Maternal and Child Health Services Title V Block Grant

Kansas

FY 2020 Application/ FY 2018 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367

Kansas Department of Health and Environment

Phone: 785-296-0461
www.kdheks.gov

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

July 15, 2019

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

To Whom It May Concern:

Attached to this letter of transmittal is a signed Application for Federal Assistance Standard Form 424 for Kansas' electronic submission of the FFY 2020 Title V Maternal and Child Health Services Block Grant Application and FFY 2018 Annual Report.

Kansas is not requesting a waiver to the 30 percent allotment requirement.

If you have questions concerning this application, please contact Rachel Sisson, Kansas Title V Director, at 785-296-1310 or rachel.sisson@ks.gov.

Sincerely,

Lee A. Norman MD ag

Lee A. Norman, MD
Secretary
Kansas Department of Health and Environment

Enclosures

Protect and Improve the Health and Environment of all Kansans

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 F of the 2018 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

KANSAS TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT PROGRAM

www.kdheks.gov/bfh

www.kansasmch.org

www.facebook.com/kansasmch

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

Kansas MCH Population

Kansas, spanning 82,278 sq. miles, is divided into 105 counties with 628 cities. The U.S. Census Bureau estimates there are approximately 2,913,123 residents living in the state in 2017. Kansas has a unique geographic layout that ranges from urban to frontier counties. In 2017, there were an estimated 38,059 infants or about 1.3% of the total population (2,913,123); 558,606 women of reproductive age 15-44 representing 19.2%; and 842,020 children and adolescents 1-21 representing 28.9%. According to the 2016-2017 National Survey of Children's Health, 20.7% of Kansas children aged 0 to 17 (est. 147,776) were identified as having special health care needs. Males (22.1%) were more likely to have a special health care need than females (19.2%). Read more in the State Overview Section.

Total Individuals Served By Title V* (Annual Report Year 2018)

Pregnant Women	7,619
Infants < 1 Year	3,554
Children 1 through 21 Years	21,369
(Children with Special Health Care Needs 2,134)	
Other (women 22+ years)	6,180
Total	38,722

**More details are available on Block Grant Form 5a.*

Assessing State Needs

Kansas continuously assesses the needs of MCH populations through an ongoing Needs Assessment, and the State Action Plan is updated as needed during interim years. With a goal to maximize the input of internal and external partners, the Kansas Title V Five Year Needs Assessment process utilizes a mixed methods approach relying on input from a diverse network of key informants, partners, and community members including families and consumers. The State Systems Development Initiative (SSDI) staff provide data capacity for informed decision-making. This comprehensive process and broad approach assist with identifying key priorities used to develop an action plan that addresses and improves MCH in Kansas while leveraging resources and partnerships across the state.

Title V MCH Priorities (FFY 2020)

Kansas identified seven priorities with the Title V mission, purpose, legislation, and measurement framework in mind.

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

Title V National Performance Measures (FFY 2020)

Kansas selected seven National Performance Measures (NPMs) that most closely align with the state priorities.

- NPM1: Well-woman visit (women 18 44 years)
- NPM4: Breastfeeding
- NPM6: Developmental screening
- NPM7: Child injury
- NPM10: Adolescent preventive medical visit
- NPM11: Medical home
- NPM14: Smoking during pregnancy and household smoking

Title V State Performance Measures (FFY 2020)

Kansas identified five State Performance Measures to monitor progress with state priority needs not addressed by NPMs.

- SPM1: Preterm births (<37 weeks gestation)
- SPM2: Physical activity (children 6 through 11 years)
- SPM3: Safe Sleep
- SPM4: Health literacy
- SPM5: Workforce development

Kansas Title V Activities & Program Highlights

The Title V plan coordinates MCH activities across funding sources, state agencies, and local providers. It relies on partnerships, high quality shared measurement, and data to track the impact and effectiveness of services, activities, and strategies. Review the full Block Grant Application to learn more about these and other activities: http://www.kdheks.gov/c-f/mch.htm.

Women/Maternal & Perinatal/Infant Health

Maternal & Pregnancy-Related Mortality: Title V in collaboration with key partners launched the Kansas Maternal Mortality Review Committee (KMMRC) in an effort to review pregnancy-related deaths, identify causes, and implement interventions to prevent future occurrences. The first formal review (beginning with 2016 death cases) took place in November 2018 with another following in March 2019. Several KMMRC meetings are scheduled for summer and fall 2019 in an effort to complete all 2016 and 2017 cases by November 2019. Information and data collected from cases will inform selection of an Alliance for Innovation on Maternal Health (AIM) patient safety bundle for statewide adoption. Title V funds support all KMMRC key activities including staffing, abstraction, meeting facilitation, and member reimbursement.

Perinatal Systems of Care/Quality & Neonatal Abstinence Syndrome: Title V is leading implementation of a state-level response to address Neonatal Abstinence Syndrome (NAS) with direction from and in partnership with the Kansas Perinatal Quality Collaborative (KPQC). Work started when policymakers met in 2017 to define NAS within the context of the opioid epidemic, introduced the Vermont Oxford Network (VON) NAS Training Program as a tool, and discussed a path for Kansas. A total of 32 birth centers are enrolled in the effort, accounting for ~84% of births in the state. Centers receive

universal education for the standardization of care in identification, evaluation, treatment and safe discharge for infants with NAS. The KPQC is working with the Departments for Children & Families, Aging & Disability Services (substance use treatment and prevention) and the Hospital Association to work on improving policies and practices that support safe environments for the mother and baby after hospital discharge.

Count the Kicks® (CTK): Title V has a formal partnership with Healthy Birth Day to implement *Count the Kicks®*, a campaign to prevent stillbirth that educates providers and patients about monitoring fetal movements during the 3rd trimester of pregnancy. The campaign kicked off August 2018 with a letter to providers inviting them to order free materials. This was followed up by media and social media events. The initiative has been successful. As of July 2019, over 170 total orders of educational materials were made from all corners of the state equating to 44,000+ pieces of materials distributed. Over 2,400 Kansans have visited the CTK website, and 650 moms have downloaded the free Count the Kicks app to track baby's movements!

One Key Question® (OKQ): Title V has a formal partnership with The Power to Decide to implement OKQ, an evidence-based intervention known to prevent unplanned pregnancy and reduce incidence of poor birth outcomes. OKQ helps a woman uncover her pregnancy intention by encouraging all health providers to routinely ask, "Would you like to become pregnant in the next year?" Title V brought The Power to Decide to Kanas in February and March 2019 to offer local providers the opportunity to become certified and integrate the intervention into practice. Current activities are focused on implementation and data collection. Title V plans to bring the *Power to Decide* back to Kansas in 2020 for cohort two.

Perinatal Community Collaboratives Implementing Becoming a Mom (BaM): Title V is committed to supporting expansion and sustainability of the Kansas Perinatal Community Collaborative (KPCC) model with local communities and the broader network of local health care and community service providers, as a consistent and proven delivery system for prenatal care education curriculum. The model brings prenatal education, clinical care, and wraparound services together. Data reveals improvements in preterm delivery, low birth weight, and breastfeeding. The outcomes for mothers and infants participating in a KPCC are improving faster when compared to the state outcomes. Most notable is the Infant Mortality Rate from pre-to post-implementation in the longest running programs (6 years): Saline County 9.0 to 5.5 and Geary County 11.9 to 5.7 (deaths/1000 live births).*
**Source: Kansas Vital Statistics 2005-2008 and 2013-2017*

Breastfeeding: Title V has a formal partnership with the Kansas Breastfeeding Coalition (KBC) to align and support breastfeeding across many programs including MCH, WIC, Child Care Licensing, Home Visiting, and others. KBC increases the capacity and strengthens the support of local breastfeeding coalitions, provides technical assistance and support for several initiatives, participates in planning for Community Baby Showers and assists with updating breastfeeding education for providers and parents. Title V works closely with WIC, breastfeeding peer counselors, and home visitors to provide consistent messaging and leverage resources at the state and local levels.

Safe Sleep: Title V has a formal partnership with the Kansas Infant Death and SIDS (KIDS) Network to reduce infant mortality through state and local safe sleep targeted efforts. Title V supports the KIDS Network to facilitate a safe sleep culture within Kansas by training a network of Safe Sleep Instructors (SSIs); developing and providing training for parents, physicians, home visitors, and child care providers; promoting consistent safe sleep messages across the lifespan; and offering technical assistance on the Community Baby Shower model (CBS), the Hospital Safe Sleep Certification program, and the Outpatient Provider Safe Sleep Star Program.

Child & Adolescent Health

Help Me Grow: Title V, in partnership with early childhood partners is expanding Help Me Grow Kansas (HMG) communities. HMG is a framework that promotes integrated, cross-sector collaboration in an effort to build efficient and effective systems that mitigate the impact of adversity and support protective factors among families. Successful implementation of HMG

leverages existing community resources, maximizes opportunities, and advances partnerships within four core components: family and community outreach, provider outreach, a centralized access point, and data collection and analysis. Kansas is an affiliate state of the Help Me Grow national network. There are 92 programs in 28 states.

Preventive Medical Visits (Annual Well Visits): Title V is actively engaged in a variety of activities that involve outreach, promotion, and support to increase access to annual preventive medical visits for children and adolescents. Visits are important for access to comprehensive services including screening and immunizations, referral, and diagnosis and treatment when indicated. Title V promotes Bright Futures™ as a standard of care in line with the Medicaid EPSDT program and is also focusing on expanding school-based health centers to increase access to care, especially for adolescents.

Oral Health: Title V has a formal partnership with Oral Health Kansas (OHK) to support a three-year initiative launched August 2018. OHK is leading the following activities: conducting an environmental scan of local MCH agencies to discover what educational materials are being used, working with the KPCC coordinator to record a webinar for the oral health prenatal education, creating and disseminating an interactive oral health poster designed to engage parents and children while in a provider's office as well as developing a free workshop for child care providers.

Behavioral Health: Kansas Title V recognizes that there cannot be whole health without behavioral health and is working to increase focus on behavioral health interventions, healthy social-emotional development, and cross systems collaboration within the State Action Plan objectives. To expand programming and increase effectiveness, Title V created a Behavioral Health Consultant (BHC) position. The BHC oversees two new federally funded projects focused on behavioral health —*Kansas Connecting Communities* (launched October 2018) and *KSKidsMap to Mental Wellness* (launching in July 2019).

Children & Youth with Special Health Care Needs

Care Coordination: The Special Health Care Needs program (KS-SHCN) continues to work towards expansion of the holistic care coordination model, launched in 2017. This approach helps families find, understand, and access services and resources within medical, school, and community systems to achieve optimal child/family health outcomes and empower and prepare parents to support their children. In 2018, KS-SHCN expanded efforts by partnering with an FQHC to integrate components into general pediatric services and within a specialty clinic.

Peer to Peer Support Network: In partnership with the Special Health Services Family Advisory Council (SHS-FAC), Title V launched a peer-to-peer support network, *Supporting You,* to connect parents and caregivers of children with SHCN with peers who have like experiences and/or life circumstances. The network is designed to help individuals connect with one another, share ideas and resources, and gain support where it would most benefit. Currently there are three participating programs: KS-SHCN, KS School for the Deaf, and SHS-FAC. The network is expected to expand to at least two other programs in the coming year.

Family Engagement: KS-SHCN contracted with a SHS-FAC member to extend care coordination services in the Wichita and surrounding areas, where the program previously lacked adequate coverage through a separate Satellite Office. This care coordinator will also begin providing Family Care Coordination Trainings and develop a train-the-trainer model to expand program capacity and extend additional training opportunities. The coordinator serves as the KS-SHCN Peer Support Administrator to assist with connecting peers through the network. As needs arise, this partnership model will be pursued whenever possible to support family engagement, leadership, and professional development.

Kansas Title V Block Grant Budget

The Federal-State Title V partnership budget totals $12,723,071 for FY2020 (federal funds $4,780,598; state funds $3,949,804; local funds $3,992,669). Federal and State MCH funds totaling more than $4.5M is allocated for FY2020 to support local agencies in providing community-based, family centered MCH services, including services for individuals with special health care needs.

III.A.2. How Federal Title V Funds Support State MCH Efforts

The majority of activities/services funded by the Block Grant are essential to overall systems development and gap filling. The federal funds truly complement state and local funds resulting in a comprehensive service delivery model that advances the state action plan and aims to improve outcomes across the life course.

The availability of federal funds coupled with state flexibility have positioned Kansas to launch critical efforts aimed at addressing substance use and depression during critical periods such as pregnancy and post-partum; mental health and wellness, particularly for pregnant and postpartum women and adolescents; and maternal mortality. Early childhood systems building efforts have relied on Title V to spread what we know has an impact and support enabled launch of Help Me Grow in our state. These partnerships and newly launched initiatives help set the stage for receipt of additional federal funding to move these important initiatives forward, leading to higher quality services and supports for Title V services.

Individuals with special health care needs (SHCN) rely on Title V for appropriate, coordinated services. Funding supports expansion of services to serve more families locally, and funding provides flexibility for the SHCN program to serve beyond state statutory limitations and consider gap-filling services, such as funding for direct assistance programs, caregiver relief, travel and interpreter services for increased access to care and services.

III.A.3. MCH Success Story

The KS-SHCN Program's holistic care coordination model encourages care coordinators (CC) to identify with and assist both the eligible child and their entire family with challenges or obstacles that could impact the child's health and well-being. The impact and value of this approach is evident in the following story.

Peyton was identified as a "Level 3" client, indicating a high need for support – the greatest need of the family was obtaining follow-up care/testing for Peyton. As the CC began engaging with Peyton's father, it quickly became evident that the family was in crisis regarding Peyton's older sibling, Emma – who had recently experienced trauma and was suicidal. The CC quickly shifted focus to getting mental health services in place for Emma (who was not eligible for KS-SHCN services). Once the crisis had passed, the family could then focus with the CC on establishing the other specialty care appointment for Peyton.

Under the former case management model, a basic referral to a mental health agency may have been made. Due to the shift in how program services are provided today, the CC's active listening training, and the flexibility of the existing model – a family was able to diffuse a crisis situation. The flexibility of Title V funds for enabling services and the encouragement to consider a population health approach to service delivery made this possible.

Note: Names have been changed to protect the anonymity of the client and their family.

III.B. Overview of the State

This section puts into context the Title V Maternal and Child Health (MCH) program within the State's health care delivery environment. The overview provides an understanding of the State Health Agency's current priorities/initiatives and the Title V role.

Overview & Authority: The Kansas Department of Health and Environment (KDHE) is responsible for administration of programs carried out with allotments under Title V. The Title V MCH Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to “provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.” KDHE convenes the Kansas Maternal and Child Health Council and contracts with local public health departments (independent entities) and Federally Qualified Health Centers (FQHCs) across the state to ensure provision of MCH services within a coordinated, family-centered system. Kansas statutes do not mandate comprehensive services for MCH populations except for Children with Special Health Care Needs (CSHCN). Pursuant to K.S.A. 65-5a01, a "child with special health care needs” means a person under 21 years of age who has a disease, defect or condition which may hinder normal physical growth and development." Statutes and regulations detail program requirements related to direct health services, in which individuals ages 0-21 with eligible medical conditions and all ages with conditions diagnosed through the state's newborn screening program are served. Kansas provides direct services for state mandated conditions, and the program provides non-direct services through community partnerships to the broader CSHCN population, as defined by MCHB/HRSA, with support and guidance from the Special Health Services Family Advisory Council (SHS-FAC).

Geography/Demography: Kansas, spanning 82,278 sq. miles, is divided into 105 counties with 628 cities.[1] The U.S. Census Bureau estimates there are approximately 2,913,123 residents living in the state in 2017. Kansas has a unique geographic layout that ranges from urban to frontier counties. Within each of its regions there are few populous cities intermixed with multiple rural areas. For example, the South-Central region includes Wichita with a population of 390,591. Within that same region also lies Pratt with a population of 6,748. This is a good example of Kansas’ diversity where rural communities are influenced by mid-sized cities and mid-sized cities are influenced by rural communities. This diversity provides challenges to service delivery, but also an opportunity for sharing resources.[2]

Population Density & Peer Groups (Urban, Semi-Urban, Densely-Settled Rural, Rural, and Frontier): The population density of Kansas was 35.6 inhabitants per square mile in 2017, a 10.9% increase from 32.0[1] persons per square mile in 1998. For comparison, the population density of the U.S. increased from 72.4 to 92.2 persons per square mile from 1998 to 2017, a 27.3% increase. In 2017, 36 of the state’s 105 counties had population densities of less than 6.0 persons per square mile. The most sparsely populated county was Greeley, with a density of 1.6 persons per square mile. The most densely populated county was Johnson, with 1,248.8 persons per square mile. Kansas counties are assigned to peer groups based on population density. Several Kansas counties were re-categorized from one population-density peer group to another, to reflect population shifts indicated by the 2010 U.S. Census. During the 2013-2017 period, the population of the urban peer group increased by 2.9%, while the frontier, rural, densely-settled rural, and semi-urban peer groups decreased by 3.7%, 2.8%, 1.8%, and 1.7%, respectively.[2]

Population Growth/Change: The percent increase in the Kansas total population from 1998-2017 was 10.8%, including a 12.4% increase for Kansas males and a 9.3% increase for Kansas females. Kansas increased in population from 2,907,289 residents in 2016 to 2,913,123 residents in 2017, a 0.2% increase. Douglas, Pottawatomie, and Johnson counties had the largest relative increases in population from 2013 to 2017 with percent changes of 5.7, 5.4, and 4.3 respectively. Morton, Lane, Geary, Clark and Comanche counties had the largest relative decreases in population, with changes of 12.8%, 9.4%. 9.4%, 8.6%, and 8.4% respectively.[2] In 2017, there were an estimated 38,059 infants living in Kansas or about 1.3% of the total Kansas population (2,913,123). Women of reproductive age 15-44 accounted for 19.2% (558,606) of the Kansas population.[2] In 2017, there were 842,020 children and adolescents aged 1-21 years living in Kansas, which represents 28.9% of the Kansas population.[3] Among families with children under 18, 29.3% are single-parent families

versus married-couple families (70.7%).[4] According to the 2016-2017 National Survey of Children's Health, 20.7% of Kansas children aged 0 to 17 (est. 147,776 children) were identified as having special health care needs. Males (22.1%) were more likely to have a special health care need than females (19.2%).[5]

Age: The median age of Kansans in 2017 was 36.6 years, a 4.0% increase from the median age of 35.2 in 1998. The median ages of Kansas males and females in 2017 were 35.4 and 37.9 respectively. Shifts in the Kansas population distribution by age from 1998 to 2017 included a decrease in the 35-44 age group of 17.4%. This decrease, and increases of 5.2% in residents 45-54 years of age, 75.6% in residents 55-64 years of age, and 43.3% in residents 65-74 years of age reflected the aging of the baby boomers. Furthermore, there were 6.0%, 2.8%, 6.9%, 10.7%, and 10.8% increases in the 0-4, 5-14, 15-24, 25-34, and 75 and over age-groups respectively.[2] The prevalence of children with special health care needs within the child population increase with age, from 18.4% of 0-5, 20.8% of 6-11, and 22.8% of 12-17.[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.

Race/Ethnicity: According to the 2017 Census Bureau estimates, 75.9% of Kansans were non-Hispanic white and 5.8% were non-Hispanic black. Hispanics made up 11.9% of Kansas' population.[2] The race and ethnicity composition of women aged 15-44 (i.e., of childbearing age) was estimated at 71.9% non-Hispanic white, 6.2% non-Hispanic black, 0.9% non-Hispanic Native American or Alaska Native, 4.3% non-Hispanic Asian and Pacific Islander, 2.8% non-Hispanic multiple race, and 13.9% Hispanic (any race).[2] The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. About one-third (30.8%) of Kansas children and adolescents (1-21 years) belong to a racial or ethnic minority. Across the age groups, about one-third (31.4%) of young children (1-5 years) are part of a racial/ethnic minority versus about three in 10 (29.2%) young adults (20-21 years). About 16.1% of Kansans age 15-21 are Hispanic, compared to 18.6% of young children.[3] The prevalence of special health care needs varied only a small amount by child's race and ethnicity with Kansas Hispanic children (19.0%) having a slightly lower prevalence than non-Hispanic white children (19.8%).[5]

Diversity/Languages: According to the 2013-2017 American Community Survey, in Kansas, 2.5% of the households met the definition of being limited English speaking compared to 4.5% of U.S. households. In Kansas, the prevalence of limited English speaking in households varies by language spoken at home. Limited English speaking among households speaking Spanish was 23.4%, other Indo-European languages 11.3%, Asian and Pacific Island languages 26.3%, and other languages 17.2%.[6] Among people at least five years old living in Kansas in 2013-2017, 11.5% spoke a language other than English at home. Of those speaking a language other than English at home, 66.2% spoke Spanish and 33.8% spoke some other language; 39.4% 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. Ninety-three percent (93.0%) of the people living in Kansas in 2013-2017 were native residents of the United States. About 59.0% of these residents were living in the state in which they were born. About 7.0% of the people living in Kansas in 2013-2017 were foreign born. Of the foreign-born population, 37.3% were naturalized U.S. citizens, and 80.8% entered the country before the year 2010. About 19.2% of the foreign born entered the country in 2010 or later. Foreign born residents of Kansas come from different parts of the world.[4]

Education: Kansas compares favorably with the U.S. average in terms of educational attainment with a 90.5% of the population with a high school education or higher compared with 87.3% for the U.S. About thirty-two percent (32.3%) of Kansans have a bachelor's degree or higher compared with 30.9% for the U.S.[4]

Income/Poverty: For 2017, the federal poverty level was $25,094 for a family of four.[7] 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 threshold to meet their most basic needs.[8] In 2017, based on the Small Area Income and Poverty Estimates (SAIPE), compared to the U.S. population, a lower percentage of Kansans lived in households with incomes below the federal poverty level (11.9% vs. 13.4% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (14.7% vs. 18.4% for the U.S.). During the past 5 years (2013-2017), Kansas experienced a significant decrease in the poverty rate for children under age

18 but in 2017 there was a slight bump from the previous year. A decrease was seen in the United States without the bump from 2016 to 2017.[9] In 2017, an estimated 102,858 Kansas children under 18 years of age were living in poverty. Five counties accounted for over half of all Kansas children (51,736 children; 50.3%) in poverty: Sedgwick (23,239), Wyandotte (11,185), Johnson (8,349), Shawnee (6,365), and Douglas (2,598). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty as well. In 2017, the percent of Kansas' families living below the federal poverty level (8.5%) was lower than the U.S. (10.5%).[10] Poverty was more common in Kansas families headed by single females with children in the household, regardless of race or ethnicity. In 2017, the Kansas percent of female headed households with related children under 18 years living below federal poverty level (37.0%) was slightly below the U.S. percent (38.7%).[10] According to the 2016-2017 National Survey of Children's Health, Kansas children living at or below poverty had an increased prevalence of special health care needs. Nearly one-half (47.5%) of children with special health care needs lived in families with incomes less than 200% of the federal poverty level.[3]

Health Insurance Coverage: Data from the Small Area Health Insurance Estimates (SAHIE) show that the percentage of Kansas children under 19 years old without health insurance decreased from 6.2% in 2013 to 5.2% in 2017, a 16.1% decrease. After a low of 4.5% in 2016, there was a slight increase in the uninsured population under age 19 in 2017 (5.2%).[11] The U.S. percentage also decreased from 7.5% in 2013 to 5.0% in 2017. In 2017, nearly half (49.3%) of all uninsured Kansas children under age 19 lived 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, the southwestern part of the state, a largely Hispanic populated area where presumably many are not KanCare (Medicaid or CHIP) eligible, has many counties with high concentrations of uninsured children under age 19. 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. According to the 2016-2017 National Survey of Children's Health, in Kansas, 97.7% of CSHCN were reported to have some type of insurance at the time of the survey: 48.6% had private coverage, 41.7% had public coverage, 7.4% had both, and 2.3% had no insurance.[5]

Primary Care Access & Workforce: In 2017, the supply of family and general practitioners per 100,000 population (23.3) was significantly lower in Kansas than the national average (38.8). So was the supply of obstetricians/ gynecologists (1.7), compared to the national average (5.8). The 2017 estimate for the supply of pediatricians in Kansas was not released/not available. (Individual occupational employment and wage estimates may be withheld from publication for a number of reasons, including failure to meet the Bureau of Labor Statistics quality standards or the need to protect the confidentiality of their survey respondents.) In 2016, the supply of pediatricians (8.9) in Kansas was slightly higher compared to the national average (8.3), although the difference was not statistically significant.[12] KDHE recognizes that while there are needs across the state, there are also unique needs in different areas of the state. Access to care has been recognized as a challenge for the maternal and child health population living in both geographic domains for different reasons. For example, women in rural areas face barriers accessing transportation and getting to providers who may be unavailable in their area. Whereas, women in more densely populated areas, have a wider availability of services yet may not have time off work or the insurance needed to receive services. The CSHCN population often experiences reduced access due to the lack of pediatric specialists in the state, in addition to the other barriers mentioned. In fact, 31.5% of CSHCN families reported that they had trouble getting specialist care versus 18.4% of non-CSHCN families.[5] 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.

Kansas Tribes: KDHE has been working over the last several 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) (1.0% of the Kansas population). As a result of improved communication and established trust with KDHE, the Kansas Tribal Health Summit took place for several years; however, there hasn't been a summit since 2017. The purpose of the annual Summit was to bring together Kansas Tribes and leadership from KDHE. The Kansas Maternal Mortality Review Committee has

tribal representation, and the Native-American population is considered for all MCH efforts and initiatives as appropriate, considering the small population and lack of information available through Vital Statistics. As stated in the Women & Maternal Health section, the MCH program is planning to partner with the March of Dimes to launch The Coming of the Blessing (comingoftheblessing.com) by 2020, starting with the Kickapoo Tribe in response to their request for support and initiatives to improve access to prenatal care and birth outcomes. The Kansas Special Health Care Needs program (KS-SHCN) partnered with faculty with the Leadership Education in Neurodevelopmental Disabilities (LEND) program at the University of Kansas Medical Center to conduct the Northeast Kansas Tribal Developmental Disabilities Needs Assessment. The primary objectives were to: assess the needs of young Native American children with intellectual and developmental disabilities (I/DD) in northeast Kansas; identify sociocultural barriers that influence access to special care and developmental services; evaluate the cultural responsiveness of disability and developmental services; and foster partnerships between tribal communities, state, and academic agencies. More information can be found on this Assessment in the CYSHCN domain report.

Heath Equity and Social Determinants of Health (SDoH)/Disparities: According to the 2018 KIDS COUNT Data Book, Kansas ranked 13th for overall child well-being, 8th in economic well-being, 21st in education, 18th in health, and 23rd in the family and community. The annual KIDS Count Data Book uses 16 indicators to rank each state across four domains - economic well-being, education, health, and family and community - that represent what children need the most to thrive. Comparing 2017 and 2013, Kansas saw an increase in the percentage of fourth graders not proficient in reading (from 62% in 2013 to 63% in 2017) and experienced a five percent rise in eighth graders not proficient in math (from 60% in 2013 to 65% in 2017). Kansas saw a decline in the percentage of 3- to 4-year-olds not attending school, from 56% in 2011-2013 to 53% in 2015-2017. The percentage of children under age 18 living in families where no parent has regular, full-time employment increased from 20% (est. 45,000 children) in 2016 to 21% (est. 146,000) in 2017. This is slightly higher than the five-year low for Kansas in 2016 and a 6% drop since 2010 (27%, 199,000). However, the percentage of children living in high-poverty areas dropped from 8% (est. 56,000) in 2008-2012 to 7% (est. 51,000) in 2013-2017.[13,14]

When looking at outcomes such as infant mortality, preterm birth and smoking during pregnancy rates, we see consistent trends based on race/ethnicity (particularly non-Hispanic black and non-Hispanic white) and socioeconomic factors (particularly Medicaid vs. non-Medicaid) in Kansas. Factors include:

- Race/Ethnicity
- Insurance Type
- Education Level
- Federal Poverty Level
- Special Health Care Needs

These variables are all tied together. For example, people with lower education levels are more likely to live in poverty.

