2.1)
2.2. Engage and support collaboration among systems for the provision of respite services for SHCN family caregivers in order to proactively address their health care needs, including physical, emotional, and dental health.	2.2.1. Conduct a respite care needs assessment, including fiscal note, payment opportunities, and family impact. 2.2.2. Seek partnerships and funding opportunities for a sustainable respite pilot project. 2.2.3. Provide support for local partners to host sibling workshops or activities.
2.3. Provide training and education opportunities to support informed, engaged, and empowered family caregivers and providers. (Title V Action Plan Objective 2.2)	2.3.1. Develop a progressive family leadership program to empower families and build strong MCH advocates. (Title V Action Plan Objective 2.2) 2.3.2. Provide family and sibling peer supports for those interested in being connected to other families with similar experiences. (Title V Action Plan Objective 2.2)

Priority 3: Behavioral health needs and supports will be integrated into the Kansas Special Health Care Needs system of care.

Objective	Strategy
3.1. Collaborate with other agencies serving individuals with behavioral health needs to support an integrated continuum of care.	3.1.1. Engage behavioral health partners (KDADS, KAIMH, NAMI, CMHCs) to assess possible opportunities for KS-SHCN to support the behavioral health field. 3.1.2. Build partnerships with health home providers and case managers to identify appropriate referrals for families and inform partners of, and offer support through, the SHCN Care Coordination efforts. 3.1.3. Partner with Medicaid to provide support for behavioral health telehealth clinics through health homes.
3.2. Educate families about behavioral health issues and provide referrals and resources of available services and peer supports.	3.2.1. Reduce stigma through community awareness and education, including parent and client education materials about behavioral health. (Title V Action Plan Objective 6.1) 3.2.2. Partner with NAMI to offer youth and adult education programs to KS-SHCN clients. (Title V Action Plan Objective 6.2)
3.3. All KS-SHCN families will have a behavioral health assessment and be supported in obtaining necessary services.	3.3.1. Integrate behavioral health assessment results in the KS-SHCN action plan resources/referrals. (Title V Action Plan Objective 7.2) 3.3.2. Develop follow-up protocols for families referred for behavioral health services and offer additional support as needed to assure services are received. (Title V Action Plan Objective 5.1)

Priority 4: Support a society that is culturally sensitive, well-informed, and respectful of all people with disabilities through training and education.

Objective	Strategy
4.1. Equip children, youth, and families to advocate for needed services, supports, and family/professional partnerships. (Title V Action Plan Objective 8.1)	4.1.1. Provide youth-focused and youth-driven initiatives, such as Faces of Change and Plan It Live It, to support successful transition, self-determination and advocacy. (Title V Action Plan Objective 8.1) 4.1.2. Conduct "Care Coordination: Empowering Families" trainings for parents of CYSHCN. (Title V Action Plan Objective 8.1)
4.2. Provide training and education for providers to promote diversity, inclusion, and integrated supports in the provision of services for the SHCN population. (Title V Action Plan Objective 6.2)	4.2.1. Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course. Promote through conferences, grand rounds, webinars, etc. (Title V Action Plan Objective 6.2) 4.2.2. Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN. (Title V Action Plan Objective 6.2)

Priority 5: Provide gap-filling health services for CYSHCN and their families through partnerships, collaboration, and direct care supports.

Objective	Strategy
5.1. Collaborate with agencies and providers in the oral health system to support increased access to, and payment of, oral health services for CYSHCN.	5.1.1. Conduct a statewide needs assessment on oral health services for CYSHCN. (Title V Action Plan Objective 3.4) 5.1.2. Provide dental hygienist services within KS-SHCN specialty clinics.
5.2. Partner with public and private insurance companies to enhance coverage of services for individuals with special health care needs for primary and specialty care.	5.2.1. Identify needed insurance policy advocacy needs and partner with organizations to inform insurers on the needs for CYSHCN. 5.2.2. Continue advocacy for state support of hemophilia and life-long coverage for PKU formula.
5.3. Increase support for outreach clinics & utilization of telehealth for the CYSHCN population.	5.3.1. Develop pilot project for developmental assessment telehealth clinics. (Title V Action Plan Objective 3.5) 5.3.2. Support increased outreach of wheelchair seating clinics. 5.3.3. Build capacity and support initiatives to expand telehealth for KS-SHCN clinics. (Title V Action Plan Objective 7..3)

Throughout this process, there has been a strong focus on an integrated system where CYSHCN is no longer a siloed population, but is included in all MCH population as a subset of the overall. Many of the KS-SHCN priorities and strategies were integrated into the larger Title V state action table: not only in the priority selected for the CYSHCN domain, but in 6 of the 8 overall state priorities and 13 different objectives. This reflects the integrated and cross-systems approach to the Kansas work. This approach is critical to the future work around the "National Standards for Systems of Care for CYSHCN," for which a comprehensive analysis will be conducted in the coming year to identify areas of needs and gaps in services across systems. The new KS-SHCN Care Coordination program will begin piloting summer 2015 with administrative RO staff. Once the pilot is completed, a robust training will begin with the remaining RO staff. Each RO will assign a participant to be part of the core team, who will participate in monthly conference calls and bi-monthly in-person meetings to evaluate and revise the project as needed throughout the first year of implementation.

Care coordinators will partner with families to assist them in understanding various state and community systems, and how to effectively (and independently) navigate these systems. As partners, Care Coordinators will work with families to identify needs and wants for the development of an Action Plan. This will help them achieve positive goals while providing the level of support they would like. Quality improvement methods will be used to monitor care coordination outcomes and make improvements as needed. Quantitative and qualitative outcomes will be measured, including: number of clients/families service, types of assistance provided, topics covered and resources provided, amount of time spent on average per client/family, and the reduction of unnecessary care (e.g. ER/urgent care visits, additional labs or x-rays, or additional medical appointments) due to care coordination, among others.

Tools to measure such outcomes have been developed and will be integrated into the new KS-SHCN electronic data system. Technical assistance has been requested from the Boston Children's Hospital Care Coordination program.

The Family Caregiver Assessment will be completed by mid-fall 2015 and will receive input from the SHS-FAC. These members will assist in the development of protocols and tools to support the utilization of this assessment with families, providing opportunity for the KS-SHCN Care Coordinators to provide appropriate referrals and resources related to the health of the whole family. Subsequently, evaluations will be designed and the family caregiver health will be piloted as part of KS-SHCN Care Coordination Program in early 2016.

In response to the need to shift services, beginning July 1, 2015, a new financial assistance model was implemented. Previously, individuals could apply for services such as payment of direct health care costs, prescriptions, low protein food products/PKU formula, durable medical equipment, hospitalizations, therapy services, among other services. Individuals qualifying for services ultimately received 100% coverage of specialty medical services up to a $20,000 annual cap. This model was dated and did not support family engagement and empowerment.

The new model accounts for this and takes an "assistance-based" approach with client/family responsibility for services. These new programs are called Direct Assistance Programs (DAPs). Families are eligible to select assistance from any two of the DAPs they feel best meet their needs. Each of the DAPs have eligibility criteria and annual maximum assistance amounts. The DAPs are as follows:

1. Co-Payments and Deductibles: This is for those with private insurance who have a patient responsibility through co-pays and/or deductible limits. This allows for up to 50% assistance towards deductible limits and/or limited support towards co-pays for medical specialty appointments.
2. Medical Services: This is for those with no insurance, or those who are ineligible for KanCare (Medicaid) and/or private insurance through the health insurance marketplace. This allows for direct payment for medical appointments, x-rays, specialty tests, hospitalizations, interpreter services, or other specialty care services. Some of these services require the patient to pay a small co-pay.
3. Orthodontic Treatment Services: This is for those with craniofacial anomalies. This provides for assistance with orthodontic evaluations and comprehensive treatment plans.
4. Hemophilia: This is for those with hemophilia, or other bleeding disorders. This provides up to $2,500 per factor treatment and a comprehensive hemophilia treatment center visit.
5. Metabolic Products: This is for those with PKU, or other amino acid disorders. This provides assistance for metabolic formula and low protein food items.
6. Medication: This is for anyone who qualifies. This provides assistance with medication, however requires the client pay a $5 co-pay for every $100 of medication supported by KS-SHCN.
7. Travel: This is for anyone who qualifies. This provides travel assistance to and from the client's home to medical specialty care appointments.
8. Medical Equipment and Supplies: This is for anyone who qualifies. This provides assistance for durable medical equipment and medical supplies. Client co-pays ranging from $25 to $100 are applicable depending on the cost of the equipment. Medical supplies can include items such as catheters, ostomy supplies, diabetic testing equipment (CF clients only), hearing aid molds/repairs, glasses, and other items deemed medically necessary.

The KS-SHCN and NBS will be integrated into the Family Support Network data system, currently under development for the Newborn Hearing Screening (NBHS) program. All SHS programs will work collaboratively to develop policies, protocols, tools, confidentiality contracts, evaluations and parent mentor trainings for the Family Support Network. SHS programs will design a parent mentor recruitment plan and staff training on how to correctly administer the program. This will be offered to all families with children identified with a NBS condition, as well as, those in the Special Health Care Needs program. Full implementation of the Family Support Network for all SHS

programs is expected to be completed by summer of 2016. This system will provide an opportunity for expansion to siblings of CYSHCN in coming years. Additionally, the capacity of the system would allow broader MCH integration, such as women, parents in home visiting programs, participants of local health department services, and youth/young adults.

KS-SHCN will continuing to strive for systems integration, seeking out new partnerships within the Bureau of Family Health and agency programs, such as school health, WIC, child care, and health promotion, and Medicaid/KanCare. Initiatives are written into the KS-SHCN five year action plan to build partnerships across systems, such as foster care, primary care providers, behavioral health, and oral health, among others. Specific activities planned this coming year include engaging the managed care organizations in the development of referral process to support reciprocal information sharing around KanCare clients on KS-SHCN. Additionally, there are plans to engage behavioral health partners and providers to assess possible opportunities for KS-SHCN to support the behavioral health system and gauge interest in behavioral health telehealth clinics. Other efforts are still under development and will be planned upon successful implementation of the Care Coordination Program and the completion of the analysis on the "National Standards for Systems of Care for CYSHCN" in Kansas.

KS-SHCN will partner with the Kansas Youth Empowerment Academy (KYEA) on a seven month training and educational program for youth with disabilities and special health care needs that will foster attitudes of civic engagement and services through the development of leadership skills. The curriculum is based on evidence-based leadership practices, with monthly in-person sessions focused on the following:

1. Job Description of a Leader (September) – Provide an introduction to the program, expectations as a participant, initial youth assessments, and an overview of leadership characteristics.
2. What is your PACE? (October) – Support youth in discovering their individual passions, tapping into their authenticity, realizing the commitment level needed to lead, and learning how to express themselves as a leader.
3. Language of Leadership (November) – Educate on various forms of communication, identifying their strengths and weakness in communicating, becoming familiar with the financial cost of change, and the art of listening.
4. Leading from the Front (December) – Assist youth in learning how to accept praise and criticism, learn from and become role models, and managing emotions and boundaries.
5. Leading from the Side (January) – Guide youth through developing skills necessary for the ability to follow, learning to delegate and receiving delegation, and learning to be a team player.
6. Leading from the Back (February) – Teach youth about motivating and enabling others to act, taking responsibility for failures, letting others lead, and self-care.
7. Going in Circles (March) - Promote the value of evaluating change, celebrating progress, reassessing their commitment, and educating on the cycle of leadership.

SHCN has requested that MCH concepts are integrated throughout the leadership curriculum in the following sessions: Language of Leadership, Leading from the Front, Leading from the Side, and Leading from the Back. This will include concepts such as communicating with medical professionals, communicating about their disability and medical needs, emergency preparedness, management of emotions, peer supports and mentoring that promote healthy mental functioning, delegating medical needs, transition, self-care and wellness, and the impact of stress on the body.

The two primary components that will enhance the participants' pathway to leadership include 1) a leadership development plan which will highlight individual goals to enhance leadership skills and 2) a community change project which they will develop and begin implementation of a plan to meet this need. KYEA will provide a list of potential topics for project focus, including but not limited to: alcohol/drug abuse, teen pregnancy, bullying, healthy living, sexual health, and others. Upon completion of the program, the youth will participate in a "graduation ceremony" where participants will present on their community change project, including the perceived impact of

change in their community and the personal growth within themselves. Ultimately, SHCN will provide an internship opportunity to at least one youth “graduate” of this program.

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

Children with Special Health Care Needs - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	58.7	64	69.9	76.2	83.1

The Kansas Special Health Care Needs program (KS-SHCN) began an extensive strategic planning process in July 2013. To date, four stakeholder meetings have been held, engaging a variety of families, medical providers, community partners, and program staff. Through these meetings five key priorities emerged: Cross-System Care Coordination, Addressing Family Caregiver Health Needs, Behavioral Health Integration, Training and Education, and Direct Health Care Services. Additional public input was obtained through the Title V Needs Assessment and “Communities for Kids” community tour, including 17 meetings in 9 cities across Kansas.

The overall strategic planning process focused around four key principles: 1) increasing the value of the program for those served; 2) evaluating relevancy of program services offered for families; 3) evaluating cost effectiveness of direct and clinical services; and 4) identifying opportunities for improvement by utilizing quality improvement methodology. This included the evaluation and revision of how clinic services are provided, including a review of billing practices and protocols to assure effective utilization of state and federal funds. Another major initiative included cross tracking the eligible medical conditions and services provided to identify gaps in services under the current structure. This is being cross-referenced with the costs associated to the state for the provision of these services, as well as what is covered under public and/or private insurance.

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

The focus of the strategic plan was to identify program needs for the target population. It was evident throughout the process that the program has room for improvement in all areas, most specifically building infrastructure and capacity for increased services. Through support cross-system care coordination and a state analysis of the systems of care in Kansas, KS-SHCN will be better positioned to strengthen the State’s enabling and population based services. Throughout the process, and based on feedback from clinic partners and families, it was evident the program was in need of an overhaul; shifting the previous “way of doing business” to more appropriately address wrap-around services provided through a medical home, such as care coordination, resource referral, and communicating among multiple team members. Additionally, focusing on truly gap-filling services and assisting

families with non-medical needs, KS-SHCN can better support families to meet their top health concerns and the unmet needs identified through the 2014-15 MCH Block Grant Public Input Survey.

A distinct need to review funding allocations and support for direct clinical services was quickly realized. This included a review of the services provided within the structure of the multi-disciplinary clinics. Through this review, it was identified that the need for these clinics varied greatly across the state. Historically, clinics are held in the Kansas City and Wichita areas, with less than 25% of clinics done in outreach locations across the state. The clinic review indicated inconsistencies in the provision of services, inequalities in funding allocation, and minimal accountability measures for sub-contractors. Therefore, a new funding process began in April 2014, completing the second year of proposal requests. This process required partners to submit a proposal for funding - demonstrating need, anticipated health outcomes of services, and evaluation measures. Clinical service requests were required to outline how they provide and bill for services and to complete an exemption request if they are seeking funding support for clinical services.

Partnerships were strengthened and cost-savings were abundant. The process supported partners by providing them opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services. Limited push-back by partners was experienced, in fact the majority shared that they appreciated the opportunity for feedback, partnership, and innovative thinking. Partners were asked to think outside the box and consider the true needs of families served through their funding. Another component of the funding request process included an expectation of the inclusion of matched partner funding. This approach was surprisingly well-received by most partners and mutual fiduciary responsibility served as a catalyst for additional buy-in and engagement from partners. Nearly 75% of the contracted services experienced a shift in the last year, as recommended by partners. Some were a simple shift with clinical services being billed to public and private insurance (an expectation not made clear in previous years). Other changes included a complete overhaul from direct services to enabling services with a focus on medical home and care coordination. Additionally, new initiatives were presented and accepted.

For SFY 2016, funding continued for the KS-SHCN Regional Offices and many of the specialty care clinics with anticipated expansion to outreach or telemedicine in many of them, as outlined below.

- Kansas City clinics: PKU (only for established patients), Cystic Fibrosis, and Cleft/Lip Cleft Palate
- Wichita clinics: PKU*, Cystic Fibrosis, Cleft/Lip Cleft Palate, Orthopedic, Specialty Team, and Wheelchair Seating
  *Kansas does not have a Pediatric Geneticist. Therefore, the majority of newly diagnosed patients are seen out of state. Partners at the Wesley Medical Center invited KS-SHCN to take part in the development of a broader genetics program, supporting a shift in the PKU clinic to a broader metabolic clinic in SFY 2017. This includes the development of treatment protocols, technical assistance and consultation from out-of-state Geneticists, and physician training/capacity building.
- Outreach clinics: Wheelchair Seating (three communities in Western Kansas, with expansion planned for SFY16), Cardiology, Rheumatology, and Special Child Clinics**
  ** Special Child clinics are diagnostic evaluation clinics for those suspected to have developmental delays. Currently, referrals are primarily received by local school district early childhood and elementary education programs. Throughout the coming year, an evaluation will be conducted to identify the feasibility and functionality of telehealth within these clinics to expand access to these services, including an expansion of referral networks.

In addition to continuing these clinics, the following new funding proposals have been received since this process began.

- *Hospital-to-Home Transition Program:* A community-based transition to home program, following a hospitalization for medically fragile patients. This pilot program will include the provision of increased

education and coordination (both initially and ongoing) to caregivers and families, increased surveillance and support in the home following discharge, and increased coordination and partnership with the discharging institution and insurers. This is anticipated to decrease re-hospitalizations, expedite and streamline discharge planning, prevent post-hospitalization infections, lower transitional stress on child and family, and improve family caregiver health and well-being, among others. This program is new in SFY 2016.