To address disparities, we have taken the following action steps to improve health equity and eliminate disparities:

- Using data to determine where to pilot/target programming, based on disparities (e.g., Smoking Cessation pilot sites chosen from the counties with the highest smoking rates)
- Increasing access to prenatal education and service access in communities with demonstrated disparities (Kansas Perinatal Community Collaboratives/Becoming a Mom®)
- Providing culturally appropriate prenatal education (bi-lingual curriculum and instructors)
    - Currently accommodate for the Hispanic population (curriculum in Spanish and program forms also translated)
    - In conversation with the March of Dimes to launch The Coming of the Blessing (comingoftheblessing.com) by 2020 (related to the current state action plan) to target the Native American population.
- Assessing the need for health coverage, transportation, housing, food, education, etc.
- Implementing nontraditional community-level outreach (minority and at-risk)
- Assuring gap-filling services for those without insurance/access
    - Expediting Medicaid eligibility for prenatal care coverage

    - Expanding the Optum/Alere Health partnership to increase availability of 17P for Medicaid-covered pregnant women in the service area (Kansas City)
- Screening for social determinants through local MCH programs
    - Need tool or screening questions to integrate into existing programs/services
- Working with the agency-appointed staff person to coordinate/advance minority health and health equity strategies (utilizing the CollN SDoH network framework and resources)
- Expanding the Community Baby Shower model focused on safe sleep to integrate smoking cessation and breastfeeding education and referral to services on site; partnering with managed care organizations (MCOs) to align efforts
- Implementing a centralized, web-based data sharing system (DAISEY) that allows for monitoring outcomes and quality improvement along MCH programs; assessing ongoing if local programs are serving those most in need, in line with the Title V purpose
- Supporting development among the MCH workforce through provision of healthy equity and SDoH trainings to the Special Health Services Family Advisory and Maternal and Child Health Councils.

State Health Agency Priorities & Initiatives - Title V 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 Reduction: Kansas Title V is a lead partner in convening and facilitating efforts to reduce infant mortality and eliminate disparities in maternal and infant health. Over the past several years, the Title V program has invested in comprehensive approaches to tobacco/smoking cessation (before, during, after pregnancy) and pre/early term birth. Focused efforts have resulted in implementation of tobacco cessation evidence-based interventions included the BABY & ME - Tobacco Free® and Smoking Cessation and Reduction In Pregnancy Treatment (SCRIPT) program. In addition, universal screening for prior preterm birth (referral and follow up) is taking place with the goal of increased access and utilization to progesterone. A partnership between Title V and Optum (Alere Health) is underway to ensure eligible women are prescribed progesterone and then referred to a case manager for follow up. Sustainability is the key to improved outcomes and long-term success. From concept to reality, the state has worked to integrate initiatives into existing systems to provide the mechanism to achieve current success and future expansion of successful programs. There were 217 infant deaths in 2017 in Kansas, a decrease of 2.7% from 223 infant deaths in 2016, though the infant mortality rate slightly increased from 5.9 infant deaths per 1,000 live births in 2016 to 6.0 in 2017. This meets the Healthy People 2020 target of 6.0 for infant deaths. The infant death rate for non-Hispanic white mothers in 2017 was 4.7, a decrease of 9.6% from 5.2 in 2016. The rate for non-Hispanic black mothers in 2017 was 11.8, a decrease of 22.4% from 15.2 in 2016. The rate for Hispanic mothers in 2017 was 7.2, an increase of 41.2% from 5.1 in 2016. Infant death rates for non-Hispanic black mothers have consistently remained higher than those of non-Hispanic white and Hispanic mothers for the past twenty years (1998-2017). Rates for Hispanic mothers have sometime been higher and sometimes lower than those for non-Hispanic white mothers.[2]

Special Health Care Needs Program (KS-SHCN): Kansas Law mandates health care services for CYSHCN pursuant to K.S.A. 65-5a01, based on medical and financial eligibility. The KS-SHCN program vision spans far beyond the mandate for services and aims to assess and address needs of all children, youth, and families. KS-SHCN continues to expand the focus of the program to address the needs of families through collaboration, systems integration, and increased statewide capacity. Utilizing quality improvement and evaluation, the program strives for sustainable and systemic changes for the CYSHCN population. The completion of the Kansas State Plan for CYSHCN in 2018 provides opportunity to further engage with partners in ways to improve the system of care, collaborate more effectively and efficiently, and consider the current needs of families across the state with CYSHCN in the upcoming 5-Year Needs Assessment. In addition, the creation of Supporting You, a peer-to-peer support network, and the focus on integration of the National Standards of Quality for Family

Strengthening and Support will greatly compliment the direction the KS-SHCN program is heading, focusing on population health, systems of care, and policy improvements.

State Systems Development Initiative (SSDI): The SSDI project provides data capacity and support to the Title V program and specifically aims to: 1) build and expand MCH data capacity, allowing for informed decision making and resource allocation to support effective, efficient and quality programming; 2) advance the development and utilization of linked information systems between key MCH datasets, including minimum/Core dataset for the Kansas Title V MCH program; and 3) support surveillance systems development to address data needs related to emerging MCH issues, for example, establishing maternal mortality review committee and conducting ongoing surveillance of pregnancy-related deaths.

Aid to Local Funding/Statewide MCH Network: When funds are allocated to external programs, the Bureau maintains contracts for the use of funds to outline the nature of the work in support of MCH priorities. Services are delivered in compliance with Title V legislation and in accordance with the KS MCH Manual: http://www.kdheks.gov/c-f/downloads/SFY19_Kansas_MCH_Service_Manual.pdf. The manual provides background on the Title V MCH Block Grant legislation/authority, KS MCH program principles, and service guidance. In addition, it outlines expectations for program supervision and staffing. In order to support local programs with carrying out activities that align with and advance the state action plan, additional resources have been developed and provided. These include a staff training/orientation checklist and several other appendix resources related to practice and national performance measures.

The contractual process with local agencies begins with the development of Grant Application Guidance/Reporting Materials annually in December. These materials are available by mid-January to local agencies applying for Title V funding as part of the aid to local process. The review process which informs funding recommendations involves external reviewers applying guidance and a scoring matrix, a funding formula based on poverty and population by county/target area, and willingness/ability to comply with grant requirements. Detailed client and service data is required to be collected, aggregate progress reports and affidavits of expenditures are required quarterly, and site visits are conducted to verify compliance with funding requirements and progress toward priorities, goals, objectives, and measures. More information about the MCH Aid to Local Program including guidance, is available online through the Kansas Grants Management System (KGMS) main site: https://khap2.kdhe.state.ks.us/KGMS/Default.aspx.

Aid to Local contract documents and the list of local 2019 MCH grantees are attached as supporting documents. The maps also indicate SHCN regions and satellite office lead counties. This information is updated annually in July to reflect new state fiscal year grantees. A map of 2020 MCH grantees/local agencies is provided in supporting documents and in other sections of the grant application.

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III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

Ongoing Review & Assessment of State Needs

The Kansas Title V team continued work related to the Title V Needs Assessment and State Action Plan in partnership with many internal and external partners, the Kansas Maternal & Child Health Council, and the Special Health Services Family Advisory Council. The primary focus since last year's application involved monitoring progress and measures/trends, discussing areas of work that have been in the plan since inception but not executed, and emerging issues for Title V populations not reflected in the plan.

Internal & External MCH Coordination

Concentrated effort has continued to be focused on aligning objectives to the priorities of other KDHE and partner programs to ensure they are not repetitive or duplicative but are collaborative. Several meetings were held with internal agency programs (e.g., Oral Health, Injury Prevention, Chronic Disease Risk Reduction, Local Public Health, Vital Statistics, Emergency Preparedness, WIC, Tobacco Cessation, Medicaid), all the state agencies (Children & Families, Education, Disability & Aging, Children's Cabinet), and a number of partnering organizations (e.g., Oral Health Kansas, Kansas Breastfeeding Coalition, Child Care Aware of Kansas, Kansas Infant Death & SIDS Network, Kansas Hospital Association, Community Care Network of Kansas, United Methodist Health Ministry Fund, American Academy of Pediatrics KS Chapter, ACOG KS Section, Midwives Alliance, etc.) to discuss opportunities for advancing the state action plan.

Major advancements in Title V efforts related to partnership and collaboration over the last year were launching Maternal Mortality Review and full implementation of the first Kansas Perinatal Quality Collaborative (KPQC) hospital-based initiative (addressing the impact of substance use during pregnancy on infants and mothers).

MCH team meetings were held monthly, coordinated by the new MCH Block Grant Coordinator and Title V Director, to review the state action plan, measurement framework data/trends, and work on partnerships and alignment related to objectives and strategies within each priority. This was to ensure we were on target with priority work and relevant efforts. A system was developed by the team for ongoing assessment to track progress with measures and identify program responses based on the data (Ex: develop a TA webinar, conduct site visits, provide resources/materials, and plan a conference or skills building session).

Example documents used by the program to continuously monitor the Title V measures are included below.

Performance Measure Snapshot: This document is updated annually—reflects all Title V NOMs, NPMs, SPMs and other measures tracked by the program. The document is shared and discussed with the Title V team and MCH Council throughout the year as it relates to review of the state action plan and priority work. The document is made available on the state MCH websites for stakeholders and the public.

Title V Outcome Measures and Performance Measures

Kansas Maternal and Child Health Services Block Grant

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NOM#	National Outcome Measures	Medicaid Measures	2013	2014	2015	2016	2017	Trend	HP2020	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		79.4%	80.0%	81.7%	80.8%	81.2%	●	**77.9%**	
	Medicaid		68.6%	70.5%	72.7%	70.2%	72.1%	▲		
	Non-Medicaid		84.7%	84.8%	86.2%	85.8%	85.5%	●		
2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations (2011, 2012, 2013, 2014, 2015Q1-Q3)		76.4	92.7	75.8	93.8	96.5†	▲	-	2
3	Maternal mortality rate per 100,000 live births (5 year rolling average)		16.5	15.1	14.2	16.4	18.8	▲	**11.4**	1,3
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		7.0%	7.1%	6.9%	7.0%	7.4%	▲	**7.8%**	
	Medicaid		8.6%	8.5%	8.7%	8.8%	9.5%	▲		
	Non-Medicaid		6.3%	6.3%	6.0%	6.1%	6.4%	●		

Evidence-based or informed Strategy Measure (ESM) Tracking Snapshot: This document is updated quarterly for internal use and discussion by the Title V state team. The information is shared periodically with the MCH Council and local agencies providing MCH services at the community level in an effort to show the status of process measures intended to advance the national performance measures.

Title V Evidence-Based or -Informed Strategy Measures

Kansas Maternal and Child Health Services Block Grant

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FOR INTERNAL USE ONLY: All data in this table are 'PROVISIONAL - SUBJECT TO CHANGE'.

ESM#	Strategy Measures		2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	Trend	Source
1.1	Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year	Num/Den	427/2361	419/2195	549/2167	454/1882	536/2037	438/1916	455/2369	355/2174	▲	1
		Percent	18.1%	19.1%	25.3%	24.1%	26.3%	22.9%	19.2%	16.3%		
1.2	Percent of women program participants (18-44 years) that received a well-woman visit in the past year	Num/Den	1577/2342	1619/2257	1529/2118	1306/1842	1454/1968	1426/1908	1400/1928	1274/1703	▲*	1
		Percent	67.3%	71.7%	72.2%	70.9%	73.9%	74.7%	72.6%	74.8%		
4.1	Percent of WIC infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"	Num/Den	230/1797	242/1766	238/1704	250/1744	226/1956	257/1820	255/1782	242/1658	▲	2
		Percent	12.8%	13.7%	14.0%	14.3%	11.6%	14.1%	14.3%	14.6%		
6.1	Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program (9-35 months)	Num/Den	105/584	103/538	105/457	85/407	121/478	111/426	94/470	57/473	▲	1
		Percent	18.0%	19.2%	23.0%	20.9%	25.4%	26.1%	20.0%	12.1%		
7.1	Number of child safety seat inspections completed by certified technicians	Quarter	280	274	225	182	171	325	248	-	▲	3
		Cumulative	1374	1648	1873	2055	2226	2551	2797	-		

Changes in MCH Population Health Status & MCH Program Response

Data were the guide, emerging issues were targeted, and actions were taken.

Maternal Mortality: The Kansas Maternal Mortality Review Committee (KMMRC) was officially established in 2018 in response to the increasing trend of maternal and pregnancy-associated deaths. The use of the Maternal Mortality Review Information Application (MMRIA) is fully integrated into the process. Of the 28 identified deaths in 2016, 14 have been reviewed to date. Four deaths were found to be pregnancy-related, four pregnancy-associated but not related, two unable to determine the pregnancy-relatedness, and four not pregnancy-related or associated (false positive pregnancy-associated deaths). Two pregnancy-related deaths occurred within the 42 days postpartum and two occurred 43 days to one year after the end of pregnancy. Two pregnancy-related deaths occurred in non-Hispanic white women, one non-Hispanic black woman, and one non-Hispanic Native American woman. One pregnancy-related death occurred at age 25-29, two deaths at age 30-34, and one death at age 35-44. The pregnancy-related deaths were caused by hypertension/disseminated intravascular coagulation (1 death), cardiovascular conditions/cardiac failure (1 death), drugs/cardiac failure (1 death), and suicide by hanging (1 death). KMMRC determined that three of the four pregnancy-related deaths could have been prevented. By the end of the year (after review of 2016 and 2017 deaths are complete), Title V will identify an AIM patient safety bundle in collaboration with the KMMRC and KPQC. Related: The Bureau of Family Health/Title V Program, in conjunction with KDHE's Vital Statistics Data Analysis Section is undertaking a project to enumerate the number of birth providers (Physicians and OBGYNs), by county, in Kansas to identify areas where there may be provider shortages. This project will focus on those providers who delivered births within the state of Kansas.

Maternal Morbidity: Title V is closely monitoring maternal morbidity as well as mortality. The maternal health initiatives

currently underway and those that will result from the review of maternal death cases are also very relevant and important as a response to the rise in maternal morbidity. Severe maternal morbidity data were attained from the Federal Maternal and Child Health Bureau, federally available data resource document: NOM2 - Rate of severe maternal morbidity per 10,000 delivery hospitalization* using data that were collected for the Healthcare Cost and Utilization Project - State Inpatient Database. Severe maternal morbidity rate among delivery and postpartum hospitalizations in Kansas has been steadily increasing in recent years from 74.6 per 10,000 delivery hospitalizations in 2008 to 96.5 per 10,000 delivery hospitalizations in 2015 Q1-Q3. Figure 2 shows trends in severe maternal morbidity in Kansas between 2008 and 2015 Q1-Q3. The Severe maternal morbidity rate steadily increased by 3.0% per year (not statistically significant).

*Delivery hospitalizations with severe maternal morbidity were identified with condition specific ICD-9-CM codes (diagnosis and procedure codes) representing 21 indicators: acute myocardial infarction, aneurysm, acute renal failure, adult respiratory distress syndrome, amniotic fluid embolism, cardiac arrest, disseminated intravascular coagulation, eclampsia, heart failure during procedure or surgery, puerperal cerebrovascular disorders, pulmonary edema/acute heart failure, severe anesthesia complications, sepsis, shock, sickle cell anemia with crisis, thrombotic embolism, conversion of cardiac rhythm, blood transfusion, hysterectomy, temporary tracheostomy, and ventilation.

Infant Mortality – SUID: Infant mortality rate (IMR) in 2017 was 6.0 deaths per 1,000 births compared to 5.9 deaths per 1,000 births in 2016. The increase in the rate (2016 to 2017) was only 1.7% and was not statistically significant. However, Sudden Unexpected Infant Death (SUID) remains a leading cause of infant death (18.6%) and an upward trend has been noted. In response to this, Title V is continuing a formal partnership with the KIDS Network to keep focus on consistent safe sleep messaging across sectors/settings and across the life course. The Community Baby Shower model evaluation results indicate the education and hands-on demonstrations are making a difference. We must continue to train home visitors, child care surveyors, and other public health/community experts so they are positioned to provide education and training at the local level on an ongoing basis. Focus should remain on parents, grandparents and other family caregivers, child care providers, and clinicians (hospitals and outpatient pediatric settings).

Preterm births: Kansas received a “C” (in terms of premature birth rate) in the March of Dimes (MOD) Report Card in November 2018. A trend analysis during 2007-2017 of the preterm birth rates in Kansas was conducted, which matched the MOD’s report time period. There was a significant decreasing trend over the interval 2007-2015 (Average Percent Change (APC) = - 0.8), followed by a non-significant increasing trend from 2015 to 2017 (APC = 4.7) in premature births in Kansas. This mirrored the national trend. We have been monitoring the trend; an increase was apparent comparing the 2016 and 2017 data. Furthermore, interestingly, in the 2018 Kansas Perinatal Community Collaborative (KPCC) evaluation process, KPCC participants were found to have a higher rate of preterm births (though not statistically significant) compared to the state overall (based on birth records). The preterm birth cases in the KPCC data were analyzed to identify if there were any correlates of note related to the increased preterm birth rate found during the evaluation. There were no areas of concern identified during the analysis of factors associated with preterm births, but future work will continue to evaluate trends and possible associated factors.

Funded by the Robert Wood Johnson Foundation, the National Institute for Children's Health Quality (NICHQ) has embarked on an exciting project to identify state-level systems, policies, structures and other contextual factors that help reduce preterm birth (PTB) rates. The goal of this project is to identify strategies that both lead to better outcomes for mothers and babies and can impact disparities in PTB rates. Kansas’s participation in the National Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CollN) and specifically the PTB learning network provides a unique opportunity to reflect on our state’s efforts to reduce PTB rates. Kansas is one of four IM CollN states invited to participate in this project. NICHQ will be developing case studies to more closely examine factors in each of the four states that may have contributed to their PTB results. Ultimately, the case studies will document and disseminate best practices, barriers and strategies with the potential to decrease PTB rates. An initial call was held with the NICHQ team in February 2019, around developing a PTB case study of Kansas - exploring what may have driven Kansas’ preterm birth rate outcomes. An in-state site visit is scheduled for August 12-13, 2019. The site visit will consist of both individual interviews and group discussions.

Kansas Maternal & Child Health Council (KMCHC)

The KMCHC serves in an advisory capacity to the Title V Program; monitors progress; and addresses specific needs for MCH populations. The Council membership totals 50-55 and is comprised of a multidisciplinary team of professionals with expertise in MCH. Memberships includes several family representatives/leaders engaged at the state level. Input/work resulting from the Family Advisory Council (FAC) informs and/or is incorporated into work of the MCH Council (read more about the FAC in the Family Partnership Section). The Kansas Chapter of the American Academy of Pediatrics (KAAP*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas and improved outcomes. The Title V needs assessment and state action plan are the guiding documents for ongoing work of the Council. KDHE and KAAP convene the Council at least once each quarter. The structure of the council meetings is key to advancing the state action plan. Each meeting entails large group discussions and presentations on MCH investments/initiatives (safe sleep, birth outcomes, breastfeeding, school health, etc.) and/or workforce development topics (Life course, human trafficking, etc.) as well as small group sessions focused on domain action plans/efforts. The full council membership participates in one of four small groups as part of every meeting (Women/Maternal, Perinatal/Infant, Child, and Adolescent). Every small group is responsible for discussing and monitoring special health care needs and cross-cutting areas of the state action plan. See sample meeting agenda below. Learn more about the MCH Council, review membership, and access materials and resources online: www.kansasmch.org.

*KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas.

Sample KMCHC Meeting Agenda

KANSAS MATERNAL & CHILD HEALTH

Kansas Maternal & Child Health Council (KMCHC)
Wednesday, July 25, 2018
9:30 a.m. – 3:00 p.m. (lunch provided)
Kansas Medical Society, 623 SW 10th Ave, Topeka, Kansas

Agenda Items		
9:30	**Welcome & Recognize New Members/Guests**	Dennis Cooley, MD, Chair
9:40	**Review & Approval of April 18, 2018 Minutes**	Dennis Cooley, MD, Chair
9:45	**Exploitation & Human Trafficking in Kansas (*Special Presentation*)**	Jennifer Montgomery, Attorney General's Office
10:45	**Responding to Human Trafficking: MCH's Role & Next Steps (*Facilitated Discussion*)**	Connie Satzler, EnVisage Consulting
11:15	**Title V MCH Block Grant Application/Action Plan/Measurement Updates**	Rachel Sisson, Heather Smith, Jamie Kim, KDHE
11:45	**Break & Lunch**	
12:15	**MCH Population Domain Small Group Discussion** Task 1 (35-45 minutes): Review of ***REVISED DRAFT*** Title V Priorities & State Action Plan Task 2 (30-45 minutes): Discuss selected Domain "problem" to address/advance. Optional: (10-15 minutes): MCH-MCO Partnership Progress Check In	
1:45	**Break**	
2:00	**Child Health Group Recommendation Presentation**	Group Members
2:30	**Announcements & October Meeting Agenda**	KDHE Staff & KMCHC Members
2:55	**Closing Remarks**	Dennis Cooley, MD, Chair

Future Meeting Dates: October 10, 2018 – January 23, 2019 – April 10, 2019

Role of the Kansas Maternal & Child Health Council (KMCHC) Monitoring/Assessing Needs

The Council actively participates in monitoring of the plan and assists with prioritization and assessment of progress on a regular basis. This is evident through the sample agenda provided above. Throughout the last year, work with the KMCHC

typically involved learning about an MCH issue affecting populations (large group) and review of the state action plan (small group) as it pertained to progress with domain priorities, objectives, and strategies. Data was also reviewed on a regular basis; data is typically reviewed in depth each July. The July meeting is a review of the block grant application/annual report and all measures. The Council small groups assigned to the domains provided input related to progress, emerging issues, recommended changes, and potential new partnerships and collaborations.

High-level summaries of the work that occurred during each council meeting since last year's report follows. NOTE: All meeting agendas, materials, and minutes are available on the Kansas MCH website. An overview of the FY18 KMCHC meetings is below.

KMCHC Meeting Highlights

2018

Large Group Presentations/Topics/Discussions

- Parent and Family Engagement: How to work in communities to get parents and families engaged in their children's health and activities
- Mental Health First Aid: How to identify, understand and respond to signs of mental health/substance abuse
- MCH Investment Spotlight: Kansas Safe Sleep Cross-Sector Initiative – the ABCs of Safe Sleep and having all organizations provide a consistent message
- Federal and State Legislative: Bills and updates affect Kansas children and their families, including updates on the Kansas Medicaid Program, KanCare
- Managed Care Organizations (MCO): Presentations on programs offered throughout the state (in alignment with the Title V State Action Plan
- Care Coordination Model with MCOs: Core functions include education, navigation, medical care coordination, and advocacy
- Birth Defects Program: Reviewed the program and looked at obtaining more specific data to evaluate
- Neonatal Abstinence Syndrome (NAS) in Kansas – Opioid Crisis
- Behavioral Health Data: The Connection to MCH Priorities – addressing social-emotional development, learning, and character development – how they all relate
- Help Me Grow Kansas: Implementation and pilot communities
- School Based Health Centers (SBHC): Information from a Kansas community that partners the medical community with School Based Health Centers to improve child health (Southeast Kansas)

Small Domain Group Work

- Reviewed the MCH State Plan to discuss additions and changes to each Domain area
- Discussion opportunities with the Kansas MCOs and on how to align and collaborate on the state action plan
- Identified priority opportunities to advance forward on the state action plan
- Worked on MCH-MCO partnership progress and next steps
- Worked on reviewing the Title V priorities and state action plan; made recommended changes for domains

Title V MCH Promotion & Outreach

Title V continues to promote the MCH block grant services and federal-state-local partnership. The state action plan priority areas and Title V investments are shared widely on an ongoing basis. Following the 2016 needs assessment, a Kansas MCH website and Facebook page were launched.

The MCH website (www.kansasmch.org) and Facebook page (www.facebook.com/kansasmch) continue to gain popularity. Analytics reveal a general increasing trend in terms of page visitors and visits since launch.

MCH Facebook Page

Facebook Page Insights

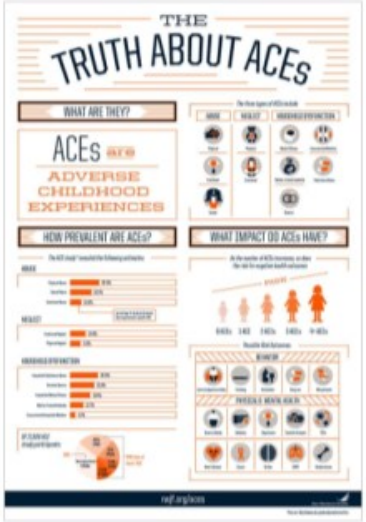
Facebook Page Likes Since Launch

September 2015 (Launch)	0 Likes
May 30, 2019 (Present)	410 Likes (+410)

Facebook Page Likes Reporting Period

October 1, 2017	254 Likes
September 30, 2018	363 Likes (+109)
Total Posts	149 Posts

The total MCH Facebook Page "likes" as of today are 410. The number has increased steadily since launch.
Several posts reached a high number of users, received a high level of "likes" and/or interaction (shared) from users. Below are some of the top/most popular posts from the reporting period.

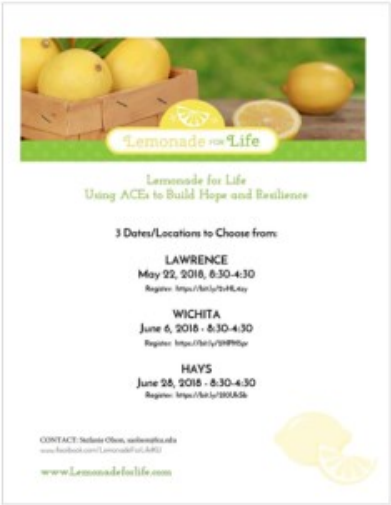


7/30/18
Reach: 3,289
Shares: 26
Likes: 16

"ACEs are Adverse Childhood Experiences and they affect how a child develops. Check out this infographic from the Robert Wood Johnson Foundation. For the full article see tinyurl.com/about-aces."

5/29/18
Reach: 1,138
Shares: 17
Likes: 25

"Did you know protection from vaccine-preventable diseases starts before birth? Get vaccine facts! https://go.usa.gov/xna9B"



5/14/18
Reach: 1,943
Shares: 12
Likes: 27

"Lemonade for Life is a trauma-informed, hope-infused approach to using Adverse Childhood Experiences (ACEs) research in our work to improve outcomes for children and families. Register soon for a summer training near you!

Registration: www.kansasmch.org/events.asp

LFL Website: Lemonadeforlife.com."

11/13/17
Reach: 2,060
Shares: 10
Likes: 3

"Since children younger than 6 months cannot get a flu vaccine, the best way to protect them is to make sure people around them are vaccinated against the flu this season. (https://go.usa.gov/xRptc)"

Kansas MCH Website

Website Insights (Google Analytics)

Website activity has been generally constant with periods of greater activity coinciding with information campaigns, initiatives, and council meetings**.** To maintain the accessibility of the site, a review is ongoing to improve accessibility in line with Web Content Accessibility Guidelines (WCAG) 2.1.

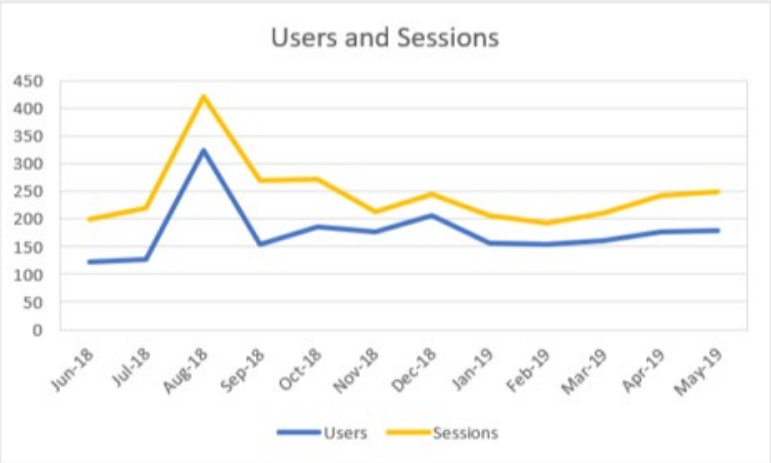
Summary Points (based on one year 2018-2019)

- The site had an average 177 users each month who viewed an average 2.62 pages during each session.
- 86% of site visitors are new, 14% are returning visitors.
- The average session duration is 2 minutes and 38 seconds.
- About 84% of users visit the site on desktop, 14% on mobile devices, and 2% on a tablet.
- After the homepage, the most viewed pages are the Maternal Mortality Review page, About Us page, and Resources page.
- Most users are located in Topeka, followed by Wichita and Kansas City.

Definitions

- Pageviews: The total number of pages viewed. Repeated views of a single page are counted.
- Users: Users who have initiated at least one session during the date range. In this case, unique users within each month.
- Sessions: A session is the period time a user is actively engaged with your website; a group of interactions one user takes within a given time frame on your website. Google Analytics defaults that time frame to 30 minutes, meaning whatever a user does on your website (e.g. browses pages, downloads resources, purchase products) before they leave equals one session.

June 2018 – May 2019



FY 2019 Application/FY 2017 Annual Report Update

Ongoing Review & Assessment of State Needs

The Kansas Title V team continued work related to the Title V Needs Assessment and State Action Plan in partnership with many internal and external partners, the Kansas Maternal & Child Health Council, and the Special Health Services Family Advisory Council. The primary focus since last year's application involved monitoring progress and measures/trends, discussing areas of work that have been in the plan since inception but not executed, and emerging issues for Title V populations not reflected in the plan.