- *Cystic Fibrosis (CF) Adherence Project:* An innovative model aimed to improve adherence to medical treatment plans for patients with CF, through utilization of telehealth and tele-education. This includes the provision of an iPad for patients to use in telemonitoring and telemedicine services, ongoing care coordination, and the strategic planning for reducing barriers to adherence for patients in Southeast Kansas.
- *FACES of Change:* A seven-month leadership program for youth with disabilities that will foster attitudes of civic engagement and services through the development of leadership skills.
- *Medicaid Collaboration for Early Detection of Developmental Delay:* In partnership with the Medicaid Managed Care Organizations (MCO), KS-SHCN is contracted with the University of Kansas to collaboratively identify children ages 0-5 who do not have a documented well-child visit, immunizations, or developmental screening with Medicaid. Once identified, KU will assist the patient in making an appointment for assessment and follow-up that could be done within the KU system, or in the patient's community. Assistance with re-applying for Medicaid, the KS-SHCN program, or other community-based services will be provided by a KU coordinator. Referrals will be made to the KS-SHCN program for additional supports or services.
- *Patient-Centered Medical Home (PCMH) Initiative:* KS-SHCN is providing pilot funding to the University of Kansas in the establishment of their PCMH through the Department of Pediatrics for at risk families and families of CYSHCN. The medical home will address the needs of patients and families through team-based practice and case management. They will provide access to community supports, referrals to medical specialty services and mental health services. Additionally, they will provide access to free legal support for health or school/IEP related matters.

The majority of these programs are pilot programs, intended to provide a gradual reduction in funding, with minimal ongoing support. An evaluation and sustainability plan were integrated into the proposal process, with the expectation that new projects will have this fully developed upon completion of the first funding year, in order to be eligible for future funding. The funding each year will decrease until only a small percentage is being supported by KS-SHCN. This process supported significant cost-savings for the program, with an approximate reduction in contract funds of 5%. Even with many new initiatives and pilots, KS-SHCN awarded approximately $50,000 less overall, without the reduction of services or discontinuing funding for existing contractors. This also included 3 brand new contractors, which accounted for approximately 10% of the funds allocated. Overall, all new initiatives accounted for approximately 20% of the approved funding proposals.

As the most highly identified need by both families and community providers, KS-SHCN staff and partners have developed a new care coordination program. Shifting away from only providing multi-disciplinary clinic services, to an enhanced cross-system care coordination model, is believed to allow the program to serve more families across the state and assure support at the local level. There is also an interest from clinic partners to reduce support for facility-based clinics and increase support for telemedicine and outreach services. This is of great interest and excitement, especially to address the needs of our large rural and frontier population areas.

KS-SHCN began evaluating care coordination models across the nation in early 2014 to develop a care coordination program for the clients on the program. This plan consists of a multi-phase tiered coordination approach that will take several years to fully implement. Phase 1 Care Coordination planning began in the spring of 2014 with the Topeka, Kansas City and Wichita Regional Offices, due to administrative and clinical oversight, working collaboratively to develop a holistic care coordination program. The development team consisted of staff in both administrative, social work, and nursing capacities from various hospital systems and the state agency. This provided robust conversation and a comprehensive approach to development of the overall plan, something that

would work for various systems. Staff identified the primary needs KS-SHCN families face include learning how to navigate healthcare and other systems to best meet their child's needs. Care coordination does not mean doing everything for families but partnering with them to learn systems and feel comfortable and skilled at finding supports to meet their child's needs.

KS-SHCN will partner with families to find, understand and access services and resources at the medical, school, and community levels to make sure they are receiving the services needed to achieve optimal child and family health outcomes. Each family has individual needs and requires services and supports tailored to meet those needs. As partners, the Care Coordinators will work with families to identify needs/wants and develop an "Action Plan." The Action Plan will consist of family/patient developed goals and the care coordinators will provide the level of support they request or identified they would benefit from. KS-SHCN goal is to empower families to feel confident in navigating services and supports, eventually needing less support as time goes on. The care coordinator will be available to all KS-SHCN clients.

Staff met regularly to design the pilot project, which was adapted from the Boston's Children's Hospital Care Coordination model. The Special Health Services – Family Advisory Council (SHS-FAC) members provided input on each aspect of the care coordination project and will continue to do so in the future. An initial assessment of child/family needs will be completed to identify which level of care coordination is needed. At this time the client/family will be assigned to a care coordinator trained to meet their specific needs. Protocols have been set that will not only support family needs, but allow for appropriate data collection to measure a variety of improved outcomes. Training is being held Summer 2015 with a pilot project in the Topeka Regional Office. Training to expand to the remaining Regional Offices will take place Fall 2015 through Summer 2016.

Identified as the second highest priority during the KS-SHCN strategic planning process, family caregiver health is a separate initiative to be integrated into the care coordination efforts. Families shared they find it difficult to take the time to care for themselves and address their own health needs, due to increased responsibilities related to taking care of their child with special health care needs. KS-SHCN, in conjunction with the SHS-FAC, is developing a program to assist caregivers in identifying their needs and steps to address those needs. By assisting caregivers to maintain their health the program is helping them improve their ability to care for their child with special health care needs.

The family caregiver health initiative included identifying and reviewing existing assessments. KS-SHCN selected the Beach Center on Disability, University of Kansas Family Needs Assessment (Kansas tiny-k version) as this most closely aligned with the vision of the program and the wishes of the SHS-FAC. The SHS-FAC has been actively engaged in identifying what needs to be addressed in the family caregiver assessment that will be used, with the Kansas Family Delegate working collaboratively with KS-SHCN staff to adapt this assessment. The goals will be to identify areas of caregiver need and provide appropriate referrals and resources related to the health of the whole family. Care coordination will focus on the needs of the KS-SHCN client, while this assessment focuses holistically on caregiver health. Upon completion, the assessment will be vetted through the SHS-FAC. The family caregiver(s) will complete the assessment and the assigned KS-SHCN Care Coordinator will provide resources, referrals and supports to assist caregivers with their identified needs. Much of this project is under development, but when completed this assessment will be integrated into the care coordination services offered by KS-SHCN.

Based on feedback throughout the KS-SHCN strategic planning process and the Title V Needs Assessment, a need for a family mentor program – where families who have children with similar special health care needs can communicate with each other and gain support from one another – was identified. In a collaborative partnership the SHS programs are working together to develop the Family Support Network. A mentor/mentee data system has been identified to assist with connecting parents, caregivers, or siblings who have similar experiences or needs, including matches based on the child or youth with special health care needs condition or services. The Newborn Hearing Screening (NBHS) Program is currently working with the vendor to customize the data system. NBHS will be

the first to begin implementation of this new program, but will be closely followed by the Newborn Screening (NBS) and KS-SHCN. A mentee parent information form has been developed and approved by the SHS-FAC for use. Policies, protocols, tools, recruitment and trainings for SHS staff and mentee parents will be developed over the next year and offered as part of care coordination services. Significant transition has occurred in the last couple of years within KS-SHCN, with much more planned for the coming year.

Throughout the strategic planning process, while the program was great about collaborating outside of the public health agency with hospitals and doctors, it was clear that the collaboration with internal partners was lacking. Even within the Special Health Services (SHS) Section, little cross-system collaboration was occurring among programs. SHS consists of services to identify and provide services for disability or developmental delay from birth to death through screening, early intervention, care coordination, and direct assistance to families. KS-SHCN is the link among each of these programs, spanning all ages and disabilities and the long-term support system for those served in the other programs. However, two years ago, there was little being done to partner with these programs. KS-SHCN has initiated new collaborative efforts with each of the other programs in SHS: Newborn Metabolic Screening (NBS), Newborn Hearing Screening (NBHS) and Infant-Toddler Services (ITS). A shared position between KS-SHCN and NBS has recently been created and filled with a Care Coordinator to assist with NBS long-term follow up and KS-SHCN Care Coordination for individuals who screen positive for a genetic/metabolic condition through the newborn screen. Program Managers are working collaboratively to develop parent education materials and protocols for referral from NBHS to KS-SHCN and a reciprocal referral process among KS-SHCN and ITS. This is only the beginning of new collaborative relationships among these programs and better services for families.

KS-SHCN was accepted to participate in a Return on Investment (ROI) Learning Collaborative immediately following the 2014 AMCHP conference. Two staff and the Kansas Family Delegate participated in this one day training in DC. Followed by monthly webinars and Technical Assistance calls with ROI experts in the field. The project was scheduled to be completed by the end of July, but the Kansas team applied to continue in the cohort to see the project to full completion. The ROI project selected was to identify if KS-SHCN Outreach Seating Clinics were cost-effective in comparison to the fixed-location clinics. The team chose to look beyond only programmatic cost-effectiveness, and analyze the possible cost-effectiveness for families, through the societal perspective. The research question posed, “Are the Cerebral Palsy Research Foundation (CPRF) outreach seating clinics cost effective in comparison to the Wichita clinic for the SHCN program and the families who attend these clinics?” provided the context and guidance of the ROI project. Upon identification and review of available data sources, staff evaluated what data was missing and how that could be collected. A questionnaire was developed to interview the clinic staff and a satisfaction survey for families. KS-SHCN staff also attended an outreach clinic to speak with the families about their experiences and to identify the gaps/barriers to providing services in an outreach setting. All data was compiled and analyzed with the assistance of the expert advisors and the MCH Epidemiologist.

Findings showed 100% of families reported being very satisfied or satisfied when attending the outreach clinics vs. 93.3% when attending the Wichita clinic. The cost benefit to KS-SHCN would be $3,809.00 savings per year if 4 fixed location clinics were replaced with 4 outreach clinics per year. The overall cost savings for families to attend an outreach clinic vs. a fixed location clinic (Wichita) was $230.00 average per visit. The project was finalized in February of 2015. The Kansas team developed a one page fact sheet and a PowerPoint Presentation to use to teach others in the Bureau of Family Health how to conduct an effect ROI. Additionally, the Kansas team is co-presenting with AMCHP at the City MatCH annual conference this Fall.

KS-SHCN was accepted into Cohort 2 of the Association of Maternal and Child Health Programs (AMCHP) Workforce Development Center (WDC) to address the needs of families of CYSHCN through collaboration, systems integration, and increased capacity for telemedicine/telehealth. The target population includes Kansas CYSHCN and their families in rural communities. The primary objective of this project is to increase capacity for utilization of telemedicine in rural communities. The project will support health transformation through improved access to care and systems integration. Utilizing quality improvement and evaluation, KS-SHCN strives for sustainable and

systemic changes for the CYSHCN population. To better meet the unique challenges of CYSHCN and their families, this project will build partnerships and engage key stakeholders to increase capacity for integration, collaboration, and systems change. The leadership team of this project consists of the state Title V CYSHCN Director and KS-SHCN Program Manager as co-leads and includes representation from Medicaid/KanCare, a community hospital partner, and coordinator for the HRSA Regional Telehealth Resource Center.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Services and supports promote healthy family functioning.	6.1 Women and families show evidence of healthy relationships and life skills that support daily family functioning through improved outcomes on annual Healthy Babies are Worth the Wait/Becoming a Mom program evaluations 6.2 Provide opportunities that promote and support informed, engaged, and empowered families as evidenced by increased referral and service delivery as collected in annual program data 6.3 Align home visiting programs	6.1.1 Address family functioning in all MCH contacts 6.1.2 Utilize the Kansas Special Health Care Needs (KS-SHCN) “Family Caregiver Assessment” to identify needs and resources for family members of clients 6.2.1 Utilize peer and social networks for women including to promote and support access to preventive health care 6.2.2 Develop a progressive family leadership program to empower families and build strong MCH advocates 6.2.3 Provide family and sibling	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks)	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	and expand services to ensure families are matched to services that meet their needs	peer supports for those interested in being connected to other families with similar experiences 6.3.1 Using an evidence-based model, provide parenting resources and mentors for adolescent caregivers 6.3.2 Redesign the universal MCH Home Visiting program to serve more families 6.3.3 Replicate MIECHV central intake model across the state to support appropriate referral and level of service/intervention	Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very			

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			good health			
Professionals have the knowledge and skills to address the needs of maternal and child health populations.	7.1 Build MCH capacity and support the development of a trained, qualified workforce serving Kansas children and families by providing professionals with up-to-date best practices and evidence-based services using a multi-faceted approach (referral network, mid-level training for home visitors, partnership support) 7.2 Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs population into adulthood 7.3 Ensure	7.1.1 Increase knowledge of Maternal Child Health 7.1.2 Professionals are up to date on best practices and evidence-based interventions and services 7.1.3 Improve coordination with the Center for Population Health specific to workforce development for primary care, etc. 7.2.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN. 7.2.2 Host webinars and online trainings for health providers on caring for CYSHCN,	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37,	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	availability of on-going, up to date education and training opportunities that promote consistent messages and curriculums for child care providers in Kansas aimed at the social-emotional development of children	adapting from the Caring for People with Disabilities course. 7.2.3 Partner with NAMI to offer youth and adult education programs to KS-SHCN clients 7.3.1 Make available and provide training to child care providers 7.3.2 Consistent messages across all entities working with early childhood (coordination)	38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health			
Information is available to support	8.1 Partner with existing programs (pediatricians,	8.1.1 Determine appropriate avenues for				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
informed health decisions and choices.	youth programs, local schools) to increase understanding of parents and teens as to the importance of and making informed decisions about healthy choices and regular self-care 8.2 Collaborate with local school districts to implement and provide youth-focused initiatives and curriculums that include progress measures so families are better equipped to advocate for all needed services, supports, and family/professional partnerships to achieve successful and healthy transitions	reaching children in middle childhood (ages 6-11) to empower them to make informed choices about health and wellness 8.1.2 Provide resources to increase education/ knowledge of healthy decision-making 8.1.3 Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence [avoiding risky behaviors], more easily available to youth and their families. 8.2.1 Distribute				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	8.3 Assist individuals and families with navigating the health care system to locate, evaluate, access and utilize appropriate health care coverage and services	The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution to children as part of orientation – incorporate into assemblies, school counselor classes, etc. 8.2.2 Provide youth-focused and youth-driven initiatives to support successful transition, self-determination and advocacy 8.2.3 Provide opportunities for parents to improve their skills in seeking out quality health-related information and services 8.3.1 Provide support to local health departments in providing services in alignment with health transformation, including insurance enrollment and				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		outreach 8.3.2 Identify opportunities to optimize health transformation in maximizing service delivery to families 8.3.3 Educate MCH staff				

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

Several state MCH priorities focus on needs and actions the cut across several, if not all, population health domains.

PRIORITY 1 specifically aims to address ***smoking in the home***, with the main program effort focused on expanding the Healthy Babies are Worth the Wait/Becoming a Mom (BAM) programs and integrating smoking cessation education, referral, and services. Special emphasis on the linkage between smoking during pregnancy/in the home with increased risk for infant mortality, especially SUID and SIDS, will be integrated into the BAM prenatal education curriculum content. Additionally, the MIECHV Program collects and reports data for the Maternal and Newborn Health Benchmark construct: Percent of enrolled pregnant women and mothers who are screened for alcohol, tobacco, and illicit drug use. Data on smoking in the household of enrolled families is also collected. MIECHV service providers offer information, referrals, and support to participants addressing smoking, alcohol and drug use. The Infant Mortality Collaborative Improvement & Innovation Network (CoIIN) initiative addresses this priority and domain. KDHE along with several partners and organizations including the March of Dimes and Kansas Infant Death and SIDS Network is actively engaged in the infant mortality CoIIN initiative, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. During the next 6-12 months, action plans, change ideas, and interventions will be tested and implemented in pilot sites and replicated across the state. Targeted pilot sites are local health departments and clinics in Crawford, Geary, Saline, and Sedgwick counties. Goals, objectives, and change ideas for the Kansas priorities/selections follow. Kansas is specifically interested in promoting and implementing three evidence-based programs/interventions: Quitline (KanQuit), BABY & ME - Tobacco Free (BMTF), and the Smoking Cessation & Reduction in Pregnancy Treatment (SCRIPT) Program. Kansas is planning a BMTF training for August 2015.

SMOKING CESSATION (primary focus: reduce smoking before, during and/or after pregnancy)
Goal: By July 2016, we will reduce the rate of smoking in women in their reproductive years by 10% with emphasis on before, during, and after pregnancy.

- Increase the percentage of women who stop smoking during pregnancy by 10%
- Increase the percentage of women who maintain cessation after delivery by 10%

- Increase the number of women enrolled in Quitline in reproductive years (15-44 years of age) by 10%
- Increase the number of providers trained on the 5A's of tobacco cessation by 10%, implementing a provider reminder system and the KS Quitline fax referral system
- In pilot sites: increase the percentage of smoking women who are referred to smoking cessation counseling and programs like Quitline to 95% or higher

Change Ideas:

Providers and support personnel refer women to evidence-based programs like Quitline

- Screen for smoking at every visit and make referrals at the time of screening
  - Cessation counseling
  - Evidence-based interventions (Quitline, Baby and Me-Tobacco Free, SCRIPT--Smoking Cessation and Reduction in Pregnancy Treatment--Programs)
- Follow up with women referred to stop smoking, inquire and refer again with advice
- Refer college age women and adolescents to evidence based support services like Quitline

Women in child bearing years avoid smoking or stop and stay quit

- Use media, social media, texting, videos, peer to peer mentoring
- Consistent, repeat messages about tobacco and nicotine across all systems
- Use of 5As and motivational interviewing techniques to help women commit to stop and stay quit

Providers recognize role in coaching and supporting women to stop and stay quit

- Providers trained in smoking interventions and aware of resources/interventions
- Put toolkits (screening, referral, resources, programs) in the hands of providers
- Enlist support of pediatricians to inquire about smoking, counseling, referrals postpartum

PRIORITY 2 focuses on services and supports to promote ***healthy family functioning***. Parents and providers indicated that family functioning was contributing to stressors across all population domains. Lack of services were an issue, but the bigger issue was lack of knowledge of services and stigma. Plans to address this priority need include:

- Addressing family functioning in all MCH contacts (importance of routines such as meal time and bedtime)
- Promoting the importance of partners (including men and fathers) as active participants in health matters
- Educating on the importance of future planning as it relates to building strong relationships and health and family considerations (spacing of children)
- Utilizing the Kansas Special Health Care Needs (KS-SHCN) “Family Caregiver Assessment” to identify needs and resources for family members of clients
- Providing education for families of children and youth with special health care needs as to how their role as a caregiver impacts the their own health and ability to care for their loved one
- Utilizing peer and social networks for women including to promote and support access to preventive health care
- Developing a progressive family leadership program to empower families and build strong MCH advocates
- Providing family and sibling peer supports for those interested in being connected to other families with similar experiences (*Foster Care, Special health care needs, other)*
- Using an evidence-based model, provide parenting resources and mentors for adolescent caregivers

PRIORITY 6 resulted from the consistently voiced need for ***trained, qualified professionals*** to deliver services across the MCH population domains. When asked what could improve services within the community, responses included, “having trained professionals who take the time and listen to our needs.” Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and

the health impact that it may have across populations. In order to address this need across MCH population health domains, the Title V program seeks to:

- Increase knowledge of Maternal Child Health and build the workforce/capacity by utilizing the *MCH Navigator* and MCH Competency Assessment at the state and local levels
- Provide professionals training on best practices and evidence-based interventions/services*
- Improve coordination with the Center for Population Health specific to workforce development for primary care, etc.
- Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN
- Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course
- Promote through conferences, grand rounds, webinars, etc.
- Partner with NAMI to offer youth and adult education programs to KS-SHCN clients
- Reduce stigma through community awareness and education, including parent and client education materials about behavioral health
- Make available and provide training to child care providers

*State MCH staff are looking to learn more from the Geary County Healthy Start/*Delivering Change* model related to the implementation of the *Lemonade for Life* ACEs screening protocol, developed by experts at the Iowa Department of Health and the University of Kansas. This information and program implementation plan will then be shared with other local grantees, to be adapted for incorporation into other community partnerships and programs. This, along with concentrated efforts around fatherhood involvement, are key areas of focus and planning for inclusion in the HBWW/BaM program across the state in the upcoming year. State MCH staff dedicated to the development and expansion of this model will be working closely with HBWW/BaM program sites and the Geary County Healthy Start/*Delivering Change* program, to ensure that successful models do not remain in isolation, but instead are shared and replicated in other communities across the state of Kansas.

Related to the issue of training for providers is that of health literacy for consumers of MCH services, the focus of **PRIORITY 8**. Individuals who utilize Title V services understand the importance of making informed decisions about regular self-care as evidenced by annual increases in preventive health measures (developmental screening, well-woman visits, and medical home). Priority 8 was identified to address the overall needs related to health literacy in the state. Empowering individuals to coordinate their own health care was approached as a cross-cutting priority so that even the very young can understand and practice self-care as well as have a continued awareness into adulthood. Issues such as immunizations, well-woman care, provider availability, qualifying for care, and even showing up for appointments were raised as examples of the need for individuals to understand the systems, have support to help navigate systems, and practice routine care. Understanding the importance of personal health, how to find services, and how to navigate the health care system promote lifelong habits for well-being. Supporting MCH populations to make ***informed health decisions and choices*** can lead to the reduction of or prevention of many of the health issues identified. The Title V Program specifically seeks to:

- Determine appropriate avenues for reaching children in middle childhood (ages 6-11) to empower them to make informed choices about health and wellness
- Provide resources to increase education/ knowledge of healthy decision-making
- Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence [avoiding risky behaviors], more easily available to youth and their families
- Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution to children as part of orientation – incorporate into assemblies, school counselor classes, etc.
- Provide youth-focused and youth-driven initiatives to support successful transition, self-determination and advocacy

- Provide opportunities for parents to improve their skills in seeking out quality health-related information and services
- Provide support to local health departments in providing services in alignment with health transformation, including insurance enrollment and outreach

Cross-Cutting/Life Course - Annual Report

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.8	10.3	9.8	9.3	8.9

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.5	21.8	20.2	18.8	17.4

Considering this is a new MCH population domain effective FFY 2016, activity and programming planned for this domain will be monitored over the next year and incorporated into the annual report component of the FFY 2017 application.

Strengthening family resilience has been a common goal among all MCH related programs at the state level in the past year. Great effort has been made by KDHE to create an awareness among local grantees of the need for focused initiatives in this area. At the annual Governor's Public Health Conference, both keynote and break out session speakers presented on fatherhood initiatives, risks related to toxic stress, and trauma informed care. Many local grantees have been partnering with other community agencies, referring into early childhood and parenting support programs. Focus on kindergarten readiness, centering around the social emotional health of the child, is a part of collaborative efforts at the community level, as highlighted by partnerships in the HBWW/BAM collaborative models in Saline and Reno counties. As a part of the Healthy Start/*Delivering Change* initiative in Geary County, the Adverse Childhood Experiences (ACEs) Screening Tool and the Protective Factors Survey have been implemented as a part of the role of the OB Navigator.

Other Programmatic Activities

Comprehensive Data Collection System: The Bureau of Family Health entered into an agreement with the University of Kansas Center for Public Partnerships & Research (KUCPPR) for 1) development of a superior performance management infrastructure, 2) training and technical assistance, and 3) analytics to allow for the best use of data to improve accountability and continuous quality improvement for best practices at the state and local levels. The scope of work centers on a phased approach to building necessary data and analytics infrastructure to support KDHE's vision for integrated and coordinated community-level maternal and child health initiatives through

the *Data Application and Integration Solution for the Early Years (DAISEY)* system. This agreement is responsive to a primary objective of incrementally designing and building components of a community-level performance management system for coordinated maternal and child health services. KUCPPR currently has more than 50 grants in the areas of early childhood, child welfare, child abuse/prevention, K-12 education, and at-risk families. KUCPPR has extensive experience providing performance management solutions and technical assistance for states implementing home visiting and early childhood programs under federal (MIECHV) and state funding initiatives. KDHE and KUCPPR have a history of strong collaboration, working together on multiple early childhood programs. The team lead is KUCPPR's Associate Director and will serve as Principal Investigator for this project by providing overall conceptual design, implementation supervision, and quality assurance on deliverables. The Associate Director serves as Principal Investigator for four large-scale state performance management solution projects that implement *Research Electronic Data Capture (REDCap*) and *DAISEY* to assist funders in the analysis, monitoring, and measurement of grantee/site performance on outcome indicators. The system is scheduled to be piloted by August 2015.

Kansas Maternal & Child Health Council: The Maternal & Child Health Council will undergo organization and structure changes over the next year, beginning with vendor and membership changes effective September 2015. The Bureau of Family Health will continue to partner with the Kansas Chapter of the American Academy of Pediatrics (KAAP) to convene, facilitate, and provide ongoing support for the panel of experts, referred to as the MCH Council. The Council is comprised of a multidisciplinary team of professionals with expertise in maternal and child health. The council members are identified and, in consultation with KDHE, selected to serve on the Council by the KAAP.The Council members provide their expertise to KDHE on issues pertaining to women/maternal, perinatal/infant, child and adolescent health in Kansas. KDHE will serve as a data resource to the Council in assessments of maternal, child and adolescent health status, health outcomes, and provider/service availability. KDHE will collaborate with KAAP staff to set the agenda and transmit recommendations of the Council as appropriate to program directors and/or policy makers to effect needed change. KAAP will recruit pediatricians, obstetricians, gynecologists, family physicians, certified nurse midwives, mid-level and specialty providers and other professionals with maternal and child health/medical expertise to serve on the Council. In addition, KAAP will, in collaboration with KDHE staff, recruit family representatives to serve as Council members. The Council will be convened least four times annually for full-day meetings that require large group as well as small group coordination and facilitation (four work groups aligned with the MCH population health domains). This will ensure the work of the Council remains focused on and in line with the needs assessment and State Action Plan for all population health domains. KAAP will consult with KDHE staff on an ongoing basis regarding emergent issues in MCH, for both clinical and public health systems. KAAP will assure online access to MCH information for the public to increase awareness and understanding of Title V block grant, services, and overall MCH priorities; a means for Council members to access member and other related information and documents; and a forum for partners and professionals to provide ongoing input (sharing and learning) at the state and local levels. All information provided at Council meetings and via the online sources will be incorporated into discussions and inform issues to be discussed/addressed.

Kansas Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: MIECHV continued with both annual formula fund and competitive development grant funds administered by KDHE BFH. Additionally, the state was awarded a new FY'15 Competitive Expansion Grant award of $9.4 million for the period of March 1, 2015 through September 30, 2017. In the targeted at-risk communities - Wyandotte County (urban Kansas City, Kansas) and Montgomery, Labette, and Cherokee counties (rural southeast Kansas) - Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs and, in Wyandotte County specifically, a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants Endangered by Substance Abuse (TIES) Program continued. From January 2012 through March 2015, 830

pregnant women and families with infants and young children have been enrolled and provided home visiting services. Training and consultation and other innovative evidence-based practices have been provided for staff to enhance effectiveness with identifying, engaging, serving and referring families with mental health and substance abuse concerns, and families with diverse cultures and languages. Coordinated outreach and referral systems in both targeted areas have been enhanced. A comprehensive, cross-program data collection and reporting system managed by the University of Kansas Center for Public Partnerships and Research has been implemented using common indicators and measures for required benchmarks and continuous quality improvement. Third-year performance data reported in October 2014 demonstrated improvement in all six benchmark areas (29 of 35 constructs). Implementation of the state home visiting strategic plan is underway.

Early Childhood Comprehensive Systems: In August 2013, KDHE was awarded a three-year Early Childhood Comprehensive Systems: Building Health Through Integration (ECCS) grant. Named the Kansas Initiative of Developmental Ongoing Screening (KIDOS), the project goal is to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers (birth to age three) across early childhood support systems at the state and local levels including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs and families. The University of Kansas Center for Public Partnerships and Research is contracted to assist with project coordination and evaluation. A pediatrician-chaired state work group provides expertise and guidance for the KIDOS project. Using the Collective Impact framework, a comprehensive community toolkit has been developed to provide resources, tools, and guidance to communities coordinating comprehensive developmental screening systems. Technical assistance will be provided to community implementation teams. Expansion of statewide capacity to provide quality training on the Ages and Stages Questionnaires (ASQ-3™ and ASQ: Social-Emotional) is underway. The KIDOS project will also enhance data collection systems for developmental screenings and referrals, and evaluate system and quality improvements.

Child Care Licensing: A 14-county Town Hall Tour was conducted from February 2014 through April 2015 with approximately 500 in attendance. Information regarding available services such as; newborn screenings, special health care needs, WIC, Part C and the Kansas Resource Guide was provided. The “Breastfeeding Friendly” initiative and oral health initiative (Healthy Smiles) were introduced and providers were encouraged to participate in available trainings. 50 Preventing Obesity in Child Care Facility books and 30 *Caring For Our Children* books were given as door prizes to encourage healthy eating and best practices in child care facilities to enhance the health of Kansas infants, children, and adolescents. In May 2015, CCL in collaboration with Health Promotions sent Sun Safety information, “Don’t Fry Day” and sun safety information sheets to all licensed providers and made the literature available on our web page.

Local Public Health (LPH)/Center for Population Health: The LPH program, in partnership with Title V, accomplished the following:

- Collaborated in and promoted quality improvement and performance management activities available to all 100 local health departments in partnership with state agencies and organizations in work toward strategic planning and accreditation application readiness;
- Coordinated a year-long accreditation readiness project, Kansas Accreditation Readiness Project, in which 17 local health departments participated. Participants reported they are more prepared to pursue accreditation;
- Promoted awareness and attainment of public health accreditation standards and quality improvement concepts by incorporating and defining targeted content in technical assistance visits, regional public health meetings, *Connections* publications, educational programs such as the Governor’s Public Health Conference, and monthly statewide KDHE public health “briefing” calls as well as by posting resources on the Local Public Health KDHE webpage;
- Provided extensive support for the Kansas Governor’s Public Health Conference including provision of

logistical support to deliver quality content for the public health workforce. A system was developed to provide scholarship funding to local health departments representing all regions of the state. The conference included specific content on maternal and child health as well as workforce development.

- Convened and conducted 18 regional meetings for local public health agency administrators (and/or staff) held in locations in the six KDHE districts of Kansas for the purpose of furthering statewide collaboration on public health topics. MCH, WIC, and Family Health initiatives including the needs assessment and state action plan were discussed and shared at the meetings.
- Coordinated monthly Population Health calls for the purpose of providing updates to local public health staff across the state
- Provided technical assistance to local health departments to identify, integrate and enhance evidence-based practices that directly impact Maternal Child Health (MCH), Family Planning (FP) and School Health programmatic priorities.
- Provided support for Kansas Health Matters, which underwent extensive updates and revisions during this time period. The website provides data related to health concerns in communities and actionable information for community health improvement in Kansas using county, regional and state health indicators. In addition, the site provides tools and resources for community health assessment, community health improvement using evidence based and promising practices, as well as health news.
- Assisted local health departments and other stakeholders with community health assessments, community health improvement plans, and strategic planning. Partnered with the Kansas Health Institute to provide training, technical assistance and minigrants to local health departments.

The agency adopted a new system in 2014, Catalyst, for all online funding announcements, application completion, fund awarding and tracking, activity reporting and progress monitoring. This system change impacts all Bureau of Family Health Aid to Local programs including Maternal & Child Health (MCH). The last year has involved intensive, ongoing work related to system configuration (functionality/development/testing), user recruitment, and training. The MCH program revised all grant guidance, including the MCH Service Manual, as a result of the centralized application/reporting system and held multiple webinars to support existing and new grantees with submitting applications for funding via the new electronic system.

Healthy Families Services: Healthy Families Services (HFS) funding began in SFY 2006 as a budget enhancement to KDHE for the purpose of expanding healthy families services in Wyandotte and Geary Counties. The purpose of the program was to reduce health disparities for women and children through the provision of nurse case management for high risk families. The grant continues to address the issue of reducing health disparities with a current focus on reduce infant mortality rates in Geary and Wyandotte counties. A variety of social and health services may be provided directly to individual participants utilizing a public health, targeted case management model. Funds may also be used to draw down Medicaid dollars to support or expand services. Grantees receiving HFS funds must engage in collaborative partnerships with related community providers to ensure the services provided are those needed by the program participants and integrated with other community efforts. The programs served 311 women and 261 children in SFY 2014 and project similar service/enrollment numbers for SFY 2016.

Pregnancy Maintenance Initiative (PMI): The Senator Stan Clark Pregnancy Maintenance Initiative (PMI) program (K.S.A. 65-1, 159a) was first established during the 1999 Kansas legislative session. The purpose of the program is to award grants to not-for-profit organizations for services to enable pregnant women to carry their pregnancies to term. PMI services are based on a case management model that incorporates an integrated, collaborative, and multi-disciplinary provider approach for the provision of a continuum of care during the pregnancy and for six months post-delivery. This approach minimizes duplication or fragmentation of services. The service model promotes public/private partnerships to facilitate the availability and ready access to affordable and appropriate care, thus improving the potential for a positive pregnancy outcome for the childbearing woman and infant. KDHE receives state general funds to support PMI programs at the local level. Grantees provide a dollar for dollar match of all funds

awarded by KDHE. In SFY 2014, 5 local programs received funding and the number of women served was 297. In SFY 2015, funding was provided to 7 local programs and the actual number of pregnant women served is expected to increase. During the next year, program enhancements are planned to improve the data collection and reporting components, including reporting women and adolescents separately.

Other noteworthy Family Health/MCH Accomplishments:

- Staff Secure Facility Regulations: The Bureau partnered with the Attorney General's Office and Kansas Department for Children and Families to successfully promulgate and implement new regulations pertaining to the licensure of Staff Secure Facilities (March 2014). Staff Secure Facilities are intended to meet the health and safety needs of child victims of human trafficking. The regulations were necessary to implement provisions of Senate Substitute for House Bill 2034. KDHE licensed the first Staff Secure Facility for housing victims of Human Trafficking in 2014.
- The Kansas Newborn Hearing Screening Loss to Follow-Up (LFU) rates have decreased from 82% in 2007 to 5%, far below the national average of 35%. The rate dropped from 13% to 5% in the last year. Strategies to reduce the percentage of infants not completing the process have been implemented over the past 6 years. These strategies have proven to have a positive impact on reducing the lost to follow-up rate through 2013. Examples of these strategies include: hospital site visits, partnership and collaboration on local and state levels with WIC, Medicaid, Healthy Start Home Visitors, Early Interventionists, and Audiologists. According to the 2012 CDC Hearing Screening & Follow-Up Survey, Kansas ranks 6th in the lowest refer rates throughout the United States/territories.
- The child care licensing online application usage has increased from a total of 1,000 applications 2013 to a combined total of 2,339 online applications (1889 renewal; 450 initial) received in 2014. More than half of all state licensing applications are now submitted via the online portal. The ability to submit an initial or renewal application online provides better customer service and reduces the length of time necessary to process an application. Additionally, the online process steam lines program workflows, increases efficiencies related to background checks, and reduces processing time. The number of online child care compliance searches was at an all-time high in 2014 since the launch of the Online Compliance Information Dissemination System (OIDS) in 2012. Utilization of the system continues to grow due to the fact it is a key resource that supports Kansas parents in making informed child care choices that best meets the needs of their family.
- Development of additional emergency preparedness resources for child care providers and facilities including a guidance policy clarifying the essential components of an emergency plan and online emergency preparedness resources to support licensees in their efforts to provide for the health and safety of the children in their care.
- Nutrition & WIC Services provided breastfeeding information to 20,890 pregnant women and breastfeeding support services to an additional 12,530 women for a total of 33,420 women.
- Kansas Infant-Toddler Services, Early Intervention Program was chosen this year to present a poster about the newly developed New Coordinator Training at the 30th Annual Division for Early Childhood (DEC) of the Council for Exceptional Children (CEC) International Conference on Young Children with Special Needs and Their Families.