Internal and External MCH Coordination

Concentrated effort has continued to be focused on aligning objectives to the priorities of other KDHE and partner programs to ensure they are not repetitive or duplicative but are collaborative. Several meetings were held with internal agency programs (e.g., Oral Health, Injury Prevention, WIC, Tobacco Cessation, Medicaid) and a number of partnering organizations (e.g., Oral Health Kansas, Kansas Breastfeeding Coalition, Child Care Aware of Kansas, United Methodist Health Ministry Fund, American Academy of Pediatrics KS Chapter, ACOG KS Section) to discuss opportunities for advancing the state action plan. One major advancement related to partnership internally involved a joint request for proposal developed by MCH and the Tobacco program. Local agency applicants were encouraged to submit proposals that offered a tobacco strategy targeted to the perinatal period. This was the second most popular tobacco strategy selected by 14 local agencies, likely due to the MCH presentation about tobacco cessation efforts at the Chronic Disease Risk Reduction Summit.

MCH team meetings were held monthly to review the state action plan—data as well as objectives and strategies within each priority. This was to ensure we were on target with priority work and relevant efforts. A system was developed by the team for ongoing assessment to track progress with measures and identify program responses based on the data (Ex: develop a TA webinar, conduct site visits, provide resources/materials, plan a conference or skills building session). Example documents used by the program to continuously monitor the Title V measures are included below.

Performance Measure Snapshot: This document is updated annually—reflects all Title V NOMs, NPMs, SPMs and other measures tracked by the program. The document is shared and discussed with the Title V team and MCH Council throughout the year as it relates to review of the state action plan and priority work. The document is made available on the state MCH websites for stakeholders and the public.

Title V Outcome Measures and Performance Measures
Kansas Maternal and Child Health Services Block Grant
2019 Application/2017 Annual Report

NOM#	National Outcome Measures	Medicaid Measures	2012	2013	2014	2015	2016	Trend	HP2020	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		78.8%	79.4%	80.0%	81.7%	80.8%	↑	**77.9%**	
	Medicaid		67.9%	68.6%	70.5%	72.7%	70.2%	↑		
	Non-Medicaid		84.4%	84.7%	84.8%	86.2%	85.8%	●		
2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations		92.7	75.8	93.8	96.5†	-	↑	-	2
3	Maternal mortality rate per 100,000 live births (5 year rolling average)		14.7	16.5	15.1	14.2	16.4	↑	**11.4**	1,3
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		7.2%	7.0%	7.1%	6.9%	7.0%	↑	**7.8%**	
	Medicaid		8.9%	8.6%	8.5%	8.7%	8.8%	●		
	Non-Medicaid		6.3%	6.3%	6.3%	6.0%	6.1%	↑		

Evidence-based or informed Strategy Measure (ESM) Tracking Snapshot: This document is updated quarterly for internal use and discussion by the Title V state team. The information is shared periodically with the MCH Council and local agencies providing MCH services at the community level in an effort to show the status of process measures intended to advance the national performance measures.

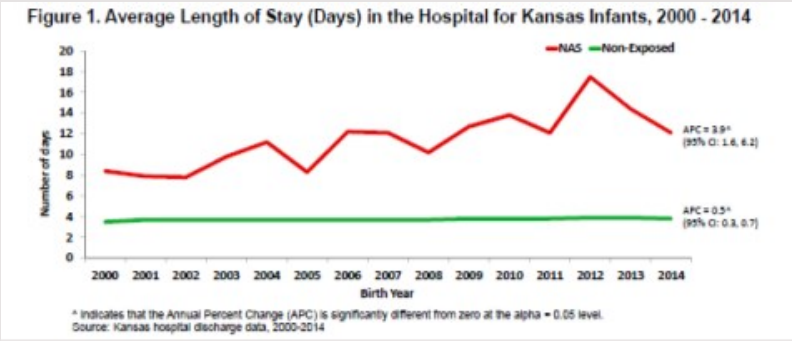
Title V Evidence-Based or -Informed Strategy Measures
Kansas Maternal and Child Health Services Block Grant
2019 Application/2017 Annual Report
FOR INTERNAL USE ONLY: All data in this table are 'PROVISIONAL - SUBJECT TO CHANGE'.

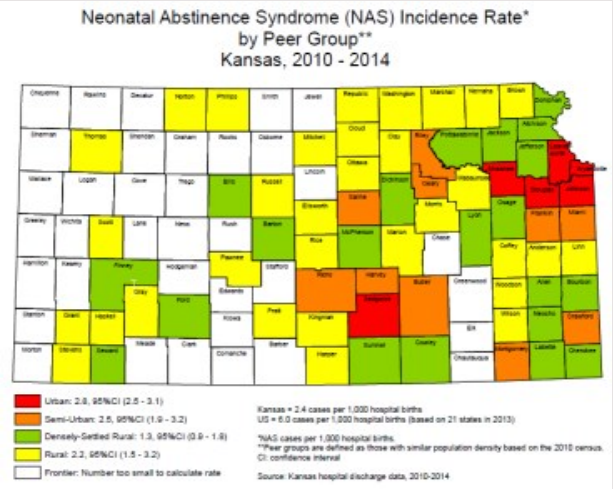
ESM#	Strategy Measures		2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Trend	Source
1.1	Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year	Num/Den	132/840	107/1061	248/1380	221/1183	197/1264	204/1248	327/1392	282/1480		◆	1
		Percent	15.7	10.1	18.0	18.7	15.6	16.3	23.5	19.1			
1.2	Percent of women program participants (18-44 years) that received a well-woman visit in the past year	Num/Den	124/840	100/1061	151/1380	132/1183	127/1264	126/1248	174/1392	129/1480		◆	1
		Percent	14.8	9.4	10.9	11.2	10.0	10.1	12.5	8.7			
4.1	Percent of WIC infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"	Num/Den	284/1436	253/1368	255/1239	230/1211	225/1324	240/1208				◆	2
		Percent	19.8	18.5	20.6	19.0	17.0	19.9					
6.1	Percent of program providers using a parent-completed developmental screening tool during an infant or child visit (9 – 35 months)	Num/Den	6/25	11/29	15/37	13/35	17/35	15/37	17/34	18/34		◆*	1
		Percent	24.0	37.9	40.5	37.1	48.6	40.5	50.0	55.9			
7.1	Number of child safety seat inspections completed by certified technicians	Quarter	232	369	234	259	280	274	225	-	-	◆	3
		Cumulative	232	601	835	1094	1374	1648	1873	-	-		

Changes in MCH Population Health Status & MCH Program Response

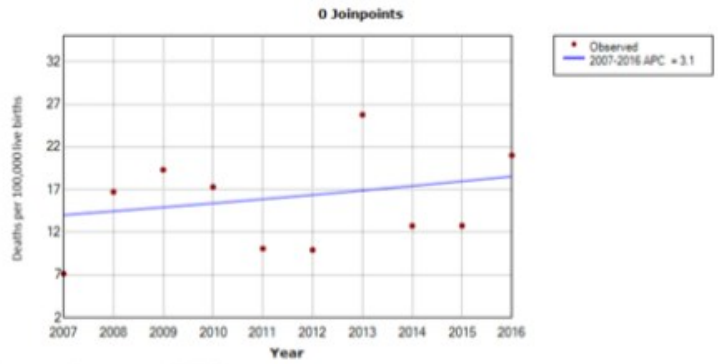
Data was the guide, emerging issues were targeted, and actions were taken. For example, the increasing trend of Neonatal Abstinence Syndrome (NAS) and maternal death led to creating new capacity, hiring new staff, shifting resources to support state-level action. See actual data and information provided to the program below.

NAS: Between 2000 and 2014, the incidence of NAS in Kansas increased almost 900% from 0.3 per 1,000 hospital births (95% confidence internal) to 2.9 per 1,000 hospital births (95% confidence interval). Although the incidence rate is lower in Kansas compared to other states, the increase in incidence for Kansas is much higher than national estimates (i.e., 300%). This means that the occurrence of NAS diagnoses are steadily increasing among newborns in Kansas. The average length of hospital stay for an infant with NAS increased significantly by 44.0% from 2000 to 2014 (from 8.4 to 12.1 days), widening the gap between length of stay for those with NAS and unexposed infants.





Maternal Mortality: Although not statistically significant, the Kansas maternal mortality rate *increased by 3.1% per year* [95% Confidence Intervals (CI): -6.4, 13.7] during the period 2007-2016.



*Rate: Deaths per 100,000 live births
Source: 2007-2016 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE

Rolling Average 1999-2016: The Kansas Maternal Mortality Rate increased from 5.6 for the five-year period 1999-2003 to 16.4 for the five-year period 2012-2016.

Year	MM	Births	Rate*	95% CI	
1999-2003	11	195,925	5.6	2.8	10.0
2000-2004	9	196,730	4.6	2.1	8.7
2001-2005	11	196,777	5.6	2.8	10.0
2002-2006	14	198,841	7.0	3.8	11.8
2003-2007	15	201,454	7.4	4.2	12.3
2004-2008	22	203,916	10.8	6.8	16.3
2005-2009	28	205,751	13.6	9.0	19.7
2006-2010	29	206,489	14.0	9.4	20.2
2007-2011	29	205,221	14.1	9.5	20.3
2008-2012	30	203,574	14.7	9.9	21.0
2009-2013	33	200,564	16.5	11.3	23.1
2010-2014	30	198,369	15.1	10.2	21.6
2011-2015	28	197,056	14.2	9.4	20.5
2012-2016	32	195,476	16.4	11.2	23.1

*Rate: Deaths per 100,000 live births
Source: 1999-2016 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE

Policy changes necessary to improve access and MCH outcomes were also the focus over the last year. Related to NAS, recommendations were made by the Title V program to expand the existing Medicaid coverage for substance use screening. The state Medicaid policy related to covering substance screening services is too narrow, only including addiction staff and treatment centers. The Governor convened an Opioid Task Force and the State Prescription Drug and Opioid Advisory Committee continues to move ahead with developing a state action plan—this plan is tied to the Title V Kansas Perinatal Quality Collaborative plan for addressing NAS and improving practices in the hospital setting. Related to maternal mortality, new legislation was introduced by the Title V program during the 2018 Legislative Session to support comprehensive review of maternal deaths. Language in HB 2573, now Kansas law, amended existing law (K.S.A. 65-177) to strengthen efforts related to monitoring maternal health, including maternal and pregnancy-associated deaths. Specifically, the amended law grants the Department access to all necessary information to implement a comprehensive process to review each pregnancy-associated death and protects all people, records, and interviews obtained as part of each review. The new law also allows for routine compilation and wide distribution of aggregate, non-individually identifiable data to further the study of causes and problems associated with deaths. This process leads to informed, data-driven recommendations for actions that reduce death and support health and wellness during the pregnancy, childbirth, and postpartum periods. The Title V program assigned a facilitator for the maternal mortality review committee/work, contracted with an abstractor, and plans to convene the committee with CDC for the first meeting and mock case review on June 12, 2018.

Kansas Maternal & Child Health Council (KMCHC)

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expertise in MCH. Memberships includes several family representatives/leaders engaged at the state level. Input/work resulting from the Family Advisory Council (FAC) informs and/or is incorporated into work of the MCH Council (read more about the FAC in the Family Partnership Section). The Kansas Chapter of the American Academy of Pediatrics (KAAP*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas and improved outcomes. The Title V needs assessment and state action plan are the guiding documents for ongoing work of the Council. KDHE and KAAP convene the Council at least once each quarter. The structure of the council meetings is key to advancing the state action plan. Each meeting entails large group discussions and presentations on MCH investments/initiatives (safe sleep, birth outcomes, breastfeeding, school health, etc.) and/or workforce development topics (Life course, human trafficking, etc.) as well as small group sessions focused on domain action plans/efforts. The full council membership participates in one of four small groups as part of every meeting (Women/Maternal, Perinatal/Infant, Child, and Adolescent). Every small group is responsible for discussing and monitoring special health care needs and cross-cutting areas of the state action plan. See sample meeting agenda below. Learn more about the MCH Council, review membership, and access materials and resources online: www.kansasmch.org.

Important historical note/context: A decision was made in September 2015 to merge the Blue Ribbon Panel on Infant Mortality with the KMCHC, resulting in greater coordination and impact. The Panel was established in 2009 to develop a set of recommendations to reduce infant mortality in Kansas. Work and membership is now integrated into the KMCHC, with most of the members previously on the Panel serving on the Perinatal/Infant Health workgroup.

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Sample KMCHC Meeting Agenda

KANSAS MATERNAL & CHILD HEALTH

Kansas Maternal & Child Health Council (KMCHC)
Wednesday, October 4, 2017

9:30 a.m. – 3:00 p.m. (lunch provided) Kansas Medical Society, 623 SW 10th Ave., Topeka, Kansas

Agenda Items		
9:30	**Welcome & Recognize Special Guests**	Dennis Cooley, MD, Chair
9:40	**Review & Approval of July 19, 2017 Minutes**	Dennis Cooley, MD, Chair
9:45	**Title V Block Grant Application & State Action Plan: Update**	Rachel Sisson, Bureau of Family Health, KDHE
10:00	**KanCare Managed Care Organization Panel**	Amerigroup, Sunflower Health Plan, United Healthcare
11:45	**Break & Lunch**	
12:15	**KanCare State & Federal Updates**	Kasey Sorell, Division of Health Care Finance, KDHE
12:30	**MCH Population Domain Small Group Discussions**	
	Purpose: Consider the community-based Medicaid services/supports and initiatives currently underway. Identify specific areas of alignment with the MCH state plan by domain and determine next steps for collaboration/action to expand and/or advance efforts in partnership with Managed Care Organizations. Reminder: All groups must consider cross-cutting/life course and special health care needs.	
	Women & Maternal Health	
	Perinatal & Infant Health	
	Child Health	
	Adolescent Health	
2:00	**Break**	
2:15	**PRAMS Update: Year 1 Reflection & Next Steps**	Lisa Williams & Julia Soap, KDHE
2:30	**Announcements**	KDHE & KMCHC Members
2:50	**Closing Remarks**	Dennis Cooley, MD, Chair

Future Meeting Dates: January 17, 2018; April 18, 2018

Role of the Kansas Maternal & Child Health Council (KMCHC) Monitoring/Assessing Needs

The Council actively participates in monitoring of the plan and assists with prioritization and assessment of progress on a regular basis. Throughout the last year, work with the KMCHC typically involved learning about an MCH issue affecting populations (large group) and review of the state action plan (small group) as it pertained to progress with domain priorities, objectives, and strategies. Data was also reviewed along with the plan each meeting. The Council small groups assigned to the domains provided input related to progress, emerging issues, recommended changes, and potential new partnerships and collaborations. High-level summaries of the work that occurred during each council meeting since last year's report follows. NOTE: All meeting agendas, materials, and minutes are available on the Kansas MCH website. An overview of 2017 and 2018 meeting activities and next steps is outlined below.

KMCHC Meeting Highlights

JANUARY 2017

Primary Topic(s)	Key Activities	Next Steps
Adverse Childhood Experiences (ACEs) and Trauma-Informed Care (TIC)	Presentation from Dr. Renaisa Anthony and a panel of experts representing "Resilient KC".	The panel discussion and updates from experts across Kansas applying these concepts in practice provided the membership and Title V team with a greater understanding as to the role MCH can play in the work.
	Specific ideas of how to create trauma-informed workplaces and schools was discussed.	Wichita State University was present to share more about work happening with Kansas Power of the Positive (KPoP), an effort focused on child abuse prevention and safe, stable, nurturing environments.

APRIL 2017

Primary Topic(s)	Key Activities	Next Steps
Reflection and discussion on ACEs and TIC	Discussion on training and workforce development.	Training the workforce – not just the research and screening but how to put in practice and infuse hope and resilience through MCH programs and services.
Family/Consumer Engagement	Discussion on interventions to address the need – What can we do?	Provide home visitors training on Mental Health First Aid and professionals on an approach known as Lemonade for Life.
	Uplifting and informative presentation from FAC members	Parents shared their experiences which led to a call to action for the Council members: Return to their respective organizations and take action to improve family and consumer engagement.

JULY 2017

Primary Topic(s)	Key Activities	Next Steps
Family and Consumer Engagement	Discussion and reflection	Members shared progress towards their commitment from last meeting. Several had completed their commitment and were considering additional ways to involve families/patients at different levels.
Safe Sleep	Special presentation	The purpose/intent, progress/results, and preliminary data were shared with the Council.
Review of State Action Plan	Small domain groups discussion	After review, groups provided recommendations for modifications to the state plan.

OCTOBER 2017

Primary Topic(s)	Key Activities	Next Steps
Managed Care Initiatives	Panel of MCO representatives to share about initiatives and value-added services	The Chief Medical Officer and MCH Program Manager for each MCO attended the meeting and participated on the panel. The MCH Council provided questions in advance. This meeting proved critical to our work involving Medicaid alignment and partnerships.
Review of State Action Plan	Small domain group discussion	Identification of opportunities to partner with the MCOs at the meeting and have continued working on implementing tasks and action plans since that time.

KMCHC Meeting Highlights

JANUARY 2018

Primary Topic(s)	Key Activities	Next Steps
New Program Initiatives (Care Coordination, Birth Defects, NAS)	Presentation by KS-SHCN Program Manager	New Care Coordination program, modeled after Boston Children's Hospital. Good discussion and interest in hearing more about progress and impact for children and families.
	Presentation by KS Birth Defects Program Coordinator	Shared information about official launch of the Birth Defects Program—the birth defects statute has been in effect since the 1980's but Kansas has not had an active surveillance system and program until now.
	Presentation by Children & Families Section Director	Efforts related to the opioid epidemic, Neonatal Abstinence Syndrome and maternal mortality provided data as well as an update on progress at the state and local levels, plans for future expansion, and more.
Managed Care Initiatives	Small domain group discussion	Discussed ideas related to collaboration with MCOs; identified opportunities to move forward

APRIL 2018

Primary Topic(s)	Key Activities	Next Steps
Help Me Grow	Presentation from the University of Kansas Center for Public Partnership and Research	Provided updates on implementation activities and discussion around existing alignment activities to support quick implementation in some communities. (e.g. Early Childhood Comprehensive Systems (ECCS) target communities are already focused on this type of model, utilizing shared data systems, and moving toward electronic referral with IRIS.
School Based Health	Presentation by FQHC/MCH Grantee, Community Health Center of Southeast Kansas	Shared about school health in the county and region, specifically the history of how the school-based health centers were started and what has contributed to the success of delivering comprehensive health services to children and adolescents.
Managed Care Initiatives	Small domain group discussion	Review of the MCO-MCH partnership opportunities/next steps and reviewed the state action plan, discussing progress over the last year and proposed changes for the year to come.

Title V continues to promote the MCH block grant services and federal-state-local partnership. The state action plan priority areas and Title V investments are shared widely on an ongoing basis. Following the 2016 needs assessment, a Kansas MCH website and Facebook page were launched. The MCH website (www.kansasmch.org) and Facebook page (www.facebook.com/kansasmch) continue to gain popularity. Analytics reveal a general increasing trend in terms of page visitors and visits since launch.

Kansas Maternal & Child Health Website Insights

Facebook Page Likes Since Launch: September 2015 - May 23, 2018

Facebook Page Likes Since Last Reporting Period: October 1, 2017 - May 23, 2018 (increase of 59)

Top 10 MCH Facebook Page Posts During October 2017 – May 2018

Kansas Maternal & Child Health
February 12 ·

The Kansas team is attending the national Association of Maternal & Child Health Programs (AMCHP) conference in DC this week! We are so proud to announce our very own Heather Moore Smith received the Emerging MCH Professional Award for Region VII. Congratulations! We thank you for your dedication to Kansas children and families. #AMCHP18

2/12/18
Reach: 2,175
Shares: 6
Likes: 186

11/13/17
Reach: 2,060
Shares: 11
Likes: 19

SYMPTOMS OF FLU
• Fever*
• Cough
• Sore throat
• Runny or stuffy nose
• Feeling feverish/chills
• Muscle or body aches
• Headaches
• Fatigue (tiredness)
#FIGHT FLU
*Not everyone with flu will have a fever.
www.cdc.gov/flu

5/14/18
Reach: 1,907
Shares: 12
Likes: 36

2/19/18
Reach: 1,105
Shares: 15
Likes: 31

4/23/18
Reach: 1,029
Shares: 6
Likes: 7

10/26/17

Reach: 926

Shares: 14

Likes: 19

1/3/18

Reach: 866

Shares: 9

Likes: 5

Kansas Maternal & Child Health Website Insights

Website Analytics: October 2016 – September 2017
**Cumulative Users for All Months*

Users:	Sessions:	Views:
1244*	2196	7074

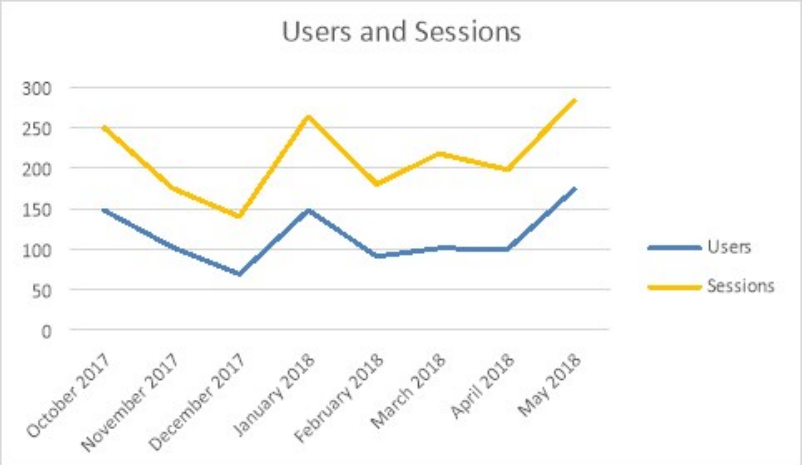
Definitions

Users: Users who have initiated at least one session during the date range. In this case, unique users within each month.

Sessions: A session is the period time a user is actively engaged with your website, a group of interactions one user takes within a given time frame on your website. Google Analytics defaults that time frame to 30 minutes, meaning whatever a user does on your website (e.g. browses pages, downloads resources, purchase products) before they leave equals one session.

Views: The total number of pages viewed. Repeated views of a single page are counted.

Overview of Website Users, Sessions, and Page Views: October 2017 to Present (May 2018)

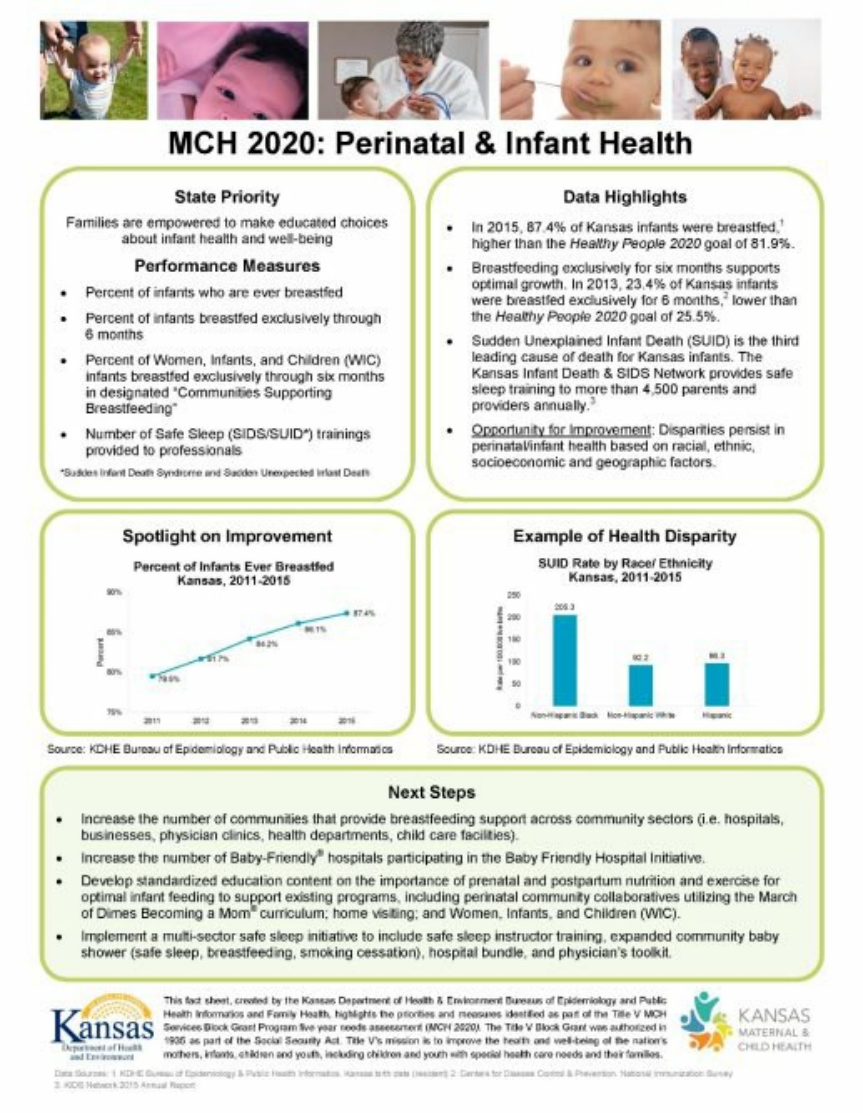


FY 2018 Application/FY 2016 Annual Report Update

Promoting the Needs Assessment & Population Domain Action Plans

As reported in previous updates, the final state action plan was transformed into a final "design" document for release and dissemination. The final document is available on websites and routinely shared with partners in the course of our work and conversations. Presentations to key stakeholder groups are ongoing.

Along with MCH branding to connect/tie all activities and materials together, the Title V team developed a “profile” for each domain which provides information about the needs assessment including: state priority(ies), measure(s), objectives, and strategies/change ideas for each population domain in an easy to read and understand 1-page snapshot.



MCH 2020: Perinatal & Infant Health

State Priority

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

Performance Measures

- Percent of infants who are ever breastfed
- Percent of infants breastfed exclusively through 6 months
- Percent of Women, Infants, and Children (WIC) infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"
- Number of Safe Sleep (SIDS/SUID*) trainings provided to professionals

*Sudden Infant Death Syndrome and Sudden Unexpected Infant Death

Data Highlights

- In 2015, 87.4% of Kansas infants were breastfed,[1] higher than the *Healthy People 2020* goal of 81.9%.
- Breastfeeding exclusively for six months supports optimal growth. In 2013, 23.4% of Kansas infants were breastfed exclusively for 6 months,[2] lower than the *Healthy People 2020* goal of 25.5%.
- Sudden Unexplained Infant Death (SUID) is the third leading cause of death for Kansas infants. The Kansas Infant Death & SIDS Network provides safe sleep training to more than 4,500 parents and providers annually.[3]
- Opportunity for Improvement: Disparities persist in perinatal/infant health based on racial, ethnic, socioeconomic and geographic factors.

Spotlight on Improvement

Percent of Infants Ever Breastfed
Kansas, 2011-2015

Source: KDHE Bureau of Epidemiology and Public Health Informatics

Example of Health Disparity

SUID Rate by Race/ Ethnicity
Kansas, 2011-2015

Source: KDHE Bureau of Epidemiology and Public Health Informatics

Next Steps

- Increase the number of communities that provide breastfeeding support across community sectors (i.e. hospitals, businesses, physician clinics, health departments, child care facilities).
- Increase the number of Baby-Friendly® hospitals participating in the Baby Friendly Hospital Initiative.
- Develop standardized education content on the importance of prenatal and postpartum nutrition and exercise for optimal infant feeding to support existing programs, including perinatal community collaboratives utilizing the March of Dimes Becoming a Mom® curriculum; home visiting; and Women, Infants, and Children (WIC).
- Implement a multi-sector safe sleep initiative to include safe sleep instructor training, expanded community baby shower (safe sleep, breastfeeding, smoking cessation), hospital bundle, and physician's toolkit.

Kansas Department of Health and Environment

This fact sheet, created by the Kansas Department of Health & Environment Bureaus of Epidemiology and Public Health Informatics and Family Health, highlights the priorities and measures identified as part of the Title V MCH Services Block Grant Program five year needs assessment (*MCH 2020*). The Title V Block Grant was authorized in 1935 as part of the Social Security Act. Title V's mission is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs and their families.