II.F.2 MCH Workforce Development and Capacity

Status of MCH workforce/capacity: The Bureau has experienced vacancies and staff turnover at the state level during the past year, an ongoing challenge. At the time of application, key MCH positions remain vacant: administrative support, Child & Adolescent Health (and School) Consultant, MCH Epidemiologist (with focus on Medicaid population/disparities). During a time of vacancies and loss of institutional history/knowledge, success and growth of Title V can be attributed to stronger commitment and focus on essential (core) functions, thoughtful planning, increased coordination and collaboration, and willingness to change the approach and address needs in

new, innovative ways. Challenges related to state capacity have driven the need and opportunity to build partnerships and increase/enhance community capacity in each of the population health domains. Recognizing the staff on the MCH team are key to building partnerships at the state level and providing support at the local levels, the new structure has led to improved state-local coordination and alignment with vision. For example, KDHE Title V partnered with the University of Kansas and Kansas State University to conduct the comprehensive statewide needs assessment; jointly presented on the process and needs assessment findings at state and national conferences including Association of Maternal & Child Health Association (AMCHP) (2014), Kansas Governor's Public Health Conference, National Association of County and City Health Official (NACCHO) (2015), and Kansas Public Health Association Conference (2015).

Capacity to coordinate and address MCH population domain needs/emerging issues: The programs and services delivered by local agencies are designed to address ongoing needs and those identified as part of the most recent needs assessment. Services are to be in compliance with Title V legislation and in accordance with the Kansas MCH Services Manual. An MCH Coordination Team was convened in 2013 and meetings continue monthly to monitor progress of the state action plan. Members are representatives from MCH, WIC (including the state breastfeeding coordinator), SHCN, Family Planning, Part C, Newborn Screening and Hearing Screening, and epidemiology. The purpose of the work/coordination is to support BFH and Title V mission. Key concepts include: Systems building, family involvement, population based, coordination systems of care, health equity, and life course. The Team goals are: Optimize Bureau resources, funding and personnel to maximize the impact of maternal and child health services, improving the health of Kansas women, children, and families; Align work and efforts with agency, Bureau and MCH missions, essential duties, and mandates with focus on MCH priorities and measures; Focus on the Life Course health perspective, taking into consideration factors impacting an individual's health in every stage of life, not just one (infancy, childhood, adolescence, childbearing age, elderly); Effectively use data to inform policy decisions and resource allocation, increase program impact, and apply continuous quality improvement; Focus on program and service integration where appropriate and necessary for moving work forward to support reaching and improving health outcomes; and Ensure Title V-funded projects "assure" services and are family-based, community centered, and integrated into the ongoing system of coordinated care for children and families. The meetings have resulted in improved communication, increased coordination across programs including MCH, and surveys/projects/agendas reflecting collective, broad input.

Capacity to collect and analyze data: Jamie Kim has served as epidemiologist since 2003 and also serves as the State Systems Development Initiative (SSDI) project director. She provides epidemiological support for MCH and affiliated programming. Her priority job assignments focus on pregnant women and infants, CYSHCN, and WIC. An identified need is increased epidemiology capacity; the Title V program is actively working to recruit a second MCH epidemiologist. An application for a CDC assignee is pending. Kari Teigen, MPH(c) is a GSEP fellow (HRSA-sponsored Graduate Student Epidemiology Program) that joined the Family Health/Title V team in May 2015. This program offers paid internships in state and city health departments to graduate students in public health by providing training in MCH epidemiology. Kari will create a profile of the selected life course indicators and preconception health indicators for the state of Kansas. The process of the project is to analyze data from the 2011/12 National Survey of Children Health (NSCH) and Behavioral Risk Factor Surveillance Survey (BRFSS) from 2011-2013 to provide a profile of the chosen life course indicators and preconception of health indicators. For all the indicators she will evaluate the prevalence of the risk or protective factor and stratify by relevant demographic variables, and make comparisons between Kansas and the rest of the United States, excluding territories. She will create baseline data for 2011 and monitor trends for indicators using BRFSS. Furthermore, she will use BRFSS Kansas specific data to look at different peer groups (e.g. urban, semi-urban, densely settled rural, rural and frontier). The product of this project will be used for on-going needs assessment, MCH Block Grant, State Systems Development Initiative Grant and the Kansas Maternal and Child Health Biennial Summary, 2016. The life course indicators chosen to be analyzed are as follow: adverse childhood experienced among children, prevalence of

children with special health care needs, diabetes, children exposed to second-hand smoke at home, hypertension for woman of reproductive age, obesity in both children and adults, cervical cancer screening, medical home for children, inability or delay in medical care or dental care for children, oral health preventive visit for children and mental health among adults. The preconception health indicators chosen to be analyzed are as follow: health status, educational status, current health-care coverage, routine check-up during the past year, recent papanicolaou test, current smoking status, fruit and vegetable intake, overweight body mass index, obesity in women of reproductive age, participation in recommended levels of physical activity, frequent mental distress, diabetes, hypertension, asthma and influenza vaccination during the preceding year.

Workforce development: The Kansas Department of Health and Environment is working towards accreditation. As part of that process, the agency must develop a workforce development plan for all of its employees. At least one representative from each Bureau was selected to participate on the group to ensure broad representation. The Kansas SHCN Program Manager was selected to represent BFH. Work centers on developing the agency workforce plan. All workgroup members were asked to begin by reviewing other state and county workforce development plans and identify what could be replicated or modified for the agency. Final completion of the project is scheduled for October 2015. This work evolved from the agency's greater Quality Improvement work which continues at the Bureau and MCH program level. The Title V CYSHCN Director participated in a KDHE-sponsored Quality Improvement Train-the-Trainer program and provided multiple trainings to Bureau staff. The initial training conducted provided an overview of quality improvement, purpose and expectations as an agency and Bureau to do quality improvement, the difference between quality improvement and quality assurance, and how to use various quality improvement tools (e.g. AIM Statement, Team Charters, Flow Charting, Five Why's/How's, and Cause & Effect Diagrams). The training also discussed that there were various uses for quality improvement in our work, such as strategic planning for new projects or services and the implementation, evaluation, and monitoring of existing projects or services. An additional session was provided to individual Sections within the Bureau of Family Health, where Directors and staff were asked to submit information about their selected quality improvement project and the trainer provided additional technical assistance and guidance around different tools that could be used by the programs. Individual technical assistance is made available upon request by the programs.

Family Leaders: In 2013, a new KS AMCHP Family Delegate Program was implemented, including a competitive process to support parent/family leadership development. In Kansas, family leaders are viewed as critical partners in the MCH workforce and the work in Kansas is intentional to support the development of leadership and advocacy skills of youth and parents. The Kansas Family Delegate is supported to attend the annual AMCHP conference in Washington, D.C. and in other MCH leadership opportunities. The Kansas Family Delegate was the first family leader appointed to the National MCH Workforce Development Center's Advisory Committee. She was recently elected as a Family Representative on the AMCHP Board of Directors and accepted into the CityMatCH City Leader program. In addition to supporting participation in nationally recognized leadership programs and in leadership roles, Kansas also provides opportunities for families to enter into the MCH Workforce through engaging families and parents in various councils or initiatives, such as: the AMCHP Return on Investment (ROI) Collaborative technical assistance, as a team member with the State's MCH epidemiologist and KS-SHCN Program Manager; the KS-SHCN Telehealth Project, as a full team member with key stakeholder interested in building state capacity for telehealth; the CoIIN on infant mortality, focused on smoking cessation and preterm and early elective births; and the Kansas Maternal and Child Health Council. The families participating in these initiatives represent the State's focus on providing expanded leadership and partnership opportunities for families, across all MCH programs and services. Family leaders will continue to participate in opportunities as available such as: the AMCHP Family Leader Action Learning Sets (ALS); joint presentations with Title V programs at the state and national level; fostering increased opportunities available to youth, and broader MCH community family representation on existing Kansas MCH Council and other councils/committees; and the development of a formal parent leadership program.

Workforce assessment and development/training needs for state staff: Title V supported staff in the Local Public

Health Program participated in and led extensive workforce development initiatives through leadership and collaboration with the Kansas Public Health Workforce Development Coordinating Council (KPHWDCC). Staff developed and delivered content to further knowledge and understanding related to MCH best practices, Core Public Health Functions, Essential Services, and Public Health Accreditation Board (PHAB) Standards and Measures to entry-level and advancing public health professionals and governing bodies. As part of this work, an extensive assessment was conducted of the Kansas public health workforce. The Kansas Public Health Workforce Assessment is designed to provide: an overall competency assessment of public health staff based at the state and local health departments (LHDs); a data-driven approach to workforce development in Kansas; an accurate picture of the Kansas workforce with extensive demographic information, which will allow workforce development opportunities to be tailored; comparisons of specific workforce segments including rural vs. urban; environmental vs. non-environmental; and small, medium and large local health departments; county-level reports for local health departments and bureau-level reports for the KDHE, which will support documentation required for accreditation through the PHAB, and will allow organizations to target their workforce development efforts; a unique identification of public health competencies perceived by some as not applicable to their positions; a tool for continuous quality improvement.

Members of the KPHWDCC collaborated on the design of the assessment tool in consultation with other states and local health departments in Kansas that had recently successfully completed a workforce assessment. The instrument questions are based on the "Council on Linkages Core Competencies for Public Health Professionals" (Council on Linkages, 2015 http://www.phf.org/resourcestools/pages/core_public_health_competencies.aspx) and are categorized into eight domains: Communication, Cultural Competency, Analytical/Assessment, Policy Development/Program Planning, Community Dimensions of Practice, Public Health Sciences, Financial Planning and Management, and Leadership and Systems Thinking. The workforce was categorized into four tiers: Tier 1—staff who carry out day-to-day tasks; Tier 2—supervisory and/or program management level staff; Tier 3—senior management and leaders of a public health organization; and the newly created Tier A—administrative and facilities support staff. A total of 1,648 respondents completed the assessment with an overall participation rate of 67%. Seventy-six percent of KDHE employees and 61% (875 respondents out of a total of 1,429) of local health department employees participated in the assessment. Twenty-seven local health departments had a 100% participation rate. Additionally, 49 health departments had a participation rate of 75% or above, 69 health departments had a participation rate of 50% or above, and 96% of health departments had at least one participant.

The ultimate outcome of the Kansas Public Health Workforce Assessment is the recognition of workforce competency gaps and the development of effective responses to support and build the capacity of the workforce. Technical assistance was provided in the identification of workforce gaps and strategies for addressing needs and gaps. Training to be developed and provided to address needs/gaps include:

- Health in 3D—which focuses on diversity, determinants, and disparities designed to increase proficiency related to cultural competence. A design team member is a MCH program manager at a local health department.
- Fundamentals in Kansas Public Health—a course which focuses on the 10 essential services from a Kansas perspective
- Kansas Public Health Training Fellowship—a year-long course which will provide a leadership experience and content focused on the Kansas public health system

Local MCH public health workforce development/training: Local Public Health program staff funded with Title V facilitated quarterly meetings in each region of the state (24 meetings per year) at which training is provided to local health department administrators and staff. Title V staff from the Bureau of Family Health and Local Public Health Program provided extensive support for the Kansas Governor's Annual Public Health Conference which included a pre-conference session focused on workforce development and Maternal and Child Health/Family Planning (MCH/FP). The workforce development training was focused on establishing workforce development plans and

individual training plans. The MCH/FP session focused on the Title V Needs Assessment Process/Selected Priorities and NPMs as well as aid to local program requirements, data collection, and reporting. The MCH and FP programs also discussed approaches to coordinating (including cross referral) and integrating services as appropriate at the local level.

The conference featured nationally recognized keynote speakers on topics including the changing landscape of public health, public health ethics, sexual exploitation and human trafficking, and the public health implications of marijuana. In addition, a wide selection of breakout sessions tailored to meet the changing needs of the populations served through public health programs and initiatives were offered. The MCH and Healthy Start Home Visitor sessions focused on baby behavior/infant development, father involvement, substance exposed newborns, and toxic stress. The Public Health sessions will include hot topics in epidemiology, strategies for physical activities and wellness, multi-jurisdictional sharing, public health accreditation, and supporting schools to implement school wellness programs. The Title V Director presented a session on the Public Health Regional Meeting tour focused on the birth outcomes using the AMCHP Compendium as a key resource for planning at the state and local levels. This tour was a primary source for input related to the Kansas Title V Needs Assessment.

Online Training/Tracking via KS-TRAIN: The Local Public Health Program provides administration, technical assistance, user support, and training for course providers of KS-TRAIN. TRAIN is being utilized for MCH professional development/training (registration, delivery, tracking/certificates) in the following ways:

- Healthy Start Home Visitor Face to Face Regional Trainings
- Child Care Licensing Relicensure Webinar
- Child Care Listening Tour
- Family Planning Archived Webinar
- WIC Online Learning (state and national)
- WIC live training opportunities

Specialized training was provided to local health department administrators and staff on program evaluation utilizing the MacMillan Matrix/map. Training objectives included:

- Recognize how to evaluate programs/services across four dimensions: fit/alignment with mission, strength of program, alternative coverage, resource attractiveness.
- Assess programs comparing mission impact to financial sustainability.
- Apply a systematic, more objective approach for strategic decision-making and direction-setting relative to programs and services offered.
- Apply assessment approach to building a business case for potential new programs under consideration.

Additional training planned for the MCH workforce (local and state) include:

- Development of training plans (4th quarter 2015)
- Changes from ICD-9 to ICD-10 billing codes

II.F.3. Family Consumer Partnership

The Kansas Special Health Care Needs Program (KS-SHCN) is involved with many initiatives to engage families as partners and support leadership development. Throughout the KS-SHCN Strategic Planning Process, staff and partners remained focused on assuring any program changes and new initiatives were centered on families and engaging families as partners.

Family Engagement and Partnerships Standards: In support of this focus, the KS-SHCN Program Manager, who also happens to be a parent and grandparent of individuals with disabilities, participated in the development of the

Kansas Family Engagement and Partnerships Standards, an initiative led by the Kansas Coalition for Effective Family Engagement (KCEFE). While the KS-SHCN Program Manager participated, she did so from a Title V standpoint, assisting to bring both a parent and state agency perspective to this collaborative group.

The process began in October 2014 with the development of five (5) core standards were, along with indicators and measurable objectives. These standards are:

1. Families as Foundation;
2. Families as Communicators;
3. Families as Advocates;
4. Families as Partners; and
5. Families as Community Members.

Currently, these standards are being piloted in preselected regions across the state based on income disparities. As part of the core team, KS-SHCN co-presented at a statewide conference for early childhood (birth to 5) providers. Two Special Health Services Family Advisory Council (FAC) members also participated to share their personal experience with parents and FAC members. Upon completion of the standards pilot, KS-SHCN will assist with dissemination of these standards to providers, community partners, but most especially, to families. These standards will become a part of the FAC framework, and be key to the development of future parent leadership programs.

Special Health Services Family Advisory Council (FAC): The FAC is in their 5th year and still a very active part of the work done through KS-SHCN. In May 2014, the FAC was expanded from the Special Health Care Needs (SHCN) to the Special Health Services (SHS) Family Advisory Council. This expansion allows focus on the SHS Programs: KS-SHCN, Newborn Metabolic Screening, Newborn Hearing Screening, and Infant-Toddler Early Intervention (Part C of IDEA). This expanded focus has proven to be valuable in providing additional information and support to the FAC members about broader MCH and CYSHCN issues. Another purpose of this expansion is to support cross program collaboration and wider family representation in those other programs.

KS-SHCN staff serve as the agency lead, with support from the Executive Committee, three FAC members wo assist in the development of agendas, bringing key issues to the table, and overview of FAC operations. The Executive Committee was created to provide an expanded leadership opportunity and allow interested FAC members to be more engaged, in addition to assuring the meetings remained focused on member interests. FAC meetings in the past year and a half have been primarily focused on the KS-SHCN Strategic Planning Process, and most recently, the Title V Needs Assessment. This was upon request by the agency lead, with approval by the Executive Committee. The FAC provided input throughout the KS-SHCN Strategic Planning Process, assisting with: the selection of five new priority areas; developing definitions and parameters around broader priority areas; participating with a larger stakeholder group in SWOT and gap analyses; assisting with the creation of objectives within priorities; and input into final strategies for the KS-SHCN Strategic Plan. The FAC holds the responsibility for assuring KS-SHCN is accountable in moving the strategic plan forward with family/consumer partnership as the central focus.

FAC members are encouraged to engage in community initiatives to support their interests. This can include members participating in local peer support groups, community projects and charitable organizations, research and advocacy efforts associated with their child's condition, and as engaged family members of other state agencies or systems, such as part of the Managed Care Organization (MCO) Consumer Groups. While financial support is not offered for these other activities, encouragement, resources, information, and assistance is available from agency staff liaisons and programs. FAC members engaged in these other efforts will share information on these activities with other members, allowing for dialogue and resource sharing during and in-between meetings.

Another type of direct support provided to FAC members is assistance with developing and delivering presentation to local and statewide audiences. This past year, multiple FAC members presented at various statewide

conferences, including the Governor's Conference for the Prevention of Child Abuse & Neglect. Two FAC members presented independently after receiving support and assistance from the FAC members and agency staff. Other FAC members participated in a panel discussion during the Kansas Division of Early Childhood Conference, with support from the KS-SHCN Program Manager.

Many FAC members have demonstrated interest in legislative advocacy, therefore a guest presenter from Interhab, a statewide association of developmental disability service providers, was offered. Ongoing education and resources are provided based upon trainings by Family-to-Family Health Information Centers. Informational updates are provided by staff and the AMCHP Family Delegate to keep FAC members up to date on anticipated policy changes or need for state or federal advocacy.

In the coming year, the FAC will be assisting in the development of a resource review process. This process was recommended by the FAC and will be implemented by agency staff to assure that the resources promoted through SHS programs are vetted for accuracy, appropriate literacy levels, and relevancy. This process will include input and recommendations from both program staff and FAC members. This will also include an opportunity for FAC members to recommend community partners and providers to be included in the Kansas Resource Guide.

While the last two years has been primarily focused on the KS-SHCN strategic planning, the FAC Executive Committee will resume the planning for agendas and the full FAC membership will begin planning for their selected focus area or project for the coming year. This process generally consists of a planning session in the Summer, identifying individual interests of FAC members, then prioritizing and selection to occur either that same meeting or the following conference calls. Additionally, per FAC requests, agency staff plan to provide MCH/Title V focused trainings, focused on the MCH Core Competencies and parent/professional partnerships. This coming year, the FAC members have expressed an interest in formalizing a network for FAC Alumni, members who have had to leave the Council due to term limits or personal reasons. Continued engagement opportunities will be offered to these seasoned and motivated family professionals, allowing them to continue their contributions and see the impact of their foundational work. Additionally, we hope to nurture their investment and expand the cross cutting community of Title V family and consumer partners.

Family Engagement and Family Delegate Role/Project: A new Kansas AMCHP Family Delegate appointment process was initiated by the CYSCHN Director in 2013 to increase the opportunities for family leadership within Title V and to ensure comprehensive supports and resources are available for delegates. A competitive application process was developed to involve a mentorship plan resulting a mutually agreed-upon project, advancing the MCH/Title V 5-year plan. Delegates are allowed to continue for two consecutive years, if interested. Donna Yadrich was appointed the first delegate through this process (2013-2014) and has continued on as the 2014-2015 Delegate. The Family Delegate also fully participates in the annual block grant review process and during the in-person site visit in 2014, shared FAC updates and input. The Family Delegate will assist Title V in developing a structured family leadership program using national guidelines and standards.

Integration of Family Representation on Kansas Maternal and Child Health Council (KMCHC): Family representation on the statewide MCH Council began May 2014. This council serves to advise the Kansas Department of Health and Environment on cross-cutting issues across the lifespan of Kansas women, children and families. This is the first time a family representative has been present during these meetings, additional family recruitment efforts will take place this coming year with some significant changes to membership and structure of the Council.

II.F.4. Health Reform

Local MCH grantees across the state are embracing the need to support health reform efforts and ensure consumer assistance related to the health insurance marketplace and coordination/collaboration with the Medicaid Managed

Care Organizations (MCOs). A number of MCH grantees employ or refer to Certified Application Counselors and/or Navigators to assist families with acquiring insurance. Additionally, on-site KanCare (Medicaid) Intake Specialists are available to assist with eligibility and enrollment. In most cases, families are screened for medical home and payor source. Clients indicating no medical home/payor source will be immediately referred to a counselor, navigator, or home visitor for assistance. Coordination with the KDHE Outstationed worker/specialist housed is expected. The Outstationed worker can assist with expediting applications for pregnant women (Presumptive Eligible - PE) versus them routing through the clearinghouse until PE is integrated into the eligibility system, reducing the amount of time it takes to receive Medicaid assistance/services. This supports early access to services including prenatal care. Many individuals served are not eligible for KanCare or the marketplace due to immigration status.** In these cases, the health department may provide services to the individual or refer to the federally qualified health center or other safety net/primary clinic for services. Since many uninsured prenatal clients cannot afford to pay private practice physicians for prenatal care, they find themselves utilizing the local public health department as their prenatal medical home.

Kansas did not expand Medicaid and few formal Title V activities have taken place at the state level; however, MCH staff presented information to the group of Kansas Medicaid Outstationed Eligibility/Outreach workers March 2014. Additionally, the Medicaid Eligibility Supervisor presented to the State MCH Coordination team April 2014, sharing changes in Kansas Medicaid as a result of health reform. The Outstationed worker list was distributed to all grantees to support referral and support for the application/eligibility process with a "no wrong door" approach to referral for eligibility/applications support. The state's capacity to address health reform from the context of the National Workforce Development Center's definition* of "health transformation" is higher due to program changes which shift the focus to the integration of public health and primary care, collaborative service delivery models, and from disease management to prevention and population health management.

There is also a shift specifically from direct clinical services to care coordination and family empowerment/self-sufficiency as it relates to special health care needs. Additionally, the focus has historically revolved around a multidisciplinary approach to the provision of services under the medical home approach. As the Title V agency, the Kansas Department of Health and Environment has been working on efforts to integrate traditional health care models (primary, specialty and tertiary care) with public health models. The Kansas Special Health Care Needs (KS-SHCN) program primarily provides diagnostic evaluations, specialized medical treatment services and care coordination. A strategic planning process began in July 2013 to identify new priorities for the program and improved service opportunities for families. Participants were asked to brainstorm ideas on new priorities to be considered by KS-SHCN for the 2020 Title V Needs Assessment. The five adopted priorities include: Care Coordination, Behavioral Health, Family Caregiver Health, Training and Education, and Direct Health Services. Throughout this process, it has been determined the KS-SHCN should support a service delivery model that shift from direct services to more community and population-based, enabling, and infrastructure building activities. In addition to an extensive cost analysis and funding review of direct, clinical services provided through KS-SHCN, the program launched development of a cross-system care coordination model and expansion of clinical services through building telemedicine capacity in rural communities. Primary hospital partners across the state have established varying telemedicine programs. The Kansas University Medical Center (KUMC), Center for Child Health and Development (CCHD) has established, through a grant award from the KS-SHCN program, telemedicine specialty clinics for patients with cystic fibrosis. The Kansas University School of Medicine, Wichita (KUSM-W) has established telegenetic clinics through a Kansas genetic counselor and a pediatric medical and metabolic geneticist in Little Rock, Arkansas. This is a project often supported by the KS-SHCN program and a current initiative is in place to expand the genetic services in this area, utilizing telemedicine and partnerships with providers from other communities and states. Wesley Medical Center has established the Wesley Care Telemedicine Network, including specialty services for neurology and stroke care.

**The National Workforce Development Center's definition of health transformation is reflected throughout Center activities and provides an opportunity for all states/territories, regardless of their environment, to embrace the changes and opportunities to promote maternal and child health. Health transformation:*

- *Shifts the emphasis of health care from disease management to prevention and population health management, while improving access to affordable health care*
- *Develops an interprofessional/interdisciplinary approach to health care*
- *Integrates primary care, specialty care and public health*
- *Develops efficient health systems that better incorporate ongoing quality improvement, and*
- *Drives partnerships across sectors to optimize the well-being of maternal and child health populations.*

***Those prenatal clients that are without U.S. Legal Residence or Citizenship are screened by the Social Workers for eligibility of SOBRA for the cost of emergency services (including labor and delivery). This coverage is available only for those people who would, except for legal status, be eligible for KanCare Medicaid.*

II.F.5. Emerging Issues

The leading issue that emerged through the needs assessment process was community norms. KDHE recognizes that it is not enough to identify and respond to needs, but that as implementation of the 2016-2020 Action Plan continues, more work will need to be done to identify and address underlying norms that prevent access to services, interest in services, and stigma associated with utilizing services. Addressing community norms is one of the guiding principles of our work. To better understand the overall MCH community norms issues, an initial scan was included in the Title V Needs Assessment survey conducted January-February 2015. Results indicate that there is a need for further work in identifying, understanding, and addressing community norms. Ten pairs of questions which were asked to better understand the relationship between individual beliefs and collective beliefs, or norms. This process provides insight into perceptions of key issues that may be barriers to service utilization, to identifying risk factors, or to engaging in behaviors that lead to negative outcomes. In interpreting the results, the mean difference is the difference between mean scores for each pair of questions, or the difference between the average score of what "I believe" and the average score of what "most adults in my community believe." Each of the pairs had a statistically significant difference between the statements, with the exception of health, weight, and nutrition for infants and children. Moreover, two areas that were identified as key components of the Five-Year Action Plan, reproductive health and breastfeeding, are the areas with the largest differences between individual and collective perceptions. These are indicators of lacking of a common understanding of key issues.

II.F.6. Public Input

The Title V Maternal Child Health (MCH) five-year needs assessment is designed to be an opportunity to review data, gather input from stakeholders, build capacity, and identify priorities. The Kansas Department of Health and Environment (KDHE) spent 18 months conducting the needs assessment with an approach focused on not only creating a meaningful, responsive action plan, but also building a strong platform to maximize resources, develop and sustain mutually reinforcing relationships, and deliver outcomes. Early on in the needs assessment, a broad approach was taken in order to capture a wide scope of input from state and local partners using in person meetings and surveys. The input came from stakeholders, local public health, health care providers, educators, consumers, and other community health programs including injury prevention, mental health, and Medicaid. The team covered six regions of the state in person, facilitating MCH regional meetings and attended, facilitated, or presented at three MCH council meetings, the Blue Ribbon Panel on Infant Mortality, and various meetings with stakeholders. The broad

approach continued with three large-scale surveys distributed over nine months. The following provides an overview of the input/data collection process.

Community In-Person Meetings

Activity	Purpose	Domain Focus	Participation	Timeframe
MCH Services Input Survey	Annual feedback to KDHE on MCH services and community needs	All	222 respondents	November 20, 2013-May 15, 2014
Public Health Regional Meetings (AMCHP Compendium served as key planning resource)	Develop partnerships at the local level to improve MCH services; identify needs at the local level related to MCH populations	All	209 (5 meetings)	May 2014-February 2015
Kansas MCH Council	Advise KDHE on MCH issues	Women, Infants, Children, Adolescents	17 attendees 20 attendees 19 attendees	September 2014, December 2014, April 2015
Blue Ribbon Panel on Infant Mortality	Through infant mortality CoIIN, reduce infant mortality in the State	Women, Infants	20 attendees	August 2014
Communities for Kids Meetings	Gather broad stakeholder input on needs of MCH populations; provide opportunity for local communities to connect with KDHE staff	All	253 attendees (17 meetings)	November 2014-February 2015
Adolescent Health Input Survey	Understand needs of youth ages 10-19	Adolescents	854 respondents	Fall 2014
Adolescent Health Focus Groups	Understand needs of youth ages 10-19	Adolescents	401 attendees	Fall 2014
SHCN Strategic Planning Meeting	Identify priority needs and shift work/realign program as necessary	SHCN	110 attendees (4 meetings)	July 2013, August 2013, November 2013, September 2014
Family Advisory Council (FAC)	Collect input from existing council/families	SHCN, Children,	15 attendees	August 2013, November 2013,

Meetings	and consumers with lived experience, especially families providing care for children and youth with special health care needs	Adolescents		February 2014, May 2014, November 2014, February 2015, May 2015
Parent Leadership Conference	Target families and the public, especially parents	All	150 respondents	November 2014
Title V Needs Assessment (Community Norms) Survey	Assess shared understanding of key community issues and beliefs/norms	All	540 respondents	January-February 2015
KDHE MCH State Coordination Meetings	Identify shared priorities and needs; align vision and approach to MCH efforts; align and integrate where appropriate	All Family Health (MCH, WIC, Family Planning, Part C, etc.)	Monthly meetings	Ongoing

The team facilitated 22 regional and community meetings to gain broad public input on the development of priority needs for MCH populations (see Meeting Timeline below). Two forums, Public Health Regional meetings (using the AMCHP Birth Outcomes Compendium as a key resource) and *Communities for Kids (C4K)* meetings, were utilized to gain input from key partners, stakeholders, service providers, and community members. NOTE: several Communities for Kids meetings were held twice at the same location - day and evening.

- October 21, 2014 Regional, Wichita
- November 13, 2014 Regional, Garden City
- December 10, 2014 C4K, Roeland Park
- December 16, 2014 C4K, Great Bend
- December 17, 2014 C4K, Concordia
- January 12, 2015 C4K, Colby
- January 13, 2015 Regional, Colby
- January 14, 2015 C4K, Garden City
- January 21, 2015 C4K, Topeka
- February 10, 2015 C4K, Junction City
- February 11, 2015 Regional, Concordia
- February 19, 2015 C4K, Wichita
- February 25, 2015 Regional, Topeka

- February 26, 2015 C4K, Parsons

Public Health (AMCHP) Regional Meetings

In an effort to collect comprehensive input while also increasing partner awareness, KDHE launched an initiative aimed at improving the health of Kansas mothers and infants. Using a collective impact framework, KDHE partnered with the March of Dimes Greater Kansas Chapter (MOD) and AMCHP to engage more than 200 stakeholders across the state between May 2014 and February 2015. This effort was not exclusively about health care, but instead focused on forging partnerships to collectively and comprehensively address issues families face in the context of their communities throughout the course of life. The primary goal has been to develop collaboration at the state and local levels, assessing what's working and what's not, and utilizing existing resources to guide the process. The MCH project team invited key partners and stakeholders to the AMCHP Regional meetings to participate in the following objectives:

- Assessing MCH supports, services and programs in each region to reveal collective strengths as well as potential service gaps;
- Identifying opportunities to engage new partners and evolve the field;
- Recommending actions to transform regional collaborations based on aligning activities with the Health Impact Pyramid to address individual and population health needs; and,
- Obtaining stakeholder input to inform the Kansas Title V Maternal & Child Health (MCH) priorities for the period 2016-2020.

The Title V Director facilitated day-long meetings with networking and interactive exercises for public health professionals and partners including managed care organizations, early intervention and behavioral health providers, and hospitals; a pre and post assessment; meeting evaluation; and, follow up materials and resources. The group exercises engaged participants in interpreting data, identifying partnership opportunities, reflecting on services in relation to the Health Impact Pyramid, and thinking about promising MCH practices. Tools created for the initiative included an online inventory of services (conducted in advance), assets, priorities, and partnerships. Prior to attending Regional Meetings, participants were asked to review the AMCHP Birth Outcomes Compendium, including the Health Impact Pyramid; the Stanford Social Innovation Review on Collective Impact; and, the Kansas MCH Block Grant Website. It was optional for participants to review local level data and/or identify gaps in service, health disparities, or other priority issues using the Kansas Health Matters. Participants were asked to come prepared to discuss recommendations/actions to be considered for their community.

Communities for Kids Meetings

The Special Health Care Needs (SHCN) Director facilitated "Communities for Kids" forums in nine locations across the state. Keeping in mind children with special health care needs are children first and foremost, KDHE was able to intimately and in detail capture the needs of all children as well as their parents and caregivers. This was an opportunity to learn from families, community and health providers, school professionals, and any member of the community interested in the health of Kansas children to voice the most prevalent maternal and child needs are within these communities. Each meeting consisted of a presentation on the state of SHCN in Kansas as well as the programs goals and philosophy of children first and the Title V needs assessment overview. The community meetings were essentially open forum and group process and comments were recorded by staff. Meeting participants actively engaged in discussing what they believed to be were needs or service gaps relating to each of the five domains. An overwhelmingly number of the meetings engaged participants at the community level and included parents as well as extended family, providers, and educators including home visitors. Families, communities and key partners had the opportunity to share information, experiences, and ideas about how maternal and child health programs can improve support and services in their community for children and adolescents, including those with special health care needs or disabilities. All were invited to attend the meetings to learn more about MCH services and provide input: parents, local officials, advocates, education professionals, and

anyone interested in maternal and child health. Most locations offered two meeting times (2 p.m./6 p.m.) to support participation at the community level.

Title V Needs Assessment (Community Norms) Survey

Addressing community norms is one of the guiding principles of our work. To better understand the overall MCH community norms issues, an initial scan was included in the Title V Needs Assessment survey conducted in January-February 2015. Results indicate that there is a need for further work in identifying, understanding, and addressing community norms. Ten pairs of questions were asked to better understand the relationship between individual beliefs and collective beliefs, or norms. This process provides insight into perceptions of key issues that may be barriers to service utilization, to identifying risk factors, or to engaging in behaviors that lead to negative outcomes. In interpreting the results (540 respondents), the mean difference is the difference between mean scores for each pair of questions, or the difference between the average score of what "I believe" and the average score of what "most adults in my community believe." Each of the pairs had a statistically significant difference between the statements, with the exception of health, weight, and nutrition for infants and children. Moreover, two areas that were identified as key components of the Five-Year Action Plan, reproductive health and breastfeeding, are the areas with the largest differences between individual and collective perceptions.

Title V Block Grant Application/Annual Report Feedback

This survey is intended to collect information, opinions, and perspectives on the DRAFT 2016 Application/2014 Annual Report from consumers and partners across the state that are informed of and concerned about the needs of the maternal and child health (MCH) populations.

Public Comment Period: June 18-July 6, 2015

Methods: The following email was sent by the Title V Director to partners including school nurses, councils/committees/boards, community-based organizations, local health departments, providers, others; the survey link was posted on the BFH website; announcements were posted online, via social media, and in newsletters.

Dear Kansas Maternal & Child Health Partner:
As the Kansas Title V Maternal & Child Health (MCH) Director, it is my pleasure to release the (draft) Kansas MCH Block Grant 2016 Application and 2014 Annual Report. The MCH Block Grant is administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health (BFH). Please take time to review this year's block grant application and provide comments/additional detail you might have to strengthen the application. After reviewing the draft document, we ask that you complete a short online survey (https://www.surveymonkey.com/r/HY95QLT). Please respond to the survey by July 6 in order to ensure that your comments are reviewed and considered for incorporation into the application. The survey and draft application are posted on the KDHE BFH website.