KANSAS MATERNAL & CHILD HEALTH

Data Sources: 1. KDHE Bureau of Epidemiology & Public Health Informatics, Kansas birth data (resident) 2. Centers for Disease Control & Prevention, National Immunization Survey 3. KDIS Network 2015 Annual Report

Domain Profile EXAMPLES (all profiles are available in the supplement documents section)

MCH 2020: Women & Maternal Health

State Priority

Women (ages 15-44 years) have access to and receive coordinated, comprehensive services before, during and after pregnancy

Performance Measures

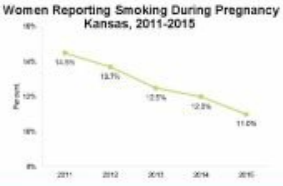
- Percent of women with a past year preventive medical visit
- Percent of women served by a Title V program that received education on the importance of a preventive medical visit in the past year
- Percent of preterm births (<37 weeks gestation)
- Percent of women who smoke during pregnancy

Data Highlights

- In 2014, 63.7% of Kansas women (18-44 years) had a preventive medical visit.[1]
- In 2015, the Kansas preterm birth rate (8.8%) was higher than the March of Dimes goal: 8.1% by 2020.[2]
- Kansas mothers who smoked anytime during pregnancy were almost two times more likely to have a baby die than mothers who did not smoke. In 2015, 11.0% (4,294 out of 39,050) of mothers reported smoking during pregnancy.[2]
- Opportunity for Improvement: Disparities persist in women/maternal health based on racial, ethnic, socioeconomic and geographic factors.

Spotlight on Improvement

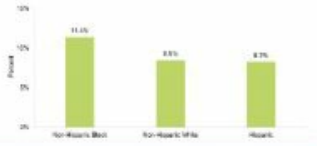
Women Reporting Smoking During Pregnancy
Kansas, 2011-2015



Source: KDHE Bureau of Epidemiology and Public Health Informatics

Example of Health Disparity

Preterm Birth (<37 Weeks Gestation) by Race/Ethnicity
Kansas, 2015



Source: KDHE Bureau of Epidemiology and Public Health Informatics

Next Steps

- Increase the number of women receiving a preventive medical visit (well woman visit) annually.
- Implement a standard prenatal/postnatal risk screening protocol, including screening for trauma, depression, and prior spontaneous preterm birth. Promote the appropriate use of progesterone therapy among pregnant women.
- Increase the number of established perinatal community collaboratives. The Kansas Perinatal Community Collaborative Model utilizes the March of Dimes Becoming a Mom® prenatal education curriculum. This public/private partnership brings together prenatal education and clinical care.
- Increase the proportion of smoking women referred to evidence-based cessation services and increase abstinence from cigarette smoking among pregnant women.
- Increase the number of women/families receiving home visiting services through improved coordination and referral.

Kansas Department of Health and Environment

This fact sheet, created by the Kansas Department of Health & Environment Bureau of Epidemiology and Public Health Informatics and Family Health, highlights the priorities and measures identified as part of the Title V MCH Services Block Grant Program five year needs assessment (*MCH 2020*). The Title V Block Grant was authorized in 1935 as part of the Social Security Act. Title V's mission is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs and their families.

KANSAS MATERNAL & CHILD HEALTH

Data Sources: 1. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2014. 2. KDHE Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

The MCH website (www.kansasmch.org) and Facebook page (www.facebook.com/kansasmch) previously reported on are gaining popularity. The Kansas MCH website analytics reveal a general increasing trend in terms of page visitors and visits for the website since January 2016. The increasing trends for traffic and "likes" could be attributed to the fact that the website and Facebook page are shared and promoted at every Kansas MCH Council meeting, state conference, committee meeting, and any other meeting/venue when the opportunity presents itself. The website and Facebook page are also shared during partner meetings and have been added to the signature for emails to support promotion and outreach. It appears that local partners and Council members are "inviting" partners to "like" the page, and the posts are receiving more traffic which results in more "sharing" and "liking" of the Kansas MCH Facebook page posts. This in turn results in more "likes" for the page itself. We are pleased to provide this resource for local MCH partners and grantees across the state. Many local agencies are unable to host their own Facebook or other social media sites, so this provides them with the opportunity to access information and resources.

MCH Facebook Page: Unique Visitors and Visits & Pages Visited (January 2016-May 2017)

The MCH Facebook page analytics reveal a trend of increased likes since launch.

MCH Facebook Page "Likes"

Ongoing Review & Assessment of State Needs

The Kansas Title V team continued work related to the Title V Needs Assessment and State Action Plan in partnership with the Kansas Maternal & Child Health Council and Special Health Services Family Advisory Council. The primary focus since last year's application involved refining the objectives, strategies, and Evidence- Based or Informed Strategy Measures (ESMs) for each of the eight National Performance Measures (NPM) Kansas selected. Additionally, discussions related to timely tracking and reviewing progress on measures (performance and strategy measures) was ongoing. A system for tracking and monitoring was determined and established. Data sources were reviewed to assure validity.

Team meetings were held monthly and more often as needed to review objectives and strategies within each priority—this was to assure they were on target with priority work and relevant efforts. Concentrated effort has continued to be focused on aligning objectives to the priorities of other Kansas Department of Health and Environment (KDHE) and partner programs to ensure they are not repetitive or duplicative but are collaborative. Strengths of this approach include the ability to ensure the individuals whose input was most important to a priority attended the meeting for that priority. Internal and external partners and subject matter experts from other areas of KDHE and partnering organizations were invited to select meetings when they could contribute to the discussion (e.g., Oral Health, Injury Prevention, WIC, Tobacco Cessation). Any and all updates to the state action plan were reviewed with and/or informed by the Kansas Maternal and Child Health Council. The Council actively participates in monitoring of the plan and assists with prioritization and assessment of progress on a regular basis.

Interim Year Changes to the State Action Plan: Based on ongoing work, progress, challenges, changing needs, and input, the following noteworthy revisions/updates were made and/or are being discussed as they relate to the state action plan for the period 2016-2020.

Updated ESM for Cross-cutting domain NPM # 14 (smoking)

Updated ESM for Adolescent domain NPM # 9 (bullying)

Merged objectives and strategies that were very similar in nature within the Child and Adolescent health domains to streamline and increase clarity and focus

Possibly develop an objective or strategy to lead and implement a coordinated state-level response to Neonatal Abstinence Syndrome

Possibly develop an objective or strategy to lead discussions and facilitate launch of a Kansas Maternal Mortality Review Committee

Possibly develop a strategy to further integrate systems and improve coordination of services at the state and community levels through affiliation as a Help Me Grow state

Possibly develop a strategy to increase access to mental health first aid training (youth and adult) for MCH local program staff including home visitors, schools, and other MCH community network partners

Children & Youth with Special Health Care Needs Update: KS-SHCN completed a strategic plan in FY15 which reflects the integrated and cross-systems approach to the Kansas work. As part of the strategic planning, an analysis of service provision led to significant changes.

The Direct Assistance Programs (DAPs) were implemented in July 2015 and have been monitored and reviewed to identify any gaps or barriers so adjustments could be made. A tracking form was developed to track client concerns/issues with DAPs and a review process was put into place to evaluate if changes were needed. This has led to a few changes in DAP policies and to some of the protocols. In 2017, a Legislative Post Audit (LPA) was conducted regarding the PKU Program, as related to the Metabolic Products DAP (above). The LPA resulted in recommendations on how to better support families, however ultimately validated the shift to this DAP model. These programs will continue to be monitored, promoted, and policies adjusted to best support the families and clients served through the program.

A direct result of the DAP program includes stronger partnerships with families. An unintended result of the DAP program includes significant cost-savings. It is believed the top contributing factor to these savings is better care coordination efforts such as fighting for insurance coverage or payment of eligible services to assure KS-SHCN funds are truly the payor of last resort. This has resulted in better accountability for providers to bill all insurances prior to submitting to KS-SHCN for payment. The process supported partners and providers with opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services. In addition to programmatic cost-savings and increased care coordination opportunities, we have experienced greater support for families and are seeing improved outcomes as families are more equipped and educated about taking care of their health needs.

The Title V Needs Assessment and new KS-SHCN priorities provided a foundation for the development of the "Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs" as part of the D-70 Integrated Community Systems for CYSHCN grant. One of the goals under the grant was to develop a "multi-system state plan that supports system standards and enhanced services for CYSHCN." The plan is attached to the grant application and is based upon the Standards for Systems of Care for CYSHCN.

FY 2017 Application/FY 2015 Annual Report Update

Finalizing the Title V State Action Plan for the Period 2016-2020
The Kansas Title V team partnered with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) to continue the work related to the Title V Needs Assessment and State Action Plan. The primary work since last year's application was to reorganize and refine the priorities and objectives, identify State Performance Measures, and develop/identify an Evidence- Based or Informed Strategy Measure (ESM) for each of the eight National Performance Measures (NPM) Kansas selected.

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

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

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

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

<u>State Performance Measures</u>

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

SPM 2: Percent of children living with parents who have emotional help with parenthood

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

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

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

Evidence-Based or Informed Strategy Measures (ESMs are still under review and may be revised as the plan is implemented and data collected):

ESM: Percent of women program participants that received education on the importance of a well-woman visit in the past year
-NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit)

ESM: Percent of WIC infants breastfed exclusively in designated "Communities Supporting Breastfeeding"
- NPM 4: Breastfeeding (Percent of infants ever breastfed; Percent of infants breastfed exclusively through 6 months

ESM: Percent of program providers using a parent-completed developmental screening tool during an infant or child visit
- NPM 6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

ESM: Number of certified child safety seat technicians in the state
- NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)

ESM: Number of schools implementing evidence-based or informed anti-bullying practices and/or programs
- NPM 9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

ESM: Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year
- NPM 10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year

ESM: Percent of families who experienced a decreased need of care coordination supports
- NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)

ESM: Percent of pregnant women program participants who smoke referred to the Tobacco Quitline
- NPM 14: Smoking during Pregnancy and Household Smoking (Percent of women who smoke during pregnancy; Percent of children who live in households where someone smokes)

Children & Youth with Special Health Care Needs: KS-SHCN completed a strategic plan in FY15, developing a 5-Year Plan with 14 objectives and 31 total strategies. The KS-SHCN five year plan five priorities, and related focus areas, are as follows: (1) Care Coordination: empowering families, improving communication among providers and systems, and stronger cross-system collaboration; (2) Family Caregiver Health: promoting health and wellness among family caregivers, increasing awareness of and access to respite services, and family leadership and peer supports; (3) Behavioral Health: collaboration to support integrated care, community education and referrals, and screening and assessments for KS-SHCN families; (4) Training and Education: advocacy, youth leadership and self-determination, and training for professional in integrated care of people with disabilities; and (5) Direct Health Services: gap-filling services such as oral health, access to adequate insurance coverage, and telehealth. These strategies are re-assessed each year by the SHS-FAC to monitor progress and make recommendation for changes, as needed.

The objectives and strategies align nicely with the Title V plan and the transformation of the Block Grant, with many of the KS-SHCN priorities and strategies integrated into the Title V state action table: not only in the priority selected for the CYSHCN domain, but in many of the overall state priorities and a variety of different objectives. This reflects the integrated and cross-systems approach to the Kansas work. While the medical home continues to be a central focus of the KS-SHCN program, the new priorities address broader needs of the child and their family and focus on stronger collaboration and integration across systems of care.

As part of the strategic planning, an analysis of service provision led to significant changes. Ultimately, the largest change resulted from the inability for KS-SHCN to monitor and track the level of funding available or authorized at any given time. The program identified a recent trend of depleting limited funds available to cover direct services, with pending service cuts if a solution was not realized. This prompted a change to a “Direct Assistance Program (DAP)” model, changing the way services were authorized rather than which services were authorized. This allowed the program to set limits per authorization and per year to better track and monitor the funds that were being spent, resulting in better accountability and an ability to identify when funds are running low and cease authorizations for that DAP until funds are made available again. Each of

the DAPs have eligibility criteria and annual maximum assistance amounts. Eight DAPs were developed, as follows:

1. Co-Payments/Deductibles/Co-Insurance: For those with private insurance who have a patient responsibility through co-pays/deductible limits or co-insurance. This allows for up to 50% assistance towards deductible limits and/or limited support towards co-pays/co-insurance for medical specialty services.
2. Medical Services: 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: For those with craniofacial anomalies to assist with orthodontic evaluations and comprehensive treatment plans.
4. Hemophilia: 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: For those with PKU or metabolic disorders. This provides assistance for metabolic formula and low protein food items.
6. Medication: Provides assistance with medication, not covered by insurance, to eligible clients. Requires the client pay a $5 co-pay for every $100 per medication supported by KS-SHCN.
7. Travel: Provides travel assistance to and from the client's home to medical specialty care appointments.
8. Medical Equipment and Supplies: Provides assistance for durable medical equipment and medical supplies. Client co-pays ranging from $25 to $100 are applicable depending on the cost of the equipment. Medical supplies can include items such as catheters, ostomy supplies, diabetic testing equipment (CF clients only), hearing aid molds/repairs, glasses, and other items deemed medically necessary.

The DAPs were implemented in July 2015 and have been monitored and reviewed to identify any gaps or barriers so adjustments could be made. A tracking form was developed to track client concerns/issues with DAP's and a review process was put into place to evaluate if changes to the DAP(s) were needed. This has led to a few changes in DAP policies and to some of the protocols. This process has led to more program accountability, increase in client/staff communication and a better understanding of previous service gap barriers. Internal DAP tools to assist staff and clients were also developed to make the DAP structure flow smoothly.

A direct result of the DAP program includes stronger partnerships with families. An unintended or unexpected result of the DAP program includes a significant cost-savings. It is believed the top contributing factor to these savings is better care coordination efforts and assuring KS-SHCN funds are truly the payor of last resort, such fighting for insurance coverage or payment of eligible services. This also has resulted in better accountability for providers to bill all insurances prior to submitting to KS-SHCN for payment. The process supported partners and providers with opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services.

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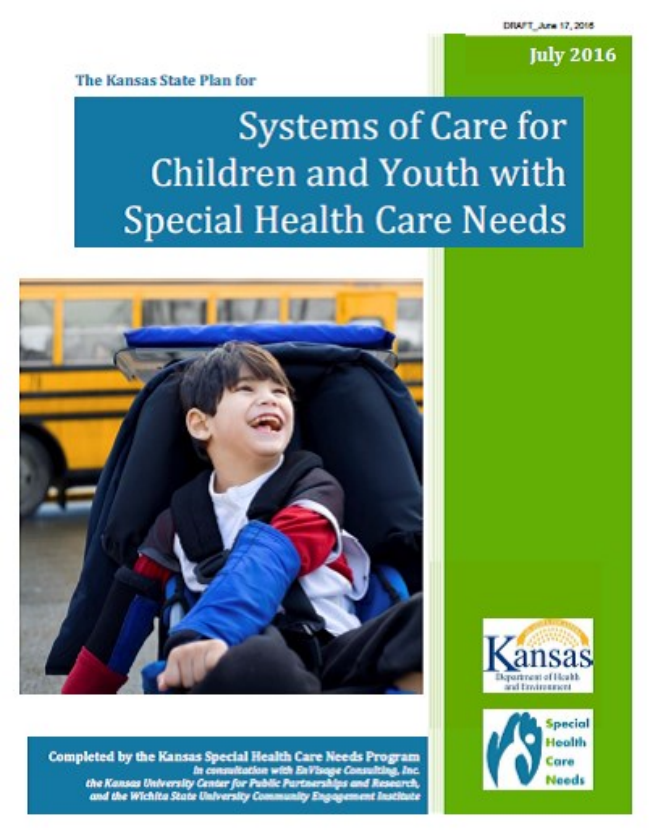


Publishing the Title V Needs Assessment

The final needs assessment comprehensive document was released and posted on the KDHE Bureau of Family Health website in June 2016 at the time the Draft 2017 Application and 2015 Annual Report was released for public input. A screen shot of the needs assessment document cover is provided below.

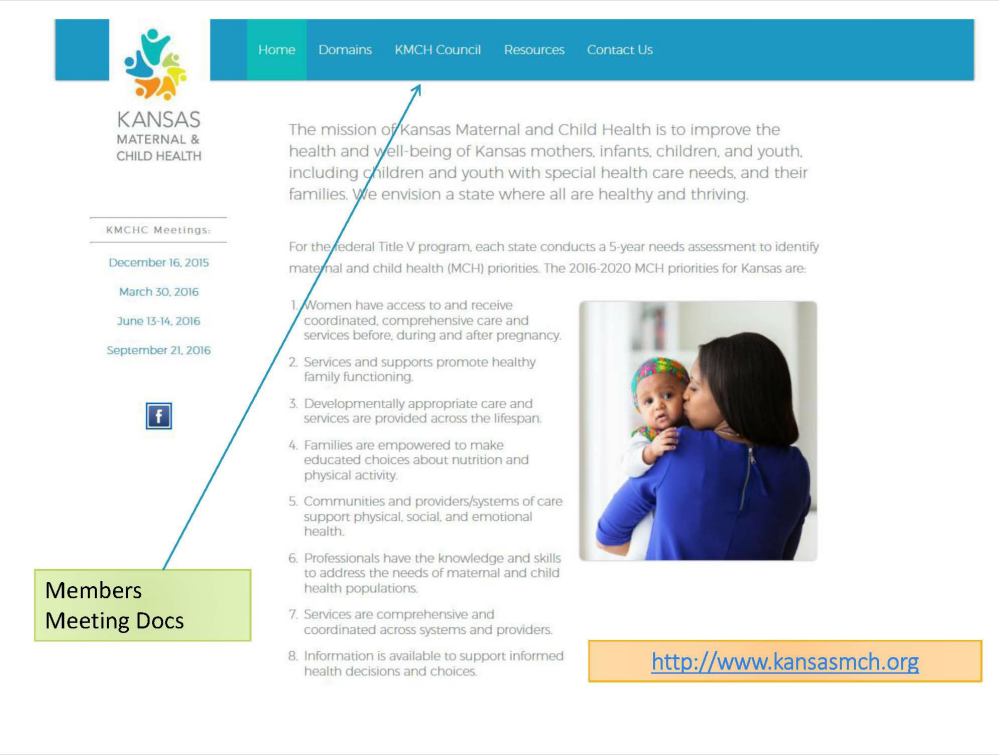
Promoting/Marketing Title V & the State Action Plan

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

KANSAS
MATERNAL &
CHILD HEALTH

In addition to finalizing the state plan and developing "branding" for a plan that is reflective of MCH efforts statewide, the Title V program launched a website and Facebook page to promote and increase awareness of the Kansas Title V/MCH programming. This has provided the opportunity to announce/share ongoing updates related to the needs assessment and will provide the platform for release of the final plan.

Kansas MCH Website (www.kansasmch.org)



Kansas MCH Facebook Page (www.facebook.com/kansasmch)

An internal document has been used with the state Title V team and Kansas Maternal & Child Health Council through the revision process. At the present time, the final version of the 5-year plan is being transformed into a "design" in preparation for release and dissemination. The design document offers one-pagers highlighting the state priorities, objectives, and related national and state measures. The final document was posted on the websites and shared with partners in August 2016. Presentations to key stakeholder groups were delivered in July (Kansas School Nurse Organization) and September (Kansas Chapter AAP). A sneak peek of the document is provided below.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

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.

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

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

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

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

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

Stakeholder Involvement 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 and comprehensiveness of the Needs Assessment, KDHE relied on partnerships to ensure all domains were adequately addressed and that priorities, objectives and strategies crossed population domains. The Title V Director coordinated and monitored the overall process and worked directly with 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/Maternal, Perinatal/Infant, Child, CYSHCN
Kansas State University Research & Extension Dr. Elaine Johannes	Contractor, Adolescent Health Needs Assessment & Report	Adolescent
University of Kansas Dr. Rebecca Gillam	Contractor, Overall Title V Needs Assessment Comprehensive Process & Final Report	Women/Maternal, Perinatal/Infant, Child, Cross-cutting/Life Course
Kansas Maternal & Child Health Council (variety of organizations represented; facilitated by American Academy of Pediatrics Kansas Chapter)	Advisory Council, recommendations related to existing priorities and need to continue, replace or add priorities (comparison of MCH 2015 with current status/needs)	All domains

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

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.

Crosswalk of Kansas MCH Priorities

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

Data Sources:

- Bureau of Epidemiology & Public Health Informatics, Annual Summary of Vital Statistics
- Bureau of Epidemiology & Public Health Informatics, Kansas Hospital Discharge Data
- National Center for Health Statistics, National Vital Statistics Reports
- National Center for Health Statistics, VitalStats
- Centers for Disease Control & Prevention, WISQARS (Web-based Injury Statistics Query & Reporting System)
- U.S. Census Bureau, American Community Survey
- U.S. Census Bureau, Current Population Survey
- U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE)
- U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE)
- Centers for Disease Control & Prevention, National Immunization Survey
- Centers for Disease Control & Prevention and Bureau of Health Promotion, Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System
- National Survey of Children with Special Health Care Needs
- National Survey of Children's Health
- Kansas Medical Assistance Program Reporting System, KAN-Be-Healthy annual participation report & Well Child for HW21 report
- The Association of Community Mental Health Centers of Kansas Inc. Mental Health Consortium, Automated Information Management System (AIMS) data database.
- Bureau of Family Health, Newborn Screening Program and Newborn Hearing Screening (SoundBeginnings)

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. 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.

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 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.

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

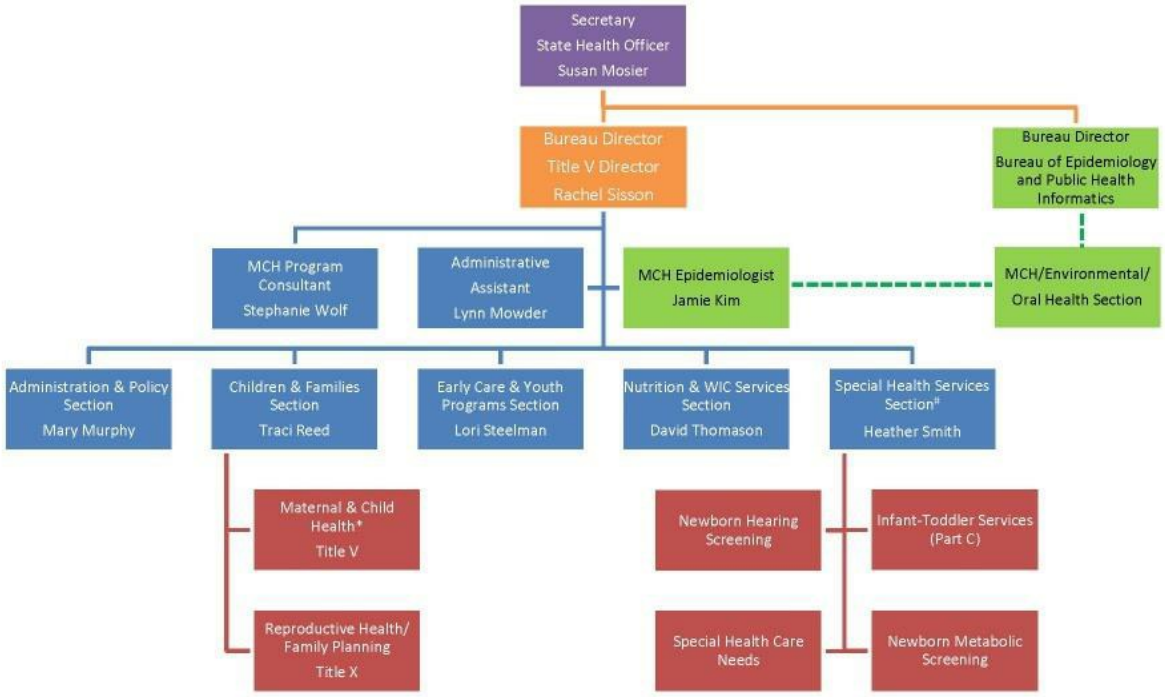
The State's public health agency, Kansas Department of Health and Environment (KDHE), is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. The Secretary of KDHE is appointed by the Governor and serves on the Governor's Cabinet. The agency Secretary, State Health Officer, and Division of Public Health Director is Susan Mosier, MD. 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). Budgeted and expended funds (federal, state, and local) expended are tracked through the agency's fiscal management system, SMART. Awards totaling $4,385,468 of the $12.6M Title V budget is allocated in FY2016 for 82 local agencies to provide community-based, family centered MCH services, including services for special health care needs. Local agencies, local public health departments and Federally Qualified Health Centers, are independent entities that apply for MCH funds annually as part of the agency's competitive Aid to Local application process.

The agency organizational charts and a local agency/grantee map are attached to this section as images.

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

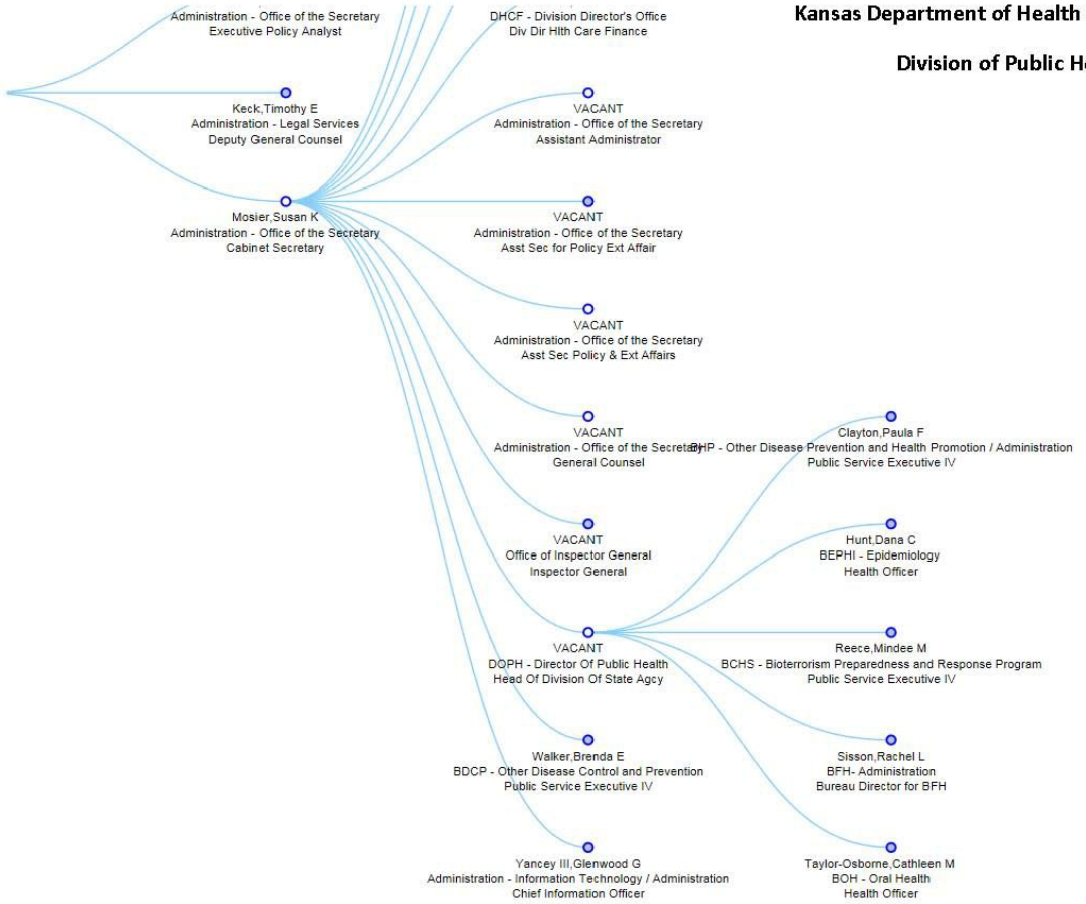


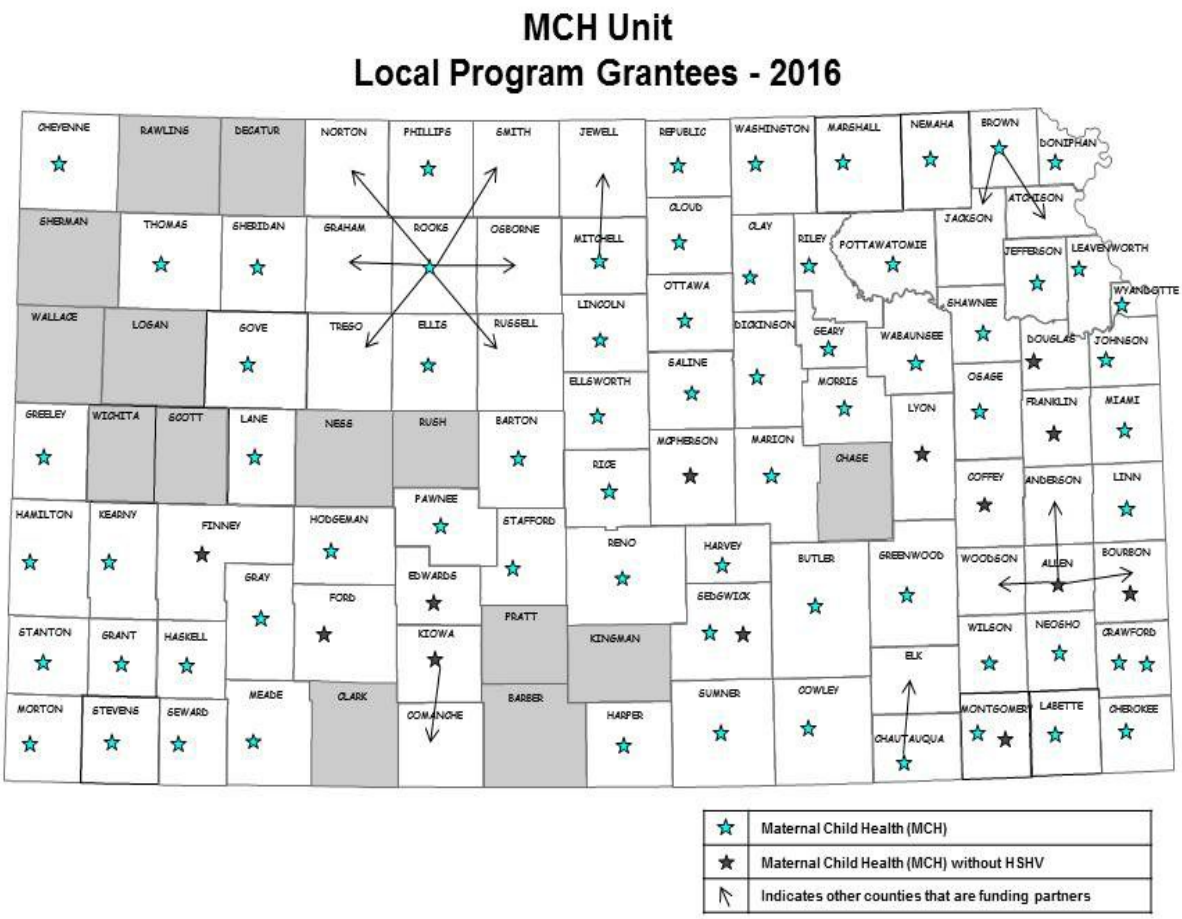
*Includes Aid to Local Programs/Grant Projects: Title V MCH, Pregnancy Maintenance Initiative (PMI), Teen Pregnancy Targeted Case Management (TPTCM), Healthy Families, Home Visiting, MIECHV, Project LAUNCH, Early Childhood Comprehensive Systems (ECCS); Abstinence Education; Healthy Start; staffing for 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

Kansas Department of Health & Environment

Division of Public Health





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
Kansas Maternal & Child Health Council	Public-Private Collaboration	Advisory council for MCH team--serves as key advisory group re: MCH population needs/issues
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.