Resources to increase your knowledge about the block grant and Kansas' priority issues for 2016-2020 can be found on the MCH Block Grant website (http://www.kdheks.gov/c-f/mch.htm). Your input is valuable and needed to assure the MCH Program is guided by the needs of Kansas families and MCH priority populations: women of reproductive age, pregnant women, infants, children, adolescents, and individuals with special health care needs. Whether you are a parent, health professional, government official, advocate, or member of the general public, the MCH block grant activities touch your life. Success lies in the strength of partnerships and collaborations to maximize reach and promote efficiency.

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

Results:

A total of 46 responses were received. There were a number of opportunities for partners, families, and the public to

provide feedback related to MCH services and populations. Nearly half (45.7%) provided input through MCH Services Input Survey (Online), followed by Public Health Regional Meetings (AMCHP Compendium) (34.8%), Title V Needs Assessment Survey (Online) (17.4%), Communities for Kids Meetings (13.0%), Special Health Care Needs Strategic Planning Meetings (13.0%), Family Advisory Council Meetings (13.0%), Adolescent Health Survey (Online) (10.9%), MCH Council Meetings (6.5%), Adolescent Health Focus Groups (4.3%), Blue Ribbon Panel on Infant Mortality Meetings (2.2%), and Parent Leadership Conference (2.2%). Eleven (23.9%) responded that they did not provide input.

The majority of the respondents strongly agreed, or agreed that the current Needs Assessment process:

- increased understanding of the Title V MCH Block Grant, initiatives, and services (100.0%).
- was effective for public input (95.3%).
- reflected broad public input (93.0%).
- was accessible (90.5%).
- was reasonable (95.3%).

Based on the information contained in the draft application/annual report, the majority of the respondents strongly agreed, or agreed that they had a better understanding of the state MCH Priorities and plans for population health domains:

- Women/Maternal Health (100.0%)
- Perinatal/Infant Health (100.0%)
- Child Health (100.0%)
- Adolescent Health (10.0%)
- Children and Youth with Special Health Care Needs (97.4%)
- Cross-Cutting/Life Course (86.5%)

The majority responded that the 2016 Application/2014 Annual Report:

- clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities (94.7%)
- demonstrates strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas (100.0%)
- accurately reflects the capacity/work/activities across Kansas as they relate to the state priorities (94.7%)

After reviewing “Five Year State Action Plan” and “Budget Narrative & Forms”, the majority responded that:

- the state action plan and strategies were adequately addressed (91.4%)
- the MCH Workforce Development and Capacity, Family/Consumer Partnership, Health Reform, and Emerging Issues were adequately addressed (94.3%)
- the resource allocation/expenditures were adequately addressed (91.4%)

II.F.7. Technical Assistance

Title V MCH/Medicaid Intragency Coordination & Collaboration: ERO 38 introduced in the 2011 Legislative Session, mandated the merger of the KDHE (Title V MCH State Agency) and the Kansas Health Policy Authority (State Medicaid Agency). Since 2012, the two Divisions have been a part of the same agency. Consultation with a national expert is needed to take steps to strengthen the mandated relationship, especially where data sharing is concerned, and identify collaborative projects aimed at reducing disparities, advancing work/efforts related to shared priorities and needs, improving outcomes, and reducing health care costs. Medicaid and CHIP provide prenatal, labor and delivery, and postpartum services for a large proportion of births in Kansas, covering 37 percent

of all births in 2013. As the largest single payer for maternity care, Medicaid and CHIP play a key role in promoting access to care and ensuring the quality of care during the perinatal period. The Medicaid/CHIP Core Sets of health care quality measures contain nine maternity care measures to help drive quality improvement efforts at the state and national levels. The child Core Set includes six maternity measures (timeliness of prenatal care, frequency of ongoing prenatal care, behavioral health risk assessment for pregnant women, Cesarean rate, low birth weight rate, and well-child visits in the first 15 months of life) and the adult Core Set includes three maternity measures (antenatal steroid use, elective delivery, and timeliness of postpartum care). Two of these measures, low birth weight rate and Cesarean rate, are specified for use with vital records, although linkage to Medicaid/CHIP administrative data is often necessary to identify women covered by Medicaid or CHIP. The state's participation in the Collaborative Improvement and Innovation Network (CoIIN) expansion to reduce infant mortality through improved availability and reporting of timely provisional data to inform efforts and tract outcomes that drive quality improvement and collaborative learning requires the state's abilities to access/use the linked vital records with Medicaid/CHIP administrative/claims data. One of the CoIIN measures, initiation of progesterone in women on Medicaid with prior preterm birth is specified for use of linked vital records birth data and Medicaid/CHIP claims data.

Data Collection and Reporting: Technical assistance is requested to effectively use data to inform program impact and continuous quality improvement. We are seeking technical assistance to address these objectives:

1. Determine objectives and needs to measure program outcomes, improvement, and compliance in accordance with Title V MCH Services Block Grant and other federal and state program requirements and goals.
2. Determine needed measures, indicators, and data elements considering both the present and future.
3. Determine strategies to efficiently and effectively track services, progress, and quality improvement with both programmatic and administrative functions.
4. Determine needed report methods and formats.
5. Identify efficient, effective data system(s) for data collection, reporting and performance management, including potential vendors.
6. Assess costs needed for designing, implementing, and maintaining system.

We are interested in expert technical assessment and advice, examples of states which have successful data collection/performance management systems (with consideration to the size and budget of Kansas), and alignment with new Title V measures as well as other state/federal MCH programs and initiatives in Kansas, and coordination with the Family Planning/Reproductive Health Program who shares the data system. This requested TA will contribute to a more effective approach to measuring and reporting on the State's priority needs/performance measures. Potential results include: Increased effectiveness with data collection and use of data; Improved capacity and efficiencies to track and report outcomes, progress, and quality improvement; Identification and development of effective, efficient and sustainable data system and technology.

Planning and Collaboration with Title X: The KDHE Children & Families Section as of March 2014 includes the MCH Title V and Title X programs. The programs spent several days together with a facilitator to set priorities, goals, objectives, and identify linkages between MCH and Title X/Family Planning. The staff also identified needed resources and potential impact on local agencies and clients/families served. Technical assistance would support continuing this work and further develop the state-level plan to leverage Title X funds and/or increase coordination and collaboration between the Kansas Title V and Title X programs. Once the state has developed a vision/plan for integrating services and programs where appropriate, messaging and activities must take place with the local level grantees/programs. The outcomes would be improved reproductive, maternal, and infant health and a continuum of care and integrated community-based services.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 4,710,420	$ 4,626,932	$ 4,670,131	$ 2,445,517
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 3,972,344	$ 3,562,624	$ 3,972,344	$ 3,527,860
Local Funds	$ 4,710,220	$ 4,775,509	$ 4,190,160	$ 4,403,168
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 13,392,984	$ 12,965,065	$ 12,832,635	$ 10,376,545
Other Federal Funds	$ 70,032,836	$ 72,095,778	$ 70,032,836	$ 78,292,923
Total	$ 83,425,820	$ 85,060,843	$ 82,865,471	$ 88,669,468

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 4,670,131	$ 3,537,640	$ 4,682,822	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 3,722,188	$ 3,625,272	$ 3,524,276	$
Local Funds	$ 4,740,394	$ 4,264,315	$ 4,401,548	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 13,132,713	$ 11,427,227	$ 12,608,646	$
Other Federal Funds	$ 80,287,199		$ 76,927,990	$
Total	$ 93,419,912	$ 11,427,227	$ 89,536,636	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 4,686,020	$
Unobligated Balance	$ 0	$
State Funds	$ 3,567,032	$
Local Funds	$ 4,401,548	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 12,654,600	$
Other Federal Funds	$ 69,994,218	$
Total	$ 82,648,818	$

III.A. Expenditures

The State maintains budget documentation for all Block Grant funding/expenditures for reporting. Expenses are tracked through the state's accounting system, SMART. All federal and nonfederal (state and local) expenditures are tracked and reported separately. Expenditure detail for SFY14 is reflected on Forms 3a and 3b. Similar to previous reporting years, at the time the block grant application was prepared, several months of the current federal budget period remains, so block grant spending and aid to local disbursements for only two (and in some cases three) of four quarters have been made. Final payouts are made in the last quarter of the fiscal year/first quarter of the new state fiscal year. Therefore, what was budgeted for FY14 and what is being reported for FY14 results in more than a 10% variance/difference. This difference can be accounted for by the process by which the Title V program funds local programs and manages Title V funds with authority to spend over a period of two years. The payment process for SFY2016 has been adjusted to pay out more of the local funds from the grant in year one.

2014 Expenditures: The SFY2014 block grant partnership expenditures were updated to reflect actuals based on the state accounting system at the time the application was compiled (reflected on Forms 2, 3a and 3b). The following expenditures were reported: $3,537,640 federal (of the total $4,736,507 budgeted and authorized); $3,625,272 state; and $4,264,315 local for total MCH expenditures of $11,427,227.

At the time of application compilation, the total SFY14, federal spending to support MCH/SHCN initiatives within the state health department included: $16,934 Office of Vital Statistics; $29,477 Local Public Health; $3,372 Health Promotion; and $30,000 to support the agency-wide online application and reporting system for the aid to local programs including MCH. Within the Bureau of Family Health (MCH Section) $541,874 in federal MCH funds was spent for staff and operating costs related to overseeing the MCH grantees/local agencies and aid to local program activities, conducting site monitoring visits, supporting local and state initiatives, and more. Special Health Care Needs (SHCN) staff, operating costs, contracts and supplies total $1,000,956. Direct Services accounted for $104,017 (12%) of the total SHCN expenditures. Expenses for Direct Services are tracked separately through the Kansas SHCN program (effective SFY14) and break down as follows by type of service: DME $9,131; Hospital $18,821; Pharmacy $38,887; Physician/Office $6,965; Lab $102; Specialty Clinic $16,100; and Orthodontic $14,011. MCH Aid to Local payments to providers for services total $1,283,754. Newborn screening follow-up

federal expenditures total $5,785 and $110,038 for Child Care Licensing. Salary and operating for the MCH epidemiologist, director, assistant, and fiscal support total $155,582.

Form 2 reveals the Title V expenditures for FY14 are in compliance with the 30% - 30% requirements: preventive and primary care for children $1,061,832 (30%) and children with special health care needs $1,301,384 (37%), similar to previous reporting periods. Other requirements related to expenditures such as administrative costs (less than 10%) and maintenance of effort are maintained.

Form 3a. Including Block Grant partnership expenditures (excluding administrative costs) totaling $3,387,640 (federal, state, and local), totals by “Types of Individuals Served” (MCH population groups) include: Pregnant Women $2,348,454 (511,987 federal/1,836,467 nonfederal); Infants <1 Year $2,348,453 (511,987 federal/1,836,467 nonfederal); Children & Adolescents 1-22 Years $5,063,356 (1,061,832 federal/4,001,524 nonfederal); and SHCN $1,516,964 (1,301,834 federal/215,130 nonfederal). The SHCN contracts will require a minimum local match beginning SFY15, which will be reported as part of the FFY17 application/FFY15 report.

Form 3b. Including all Block Grant partnership expenditures, totals by “Types of Services” (MCH pyramid) include: $135,270 (104,017 federal/31,253 nonfederal) (1%) for Direct Services; $6,373,876 (1,608,077 federal/4,765,798 nonfederal) (57%) for Enabling Services; and $4,918,081 (1,825,546 federal/3,092,536 nonfederal) (42%) for Public Health Services and Systems. The continued decline of CYSHCN expenditures from Direct Services to other types of services can be attributed to the shift to focus on promoting and supporting other critical services including outreach, education, care coordination, and medical homes. In addition, SHCN strictly adheres to the mandate of Title V as the payer of last resort, and the direct services paid only reflect services that were not covered or reimbursed through another provider. All expenditures are in line with previous reporting periods with no significant variations to be discussed. The state is well within its required maintenance of effort of $2,352,511 with expenditures of $3,625,272 in SFY14. Kansas meets its match requirement through the use of State funds.

III.B. Budget

Kansas Maternal & Child Health (MCH) and Special Health Care Needs (SHCN) Directors provide input into the allocation and budgeting process for the Title V MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based on the State MCH Needs Assessment.

2016 Budget: The total State budget submitted for FY2016 and detailed on Form 2 is $82,648,818. This amount represents the budgeted MCH federal allocation, state contribution/funds, local contribution/funds, and other federal funds under the control of the Title V Director in the Bureau of Family Health. The amounts break down as follows: budgeted MCH federal allocation $4,686,020 (based on the allocated amounts in the State budget and a projected award amount estimated based on FFY14 and FFY15 authorized amounts); state MCH funds $3,567,032; local MCH funds $4,401,548; and other federal funds $69,994,218. Other federal funds totaling $69,994,218 includes $398,223 for Abstinence Education; $10,456,142 for MIECHV ($1,056,142 formula funding; $9,400,000 development funding); $140,000 for Early Childhood Comprehensive Systems; $2,522,000 for Family Planning (Title X); $50,831,875 for Women, Infants, and Children (WIC); $4,217,833 for Part C; $95,734 for State Systems Development Initiative (SSDI); $250,000 for universal newborn hearing screening; $625,000 for Healthy Start; and $457,411 for breastfeeding peer educator.

Form 2. Overall, Kansas' MCH federal-state partnership budget totals $12,654,600. The federal allocation is budgeted to support MCH/SHCN initiatives within the state health department as follows: $27,414 Office of Vital Statistics; $56,603 Local Public Health Program; $10,000 Health Promotion (PRAMS pilot). Within the Bureau of Family Health, $320,512 for staffing, MCH aid to local programming, monitoring, and other operations; $480,745 for epidemiologists, director, assistant, and fiscal support; $1,176,462 for SHCN programming, outreach, care coordination; $130,718 for direct services (not reimbursed by other providers); $150,000 for perinatal community collaboratives (capacity and infrastructure building); and $1,977,940 for local agencies providing community-based, family centered MCH services.

The Kansas budget for FY16 meets the maintenance of effort requirement of $2,352,511.The Title V match requirement is achieved through projected State matching funds budgeted at $3,567,032 which include $36,093 for MCH aid to local services; $237,914 for universal home visiting services delivered by MCH grantees/local health departments; $96,734 for Kansas Infant Death and SIDS (KIDS) Network of Kansas (safe sleep initiatives); $245,000 for newborn screening follow up; $234,400 for SHCN case management and services; $2,114,447 for MCH aid to local programming; $338,846 for Pregnancy Maintenance; and $26,044 for SHCN direct services. Local match is projected to total $4,401,548 (estimated based on total SFY14 match reported by local grantees).

The Title V budget and funding allocations are in compliance with the 30% - 30% requirements: preventive and primary care for children $1,560,389 (33.3%) and children with special health care needs $1,511,975 (32.3%), similar to previous reporting periods (see Form 2). Other requirements related to budget categories such as administrative costs (less than 10%) and maintenance of effort are maintained. The current indirect cost rate for KDHE is 18.75%. Administrative costs charged to the block grant are indirect costs within the 10% limit set forth in federal Title V law. For this budget period, $200,000 is budgeted (4.3%).

Considering the total budget of $12,654,600, Form 3a details the (federal/nonfederal) budgeted amounts by types of individuals served including $2,771,051 (706,828/2,064,223) for pregnant women; $2,771,051 (706,828/2,064,223) for infants < 1 year; $5,320,080 (1,560,389/3,759,691) children 1-22 years; $1,792,419 (1,511,975/280,444) SHCN. Form 3b details the (federal/nonfederal) budgeted amounts of types of services including approximately $156,762 (130,718/26,044) for direct services (1%); $6,985,189 (2,136,431/4,848,758) for enabling services (55%); and $5,512,649 (2,418,871/3,093,778) (44%) for public health services and systems. There are no significant variations in the budgeted amounts reported by the state on Forms 2 and 3, as compared to previous years' reporting.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DRAFT Medicaid HCF-DOH Agreement FFY2016MCHBG Application.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Needs Assessment Regional_Community Meetings.pdf

Supporting Document #02 - Adolescent Exec Summary.pdf

Supporting Document #03 - MCH_SHCN Funding Process.pdf

Supporting Document #04 - SHCN Telehealth Project.pdf

Supporting Document #05 - 2016 Executive Summary_2014 Biennial Summary.pdf

VI. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Kansas

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 4,686,020	$ 3,537,640
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 1,560,389	$ 1,061,832
B. Children with Special Health Care Needs	$ 1,511,975	$ 1,301,834
C. Title V Administrative Costs	$ 200,000	$ 150,000
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 3,567,032	$ 3,625,272
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 4,401,548	$ 4,264,315
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 7,968,580	$ 7,889,587
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 2,352,511	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 12,654,600	$ 11,427,227
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 69,994,218	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 82,648,818	$ 11,427,227
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 4,670,131
A. Preventive and Primary Care for Children	$ 1,550,312
B. Children with Special Health Care Needs	$ 1,444,782
C. Title V Administrative Costs	$ 250,000
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 3,722,188
4. LOCAL MCH FUNDS	$ 4,740,394
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 8,462,582

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 398,223
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 10,456,142
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	$ 140,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	$ 2,522,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 50,831,875
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers;	$ 4,217,833
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 95,734

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start;	$ 625,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Breastfeeding PeerEd;	$ 457,411

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The total amount authorized/budgeted is obligated at 100%; however, expenditures for aid to local payments and other related will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between two budget periods.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The total amount authorized/budgeted is obligated at 100%; however, expenditures for aid to local payments and other contracts/related expenses will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between two budget periods.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Administrative costs will be reflected closer to the end of the current budget period during the next quarter as final federal expenditures are calculated.	
4.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This estimated budget amount is calculated each year based on the total amount of aid to local match county health departments and agencies are putting toward the MCH grant/services. This number fluctuates each year based on local reporting/budgets. The FFY14 actual is lower than anticipated/budgeted as compared to previous years including FFY13.	
5.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**

Column Name:	Annual Report Expended

Field Note:
The total amount authorized/budgeted is obligated at 100%; however, expenditures for aid to local payments and other related will be spent down over the next quarter as the liquidation period closes. Due to the two-year spending authority, aid payments are split between two budget periods.