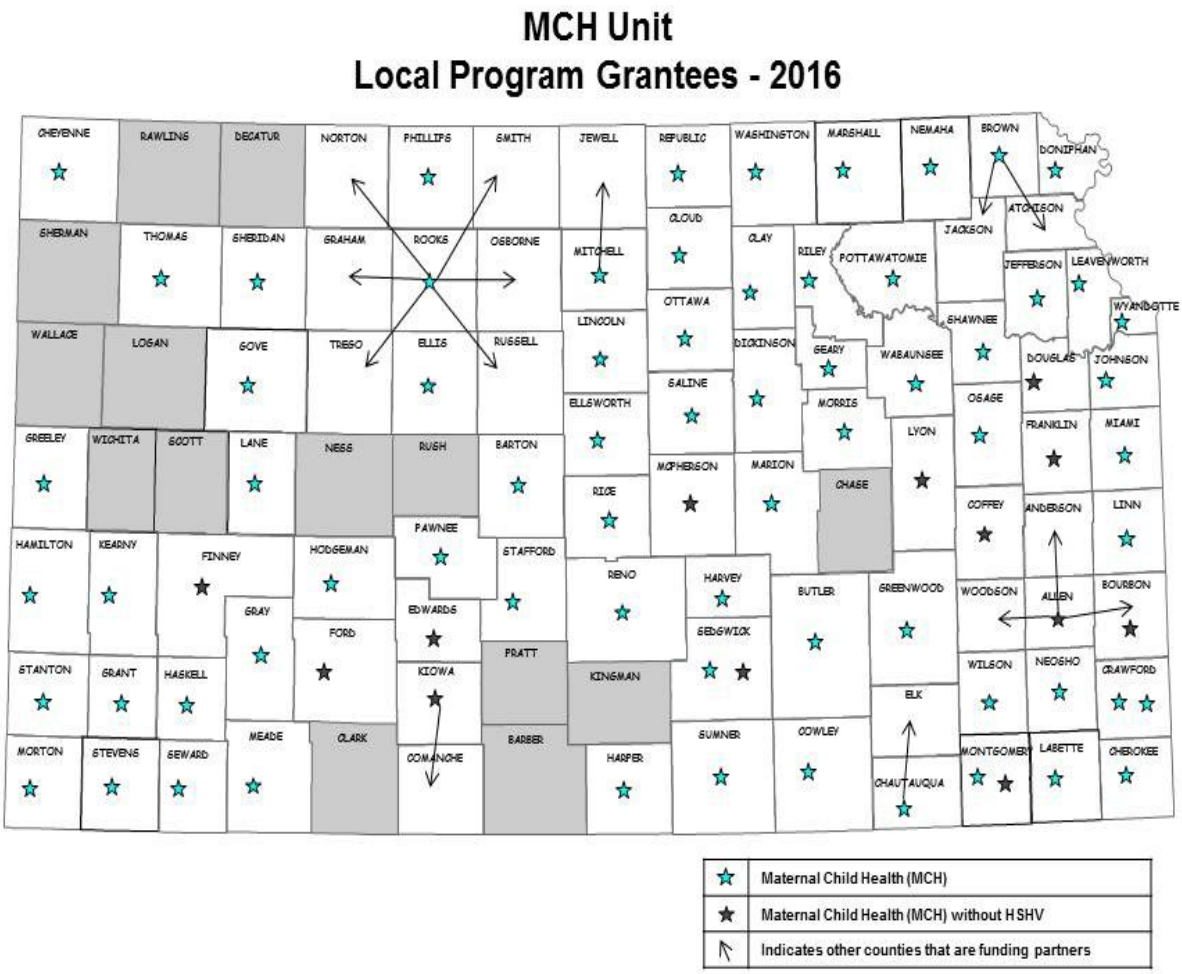
State support for communities: The majority of programs funded by the Block Grant are delivered by health departments and safety net clinics (independent entities). These agencies are positioned to provide many core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The 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. Detailed client and service data is required to be collected, aggregate progress reports and affidavits of expenditures are required quarterly, and site visits are conducted to verify compliance with funding requirements and progress toward priorities, goals, objectives, and measures. More information about the MCH Aid to Local Program (http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html) including program guidance is available online. Aid to Local contract documents and the list of local 2016 MCH grantees statewide are attached as supporting documents. A map of local agencies is provided in this section.

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.

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 agencies such as health departments and safety net clinics (FQHCs), 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 Title X clinic, FQHC, 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 services other than primary care 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 county officials. 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 (4 vacancies). Nutrition & WIC has 15 FTEs including 3 nutritionists. Child Care Licensing has 20.2 FTEs including a Director and 5 Coordinator of Children's Services staff located in KDHE District Offices across the state with responsibility for supporting regulatory 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 and Kansas Special Health Care Needs (SHCN) Director. From 2009 to 2013, she served as a Project Coordinator for 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.

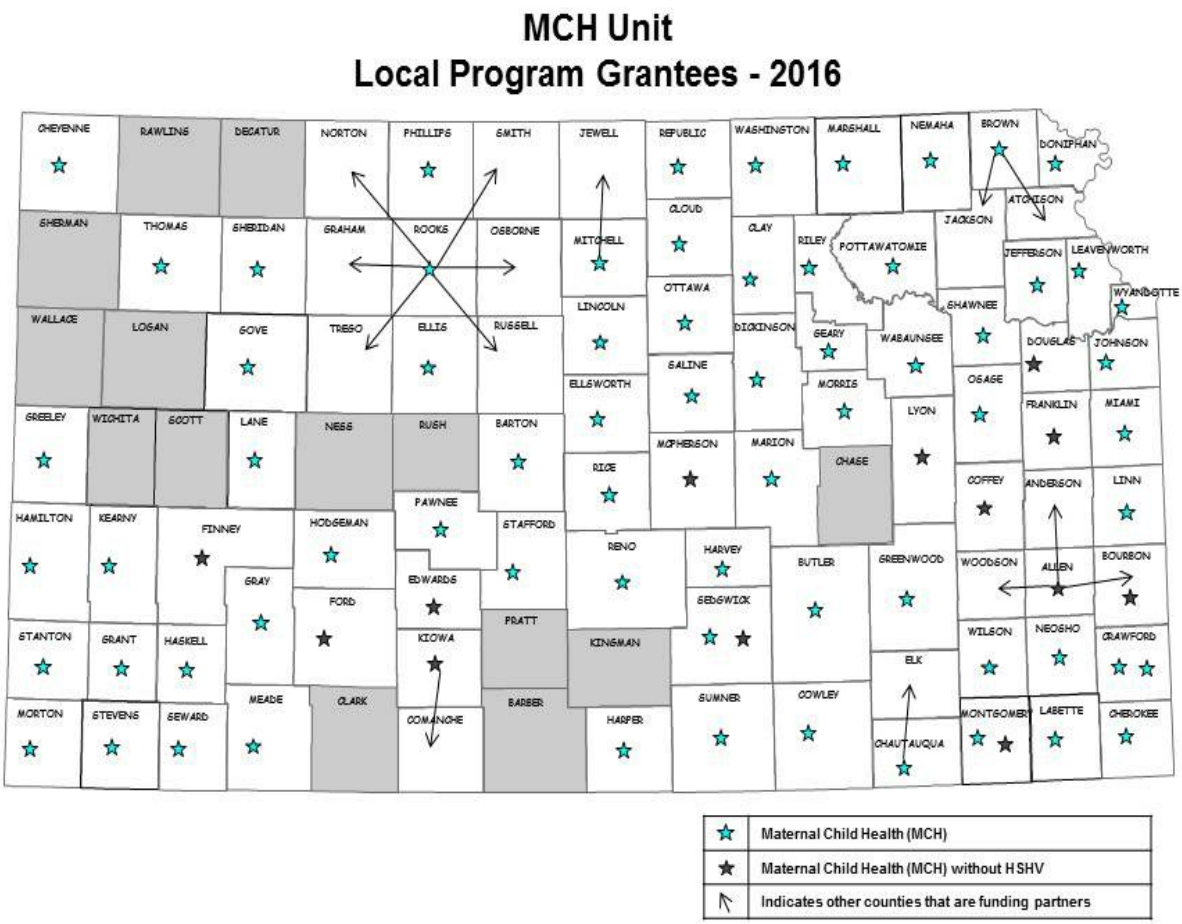
Traci Reed serves as the Children and Families Section Director. She is primarily responsible for management and oversight of the Title X Family Planning and MCH Aid to Local (ATL) programs, including Home Visiting. She also has responsibility for MIECHV and additional ATL programs: Healthy Families, Teen Pregnancy Targeted Case Management, and Pregnancy Maintenance Initiative. Prior to her current position Traci worked in State child welfare programs for 19 years, including work as an Assessment and Prevention Administrator (family services programs) with the Kansas Department of Children & Families. 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 and 15 years of experience with a local school district (Applied Behavioral Analysis (ABA) therapy, speech therapy and assisting with occupational and physical therapies and classroom education). Kayzy has an AA in Pre-Social Work from Allen County Community College. 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 the MCH 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.

The Title V team has experienced significant vacancies and staff turnover at the state level during the past year (actively recruiting). However, the current team and partnerships have led to the greatest MCH advancements experienced in decades! KDHE contracts with health departments and safety net clinics (independent entities) for statewide impact.



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.

Kansas Maternal & Child Health Council (KMCHC): The KMCHC serves in an advisory capacity to KDHE, Bureau of Family Health, Title V Program; monitors progress; and addresses specific MCH population needs for MCH populations. The Kansas Chapter of the American Academy of Pediatrics (KAAP*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas and improved outcomes. The Title V needs assessment and state action plan is the guiding document as it relates to the ongoing work of the Council. The KMCHC is chaired by Dennis Cooley, MD, FAAP, and has between 30-35 members at any given time (a roster included in this section as an image). KDHE and KAAP convene the Council at least once each quarter. The Council is comprised of a multidisciplinary team of professionals with expertise in MCH. The council members are

identified and, in consultation with KDHE, selected to serve on the Council by the KAAP. A decision was recently made (Sept. 2015) to merge the Blue Ribbon Panel on Infant Mortality with the KMCHC, resulting in greater coordination and impact. The BRPIM was established in 2009 to develop a set of recommendations to reduce infant mortality in Kansas. After the recommendations the Panel voted to continue meeting but recently voted to join the work of the KMCHC due to the strong plans to address infant mortality. *KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas, KAAP is willing to assemble individuals with professional expertise to assist and advise KDHE to achieve the best possible health outcomes for Kansas MCH populations.

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 targets at-risk communities in 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 (now integrated into the MCH State Action Plan). The project has been named the Kansas Initiative of Developmental Ongoing Screening (KIDOS).

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 and state bullying prevention efforts; the MCH action plan reflects shared priorities and strategies in these areas. 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 health departments to assist with data needs, Perinatal Periods of Risk (PPOR) Analysis, Fetal and Infant Mortality Review (FIMR), local public health system assessment, Pregnancy Risk Assessment Monitoring System (PRAMS) pilot, and State Health Assessment (MCH Focus Area). 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/KanCare partnership, was shared; discussion continues and has resulted in a stronger partnership. Turnover in Medicaid and change in KDHE Secretary has delayed a signed agreement; however, 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). Joint projects identified with Medicaid include: Collaboration 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,

safety net clinics/FQHCs, coalitions, hospitals, foundations, 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. Title V is planning implementation of MOD's signature program, The Coming of the Blessing, for American Indian and Alaska Native populations. The program offers women and families prenatal education (Becoming a Mom curriculum), training and resources based on traditional beliefs, lessons from ancestors, and a circle of support.

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 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.

KANSAS MATERNAL CHILD HEALTH COUNCIL (KMCHC)

2015-2016

Chair				
Cooley	Dennis	MD FAAP	Pediatrician - current KMCHC chair	Pediatrics Associates of Topeka
Members				
Benyshek	Katrina	RN	School Nurse Assoc. - 2014 president	Kansas School Nurse Organization (KSNO)
Daldrup	Diane		Community Volunteer	Previously March of Dimes Kansas Chapter
Gabel	Lisa	RN BSN CCM	Director of Health Care Management Services	Amerigroup Kansas, Inc.
Harris	Kari	MD	Pediatrics	KU Wichita
Hortenstine	Sara		Office of Kansas Attorney General Derek Schmidt	State Child Death Review Board
Jones	Wes	PhD	Psychologist	Mental Health Ctr-East Central KS
Lauer	Steve	PhD MD	Associate Chair	Dept. of Pediatrics
McDiffett	Pam	MSW	Consumer Affairs	KDADS
McNamar	Patricia	DNP, ARNP, NP-C	Nurse - Rural Hospital & Clinic	Medicine Lodge Memorial Hospital and Physicians Clinic
Pate	Brian	MD FAAP	Chair, Dept of Pediatrics - KUMC-Wichita	Wesley Medical Arts Tower
Pezzino	Gianfranco	MD, MPH	Media - Kansas Health Institute	Kansas Health Institute
Rodriguez	Melissa	RN, BSN	Family member	
Sage	Cherie		Representative - KS Safe Kids	Kansas SAFE KIDS
Schunn	Christy	LSCSW	KIDS Network - Exec. Dir.	KS Infant Death and SIDS Network
Shaw	Pam	MD FAAP	Pediatrician - KU - developmental screen	KUMC-Dept of Peds
Spainhower	Michele		Health Department MCH Staff	Sedgwick County Health Dept
Vaughn	Erick	LMSW	Director, Headstart	Kansas Head Start Association
Yadrich	Donna		Owner and Principal Patient-Centered Care Advocate	Kansas Title V Family Delegate
Johannes	Elaine	PhD	Youth Health and Education	Kansas State University Research & Extension
Kuhlmann	Zak	MD	Physician	
Pence	Susan	MD	Pediatrician	Community Health Center of SE Kansas (FQHC)
Garrison	Terrie	RN, BSN	Deputy Director /MCH Supervisor/Grantee	Unified Government Public Health Department
Ex-officio				
Akin	Carrie		MCH Consultant	KDHE - Bureau of Family Health
Bigler	Kayzy		Special Health Care Needs Program Manager	KDHE - Bureau of Family Health

Crawford	Greg		Director, Vital Statistics Data Analysis	KDHE - Vital Statistics
Haskett	Lori		Injury Prevention Disability & Health	KDHE - Bureau of Health Promotion
Kim	Jamie	MPH	MCH Epidemiologist	KDHE - Bureau of Family Health
Mosier	Susan	MD	Secretary & State Health Officer	KDHE
Reed	Traci		Director, Children & Families	KDHE - Bureau of Family Health
Richardson	Debbie	PhD	Home Visiting Manager, Children & Families	KDHE - Bureau of Family Health
Seymour-Hunter	Fran		Medicaid	KDHE - Division of Health Care Finance
Sisson	Rachel	MS	Bureau Director	KDHE - Bureau of Family Health
Smith	Heather	MPH	Director, Special Health Services	KDHE - Bureau of Family Health
Steelman	Lori		Director, Child Care Licensing	KDHE - Bureau of Family Health
Thomason	David	MPA	Director, Nutrition & WIC Services	KDHE - Bureau of Family Health
White	Kay		MCH Administrative Consultant	KDHE - Bureau of Family Health
Wolf	Stephanie	RN, BSN	KDHE - MCH/Perinatal Health Consultant	KDHE - Bureau of Family Health
Staff				
Steege	Chris		KAAP Exec. Dir.	Kansas Chapter of AAP
Satlzer	Connie		Facilitator	Envisage, Inc.

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Lauer	Steve	PhD MD	Associate Chair	Dept. of Pediatrics
McDiffett	Pam	MSW	Consumer Affairs	KDADS
McNamar	Patricia	DNP, ARNP, NP-C	Nurse - Rural Hospital & Clinic	Medicine Lodge Memorial Hospital and Physicians Clinic
Pate	Brian	MD FAAP	Chair, Dept of Pediatrics - KUMC-Wichita	Wesley Medical Arts Tower
Pezzino	Gianfranco	MD, MPH	Media - Kansas Health Institute	Kansas Health Institute
Rodriguez	Melissa	RN, BSN	Family member	
Sage	Cherie		Representative - KS Safe Kids	Kansas SAFE KIDS
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Ex-officio				
Akin	Carrie		MCH Consultant	KDHE - Bureau of Family Health
Bigler	Kayzy		Special Health Care Needs Program Manager	KDHE - Bureau of Family Health

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,686,020	$4,758,053	$4,689,065	$4,729,794
State Funds	$3,567,032	$3,775,412	$3,557,713	$3,556,155
Local Funds	$4,401,548	$3,906,503	$3,981,689	$3,832,636
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$12,654,600	$12,439,968	$12,228,467	$12,118,585
Other Federal Funds	$69,994,218	$69,501,932	$58,007,639	$66,300,416
Total	$82,648,818	$81,941,900	$70,236,106	$78,419,001

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,651,427	$4,777,544	$4,756,879	
State Funds	$3,531,773	$3,800,940	$3,531,621	
Local Funds	$3,906,504	$5,186,201	$3,911,125	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$12,089,704	$13,764,685	$12,199,625	
Other Federal Funds	$71,105,934	$70,975,390	$69,627,621	
Total	$83,195,638	$84,740,075	$81,827,246	

	2020	
	Budgeted	Expended
Federal Allocation	$4,780,598	
State Funds	$3,949,804	
Local Funds	$3,992,669	
Other Funds	$0	
Program Funds	$0	
SubTotal	$12,723,071	
Other Federal Funds	$70,031,333	
Total	$82,754,404	

III.D.1. Expenditures

The State maintains budget documentation for all Block Grant funding allocations and expenditures for tracking and reporting. Expenses are tracked through the state's accounting system, SMART. All federal and non-federal (state and local) expenditures are tracked and reported separately. Expenditure detail for State Fiscal Year (SFY) 2018 is reflected on Forms 3a and 3b.

2018 Expenditures: The FY 2018 block grant partnership expenditures were updated to reflect actual expenditures based on the state accounting system at the time the application was compiled (reflected on Forms 2, 3a and 3b). The following expenditures were reported: $4,777,544 federal; $3,800,940 state; and $5,186,201 local for total MCH expenditures of $13,764,685. Other federal funds overseen by the Title V Director totaled expenditures of $70,975,390 for a grant total FY 2018 amount of $84,740,075

The total FY 2018, federal only spending to support MCH and CSHCN initiatives within the state health department included:

- $106,557 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics;
- $47,056 Local Public Health program;
- $109,411 Child Care Licensing;
- $252,387Title V Administration/Staffing ;
- $1,417,971 Children & Families/MCH Section expenditures 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;
- $1,696,155 MCH Aid to Local payments to local agencies for services totals.
- $701,160 Special Health Care Needs (SHCN) staff, operating costs, contracts and supplies;
- $66,064 Direct Services*

  *Expenses for Direct Services are tracked separately through the Kansas SHCN program (effective SFY 2014) and break down as follows by type of service: Durable Medical Equipment (DME) $9,094; Hospital $12,018; Pharmacy $16,952; Physician/Office Charges $19,403; Lab $233; Orthodontic/Dental $8,364.
- $739 Newborn Screening Follow Up
- $51,044 Fiscal Management
- $329,000 Administrative Costs

Form 2 Expenditures Details: Form 2 reveals the Title V expenditures for FY 2018 are in compliance with the 30% - 30% requirements for priority populations: preventive and primary care for children $1,618,153 (34.0%) and children with special health care needs $1,435,328 (30.0%), similar to previous reporting periods. Other requirements related to expenditures such as administrative costs at $329,000 (7.0%) (less than 10%) and maintenance of effort are maintained.

Form 2 also provides expenditures for other federal funds administered through the Bureau of Family Health, overseen by the Title V Director. The total expenditures for FY 2018 are $70,975,390 and include the following: Women, Infants, and Children (WIC) $54,320,570; Breastfeeding Peer Counselor Program $480,393; Early Childhood Comprehensive Systems $401,075; Newborn Hearing Screening $182,352; Newborn Hearing Screening Data Enhancement $130,232; Maternal, Infant and Early Childhood Home Visiting (MIECHV) Development $1,535,277; MIECHV Formula $4,293,449; MIECHV Innovation $4,844 (grant ended and we are in the carryover phase preparing for closeout); Part C Infant-Toddler Services $4,304,797; Abstinence Education $659,466; Title X Family Planning $2,601,750; Toxic Substances (Lead Hazard) $343,778; Healthy Start $750,175 (ended 3/31/2019); Pregnancy Assistance Fund – LYFTE $875,971; Systems Integration $91,261; .

Form 3a Expenditures by Types of Individuals Served: All Block Grant partnership expenditures (federal, state, and local), not including administrative costs of $329,000, total $13,435,685 ($4,448,544 Federal; $8,987,141 Non-Federal). Expenditures by "Types of Individuals Served" (MCH population groups) includes: Pregnant Women and Infants <1 Year

$5,270,170; Children & Adolescents 1-22 Years $4,575,605; and CSHCN $3,589,909. Note: State match included may not be the full amount of state dollars contributed to the block grant partnership; the state reports at least the minimum match from all non-federal sources.

Form 3b Expenditures by Types of Services: All Block Grant partnership expenditures (federal, state, and local), total $13,764,685 (including administrative costs). Expenditures by “Types of Services” (MCH pyramid) include: Direct Services $ ($66,064 federal/$42,187 non-federal) (1%); Enabling Services $6,564,627 ($1,703,905 federal/$4,860,721 non-federal) (48%); and Public Health Services and Systems $7,091,807 ($3,007,575 federal/$4,084,232 non-federal) (52%). The Kansas Title V MCH and CSHCN programs strictly adhere to the mandate of Title V as the payer of last resort, and the direct services paid only reflects services that were not covered or reimbursed through another provider (payer).

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 $4,777,544 in FY 2018 at the time of reporting. Kansas meets its match requirement through the use of State funds that support Maternal and Child Health programming and affiliated programming, including newborn screening and other state-funded programs and services.

III.D.2. Budget

Kansas Maternal & Child Health (MCH) and Special Health Care Needs (SHCN) Directors in partnership with the state Council and programs provide input into the allocation and budgeting process for the Title V MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based on the State MCH Needs Assessment and 5-Year State Action Plan.

2020 Budget: The total State budget submitted for Fiscal Year 2020 and detailed on Form 2 is $82,754,404. This amount represents the budgeted MCH federal allocation, state contribution/funds, local contribution/funds, and other federal funds administered under the direction of the Title V Director in the Bureau of Family Health. The amounts break down as follows: budgeted MCH federal allocation $4,780,598 (based on the allocated amounts in the State budget and a final authorized federal MCH award amounts for FFY18 and FFY19); state MCH funds $3,949,804; local MCH funds $3,992,669; and estimated other federal funds $70,031,333. Other federal funds includes the following: Women, Infants, and Children (WIC) $53,786,823; Breastfeeding Peer Counselor Program $583,299; Early Childhood Comprehensive Systems $410,910; Safeguarding Two Lives Maternal Mental Health $648,994; Pediatric Mental Health Care Access $444,577; Universal Newborn Hearing Screening $249,995; Newborn Hearing Screening Data Enhancement $135,900; Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula $4,782,829 and Innovation $803,864; Part C Infant-Toddler Services $4,309,122; Title X Family Planning $2,614,946; Toxic Substances (Lead Hazard) $318,599; Pregnancy Assistance Fund (Office of Adolescent Health; (KS project: Lifting Young Families Toward Excellence – LYFTE) $941,475. Two grants included in the previous years' "other federal funds" category that are not included this year are: Healthy Start (ended March 2019) and Abstinence Education (ended September 2018). The state as grantees for Title V no longer oversees these projects directly. Note: Some "other" federal funds budgeted amounts reflect the state's budget at the time of the application submission. The actual amount the agency receives will not be known until the official Notice of Award is received from the funding agency. NOTE: State Systems Development Initiative (SSDI) funding is administered through the Bureau of Epidemiology and Public Health Informatics (BEPHI), not Bureau of Family Health/Title V Director; however, 100% of the SSDI funding supports MCH Epidemiology and data capacity activities.

Form 2 MCH Budget Details. Overall, Kansas' MCH federal-state-local partnership budget totals $12,723,071 (federal MCH funds $4,780,598; state MCH funds $3,949,804; local MCH funds $3,992,669). The federal allocation is budgeted to support Title V MCH and SHCN initiatives, workforce development, and infrastructure/systems within the state health department as follows: $137,433 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics; $55,000 Local Public Health Program. Within the Bureau of Family Health, $47,211 is allocated to support Child Care Licensing activities and partnerships related to MCH and Child Care initiatives (such as breastfeeding, oral health, early literacy); $376,485 for MCH staffing, MCH aid to local programming, monitoring, and other operations; $297,938 for Bureau/Title V director, Block Grant Coordinator, Assistant, and fiscal support; $944,945 for SHCN staffing, programming, outreach, and direct services (federal portion of direct services totals $104,367; amount needed to support SHCN that's not reimbursed by other providers; estimate is based on 2019 expenditures and authorized plans); $65,000 for safe sleep initiatives (training, capacity, infrastructure building, and community baby shower expansion); $25,000 for breastfeeding support and capacity (additional support is provided by WIC); $60,000 for advancing state action plan activities related to early care and education settings; $65,020 to support the Kansas Maternal & Child Health Council and state action plan development, implementation, and monitoring activities; $304,000 to support data collection/reporting shared measurement systems; and $65,000 to support adolescent health state action plan activities related to mental health, healthy decision making (reducing risky behaviors), well visits, and more); $1,765,100 for local MCH agencies providing community-based, family centered services including home visiting (local public health departments, community health centers, hospitals, health foundations); and $300,000 for administration costs.

The Kansas budget for FY 2020 meets the maintenance of effort requirement of $2,352,511.The Title V match requirement is achieved through projected State matching funds budgeted at $3,949,804 which include $30,000 for MCH aid to local operations; $237,914 for universal home visiting services delivered by MCH grantees/local agencies; $96,374 for Kansas Infant Death and SIDS (KIDS) Network of Kansas (foundational support allocated through the Governor's Budget to the

Children's Cabinet and Trust Fund, administered through KDHE Bureau of Family Health); $452,526 for newborn screening follow up; $319,719 for SHCN administration, case management, care coordination, and direct services ($41,563); $338,846 for Pregnancy Maintenance pursuant to state statute; $2,169,614 for MCH aid to local programming; $105,537 for SHCN seating clinics; $199,274 for PKU direct services. Local match is projected to total $3,992,669. Note: The amount of local match for State FY 2018 exceeded the typical amount of match documented over the past several years by more than $1M. Since the Title V program does not know whether or not local programs will continue to "overmatch" and local match is self-reported to the state (versus verified on site), the total local match for FY 2020 was estimated based on actual State FY 2017 and State FY 2018 match reported by local grantees/agencies.

The Title V budget and funding allocations are in compliance with the 30% - 30% requirements: preventive and primary care for children $1,523,371 (31.9%) and children with special health care needs $1,481,251 (31.0%), similar to previous reporting periods (see Form 2). Other requirements related to budget categories such as administrative costs ($300,000; 5.5%, less than 10% as required) and maintenance of effort are maintained. The indirect cost rate for KDHE is 20.3% effective July 1, 2019, an increase compared to the previous rate of 17.6%.

Form 3a Budget by Types of Individuals Served. Considering the total budget of $12,723,071 ($12,488,071 excluding budgeted administration costs of $300,000), Form 3a details the (federal/nonfederal) budgeted amounts by types of individuals served including $1,471,967 federal and $3,775,434 nonfederal for pregnant women and infants under 1 year of age; $1,527,371 federal and $ 2,859,496 nonfederal for children and adolescents 1-22 years; $11,481,251 federal and $1,372,543 nonfederal for children with special health care needs (CSHCN).

Form 3b Budget by Types of Services. Considering the total budget of $12,723,071, Form 3b details the (federal/nonfederal) budgeted amounts by types of services including $104,367 federal and $49,413 nonfederal for direct services (1.3%); $1,960,450 federal and $4,371,274 nonfederal for enabling services (51.1%); and $2,715,781 federal and $3,182,939 nonfederal for public health services and systems (47.6%). There are no significant variations in the budgeted amounts reported by the state on Forms 2 and 3, as compared to previous years' reporting.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Kansas

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

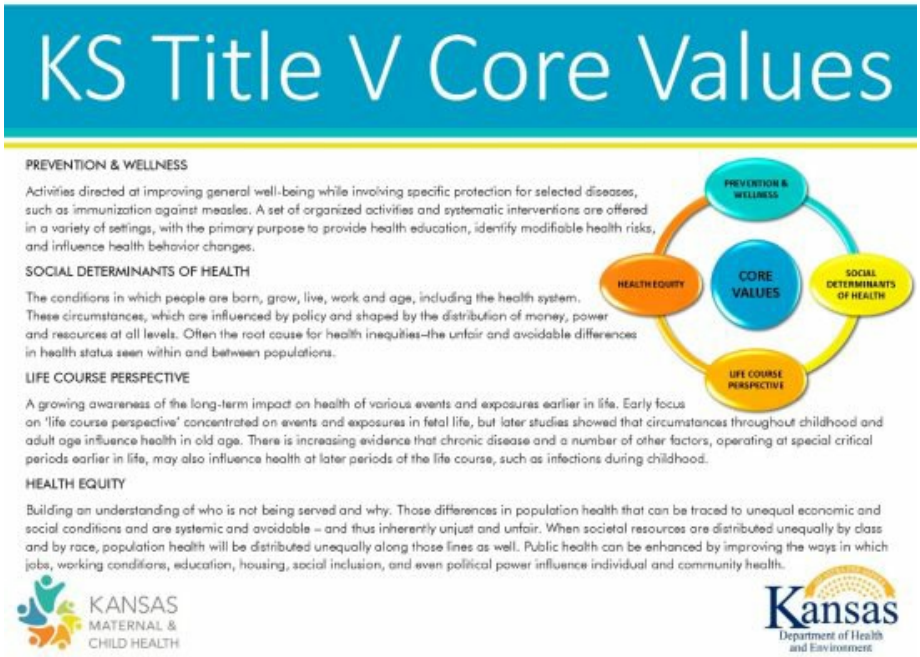
III.E.2.a. State Title V Program Purpose and Design

Vision & Commitment

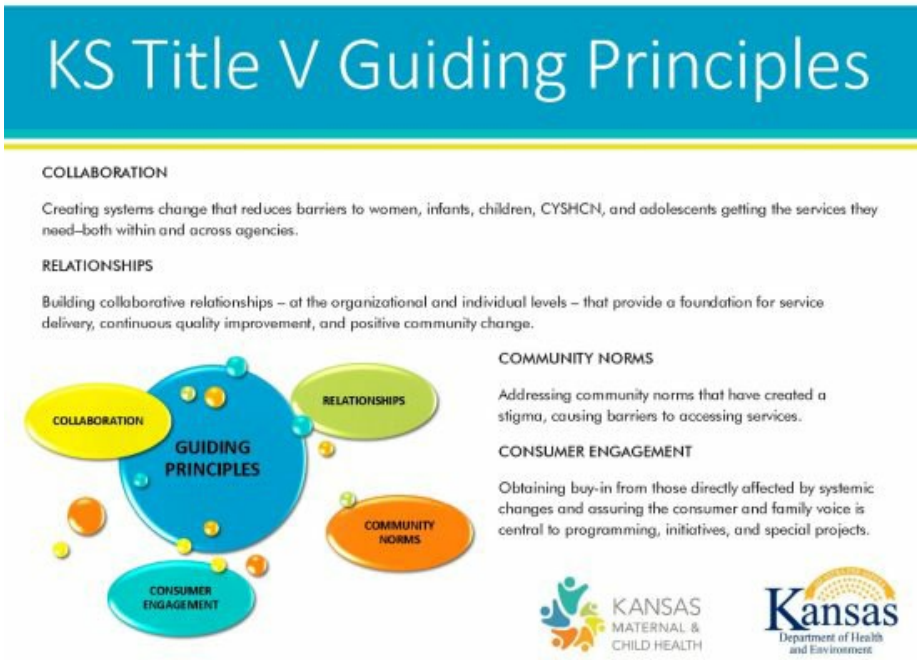
The KS Title V program demonstrates strong commitment to coordinating and collaborating beyond mandated work such as reducing infant mortality and providing services to individuals with special health care needs. The state is truly committed to addressing the emerging and ongoing needs of all MCH populations and continuously focusing on quality improvement. This commitment drives development of integrated systems of care and assessment for community level MCH initiatives. There is a renewed focus on family engagement and service coordination through innovative approaches to ensure families receive the right support and services they need to thrive. There is increased understanding about how behavioral health is part of whole-person health, and the needs of MCH populations have been greatly impacted by issues such as substance use, anxiety, and depression. Transforming systems to better serve individuals and families in our state means taking good ideas and scaling up, out, and deep through innovation and a commitment to use the right tools and data to measure what matters and make informed improvements, especially for those most vulnerable and at risk. Title V goals are infused in, and supported by, the entirety of the Bureau's work across programs, funding sources, resources, and shared infrastructure. Data-driven decision making to improve outcomes and drive priority activities is at the core of the KS system. Activities are supported and made possible through strong leadership, a committed team, and epidemiology capacity.

Core Values & Guiding Principles

In addition to the MCH conceptual framework and public health essential services, the Title V Program depends on core values and guiding principles when approaching any and all phases of work: planning, design, implementation, and ongoing assessment/monitoring/evaluation.



Kansas Title V recognizes and understands the connections between priorities across MCH population domains. In alignment with and including critical elements of the Collective Impact framework, Kansas' approach is supported by the tangible and intangible elements of collaboration, relationship building, and innovation. Four overarching themes have been identified as guiding principles that impact MCH work in KS. 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.

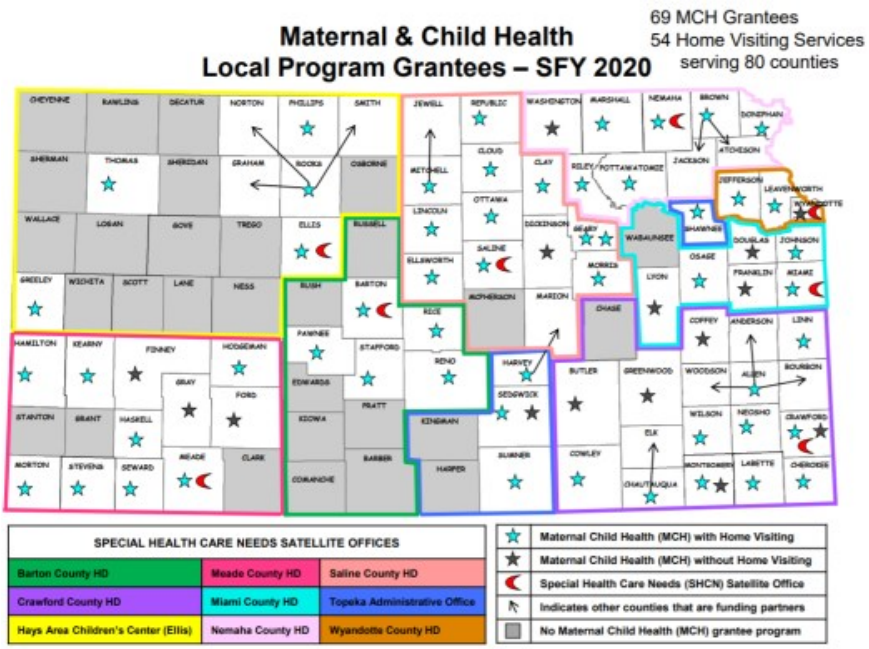


Title V Leadership, Partnerships & Collaboration = Access & Delivery of Quality Services

A major focus of Title V and BFH policy and program initiatives is collaborative partnerships. Engaging stakeholders, providers, and consumers/families is essential to success. The vision and strategic, intentional approach of the Kansas program has not only significantly contributed to building and sustaining relationships over the years, leading to growth and success, but has also positioned the Title V program to face ongoing challenges and emerging issues. Our partners support the program's approach and stand ready to work on issues when called upon.

This commitment to collaboration is proven by partnerships at the state and local levels, which ensure coordination of the health components of the MCH system. Through the Kansas Maternal and Child Health Council (KMCHC), which also includes the PRAMS Steering Committee, and regular communication with local agencies such as health departments, safety net clinics (FQHCs), and hospitals, the state MCH team provides expertise, gathers feedback, and makes connections to maximize the effectiveness of the overall system. Title V strategically partners with state-level organizations to target priorities and implement the action plan (as described throughout the domain sections).

In addition to partnerships with state-level organizations working directly with communities, Title V contracts with nearly 70 local agencies, 54 offering home visiting, serving 80 counties to provide MCH services across the population domains. The majority of local programs funded by the Block Grant are delivered by local health departments and safety net clinics (independent entities). These agencies are positioned to provide core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The services delivered by local agencies are designed to address ongoing needs and those identified by the most recent needs assessment. A map displaying reach is included below.



Title V is truly the leading vision for MCH in KS, with all other initiatives targeted to populations across the life course providing targeted efforts and focus on special needs and issues. MCH stakeholders in KS have a successful history of working together, and the Title V funding has been a catalyst for positive, innovative systems change.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Kansas Title V Workforce: State & Local

The Bureau of Family Health (BFH) has experienced, committed, and visionary staff. The MCH teams are key to building partnerships at the state level and providing support to local communities and families. Title V funding supports critical positions that provide leadership as well as facilitate conversations and activities necessary to address the needs of MCH populations.

Effective July 2019, BFH has 88.5 full-time equivalent positions. The majority of Title V funded agency staff are located in downtown Topeka, directly adjacent to the State Capitol. MCH Block Grant funds provide salaries for approximately 22% of the staffing in the Bureau, supporting administration, SHCN and MCH staff, and Epidemiologists.

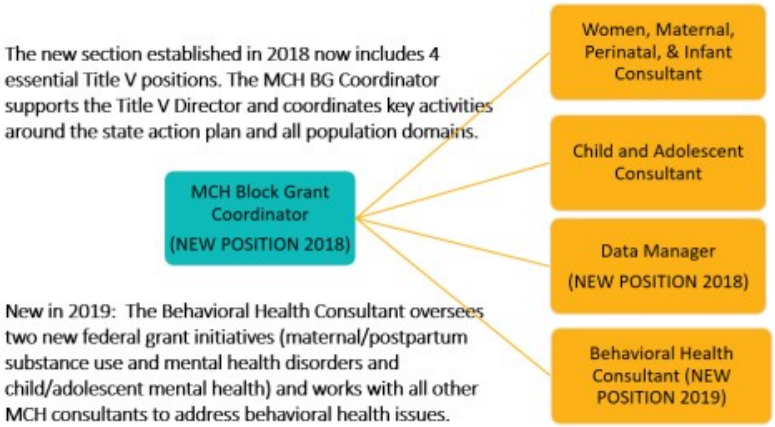
The Title V program understands the importance of staffing at all levels, across sectors, and within multiple parts of the system to impact change. This understanding is evidenced by Title V's support within the state health agency, through existing state-level coalitions, private and public partners. Innovative approaches to shared staffing, when and where appropriate, has supported success. The BFH programs partially funded by the federal-state Title V Block Grant include MCH, Special Health Care Needs (SHCN), and Child Care. Within the Division of Public Health, other Bureaus that receive regular support include the Bureau of Community Health Systems (BCHS) (for local public health workforce development, training, capacity building, systems development) and the Bureau of Epidemiology and Public Health Informatics (BEPHI) (for Vital records data sharing, analysis, reporting). MCH and SSDI funding supports two full-time MCH epidemiologists within BEPHI who interface with epidemiological work conducted in other Bureaus inside the agency and with other organizations and efforts in the state. Both epidemiologists coordinate all data analyses for the Title V needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH. One position is specifically assigned to work with Medicaid (data sharing, review/analysis, application and impact on programmatic efforts and state and local initiatives).

As the Kansas vision has become even more expansive and collaborative in nature, recruitment and retention of qualified staff has become even more of a priority. There are many exciting initiatives being led by Title V that are impacting both state and community policies and systems. Therefore, more focus has been in recruiting the right people (and retaining them) to not only to sustain existing efforts but advance and move forward–scaling up efforts and continuous improvement. Position descriptions are updated regularly and interview questions/processes reflect the needs of the program. For example, questions related to behaviors, lived experience, and understanding of issues facing public health/MCH populations, health equity, and health disparities have been incorporated. Professional development plans and opportunities support professional and personal growth beyond what is "expected" as part of the agency's performance review process.

Beyond the agency Title V staff, hundreds of local MCH experts, staff, and family leaders make up the workforce. Read more about the Kansas Title V workforce, program partnerships, and collaboration in other sections.

Reorganization to Meet Workforce Goals & Title V Vision for Holistic Care/Support

A need for greater capacity around the ongoing needs assessment, monitoring of the state action plan, and state-local partnerships necessary to advance the MCH state action plan was identified, so a new section and two new positions were created in 2018 (MCH Block Grant Coordinator and Data Analyst). During this past year the new section was expanded further to add a new Behavioral Health Consultant. The Title V program has put more attention to building a multidisciplinary team as necessary to make change happen, especially within areas tied to behavioral health (substance use and mental health).



In addition, a 2nd new position was added effective June 2019 to support increased work around the KPQC and MMRC. The position reports to the Title V/Bureau of Family Health Director and was filled effective July 1, 2019.

State Title V Workforce Development & Training Needs

In addition to required agency training programs like Public Health Quality Improvement, the Bureau and Title V state staff participate in annual training. Past events that applied to all staff in the Bureau include topics/titles such as The Change Cycle, Leadership Challenge, Everyday Leadership, Bridges Out of Poverty, Health Equity, Quality Improvement, Mindfulness, and more. The 2019 all-staff event planning is underway. Staff training needs include cultural competency, health equity and disparities, Medicaid policies, Quality Improvement (cycles/data collection), program evaluation, drafting aim and outcome statements, monitoring sub-recipients, care coordination, substance use and mental health, trauma-informed systems of care, and telehealth. In addition, there is special emphasis on training the local workforce on these same topics, as well as the importance of data-driven decisions and use of data to advance public health, including sharing data and integrating systems.

Local MCH Workforce Development

The MCH Navigator and online MCH Assessment are utilized and fully integrated into the professional development planning and performance reviews for all staff. Local MCH program staff and supervisors must complete MCH training via the online MCH Navigator. Two courses must be completed within three months of grant award or hire, whichever applies (MCH 101 and MCH Orientation). In addition to basic training and orientation, local program staff delivering certain messages or services, including education, are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination, etc.). Annual/ongoing training requirements for all local MCH staff include Technical Assistance (TA) Calls/Webinars throughout the year led by the state MCH team and the annual Governor's Public Health Conference. Home Visitors are required to attend the annual training, typically held in the fall. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing the online MCH Navigator Self-Assessment.

Technical assistance for local MCH grantees is planned for FY20 and includes enhancements to be more tailored to specific grantee needs. A series of regional meetings is being planned, BHF staff will travel to six regions in the state in an effort to build stronger, supportive relationships directly with grantees. Tentative agenda items include a review of data currently

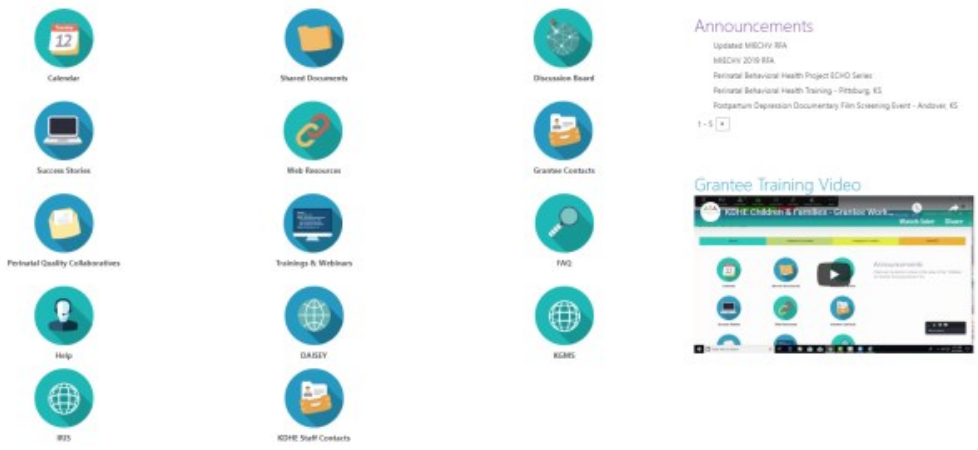
being collected with an emphasis on quality and on identified gaps and needs as well as well as facilitated conversations that will allow regional grantees to share successes and lessons learned regarding data and program implementation as well as client engagement and recruitment. on g. Additionally there will be an opportunity for individual grantees to connect with their individual program consultants from KDHE to seek individualized technical assistance. Ongoing webinars and additional TA opportunities will be driven by grantee needs and staff concerns related to data trends and quarterly program reports.

SFY2020 Maternal & Child Health Technical Assistance Webinars

MCH Technical Assistance Webinars *Attendance REQUIRED*		
Date	**Topic**	**Registration Link**
8/15/2019	DAISEY Data Review	https://attendee.gotowebinar.com/register/2450411595264211979
11/21/2019	To be determined based on TA Needs	

MCH Training Webinars *Attendance Highly Recommended*		
Date	**Topic**	**Registration Link**
9/18/2019	SFY20 MCH Progress Report	https://attendee.gotowebinar.com/rt/2088542527353432075
9/26/2019	SFY20 MCH Progress Report	
1/23/2020	SFY21 MCH Application	https://attendee.gotowebinar.com/rt/2846869099960988683
1/29/2020	SFY21 MCH Application	

Another tool launched in January 2019 will also increase opportunities for on-going support, a WorkStation for MCH grantees was built to offer shared access to resources, a calendar, videos, discussion boards, contact lists, and more. The platform has already proven useful for grantees to troubleshoot challenges with one another. The image below was taken from the homepage of the WorkStation.



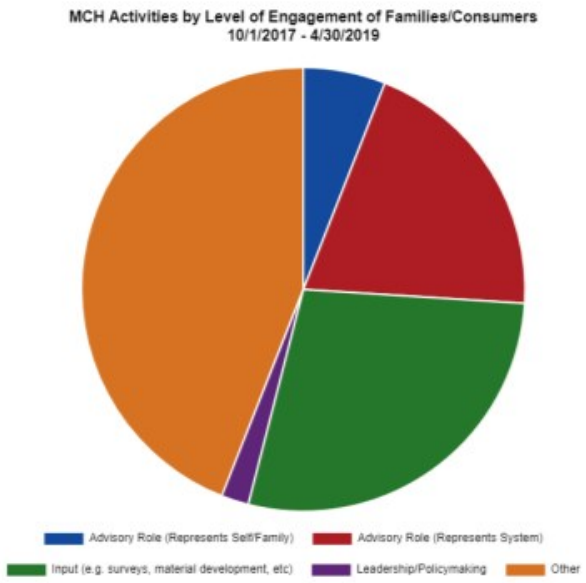
III.E.2.b.ii. Family Partnership

*Kansas invests in family **engagement** and family **partnership** to affirm that the family voice is a critical component to moving services in the right direction.*

The Kansas Title V Program provides opportunities for meaningful engagement and leadership at varying levels of involvement and intensity to fit the needs of consumers and families. Families and consumers 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 MCH populations, especially CSHCN. Individual parents and/or parent groups are represented in both place-based communities, serving as a conduit of information, communication and outreach to other families. Peer to peer connections build engagement and social supports, which are a protective factor to support family well-being.

Awareness & Commitment: Bureau of Family (BFH) Health & Core MCH Team

The program prioritizes family engagement and demonstrates this commitment through time and resources. The Title V Director has set clear expectations that families are to be engaged at all stages (design, planning, implementation, evaluation) in an ongoing, continuous way. Input from consumers is utilized in making decisions around program implementation, program updates/revisions/improvements, and priority areas for focus in the future. The BFH Family Liaison was created as part of the KS-SHCN Program Manager job responsibilities to help program staff think critically around advancing and enhancing consumer and family engagement across programs. The Liaison is available to provide technical assistance to any interested program. The MCH Consultants also have family engagement activities within their job responsibilities to build in an *integration* component centered on consumer and family engagement. There is a need to support at least a half-time position focused on family engagement; discussions are underway between the Title V MCH and CSHCN Directors to determine options.



Measuring Family Engagement

The levels of family engagement in MCH activities is tracked in the MCH Community Check Box, a web-based tool that supports evaluation of the implementation of the action plan and monitors progress towards MCH goals and outcomes. The chart below depicts the level of engagement for activities during the 2018 reporting period.

The “other” category likely indicates no direct involvement, rather activities focused on families and consumers. We are looking into this and revising the options to select in an effort to collect the most meaningful data.

Families Participate in Kansas MCH Efforts as Council Members, Professionals, & Experts

Special Health Services Family Advisory Council (SHS-FAC)
Family consumer partnerships continue to be a focus for SHS programs, especially the Title V KS-CSHCN program which utilizes input from the SHS-FAC on a regular basis. It is understood and expected that new initiatives, policy changes, or special projects will engage families and obtain feedback on the added value of the effort during the development and through the implementation phase. This value stems from the philosophy “nothing about us without us,” so buy-in from those directly affected by changes occurs frequently.

Financially supported by Title V, SHS-FAC members are eligible to receive a consultant fee, travel reimbursement, and child care costs meetings. Council membership is intended to be diverse, with families of children of varying ages and special health care needs. While a key activity of the council is to advise the SHS programs, the council also identifies a project each year to assist in program and material development and promotional activities relevant to the needs of the program populations. SHS-FAC members receive valuable training on Title V and MCH core competencies. More information about SHS-FAC projects can be found in the CSHCN domain narratives.

Organizationally, the Title V CSHCN Director, KS-SHCN Program Manager, and SHS Administrative Specialist serves as Council “staff”; however, the Executive Committee is comprised of three FAC members who assist in the development of agendas, bring key issues to the table, and provide oversight 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 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.

The SHS-FAC Alumni and Mentorship Program (AMP) was developed in 2016 for members who have to leave the Council due to term limits or personal reasons, but would still like to be involved at some level. Continued engagement opportunities are offered to these seasoned and motivated family professionals, allowing them to continue their contributions and see the impact of their foundational work. The mentor program is designed to assist new members in learning about the SHS-FAC and their role as a member. Former or current members who have served two or more years as an FAC member can participate in a mentor capacity. Additionally, we hope to nurture their investment and expand the cross cutting community of Title V family and consumer partners.

Kansas Maternal & Child Health Council
At the present time, the Council includes four representatives dedicated to serving in the role of a family/consumer member. Recruitment for additional members is ongoing considering the goal is to have at least two family member representatives for each domain group (total of eight).The BFH Family Liaison provides orientation prior to a member’s first meeting where they receive a notebook with information about Title V, the State Action Plan, and overview of MCH data. Immediately following meetings, all family members join the Liaison in a “debriefing session” to answer questions, clarify discussions, and provide additional information they may need. The Liaison continues to be available between council meetings for questions when needed. Each family member receives a small stipend for attending the in-person meetings, assistance with mileage and child care, if needed. This support continues to be effective in keeping families engaged and confident in their role on the Council.

Family Delegate Program
The KS AMCHP Family Delegate appointment process was initiated by the CSHCN Director in 2013 to increase opportunities for family leadership within Title V and ensure comprehensive supports and resources are available for delegates. A competitive application process involves a mentorship plan resulting in a mutually agreed-upon project to advance the

MCH/Title V 5-year plan. Delegates are allowed to continue for two consecutive years, if interested.

The 2018-2020 Family Delegate is Cassandra Sines. She's been a member of the SHS-FAC since 2013 and has served as a member of the Executive Committee. Additionally, she participated as a consumer member of the adolescent health school-based health center initiative conducted in partnership with the National MCH Workforce Development Center.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

State Systems Development Initiative (SSDI)

As part of the ongoing epidemiologic support, SSDI continues to assist with: refining the 5-year State Action Plan, Evidence-based or -informed Strategy Measures (ESMs) and State Performance Measures (SPMs), setting annual objectives (linear forecasts) for each of the National Performance Measures (NPMs) and SPMs, writing trend analysis, highlighting major statistical findings and providing interpretation, developing funding formula for the MCH Block Grant allocation to local health departments and grantees, and preparing the resources/tools to increase knowledge and understanding about the Kansas Title V MCH federal-state partnership, services, block grant, and the state's priority issues for 2016-2020. These can be found at: http://www.kdheks.gov/c-f/mch.htm.

Kansas was one of two states, among 51 states and jurisdictions that participated in the Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CoIIN), that sought methods to more effectively analyze the infant mortality rate (IMR) for subsets of the populations with an infrequent number of deaths. Kansas found the statistical process control (SPC) charts useful to look at data in an exploratory way and raised questions to see if there was anything worth exploring further. Led by the National Institute for Children's Health Quality (NICHQ), which SSDI contributed, a manuscript *Using infant mortality data to improve maternal and child health programs: An application of statistical process control techniques for rare events* has been published in Maternal and Child Health Journal and selected for inclusion in an issue and will be printed soon: https://link.springer.com/article/10.1007%2Fs10995-018-02710-3. Additionally, a multi-state collaborative project with the National Birth Defects Prevention Network, which SSDI contributed, investigating Gastroschisis Trends and Ecologic Link to Opioid Prescription Rates - United States, 2006–2015 has been published in the Morbidity and Mortality Weekly Report: https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6802a2-H.pdf.

SSDI completed the 2018 Kansas Perinatal Community Collaboratives (KPCCs) program evaluation reports for the 11 sites and statewide: Clay, Crawford, Dickinson, Geary, Lyon, Montgomery, Reno, Riley, Saline, Sedgwick and Wyandotte counties. These reports summarize findings from the pre- and post-surveys and follow-up health outcome questionnaires. KPCCs, 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 perinatal collaboratives utilizing March of Dimes Becoming a Mom/Comenzando Bien® as a consistent and proven prenatal care education curriculum. The model brings prenatal education and care together. Birth outcome data reveals improvements in preterm delivery, low birthweight, and breastfeeding initiation. Most notable is the Infant Mortality Rate (IMR) per 1,000 live births (5-year average) from pre-implementation to post-implementation in the counties of our two longest running KPCC sites. IMR in these two counties has significantly decreased since the inception of local perinatal community collaboratives. The Saline County IMR decreased significantly from 9.0 (95% CI 7.2-13.7) in 2005-2008 to 5.5 (95% CI 2.5-7.1) in 2013-2017. The Geary County IMR decreased significantly from 11.9 (95% CI 8.6-16.0) in 2005-2008 to 5.7 (95% CI 3.6-7.7) in 2013-2017.

In April 2018, the Bureau of Epidemiology and Public Health Informatics (BEPHI) - Vital and Health Statistics Data Analysis Section re-established annual linkage of birth records to Medicaid (mother-infant dyads) and hospital discharge data (mothers only; no mother-infant dyads, due to limited identifying information for the infant in the hospital discharge data). The BEPHI - Vital and Health Statistics Data Analysis Section also made a linkage possible between birth records and WIC eligibility files which is performed on an as needed basis.