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Kansas

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 706,828	$ 511,987
2. Infants < 1 year	$ 706,828	$ 511,987
3. Children 1-22 years	$ 1,560,389	$ 1,061,832
4. CSHCN	$ 1,511,975	$ 1,301,834
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 4,486,020	$ 3,387,640
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 2,064,223	$ 1,836,467
2. Infants < 1 year	$ 2,064,222	$ 1,836,467
3. Children 1-22 years	$ 3,759,691	$ 4,001,523
4. CSHCN	$ 280,444	$ 215,130
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 8,168,580	$ 7,889,587
Federal State MCH Block Grant Partnership Total	$ 12,654,600	$ 11,277,227

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Kansas

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 130,718	$ 104,017
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 130,718	$ 104,017
2. Enabling Services	$ 2,136,431	$ 1,608,077
3. Public Health Services and Systems	$ 2,418,871	$ 1,825,546
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 38,887
Physician/Office Services		$ 6,965
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 18,821
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 9,131
Laboratory Services		$ 102
Other		
Orthodontic		$ 14,011
Specialty Clinic Fees		$ 16,100
Direct Services Total		$ 104,017
Federal Total	$ 4,686,020	$ 3,537,640

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 26,044	$ 31,253
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 26,044	$ 31,253
2. Enabling Services	$ 4,848,758	$ 4,765,798
3. Public Health Services and Systems	$ 3,093,778	$ 3,092,536
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 31,253
Laboratory Services		$ 0
Direct Services Total		$ 31,253
Non-Federal Total	$ 7,968,580	$ 7,889,587

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Kansas

Total Births by Occurrence 39,776

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Methylmalonic acidemia (methylmalonyl-CoA mutase)	39,776 (100.0%)	7	0	0 (0%)
Isovaleric acidemia	39,776 (100.0%)	7	1	1 (100.0%)
3-Methylcrotonyl-CoA carboxylase deficiency	39,776 (100.0%)	7	1	1 (100.0%)
Glutaric acidemia type I	39,776 (100.0%)	9	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	39,776 (100.0%)	18	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	39,776 (100.0%)	14	5	5 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	39,776 (100.0%)	5	0	0 (0%)
Argininosuccinic aciduria	39,776 (100.0%)	1	1	1 (100.0%)
Citrullinemia, type I	39,776 (100.0%)	1	0	0 (0%)
Maple syrup urine disease	39,776 (100.0%)	48	1	1 (100.0%)
Homocystinuria	39,776 (100.0%)	99	0	0 (0%)
Classic phenylketonuria	39,776 (100.0%)	48	6	6 (100.0%)
Tyrosinemia, type I	39,776 (100.0%)	6	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Primary congenital hypothyroidism	39,776 (100.0%)	40	37	37 (100.0%)
Congenital adrenal hyperplasia	39,776 (100.0%)	5	2	2 (100.0%)
S,S disease (Sickle cell anemia)	39,776 (100.0%)	7	6	6 (100.0%)
S,C disease	39,776 (100.0%)	6	6	6 (100.0%)
Biotinidase deficiency	39,776 (100.0%)	2	1	1 (100.0%)
Cystic fibrosis	39,776 (100.0%)	48	10	10 (100.0%)
Classic galactosemia	39,776 (100.0%)	6	0	0 (0%)
Hearing loss	39,214 (98.6%)	81	63	63 (100.0%)

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	39,212 (98.6%)	500	63	63 (100.0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

Newborn Metabolic Screening (NBS): NBS Follow-up generally ends at the onset of treatment, however referrals into the Special Health Care Needs (SHCN) program can provide opportunity for ongoing long-term follow-up. Additionally, a new staff position, shared by NBS and SHCN, will be utilized to develop a long-term NBS follow-up program in the coming years. \r\n\r\nNewborn Hearing Screening (NBHS): The SoundBeginnings program follows hearing screens on infants from the initial screens in the hospital to appointments with hearing specialists and to other agencies that provide services for children with hearing loss. Infants identified with hearing loss are referred to early intervention so they can receive the appropriate services to support normal speech and language development. As with NBS, NBHS will refer children with identified hearing loss to SHCN, providing opportunity for ongoing follow-up and support for specialty services.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2014**
	Column Name:	
	Field Note: Final: Calendar Year 2013	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Kansas

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	**(A) Title V Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private / Other %**	**(E) None %**	**(F) Unknown %**
1. Pregnant Women	7,899	17.5	12.7	15.8	49.0	5.0
2. Infants < 1 Year of Age	10,099	30.2	19.4	15.6	23.5	11.3
3. Children 1 to 22 Years of Age	105,766	31.1	15.2	32.7	20.2	0.8
4. Children with Special Health Care Needs	5,049	33.6	3.8	38.7	13.3	10.6
5. Others	3,790	28.9	17.4	29.6	20.5	3.6
Total	132,603					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data NOTE: The CYSHCN data does include a duplicate count of children seen in SHCN clinics, due to incomplete reporting. This was address with clinic data staff in 2015, therefore this should be resolved for SFY2015 Reporting. Primary Source of Coverage Breakdown includes an educated estimate due to limited reporting from clinics, as indicated previously. The percentages are based on the average % per source from reported clinic data and the KS-SHCN data system reports. Primary Source of Coverage Breakdown includes an educated estimate due to limited reporting from clinics - based on the average % per source from reported clinic data and CYSHCN data system report	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Kansas

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	6,882
2. Infants < 1 Year of Age	39,776
3. Children 1 to 22 Years of Age	902,980
4. Children with Special Health Care Needs	5,049
5. Others	3,571
Total	958,258

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data Pregnant women served through Aid to Local.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: Final: Calendar Year 2013 Infants received services through the newborn screening programs.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2014**
	Field Note: Final: Calendar Year 2013 Children population health domain served through Aid to Local.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data NOTE: The CYSHCN data does include a duplicate count of children seen in SHCN clinics due to incomplete reporting. This was addressed with clinic data staff in 2015, therefore this should be resolved for SFY15 Reporting.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2014**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data Others served through Aid to Local	

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Kansas

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	39,949	32,966	2,808	203	1,164	64	811	1,933
Title V Served	6,882	6,011	382	53	93	13	220	110
Eligible for Title XIX	12,124	9,451	1,569	226	335	22	0	521
2. Total Infants in State	39,776	32,845	2,781	203	1,160	63	806	1,918
Title V Served	39,776	32,845	2,781	203	1,160	63	806	1,918
Eligible for Title XIX	17,195	13,277	2,314	344	440	31	0	789

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	33,676	6,223	50	39,949
Title V Served	4,869	2,013	0	6,882
Eligible for Title XIX	9,003	3,121	0	12,124
2. Total Infants in State	33,541	6,186	49	39,776
Title V Served	33,541	6,186	49	39,776
Eligible for Title XIX	12,727	4,468	0	17,195

Form Notes For Form 6:

Final: Calendar Year 2013

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Final: Calendar Year 2013 Total deliveries in State = Occurrence live births and stillbirths	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Final: State Fiscal Year 2014 (July 1, 2013 to June 30, 2014) data	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Final: Calendar Year 2013	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Final: Calendar Year 2013 Total infants in State = Occurrence live births	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Final: Calendar Year 2013	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**

Field Note:
Final: Calendar Year 2013

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Kansas

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 332-6262	(800) 332-6262
2. State MCH Toll-Free "Hotline" Name	Kansas Resource Guide	Kansas Resource Guide
3. Name of Contact Person for State MCH "Hotline"	Genoveva Fernandez	Genoveva Fernandez
4. Contact Person's Telephone Number	(785) 296-1313	(785) 296-1313
5. Number of Calls Received on the State MCH "Hotline"		1,597
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Kansas

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Rachel Sisson
Title	Bureau of Family Health Director
Address 1	1000 SW Jackson Street, Suite 220
Address 2	
City / State / Zip Code	Topeka / KS / 66612
Telephone	(785) 296-1310
Email	rsisson@kdheks.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Heather Smith
Title	Special Health Services Section Director
Address 1	1000 SW Jackson Street, Suite 220
Address 2	
City / State / Zip Code	Topeka / KS / 66612
Telephone	(785) 296-1316
Email	hsmith@kdheks.gov

3. State Family or Youth Leader (Optional)

Name	Donna Yadrich
Title	Owner, AudreySpirit LLC
Address 1	13605 Rolfer Road
Address 2	
City / State / Zip Code	Topeka / KS / 66109
Telephone	(913) 980-6282
Email	donna@audreyspirit.com

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Kansas

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	New	
2.	Services and supports promote healthy family functioning.	New	
3.	Developmentally appropriate care and services are provided across the lifespan.	New	
4.	Families are empowered to make educated choices about nutrition and physical activity.	New	
5.	Communities and providers support physical, social, and emotional health.	New	
6.	Professionals have the knowledge and skills to address the needs of maternal and child health populations.	New	
7.	Services are comprehensive and coordinated across systems and providers.	New	
8.	Information is available to support informed health decisions and choices.	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Kansas

Form Notes for Form 10a NPMs and NOMs:

NPM 4A: Kansas birth certificate NPM 4B: National Immunization Survey, Breastfeeding NPM 7: A combined objective for the full population (ages 0 through 19) NPM 14A: Kansas birth certificate NPM 14B: National Survey of Children's Health

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	79.6 %	0.2 %	30,846	38,743
2012	78.9 %	0.2 %	31,663	40,128
2011	77.4 %	0.2 %	29,663	38,337
2010	75.3 %	0.2 %	29,814	39,611
2009	74.8 %	0.2 %	29,610	39,605

Legends:
🚩 Indicator has a numerator <10 and is not reportable
ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	111.6	5.5 %	417	37,351
2011	97.4	5.1 %	362	37,177
2010	103.3	5.2 %	394	38,142
2009	103.6	5.1 %	411	39,673
2008	95.2	4.9 %	380	39,917

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

NOM-2 Notes:

None

Data Alerts:

None

NOM-3 Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	20.4	3.2 %	41	200,867
2008_2012	17.7	2.9 %	36	203,861
2007_2011	15.6	2.8 %	32	205,524
2006_2010	15.0	2.7 %	31	206,850
2005_2009	14.1	2.6 %	29	206,089

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

NOM-3 Notes:

None

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.0 %	0.1 %	2,721	38,824
2012	7.1 %	0.1 %	2,879	40,324
2011	7.2 %	0.1 %	2,854	39,620
2010	7.1 %	0.1 %	2,881	40,628
2009	7.3 %	0.1 %	3,011	41,381

Legends:
🚩 Indicator has a numerator <10 and is not reportable
ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.3 %	0.1 %	484	38,824

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	1.3 %	0.1 %	531	40,324
2011	1.3 %	0.1 %	509	39,620
2010	1.2 %	0.1 %	487	40,628
2009	1.4 %	0.1 %	567	41,381

Legends:
🏴 Indicator has a numerator <10 and is not reportable
ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.8 %	0.1 %	2,237	38,824
2012	5.8 %	0.1 %	2,348	40,324
2011	5.9 %	0.1 %	2,345	39,620
2010	5.9 %	0.1 %	2,394	40,628
2009	5.9 %	0.1 %	2,444	41,381

Legends:
🏴 Indicator has a numerator <10 and is not reportable
ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.9 %	0.1 %	3,447	38,824
2012	9.0 %	0.1 %	3,635	40,322
2011	9.1 %	0.1 %	3,596	39,601
2010	8.8 %	0.1 %	3,563	40,589
2009	9.2 %	0.1 %	3,808	41,325

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.7 %	0.1 %	1,035	38,824

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	2.7 %	0.1 %	1,078	40,322
2011	2.6 %	0.1 %	1,043	39,601
2010	2.5 %	0.1 %	1,014	40,589
2009	2.6 %	0.1 %	1,082	41,325

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.2 %	0.1 %	2,412	38,824
2012	6.3 %	0.1 %	2,557	40,322
2011	6.5 %	0.1 %	2,553	39,601
2010	6.3 %	0.1 %	2,549	40,589
2009	6.6 %	0.1 %	2,726	41,325

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.0 %	0.2 %	8,936	38,824
2012	24.6 %	0.2 %	9,905	40,322
2011	25.4 %	0.2 %	10,043	39,601
2010	25.7 %	0.2 %	10,447	40,589
2009	26.8 %	0.2 %	11,067	41,325

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	8.0 %			

Legends:
Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.6	0.4 %	258	38,954
2012	6.9	0.4 %	281	40,479
2011	6.1	0.4 %	243	39,762
2010	6.2	0.4 %	252	40,759
2009	6.7	0.4 %	277	41,529

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

NOM-8 Notes:

None

Data Alerts:

None

NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.5	0.4 %	252	38,839
2012	6.3	0.4 %	254	40,341
2011	6.2	0.4 %	247	39,642
2010	6.2	0.4 %	252	40,649
2009	7.1	0.4 %	294	41,396

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

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.4	0.3 %	169	38,839
2012	4.3	0.3 %	174	40,341
2011	4.0	0.3 %	159	39,642
2010	4.2	0.3 %	172	40,649
2009	4.3	0.3 %	178	41,396

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

NOM-9.2 Notes:

None

Data Alerts:

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.1	0.2 %	83	38,839
2012	2.0	0.2 %	80	40,341
2011	2.2	0.2 %	88	39,642
2010	2.0	0.2 %	80	40,649
2009	2.8	0.3 %	116	41,396

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

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	213.7	23.5 %	83	38,839

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	205.8	22.6 %	83	40,341
2011	204.3	22.7 %	81	39,642
2010	196.8	22.0 %	80	40,649
2009	236.7	23.9 %	98	41,396

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

NOM-9.4 Notes:

None

Data Alerts:

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	133.9	18.6 %	52	38,839
2012	111.6	16.6 %	45	40,341
2011	106.0	16.4 %	42	39,642
2010	100.9	15.8 %	41	40,649
2009	118.4	16.9 %	49	41,396

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

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	4.7	0.4 %	174	37,355
2011	4.2	0.3 %	157	37,177
2010	3.4	0.3 %	129	38,142
2009	2.3	0.2 %	93	39,677
2008	1.8	0.2 %	71	39,917

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

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.1 %	1.3 %	120,620	666,589

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	24.1	2.6 %	88	365,495
2012	19.6	2.3 %	72	366,922
2011	22.2	2.5 %	81	365,569
2010	27.0	2.7 %	99	367,153
2009	21.8	2.5 %	79	362,262

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

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	31.9	2.8 %	128	401,152
2012	32.9	2.9 %	132	400,793
2011	32.2	2.8 %	130	404,061
2010	38.2	3.1 %	154	402,705
2009	39.0	3.1 %	157	402,855

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

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	14.4	1.5 %	87	605,975
2010_2012	18.2	14.8 %	111	609,260
2009_2011	20.2	16.7 %	124	613,565
2008_2010	23.4	19.6 %	144	615,409
2007_2009	24.1	20.2 %	149	619,073

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

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	13.0	10.3 %	79	605,975
2010_2012	13.6	10.9 %	83	609,260
2009_2011	10.3	7.9 %	63	613,565
2008_2010	9.6	7.3 %	59	615,409
2007_2009	8.7	6.6 %	54	619,073

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

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	139,623	720,400
2007	20.7 %	1.3 %	144,683	699,044
2003	20.4 %	1.1 %	141,515	692,847

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

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	22.8 %	2.1 %	25,499	111,748

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.0 %	0.3 %	5,857	604,484
2007	1.0 %	0.3 %	5,819	582,082

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.8 %	1.1 %	53,268	603,604
2007	7.2 %	0.8 %	41,542	580,463

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

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.6 %	5.5 %	37,787	52,077
2007	72.2 %	5.1 %	38,051	52,674
2003	62.9 %	5.5 %	32,093	51,056

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

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	86.8 %	1.2 %	624,437	719,046
2007	85.3 %	1.2 %	596,113	698,929
2003	86.3 %	1.0 %	597,734	692,666

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

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.2 %	2.3 %	95,210	315,762
2007	31.1 %	2.1 %	90,333	290,635

Year	Annual Indicator	Standard Error	Numerator	Denominator
2003	30.0 %	1.9 %	93,959	312,892

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	29.7 %	0.3 %	8,901	29,964

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.9 %	1.4 %	40,990	141,855
2011	24.1 %	1.1 %	32,928	136,688
2009	25.1 %	1.5 %	33,233	132,280
2007	25.3 %	1.6 %	32,253	127,528
2005	24.9 %	1.3 %	35,358	141,896

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

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.7 %	0.6 %	48,325	718,520
2012	6.9 %	0.5 %	49,694	719,066
2011	6.1 %	0.5 %	44,263	721,601
2010	7.7 %	0.6 %	55,698	725,339
2009	8.2 %	0.6 %	57,156	700,793

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	68.7 %	3.6 %	39,644	57,726
2012	65.0 %	3.4 %	37,798	58,137
2011	73.5 %	3.6 %	43,953	59,803

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010	54.9 %	3.8 %	32,378	58,955
2009	46.0 %	4.4 %	28,749	62,455

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	57.5 %	2.0 %	391,033	680,154
2012_2013	45.9 %	1.9 %	310,168	676,228
2011_2012	47.8 %	2.4 %	313,530	656,064
2010_2011	47.0 %	3.2 %	308,085	655,501
2009_2010	39.0 %	1.6 %	271,928	697,252