Other Epidemiology & Data Analysis Capacity

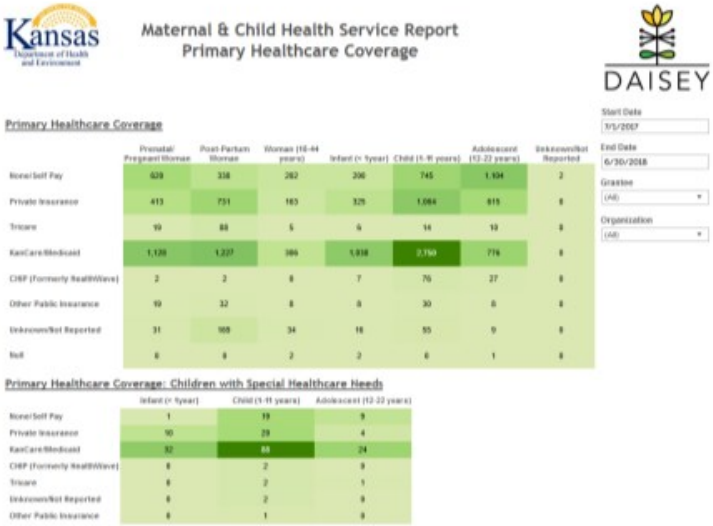
Lawrence J. Panas, PhD, MCH Epi, was recruited July 2018. His major responsibilities involve analysis of data collected through DAISEY, the web-based shared measurement data system. Specifically he evaluates the Perinatal Community Collaboratives (local models working to improve maternal and infant health outcomes in the pregnancy and postpartum periods). A large portion of his work is also dedicated to the Title V-Medicaid partnership as far as utilizing data to improve outcomes.

James Francis, MPH, Data Analyst, was recruited March 2019. He serves as point of contact for the data housed in multiple systems, some shared by several programs; prepares maternal and child health, family planning, and other program data for reporting and collaborates with program directors, epidemiologists and team members; extracts clean data from systems of record, review, and finalize for progress reports, performance reports, and other narrative and measure reporting; and more.

Data-Driven Approach & Commitment to Capacity Building: DAISEY

The 2015 launch of DAISEY supports Title V's vision for shared measurement/data collection and integrated community-level MCH initiatives. Increased data capacity allows the program to demonstrate the impact of coordinated, essential MCH services on improved outcomes. DAISEY is available free to all local providers as the required centralized collection system for MCH services. Eight state-level programs are utilizing DAISEY for data collection and reporting, including Title V. In 2017-2018, DAISEY's data and analytics infrastructure were enhanced to further support KDHE's vision for integrated and coordinated community-level maternal and child health initiatives. Focus shifted from implementation to using data to drive decisions and quality MCH services. Customized, visual reports in DAISEY allow users and KDHE to review data quality, meet compliance reporting, and implement program improvements through review of clients served, services provided, and referrals made. DAISEY reports help local agencies and KDHE easily demonstrate the need for MCH services and to share the impact of their programs at the community, regional, and statewide level. KDHE and KU staff provide extensive training and technical assistance, and a DAISEY Helpdesk is available for system users. A website was developed to provide a centralized access point. Users as of June 2019 are 1,126 (representing 91 grantees and 159 organizations). The largest growth has been MCH and Family Planning (+30), followed by Healthy Start (+13), MIECHV (+11), and LYFTE (+10). A new module and set of users was added in 2019, the Kansas Perinatal Quality Collaborative (KPQC) (+27).

DAISEY Solutions Website (http://daiseysolution.com/kdhe/) & Sample Report



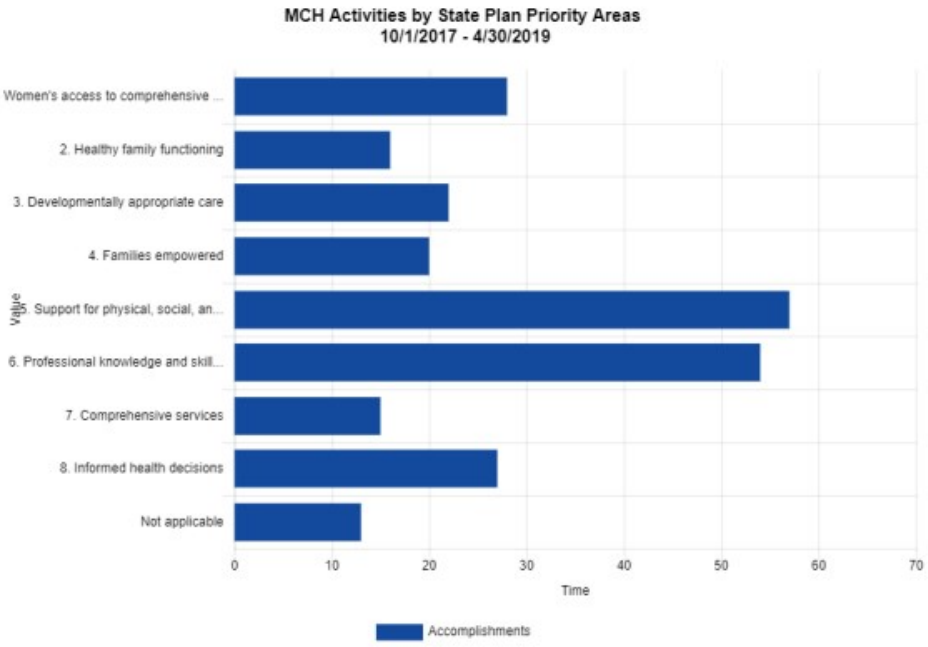
Integrated Referral & Intake System (IRIS)
http://connectwithiris.org/knowledgebase/introduction-to-iris/

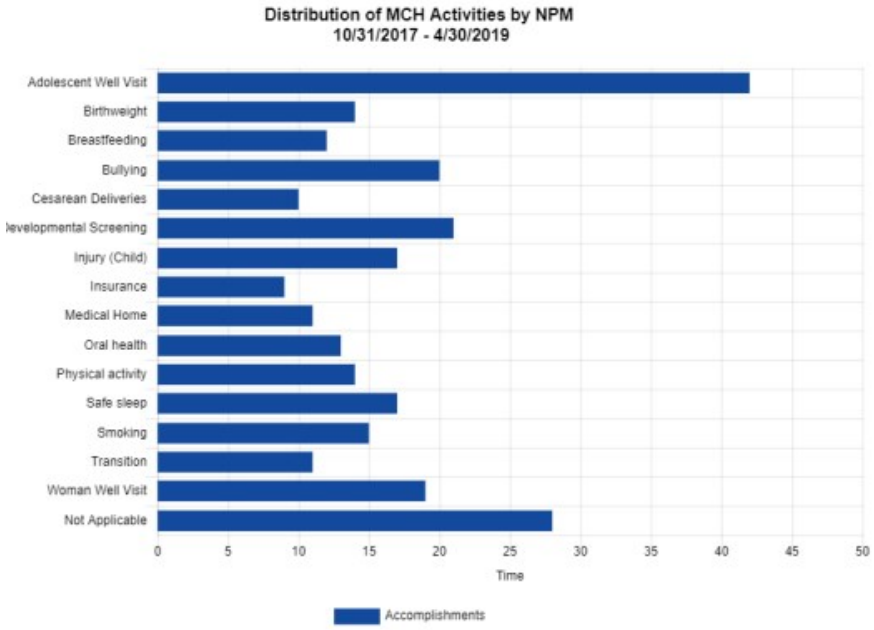
Title V is partnering with KU to implement IRIS, a web-based community referral system to support best practices in social service referral and coordination among community partners. Its primary purpose is to enable service providers to make, receive, track, and respond to referrals. Data collected will provide insight into what's working and not working at the local level for families as far as connecting to needed services. Read more in the Child Health Section.

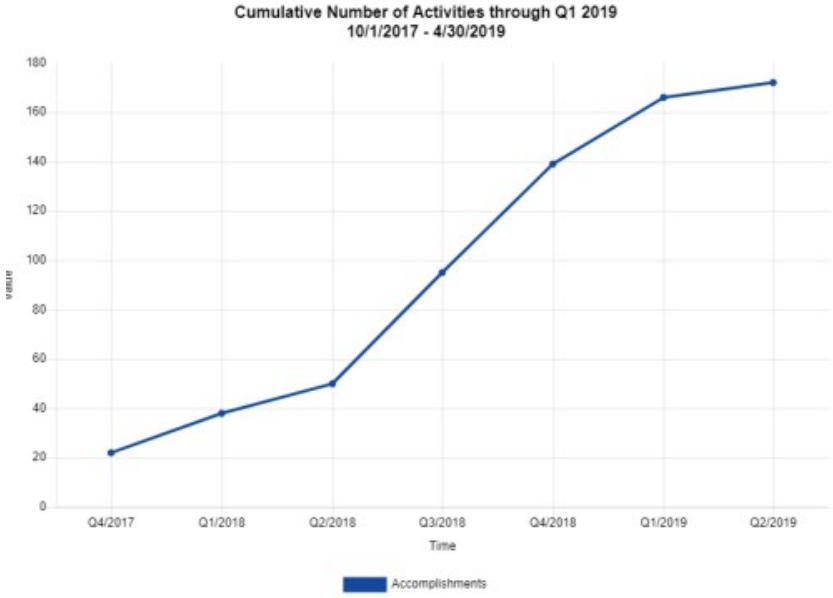
MCH Community Check Box: Monitoring the State Action Plan
developed by the KU Center for Community Health and Development (http://communityhealth.ku.edu)

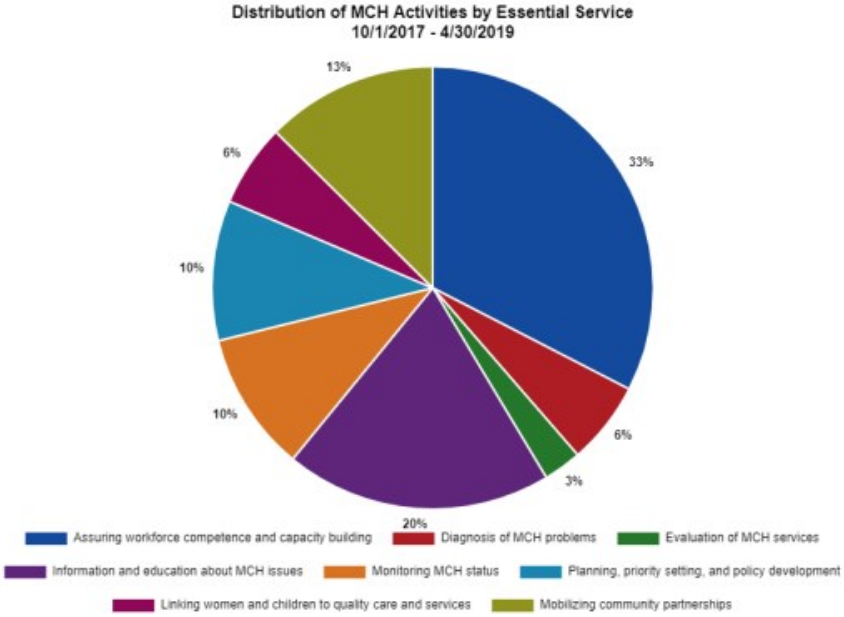
Title V captures, characterizes, and communicates what we are doing across the state in the MCH Check Box. The information collected is used for learning, improved collaboration, quality improvement, monitoring the extent to which state and local partners are building capacity and taking action to address the plan priorities and measures, and how these activities may be influencing key indicators such as maternal and infant mortality. The team has used the tool since May 2017.

Sensemaking sessions take place quarterly with the Title V state and KU team. The graphs below detail the extent to which efforts are focused on priority areas and performance measures as well as through what means or essential MCH service.


MCH Activities by State Plan Priority Areas
10/1/2017 - 4/30/2019
Women's access to comprehensive ...
2. Healthy family functioning
3. Developmentally appropriate care
4. Families empowered
5. Support for physical, social, an...
6. Professional knowledge and skill...
7. Comprehensive services
8. Informed health decisions
Not applicable
Value
0
10
20
30
40
50
60
70
Time
Accomplishments


Distribution of MCH Activities by NPM
10/31/2017 - 4/30/2019
Adolescent Well Visit
Birthweight
Breastfeeding
Bullying
Cesarean Deliveries
Developmental Screening
Injury (Child)
Insurance
Medical Home
Oral health
Physical activity
Safe sleep
Smoking
Transition
Woman Well Visit
Not Applicable
0
5
10
15
20
25
30
35
40
45
50
Time
Accomplishments

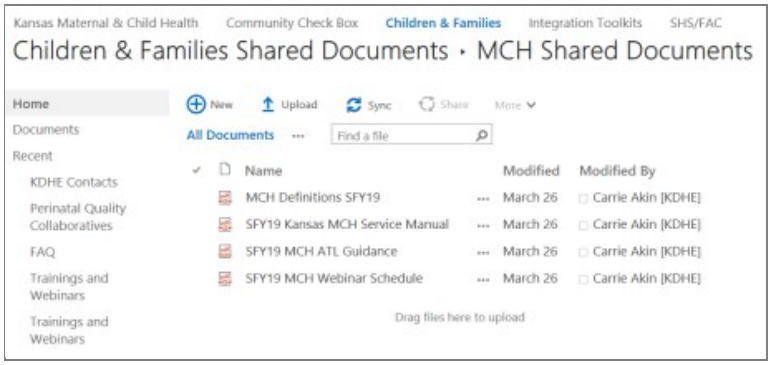

Cumulative Number of Activities through Q1 2019
10/1/2017 - 4/30/2019
180
160
140
120
100
80
60
40
20
0
Q4/2017
Q1/2018
Q2/2018
Q3/2018
Q4/2018
Q1/2019
Q2/2019
Time
Accomplishments


Distribution of MCH Activities by Essential Service
10/1/2017 - 4/30/2019
13%
6%
10%
10%
20%
3%
6%
33%
Assuring workforce competence and capacity building
Diagnosis of MCH problems
Evaluation of MCH services
Information and education about MCH issues
Monitoring MCH status
Planning, priority setting, and policy development
Linking women and children to quality care and services
Mobilizing community partnerships

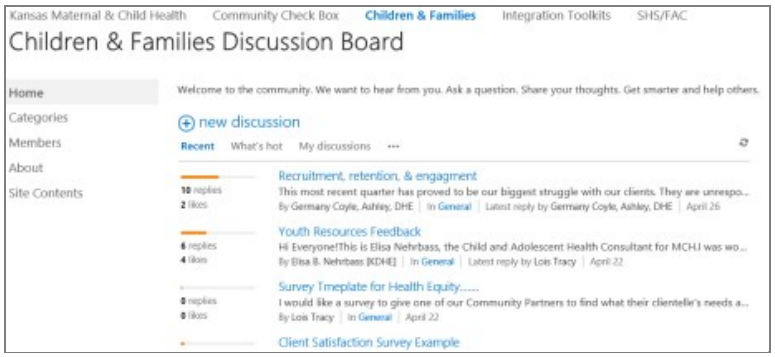
BFH invested in the development of a shared collaborative SharePoint application within the Community Check Box, commonly referred to as the WorkStation. This tool is being used to enhance training and technical assistance while also increasing statewide connections and collaboration amongst program staff and grantees.

Screenshot of the MCH WorkStation – Main Page https://www.myctb.org/wst/KansasMCH/cf

Screenshot of the MCH WorkStation - MCH Shared Documents Page



Screenshot of the MCH Workstation - Discussion Board Page



III.E.2.b.iv. Health Care Delivery System

Collaborative Work & Relationships

The KDHE BFH and Title V Program have partnerships at the state and local levels to ensure capacity meets the coordination of components within the MCH health care delivery system. The program prioritizes the intentional alignment of federal-state-local initiatives; interaction with state advisory groups (especially MCH Council, Family Advisory Council, Perinatal Quality Collaborative, PRAMS Steering Committee, Maternal Mortality Review Committee); and regular communication with public and private local agencies and organizations such as public health departments, safety net clinics (FQHCs), primary care settings, hospitals, community mental health centers, social service agencies, and school districts. As a leader and partner, the state MCH team provides expertise, gathers feedback, and makes connections to assure access to services and maximize the effectiveness of the health system as well as other systems impacting overall health and well-being. The primary Title V services are provided across the state through local agencies contracting with the Title V program to provide family centered, community based and culturally competent services and care to MCH populations throughout the life course. Grants are awarded annually through an Aid-To-Local competitive funding process that runs along the state fiscal year (July to June). Local awards are based on MCH population data (census as source), plans, performance, collaboration, and potential to impact.

Other Federal Maternal & Child Health Bureau Investments

BFH staff is exploring ways to better coordinate and integrate the Healthy Start; Maternal, Infant and Early Childhood Home Visiting (MIECHV); Early Childhood Comprehensive Systems (ECCS); Maternal Depression and Other Behavioral Disorders/Kansas Connecting Communities (KCC); and Pediatric Mental Health Care Access/KSKidsMAP initiatives with multiple programs. Title V vision leads the way and provides the overall direction for all we do in Kansas for birth through adulthood. Strong linkages have been identified across plans and needs assessment findings. Coordination meetings with leaders and experts take place on a regular basis (monthly to quarterly) to continue aligning and integrating the initiatives at the state and local levels. Regular conversations are also held with the evaluation and project coordination teams at the University of Kansas. This commitment to continuously improve, create efficiencies, and add value is what has resulted in major systems change resulting from initiatives launched and/or supported by Title V (EX: Help Me Grow Kansas). We expect the new behavioral health programming to lead to something bigger for the state's behavioral health system.

Title XIX & XXI – Medicaid

Kansas Title V has an agreement in place with Medicaid and has been working to strengthen the relationship for a number of years. This most recent agreement (executed in 2016 and updated in 2019) outlines the formal partnership. The original agreement was reviewed and revised in 2019 to further define and detail the relationship between Title V and Medicaid as it relates to Maternal Mortality Review. Although notable progress has been made, there have been delays with advancing aspects of the Medicaid alignment, integration, and data sharing. This is likely attributed to significant and repeated changes in leadership positions (Secretary, Medicaid Director, State Health Officer), since December 2017. The Medicaid Director and Secretary changed again in January 2019 with the new Governor. All leaders currently in these positions embrace, understand, and support the need for increased collaboration and communication, including data sharing. As a testament to the agency's commitment to doing more across the Divisions of Public Health and Health Care Finance (Medicaid), a new "shared" position was created in May 2018, and the position was filled soon after. The new position involves working as a liaison across public health and Medicaid to utilize data, analyze patterns, and respond with policy recommendations, interventions, new programs, or other solutions that address the needs of target populations and result in greater impact. Several conversations have been taking place with Medicaid staff and MCOs.

Over the past year, the following steps were taken to advance shared goals/work and target poor outcomes identified for Title V-Title XIX shared participants.

- Title V was involved in conversations that led to KDHE's Vital Statistics receiving Medicaid data to link to the birth

records for resident mothers for calendar year 2015.

- Title V Director presented to the Kansas MCOs: introduced the Federal partnership requirements, discussed the MCH measures targeting the Medicaid and non-Medicaid population disparities.
- Title V leveraged Medicaid funding to support collaborative Medicaid-Public Health initiatives to advance MCH efforts around the utilization of 17P to prevent preterm birth; expanding access to prenatal education, maternal depression screening, long acting reversible contraceptives, and substance use screening (plus education, referral and treatment). These five design projects are supported by Wichita State University Community Engagement Institute. More about each of these design projects can be found in the domain narratives.
- Title V CYSHCN worked collaboratively with Medicaid representatives to gain access to the Medical Management Information System (MMIS) and the Kansas Eligibility Enforcement System (KEES) to reduce the burden of program staff in confirmation of Medicaid and other state service benefits. This also reduces the burden placed on families in applying to the KS-SHCN program by reducing the paperwork required for submission when it can be verified through these systems. The MMRC Abstractor is currently in the process of requesting access to the system to verify benefits and care/services for the purposes of case reviews.

The KS-SHCN program works collaboratively with Medicaid and MCO partners to make sure clients are receiving appropriate services and quality case management or care coordination. KS-SHCN receives a monthly MCO report that provides valuable information to the Care Coordinators around authorized services from the MCO. This allows them to assist clients in getting appointments scheduled, fill prescriptions, effectively communicate with providers, etc. KS-SHCN coordinates with MCO care coordinators around gaps or barriers in the client's services they may not be aware of. For more on the impact this collaboration has on dually enrolled clients and the overall system of care available for CYSHCN, please see the CYSHCN domain narrative section.

III.E.2.c State Action Plan Narrative by Domain

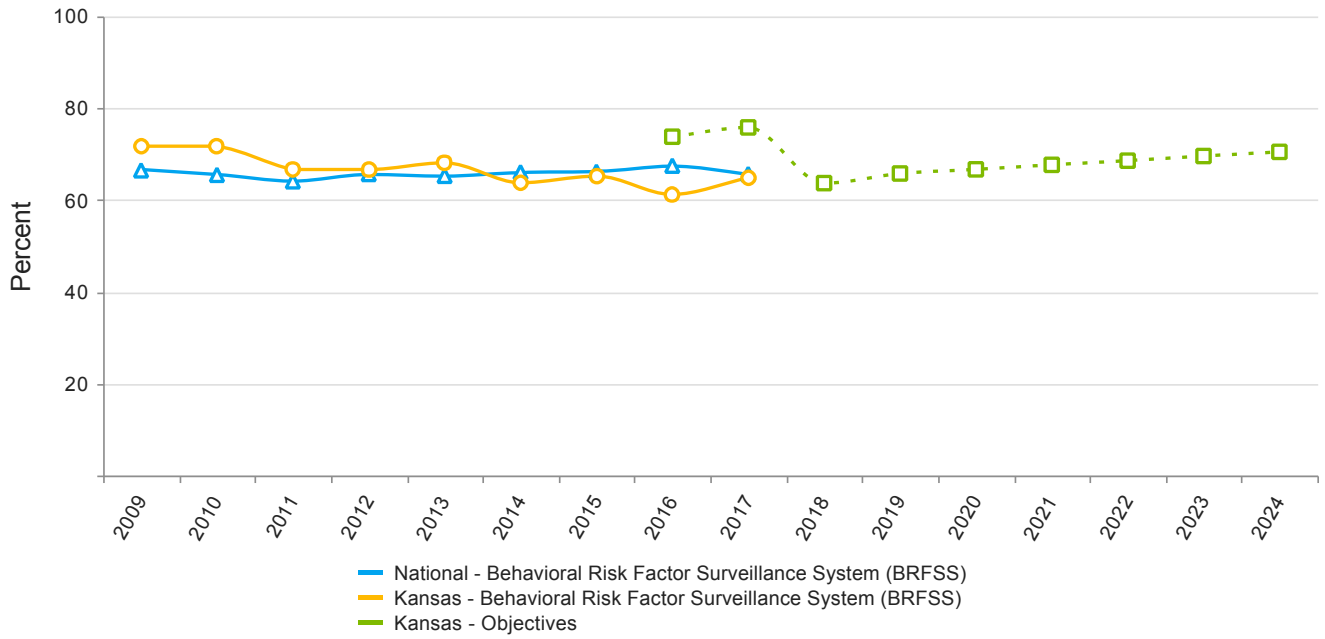
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	96.5	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	7.4 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	9.6 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	25.7 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	6.8	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	6.0	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.9	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.1	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	199.7	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	128.8	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	3.5	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	91.0 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	21.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	12.4 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	73.7	75.7	63.6
Annual Indicator	65.1	61.0	64.8
Numerator	317,072	294,297	311,046
Denominator	486,998	482,804	480,042
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	65.7	66.6	67.6	68.5	69.5	70.4

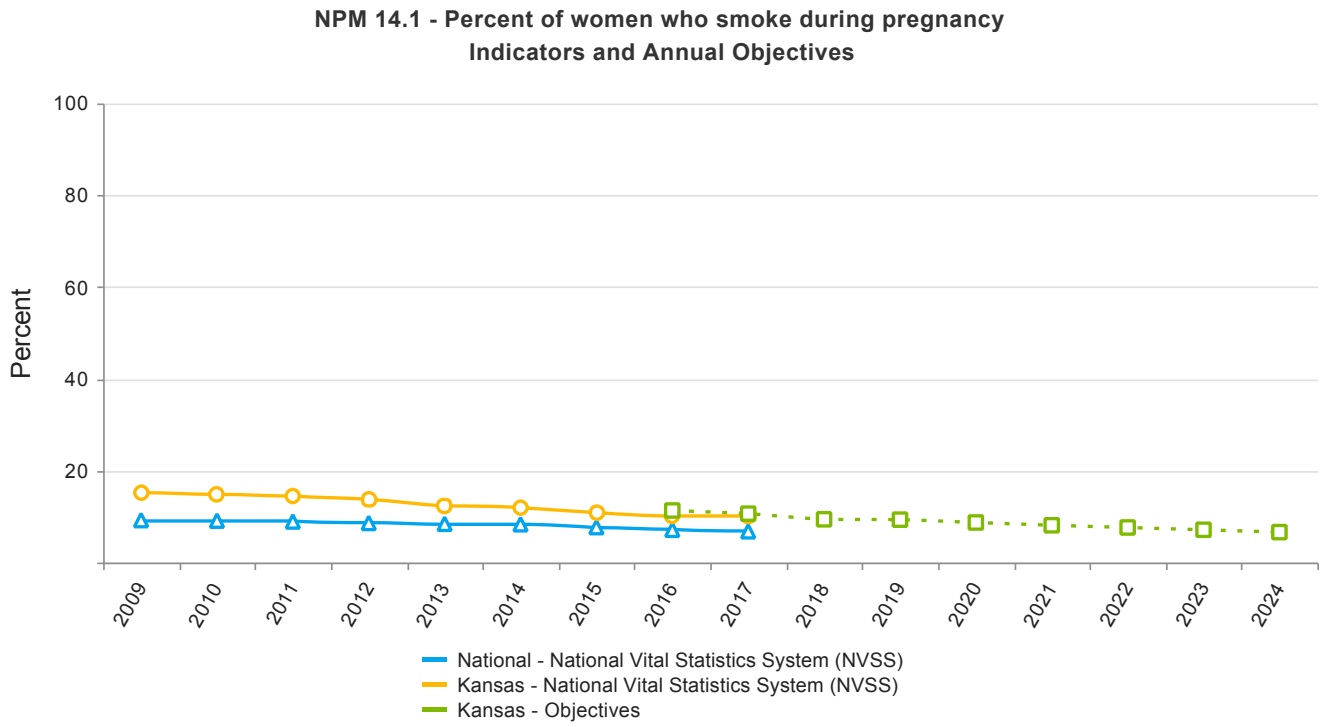
Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		20	30
Annual Indicator	24.7	28	25.9
Numerator	1,604	1,773	1,702
Denominator	6,496	6,335	6,578
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	35.0	40.0	45.0	50.0	55.0



Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2016	**2017**	**2018**
Annual Objective	11.4	10.7	9.5
Annual Indicator	11.0	10.2	10.1
Numerator	4,298	3,877	3,683
Denominator	39,083	37,965	36,434
Data Source	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017

State Provided Data			
	2016	2017	2018
Annual Objective	11.4	10.7	9.5
Annual Indicator	11	10.2	10.1
Numerator	4,294	3,878	3,680
Denominator	39,052	37,961	36,374
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.4	8.8	8.2	7.7	7.2	6.7

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		15	30
Annual Indicator	31.1	38.9	43.5
Numerator	42	96	104
Denominator	135	247	239
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		8.3	8.9
Annual Indicator	8.8	9.1	9.6
Numerator	3,426	3,457	3,492
Denominator	39,105	38,033	36,440
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.1	8.7	8.2	7.8	7.4	7.1

State Action Plan Table

State Action Plan Table (Kansas) - Women/Maternal Health - Entry 1

Priority Need

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

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

1.1 Increase the proportion of women receiving a preventive medical visit annually.

1.2 Increase the proportion of women developing a reproductive life plan annually.

1.3 Increase the number of communities utilizing the MCH collaborative model and prenatal education curriculum by at least 5 annually by 2020.

Strategies

1.1.1 Increase the number of health departments and health centers educating on the importance of an annual well visit and providing on-site assistance for accessing health care coverage (certified application counselors or Medicaid eligibility workers), especially to ensure coverage beyond the post-partum period. 1.1.2 Utilize peer and social networks for women, including group education models, to promote and support access to preventive care. 1.1.3 Promote individuals' responsibility through the development and documentation of personal health plans that include the annual visit. 1.1.4 Promote consumer awareness about the importance of preconception care, and inter-conception care, and birth spacing.