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	39.9 %	5.0 %	38,897	97,402
2012	42.7 %	5.4 %	41,349	96,737
2011	37.2 %	4.5 %	36,187	97,259
2010	40.2 %	4.3 %	38,353	95,491
2009	44.1 %	5.4 %	41,245	93,442

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.1 %	4.4 %	25,770	102,720
2012	13.5 %	3.5 %	13,813	101,998
2011	NR	NR	NR	NR

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	84.6 %	2.5 %	169,347	200,122
2012	92.2 %	1.7 %	183,268	198,735
2011	79.1 %	2.8 %	158,210	199,999
2010	76.8 %	2.4 %	151,261	196,881
2009	63.6 %	3.5 %	122,436	192,607

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	55.9 %	3.5 %	111,787	200,122

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	55.9 %	3.7 %	111,176	198,735
2011	47.7 %	3.4 %	95,410	199,999
2010	50.2 %	2.9 %	98,866	196,881
2009	38.3 %	3.5 %	73,838	192,607

Legends:

🏴 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

ϟ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Kansas

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	79.9	80.4	81.0	81.5	81.9

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	21.7	24.7	28.1	31.9	36.3

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	151.4	142.1	133.4	125.1	117.4

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	7.9	5.6	4.0	2.8	2.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.2	89.0	91.9	95.0	98.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	58.7	64.0	69.9	76.2	83.1

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.8	10.3	9.8	9.3	8.9

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objective	23.5	21.8	20.2	18.8	17.4

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Kansas

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Kansas

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Kansas

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	71	72	81	70	
Denominator	71	72	81	70	
Data Source	Kansas Newborn Screening data, 2011	Kansas Newborn Screening data, 2012	Kansas Newborn Screening data, 2013	Kansas Newborn Screening data, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	66.0	73.0	73.0	74.0	74.0
Annual Indicator	72.6	72.6	72.6	72.6	
Numerator					
Denominator					
Data Source	National CSHCN	National CSHCN	National CSHCN	National CSHCN	

	2011	2012	2013	2014	2015
	2009/2010. KS Estimate.	2009/2010. KS Estimate.	2009/2010. KS Estimate.	2009/2010. KS Estimate.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

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

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

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	60.0	50.0	51.0	54.0	56.0
Annual Indicator	49.4	53.8	53.8	53.8	
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

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

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

2. **Field Name:** **2013**

Field Note:
For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in

2011-2012. The same questions were used to generate the NPM 3 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

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

3.	**Field Name:**	**2012**

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

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

4.	**Field Name:**	**2011**

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

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	65.0	61.0	61.0	76.0	78.0
Annual Indicator	60.0	75.2	75.2	75.2	
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

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

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

2. **Field Name:** **2013**

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

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

3. **Field Name:** **2012**

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

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

4. **Field Name:** **2011**

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

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	93.0	67.0	68.0	68.0	69.0
Annual Indicator	66.8	66.8	66.8	66.8	
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. 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.

4. **Field Name:** **2011**

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

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	53.0	53.0	54.0	54.0	55.0
Annual Indicator	52.7	52.7	52.7	52.7	
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

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

2.	**Field Name:**	**2013**

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

3.	**Field Name:**	**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 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.

4.	**Field Name:**	**2011**

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

However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	79.0	83.0	85.0	70.0	70.0
Annual Indicator	77.7	68.0	68.7	68.7	
Numerator					
Denominator					
Data Source	CDC National Immunization Survey 2011	CDC National Immunization Survey 2012	CDC National Immunization Survey 2013	CDC National Immunization Survey 2013	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
The 2014 column is populated with 2013 data. 2014 data will be available Fall 2015.

2. **Field Name:** **2013**

Field Note:
DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3:1:4 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2013. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/13/tab03_antigen_state_2013.pdf The 2013 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine [>=3 or >=4 doses (full series) depending on brand type], 3 or more doses of HepB vaccine, 1 or more doses of varicella vaccine, and 4 or more doses of pneumococcal conjugate vaccine (PCV). The 2013 data are not comparable to previous years. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age.

3. **Field Name:** **2012**

Field Note:
DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2012. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/12/tab03_antigen_state_2012.pdf The 2012 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine (3 or 4 doses depending on the brand) and 3 or more dosese of HepB vaccine. The 2011 and 2012 data not comparable to previous years. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age.

4. **Field Name:** **2011**

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

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

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

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	20.0	18.0	15.0	14.0	14.0
Annual Indicator	15.5	14.5	12.5	11.8	
Numerator	896	833	721	683	
Denominator	57,687	57,341	57,704	57,704	
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:

Data Source: Numerator = Birth certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE; Provisional Denominator = U.S. Census Bureau, 2013

2.	**Field Name:**	**2013**

Field Note:
Data Source: Numerator = Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE Denominator = U.S. Census Bureau

3.	**Field Name:**	**2012**

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

4.	**Field Name:**	**2011**

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

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.0	41.0	38.0	38.0	40.0
Annual Indicator	35.7	35.7	35.7	35.7	
Numerator					
Denominator					
Data Source	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012	KDHE, Smiles Across Kansas: 2012	KDHE, Smiles Across Kansas: 2012	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Data Source: KDHE, Bureau of Oral Health. Smiles Across Kansas: 2012.

2. **Field Name:** **2013**

Field Note:
Data Source: KDHE, Bureau of Oral Health. Smiles Across Kansas: 2012.

3. **Field Name:** **2012**

Field Note:
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

4. **Field Name:** **2011**

Field Note:
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	2.5	3.6	2.6	3.1	2.4
Annual Indicator	2.8	3.3	2.6	2.1	
Numerator	17	20	16	13	
Denominator	605,120	606,608	605,708	605,708	
Data Source	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Data Source: Numerator = Death certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE; Provisional Denominator = U.S. Census Bureau; 2013 estimates.

2. **Field Name:** **2013**

Field Note:
Data Source: Numerator = Death certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE Denominator = U.S. Census Bureau; 2013 estimates.

3. **Field Name:** **2012**

Field Note:
Data Source: Numerator = Death certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE Denominator = U.S. Bureau of the Census; 2012 estimates.

4. **Field Name:** **2011**

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

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	50.0	42.0	47.0	44.0	44.0
Annual Indicator	45.1	41.8	40.3	40.3	
Numerator					
Denominator					
Data Source	National Immunization Survey, 2009 births	National Immunization Survey, 2010 births	National Immunization Survey, 2011 births	National Immunization Survey, 2011 births	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
The 2014 column is populated with 2013 data (2011 births). Data will be available in 2016.

2. **Field Name:** **2013**

Field Note:
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Breastfeeding Report Card - United States, 2014
http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf

3. **Field Name:** **2012**

Field Note:
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Breastfeeding Report Card - United States, 2013
http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf

4. **Field Name:** **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

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.2	99.0	99.0	99.0	99.0
Annual Indicator	98.7	98.7	98.6	97.7	
Numerator	39,908	40,636	39,214	39,214	
Denominator	40,452	41,177	39,773	40,130	
Data Source	KDHE. Kansas Newborn Screening program, 2011	KDHE. Kansas Newborn Screening program, 2012	KDHE. Kansas Newborn Screening program, 2013	KDHE. Kansas Newborn Screening program, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:

DATA SOURCE: Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2014. Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences.

2.	**Field Name:**	**2013**

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

3.	**Field Name:**	**2012**

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

4.	**Field Name:**	**2011**

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

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	8.0	7.5	9.2	5.8	5.5
Annual Indicator	9.4	6.1	6.1	6.1	
Numerator					
Denominator					
Data Source	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data for 2014 are not available. 2012 data were used to pre-populate this performance measure. Data for 2014 will be available in Fall 2016	
2.	**Field Name:**	**2013**
	Field Note: Data for 2013 are not available. 2012 data were used to pre-populate this performance measure. Data for 2013 will be available in Fall 2015	
3.	**Field Name:**	**2012**
	Field Note: Data Source: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HIB-5. Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2012. http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html	
4.	**Field Name:**	**2011**
	Field Note: DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HIB-5. Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2011. http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html	

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	28.0	28.0	27.0	27.0	27.0
Annual Indicator	28.4	28.4	23.7	23.6	
Numerator	10,657	10,657	10,399	9,682	
Denominator	37,524	37,524	43,946	40,979	
Data Source	Kansas PedNSS, 2011	Kansas PedNSS, 2011	Kansas WIC, 2013	Kansas WIC, 2014	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports. Data source for 2014 is Kansas WIC data base, KWIC. The 2013 and 2014 data are not comparable to previous years.	
2.	**Field Name:**	**2013**
	Field Note: CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports. Data source for 2013 is Kansas WIC data base, KWIC. The 2013 data are not comparable to previous years.	
3.	**Field Name:**	**2012**
	Field Note: The 2012 and 2013 columns are populated with 2011 data. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.	
4.	**Field Name:**	**2011**
	Field Note: Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2011(Kansas WIC database).	

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.5	12.0	11.0	10.0
Annual Indicator	12.2	11.5	10.5	9.9	
Numerator	4,795	4,624	4,072	3,875	
Denominator	39,441	40,212	38,730	39,140	
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data Source: Birth certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE; Provisional Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.	
2.	**Field Name:**	**2013**
	Field Note: Data Source: Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.	
4.	**Field Name:**	**2011**
	Field Note: Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.	

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	9.0	10.0	10.0	13.0	12.0
Annual Indicator	10.5	13.8	13.2	12.5	
Numerator	64	84	80	76	
Denominator	608,906	609,260	605,975	605,975	
Data Source	Kansas Vital Statistics, 2009-2011	Kansas Vital Statistics, 2010-2012	Kansas Vital Statistics, 2011-2013	Kansas Vital Statistics, 2012-2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0. Denominator = U.S. Census Bureau 2012-2014 data are U.S. Census estimates (Bridged-Race Vintage data set); Provisional	
2.	**Field Name:**	**2013**
	Field Note: Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0. Denominator = U.S. Census Bureau 2011-2012 data are U.S. Census estimates (Bridged-Race Vintage data set)	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Numerator = Death certificate (resident) data, 2010-2012, Bureau of Epidemiology and Public Health Informatics, KDHE Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0. Denominator = U.S. Census Bureau 2010-2012 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.	
4.	**Field Name:**	**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. Census Bureau 2009-2011 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.	

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	87.0	87.0	88.0	88.0	89.0
Annual Indicator	86.6	87.1	86.6	82.7	
Numerator	425	438	387	374	
Denominator	491	503	447	452	
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Provisional: Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Medical Center (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).	
2.	**Field Name:**	**2013**
	Field Note: Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Medical Center (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Birth certificate (resident instate births) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Medical Center (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).	
4.	**Field Name:**	**2011**
	Field Note: Data Source: Birth certificate (resident instate births) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).	

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	80.0	80.0	82.0
Annual Indicator	77.3	78.9	79.4	80.0	

	2011	2012	2013	2014	2015
Numerator	29,618	31,457	30,618	30,985	
Denominator	38,296	39,871	38,546	38,708	
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data Source: Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE; Provisional	
2.	**Field Name:**	**2013**
	Field Note: Data Source: Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE	
4.	**Field Name:**	**2011**
	Field Note: Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE	

Data Alerts:

None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Kansas

SPM 2 - The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.

	2011	2012	2013	2014	2015
Annual Objective	14.4	13.5	13.0	12.5	12.0
Annual Indicator	17.7	15.7	14.1	14.1	
Numerator					
Denominator					
Data Source	Kansas BRFSS, 2011	Kansas BRFSS, 2012	Kansas BRFSS, 2013	Kansas BRFSS, 2013	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
The 2014 column is populated with 2013 data. 2014 data will be available Fall 2015.

2. **Field Name:** **2013**

Field Note:
Data Source: Kansas BRFSS 2013 Note: The 2011, 2012 and 2013 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

3. **Field Name:** **2012**

Field Note:
Data Source: Kansas BRFSS 2012 Note: The 2011 and 2012 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

4. **Field Name:** **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.

Data Alerts:

None

SPM 3 - The percent of live births that are born preterm less than 37 weeks of gestation.

	2011	2012	2013	2014	2015
Annual Objective	9.1	8.6	8.6	8.4	8.4
Annual Indicator	9.1	9.0	8.9	8.7	
Numerator	3,598	3,629	3,448	3,421	
Denominator	39,593	40,282	38,789	39,183	
Data Source	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2013	Kansas Vital Statistics, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
Data Source: Birth certificate (resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE; Provisional; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

2. **Field Name:** **2013**

Field Note:
Data Source: Birth certificate (resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

3. **Field Name:** **2012**

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

Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

4.	**Field Name:**	**2011**

Field Note:
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

Data Alerts:

None

SPM 5 - The percent of children age 0 to 17 who received coordinated, ongoing, comprehensive care within a medical home.

	2011	2012	2013	2014	2015
Annual Objective	63.0	63.0	62.0	62.0	64.0
Annual Indicator	59.1	59.1	59.1	59.1	
Numerator					
Denominator					
Data Source	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

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

4.	**Field Name:**	**2011**

Field Note:
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

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

Data Alerts:

None

SPM 6 - The percent of high school students who had at least one drink of alcohol during the past 30 days.

	2011	2012	2013	2014	2015
Annual Objective	37.0	37.0	30.0	30.0	28.0
Annual Indicator	32.6	32.6	27.6	27.6	
Numerator					
Denominator					
Data Source	YRBS, 2011	YRBS, 2011	YRBS, 2013	YRBS, 2013	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
The 2014 columns are populated with 2013 data. The YRBS is conducted in the spring of odd-numbered years and results are released in the summer of the following year.

2.	**Field Name:**	**2013**
	Field Note: DATA SOURCE: CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2013. http://nccd.cdc.gov/YouthOnline/App/Results.aspx?LID=KS	
3.	**Field Name:**	**2012**
	Field Note: The 2012 columns are populated with 2011 data. The YRBS is conducted in the spring of odd-numbered years and results are released in the summer of the following year.	
4.	**Field Name:**	**2011**
	Field Note: DATA SOURCE: CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2011. http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.	

Data Alerts:

None

SPM 7 - The Percent of children who are obese.

	2011	2012	2013	2014	2015
Annual Objective	13.1	12.6	12.4	12.2	12.0
Annual Indicator	12.8	12.8	12.6	12.6	
Numerator	4,803	4,803			
Denominator	37,523	37,523			
Data Source	Kansas PeNSS, 2011	Kansas PeNSS, 2011	YRBS, 2013	YRBS, 2013	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: SOURCE: CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2013. http://nccd.cdc.gov/YouthOnline/App/Results.aspx?LID=KS	
2.	**Field Name:**	**2013**

Field Note:
SOURCE: CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2013. http://nccd.cdc.gov/YouthOnline/App/Results.aspx?LID=KS

3. **Field Name:** **2012**

Field Note:
The 2012 column is populated with 2011 data.

4. **Field Name:** **2011**

Field Note:
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2012(Kansas WIC database).

Data Alerts:

None

SPM 9 - The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.

	2011	2012	2013	2014	2015
Annual Objective	84.0	84.0	85.0	85.0	86.0
Annual Indicator	83.5	83.5	83.5	83.5	
Numerator					
Denominator					
Data Source	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore,

the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the NS-CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

SPM 11 - The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective			66.0	66.0	68.0
Annual Indicator	65.1	55.3	54.0	66.7	
Numerator	41	52	34	42	
Denominator	63	94	63	63	
Data Source	SoundBeginning, 2011	SoundBeginning, 2012	SoundBeginning, 2013	SoundBeginning, 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data Source: SoundBeginnings Program data, 2014 Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age Denominator = Number of infants identified with PCHL	
2.	**Field Name:**	**2013**
	Field Note: Data Source: SoundBeginnings Program data, 2013 Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age Denominator = Number of infants identified with PCHL	
3.	**Field Name:**	**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	
4.	**Field Name:**	**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	

Data Alerts:

None

SPM 12 - The percent of Non-Medically Indicated (NMI) early term deliveries (37,38 weeks) among singleton early term deliveries (37,38 weeks).

	2011	2012	2013	2014	2015
Annual Objective				26.0	23.1
Annual Indicator	35.8	33.0	29.3	28.9	
Numerator	2,689	2,368	1,877	1,937	
Denominator	7,503	7,169	6,415	6,692	
Data Source	Kansas birth certificate, 2011.	Kansas birth certificate, 2012.	Kansas birth certificate, 2013.	Kansas birth certificate, 2014.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data Source: Birth certificate (in state resident) data, 2014, Bureau of Epidemiology and Public Health Informatics, KDHE; Provisional	
2.	**Field Name:**	**2013**
	Field Note: Data Source: Birth certificate (in state resident) data, 2013, Bureau of Epidemiology and Public Health Informatics, KDHE	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Birth certificate (in state resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE	
4.	**Field Name:**	**2011**
	Field Note: Data Source: Birth certificate (in state resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE	

Data Alerts:

None

SPM 13 - The percentage of newborns who have been screened for critical congenital heart defects (CCHD)

before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective				70.0	99.0
Annual Indicator	66.7	66.7	66.7	98.7	
Numerator	25,895	25,895	25,895	38,858	
Denominator	38,801	38,801	38,801	39,368	
Data Source	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2014.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: Annual Objective for 2015 is 99%.	
2.	**Field Name:**	**2014**
	Field Note: Data Source: Kansas newborn screening data based on the 2014 survey.	
3.	**Field Name:**	**2013**
	Field Note: Data Source: Kansas newborn screening data based on the 2013 survey.	
4.	**Field Name:**	**2012**
	Field Note: Data Source: Kansas newborn screening data based on the 2013 survey.	
5.	**Field Name:**	**2011**
	Field Note: Data Source: Kansas newborn screening data based on the 2013 survey.	

Data Alerts:

None

Form 11

Other State Data

State: Kansas

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Kansas

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table