1.2.1 Develop, evaluate and disseminate culturally competent reproductive life planning tools. 1.2.2 Increase number of health departments and health centers utilizing reproductive life planning tools including One Key Question®. 1.2.3 Promote consumer awareness about the importance of reproductive life plans, including birth spacing. 1.2.4 Increase provider knowledge of the importance of reproductive life plans and improve reproductive life planning counseling skills.

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

ESMs	Status
ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Kansas) - Women/Maternal Health - Entry 2

Priority Need

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

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

1.5 Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

Strategies

1.5.1 Promote provider training on tobacco use and smoking with focus on pregnancy, identifying resources and interventions available including Nicotine Replacement Therapy (NRT). 1.5.2 Promote referral to the Quitline, Baby & Me Tobacco Free program, Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program, and other evidence-based interventions where available. 1.5.3 Place toolkits (screening, referral, resources, and programs) in the hands of providers. 1.5.4 Standardize smoking history and screening forms to collect information at initial and follow-up visits. 1.5.5 Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum.

ESMs	Status
ESM 14.1.1 - Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services	Active

NOMs

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

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

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Kansas) - Women/Maternal Health - Entry 3

Priority Need

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

SPM

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

Objectives

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

1.6 Implement the Vermont Oxford Network (VON) Neonatal Abstinence Syndrome (NAS) Universal training program statewide in partnership with the Kansas Perinatal Quality Collaborative (KPQC) and birthing hospitals (Target: 62 hospitals). (New)

Strategies

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

1.6.1 Assist 85% of participating birthing facilities enrolled in the NAS Universal Training Program with achieving “Center of Excellence” designation. 1.6.2 Reduce the percent of infants at risk for NAS admitted directly to the NICU to less than 50%. 1.6.3 Decrease the percent of infants at risk for NAS who require pharmacological treatment by 25%. 1.6.4 Decrease the hospital length of stay for infants with NAS treated pharmacologically by two days.

Women/Maternal Health - Annual Report

PRIORITY 1: Women have access to and receive coordinated, comprehensive services before, during and after pregnancy

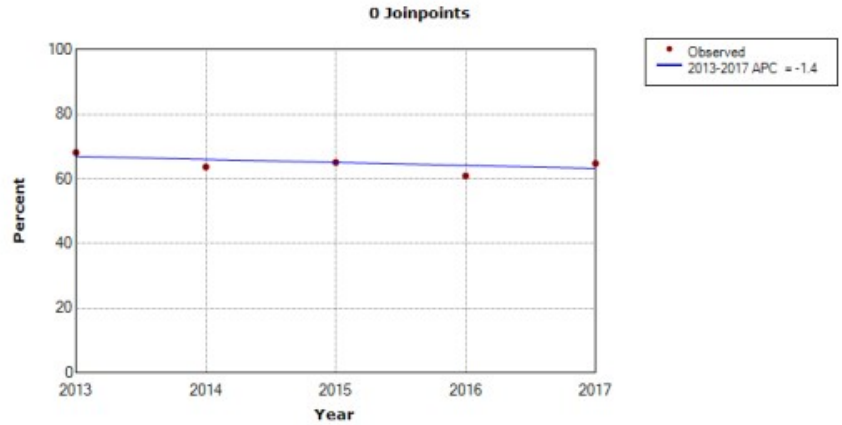
NPM 1: Well-woman visit (Percent of women, 18-44, with a past year preventive medical visit)
SPM 1: Preterm births (<37 weeks of gestation)
NPM 14: Smoking (during pregnancy and household)

Local MCH Reach: During SFY2018, 50 of 70 grantees (71%) and during SFY2019, 61 of 71 grantees (86%) provided services to the Woman & Maternal population.

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

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

A yearly routine checkup is a great way to remain proactive about one's health. The benefits of having an annual checkup include early diagnosis and treatment of existing conditions and prevention of future medical problems. [1] Data from the Kansas Behavioral Risk Factor Surveillance Survey (BRFSS) indicated that, although not statistically significant, from 2013 (68.2%) to 2017 (64.8%), a declining trend was apparent in the overall prevalence of Kansas women aged 18-44 years who reported having a routine checkup within the past year (Annual Percent Change =-1.4%, 95% Confidence Interval: -4.5%, 1.7%).
NPM1: Well-Women Visit

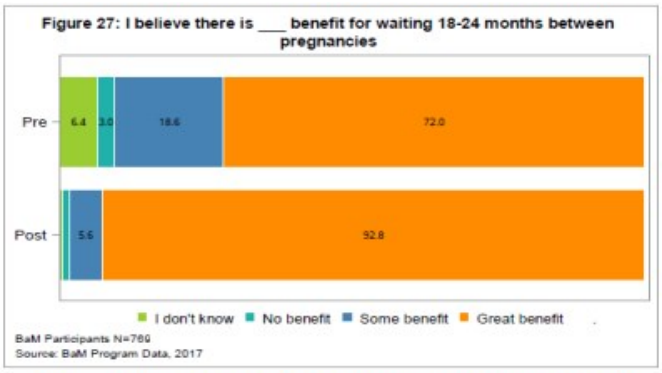


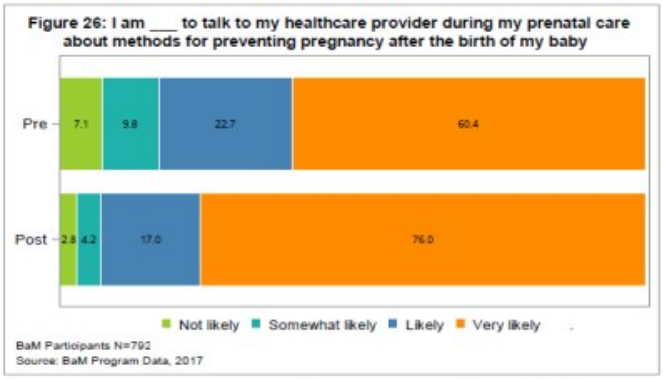
^ Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

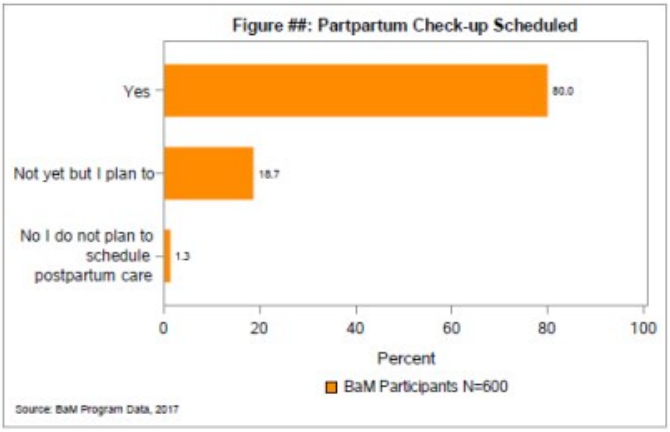
In 2017, an estimated 64.8% of Kansas women aged 18-44 years reported having a routine medical checkup within the past year. The prevalence of having a routine checkup within the past year increased with household income poverty level. Non-Hispanic Black (75.6%) women were significantly more likely than Non-Hispanic white (63.6%) women to have received a routine checkup within the past year. Women with a college education (69.7%) compared to women with less than a high school education (56.8%) were significantly more likely to have received a routine checkup in the past year. Uninsured women (41.2%) were significantly less likely to have had a routine checkup within the past year than insured women (69.5%). Women ages 35-44 (66.8%) were significantly more likely to have a routine checkup than women ages 18-24 (62.5%) or women ages 25-34 (61.6%). Married women (67.8%) were significantly more likely to have received a routine checkup than unmarried women (62.0%). Place of residence (non-metropolitan statistical area (MSA), MSA/Central City, and MSA/non-Central City) were not significantly associated with use of routine checkups.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Based on the above cited data, demonstrating the decline in Kansas women reporting having a routine checkup within the past year, as well as trends being

lower for low-income and less educated women, it has been a priority for perinatal community collaboratives utilizing the March of Dimes (MOD) Becoming a Mom® (BaM) curriculum to focus on women's health in the inter-conception period. This includes the integration of personal health plans and the development of a reproductive life plan for each woman completing the BaM program. The handout "Keeping Healthy After Pregnancy" and resource "Show Your LOVE – Steps to a Healthier me!" by the CDC have been incorporated into the lesson and activity plans for session 6 of the curriculum, where participants set goals for their health plan, including: scheduling their postpartum appointment and annual well-woman exam with their provider; planning for the prevention of an unplanned pregnancy; healthy diet and exercise plan; planning for daily consumption of at least 400 mcg of folic acid; updating and maintaining vaccinations; practicing stress management techniques; managing chronic health conditions. Program evaluation data shows the following improvements in knowledge and planned behavior related to the education received:

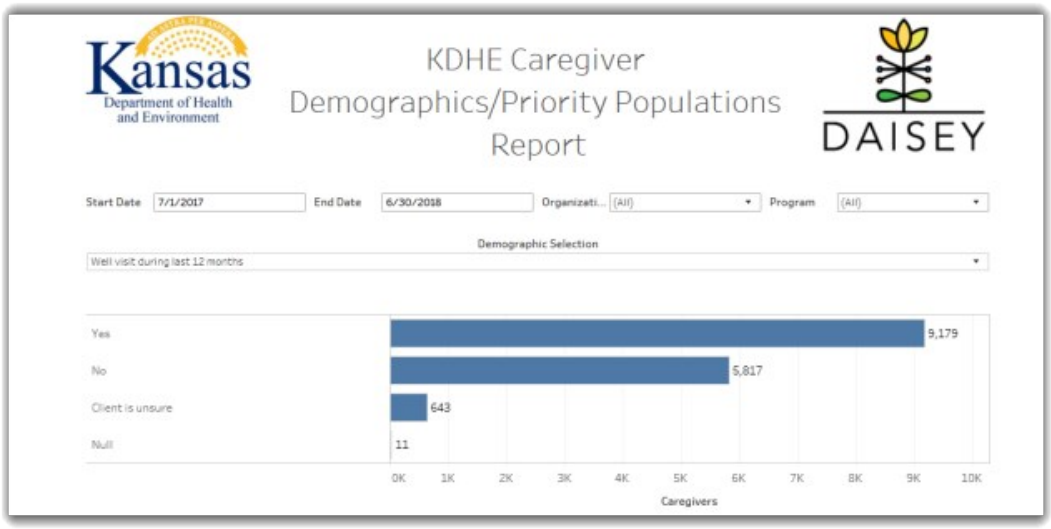






Local MCH agencies: Local MCH agencies worked in collaboration with Title X Family Planning (FP) programs to educate on the importance of preventative care and screen all clients to determine if a preventative visit took place in the last twelve months. This required information is collected on the KDHE Program Visit Form in DAISEY at least annually, but most agencies verify at every visit if there are any changes from the last visit. All Aid-to-Local grantees (MCH (including home visiting), FP, Pregnancy Maintenance Initiative (PMI), and Teen Pregnancy Targeted Case Management (TPTCM)) complete this form for all clients at every visit. The image below shows the results of the screening

question from every program. Although majority (58.7%) reported receiving a well visit in the last 12 months, additional work and follow-up needs to be done to address the clients who answered no or unsure. We will address this with MCH grantees for consistency.



Other Activities Related to the Annual Preventive Medical/Well-Woman Visit

One Key Question® State Initiative: To support broader reproductive health and MCH goals related to the annual preventive medical visit, implementation of the One Key Question® (OKQ) initiative got underway in 2018, in partnership with Power to Decide. The one key question, "Would you like to become pregnant in the next year?" and responses were built into the shared data system, DAISEY, in anticipation of planning for implementation of the full approach. Following early introduction to this key question via our data system, an informational session was provided for grantees at the Governor's Public Health Conference (GPHC) in April 2018. The presentation was delivered by Michele Stranger Hunter, national contributor, expert, and consultant for OKQ. MCH and Family Planning local agencies learned about how OKQ changes the conversation to equally support women who want to become pregnant in the next year and those who do not. They learned what OKQ fidelity means and how it can be implemented in the local setting. Following introduction to the initiative at the GPHC, KDHE continued to promote and prepare local grantees for full implementation.

Available Data in DAISEY Related to the One Key Question (SFY2018)

SFY2018 - Local MCH Agencies Entering Client Level Data in DAISEY				
OKQ	No	Yes	Unsure	OK either way
Prenatal/Pregnant Woman	2,109	73	166	50
Post-Partum Woman	2,506	32	108	38
Woman	664	15	40	23

Long Acting Reversible Contraceptives (LARC): "The unintended pregnancy rate is a key public health indicator, mistimed, unplanned, or unwanted pregnancies are associated with an increased risk of poor health outcomes for mothers and babies, including delayed access to prenatal care, preterm birth, and negative physical and mental health effects[2]". In Kansas, the Pregnancy Risk Assessment Monitoring System (2017 births; 2019 report) revealed that 26.7% of women had

unintended pregnancies.

Contraceptive Implants and IUDs (LARCs) are the most effective reversible contraceptive method available, with failure rates of less than one percent[2]. For that reason, Kansas Title V has chosen to recommend the use of LARC as a prevention effort to:

- Reduce untended pregnancy
- Reduce teen pregnancy
- Support adequate/safe birth spacing
    - Prevent preterm birth and low birthweight
    - Reduce risk of maternal and infant morbidity and mortality
- Reduce incidence of substance exposure to infants in utero
- Support strong families and good outcomes for children (timing/planning)

In 2017 Title V partnered with KDHE's Title X program, Wichita State University Community Engagement Institute and other local partners to form a LARC work group to help identify strategic priorities and provide direction for assuring access to LARC services in local communities. In fall of 2018 a LARC environmental scan showed the following results:

- 69 organizations responded
    - 63 Local Health departments
    - 2 Health Centers
    - 4 Community Organizations
- 26 organizations currently provide insertion services (43 do not)
    - Top reasons for no access/insertion services
        - no trained staff
        - devices too expensive
- Supports needed to provide LARC education
    - staff training;
    - written materials for clients (Bedsider)
- 41 organizations do not provide referrals for LARC
    - Top reasons for no referral
        - need training on referral process (MOUs, guidance)
        - no location to refer low income women to (only provider that offers LARC does not accept Medicaid or has no sliding fee scale which woman may not be able to afford)

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

[2] Association of State and Territorial Health Officials. 2014. Long-Acting Reversible Contraception (LARC) Fact Sheet. Associate of State and Territorial Health Officials. Arlington, VA. www.astho.org

Several LARC focused activities are underway to help overcome the barriers identified in this environmental scan, please see more details in the Women/Maternal Plan.

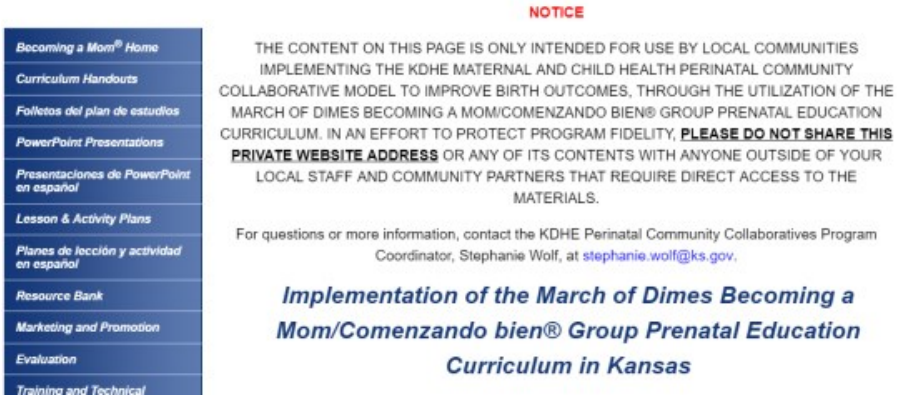
Objective: Increase the number of communities utilizing the MCH collaborative model and prenatal education curriculum by at least 5 annually by 2020.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): With proven success, KDHE Bureau of Family Health (BFH) Title V program has been committed to supporting expansion and sustainability of this initiative, providing training and technical assistance on community collaborative development and MCH program integration. Title V has provided extensive staff time and funding to position the state and communities for this expansion. The primary goal has been to build capacity for existing collaborations and expand the model to include both rural and urban communities. This model provides the backbone for dissemination of targeted public health programming and affords communities with a successful vehicle for future sustainability. Program capacity-building is dependent on shared resources (patients, staff,

facilities, educational materials, toolkits, etc.) and services (clinical/public health) across the patient care continuum. Standardization of screening, referral, education and outcome measurement processes has been pivotal to Kansas expansion efforts. Targeted toolkits have been developed to facilitate integration into this infrastructure. This “plug-n-play” approach is effective - providing implementation technical assistance, educational resources for clients and providers and standardized screening, referral and outcome measurement systems. Toolkits such as the Mental Health Integration Toolkit (see more details below), as well as toolkits on tobacco cessation, breastfeeding, safe sleep, and oral health have been produced, piloted, and are currently undergoing revisions and adaptations for broader MCH use.

The prenatal education component of the collaborative model, featuring the March of Dimes Becoming a Mom/Comenzando bien® curriculum, has been standardized to insure program fidelity across communities. A MOU is now required for all sites to gain access to training and programmatic resources. In addition, KDHE (in partnership with the University of Kansas) has developed referral and evaluation systems to support collaboration and outcome measurement among sites. Resources identified as needed for statewide expansion and protection of program fidelity and MOD trademark agreement have been developed and include: 1) guidance documents and training videos; 2) standardized program resources such as session PowerPoints, lesson plans, activity plans and supplemental handouts; 3) promotional material templates; 4) a private website portal to provide direct access to these resources. Phase 1 website development concluded with official launch in July 2017. A large focus during 2018 was the translation of curriculum and above related resources to Spanish, which was done in partnership with the University of Kansas School of Medicine-Wichita, Department of Pediatrics (KU SOM-DOP), and included a workgroup with representation from five Spanish dialects. All these extensive tools and resources have provided the mechanism for statewide expansion and will insure both growth and future sustainability of this initiative.

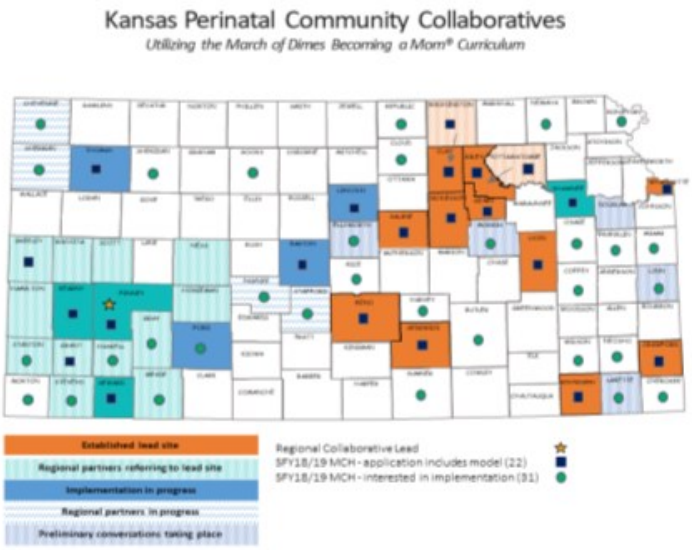
Screenshot of Kansas Perinatal Community Collaboratives Private Portal/Website



Statewide expansion to include all communities regardless of size was a high priority in 2018. The BFH included

KPCC/BaM in the Title V Aid-to-Local (ATL) grant application criteria in SFY17 and again in SFY18 and SFY19 to encourage statewide implementation utilizing Block Grant resources. In late 2017 KPCCs utilizing the MODs BaM curriculum expanded from 11 sites to 12, and to 15 sites by January 2018, with an additional site launching in Northwest Kansas (NWK) in October 2018.

Kansas Perinatal Community Collaboratives Map – Status of Existing Sites and Expansion



NWK is an area of the state with historically limited engagement in offering Title V MCH services. Currently, there are another 32 counties that have indicated interest in launching this program model in the future as well and are navigating the public KPCC website in preparation for implementation in 2019. The first regional perinatal community collaborative (launched in Southwest Kansas in 2017) is now operational with 4 lead sites serving a total of 16 counties. This is the regional collaborative prototype that will be replicated in additional communities in SFY20. Infrastructure assessments, training and technical assistance have been ongoing throughout the past two years, with multiple in-person TA visits facilitated by state Title V staff and attended by many partners across local public health, private clinical practices and birthing facilities in the region, with continued TA calls being provided on an ongoing basis. The SWK Perinatal Collaborative has come to be the greatest cross-sector collaborative formed to date, with the region's four leading (and competing) birthing facilities working collaboratively with each other, public health departments, FQHCs, large employers, and other community partners. Partners within this collaborative have worked to develop regional marketing tools, press releases, shared class schedules, and numerous other resources, all in an effort to engage pregnant women across the region while offering multiple class locations and schedules to choose from. One of the greatest examples of collaboration that has come out of this regional effort is that between the Seward County Health Department, Southwest Medical Center and National Beef. In this partnership, Seward County HD and Southwest Medical Center staff jointly facilitate prenatal education sessions at the hospital location, where National Beef employees participate in the program as a benefit of their health insurance plan. National Beef thereby requires all pregnant employees or spouses who are enrolled in their health care plan to attend sessions, and if they complete all sessions, their co-pay for prenatal care and delivery is waived. This is a tremendous example of the impact and potential of this MCH investment—public health, clinical care, and private business working together to better serve their shared population.

Infant Mortality Rate[1]	Geary Collaborative established* July 2012	Saline Collaborative established* Jan. 2010
2005-2008	11.9	9.0
2013-2017	5.7	5.5

Preterm Birth Rate (<37 weeks)	All Community Collaboratives[2,3]	Kansas/State[1]
2015-2017 3 year avg.	8.5%	9.1%

Since inception in 2010, KPCCs have been a driving force behind improved birth outcomes in Kansas. Special recognition should be called to the improvement in Infant Mortality Rate (IMR) per 1,000 live births (5-year average) from pre-implementation to post-implementation in the counties of our two longest running KPCC sites. IMR in these two counties has significantly decreased since the inception of local perinatal community collaboratives. The Saline County IMR decreased significantly from 9.0 in 2005-2008 to 5.5 in 2013-2017. The Geary County IMR decreased significantly from 11.9 in 2005-2008 to 5.7 in 2013-2017.

Sources: [1] KDHE, Bureau of Epidemiology and Public Health Informatics; [2] 2015 March of Dimes; 2016-2017 [3]KDHE, Bureau of Family Health

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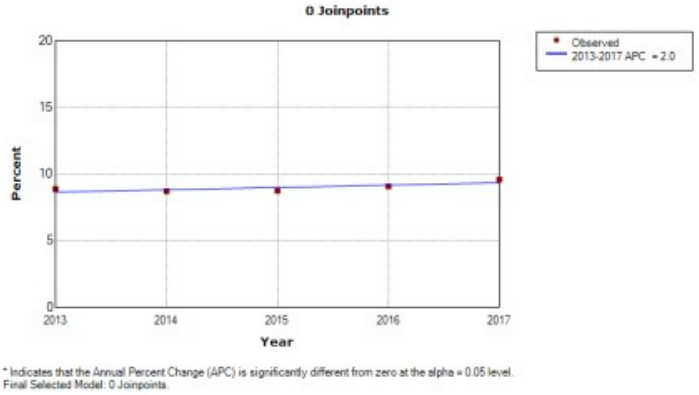
SPM 1: Preterm births (<37 weeks of gestation)

The preterm birth rate, those occurring before 37 weeks gestational age, has increased slightly to 9.6% in 2017 from 9.1% in 2016, although this increase was not statistically significant. Increases in preterm births were seen among Hispanic (9.3% in 2017 from 8.2% in 2016), non-Hispanic whites (9.1% in 2017 from 8.9% in 2016) and non-Hispanic black mothers (14.3% in 2017 from 13.5% in 2016). In 2017, the rate for preterm births, was lower in Kansas (9.6%) than the U.S. (9.9%). The Kansas prematurity rate in 2017 exceeded the Healthy People 2020 goal of 11.4%. Both non-Hispanic white and Hispanic premature birth rates were lower than the State average rate. The preterm birth rate was significantly higher for births with Medicaid indicated as the payer on the birth certificate (11.3%) than other non-Medicaid payers (8.8%). This pattern was consistent for2013- 2017. During 2013-2017, the overall preterm birth rate for Kansas showed a non-significant increase.



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

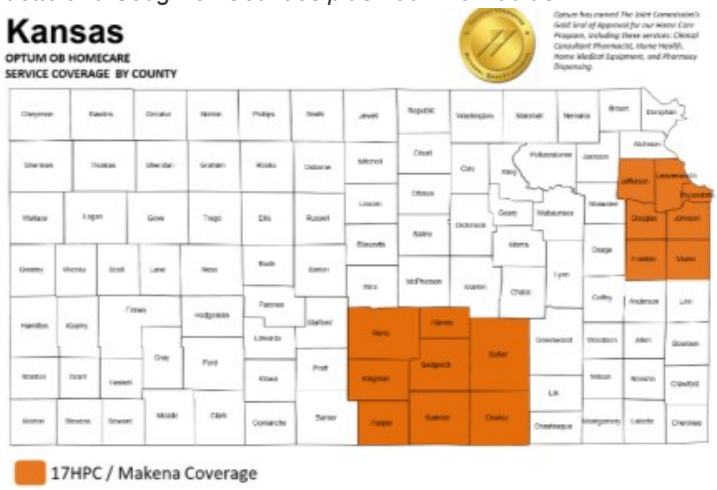
Increasing Utilization of 17 P + Optum/Alere Health Partnership: Increased use of prophylactic progesterone is a long-term priority to support reduction of Kansas preterm birth and infant mortality rates. Women who have had a previous spontaneous preterm birth are 1.5 to 2.0 times more likely to have a recurrence with subsequent pregnancies. The administration of 17P throughout the pregnancy can annually reduce this rate by 33% resulting in a projected 2.3% improvement (79 preterm births). Since 2012, Kansas has seen a modest improvement among Medicaid-eligible women in 17P utilization from 273 to 491 in 2017 (see 17P Fact Sheet below). A pilot alpha-hydroxyprogesterone caproate intervention was begun in 2017 under the Infant Mortality CoIIN initiative. Emphasis was placed on women who had a previous spontaneous preterm birth. Kansas does not have a serial screening for short cervix, so the use of vaginal progesterone was not a priority intervention. In 2018/2019 the focus is on infrastructure development to refine and expand this effort

through improved screening, accessibility and utilization of 17P.

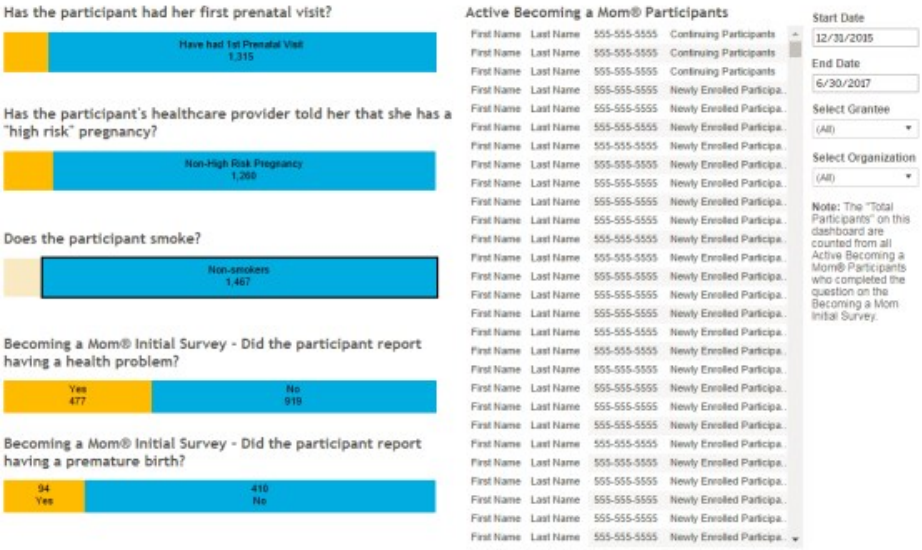
In summer 2018, expansion of 17P utilization was discussed in regional meetings with the local public health network/MCH agencies. Many were interested in promoting/referring for the service as well as providing 17P as part of their existing operation. In response, the Title V program has worked to provide guidance and support as local programs educate patients and providers on the importance and appropriate utilization of 17P. Kansas developed a comprehensive training package for providers that included administration protocols and guidelines, resources for screening, patient education and referrals and development of cross-sector partnerships to promote 17P initiation and continuation. The training package was delivered in two webinars presented to 32 providers (representing 16 counties) in November 2018. Public health providers represented the majority of attendees so special emphasis was placed on universal screening through a standardized prenatal education screening tool (updated in 2018 to include identification of spontaneous preterm birth occurrence). Partner roles and responsibilities (screen, educate, refer, prescribe, administer, track) were clarified and tools were provided to facilitate activities. These included screening and referral tools, a process flow chart and prenatal education resources including a patient brochure.

The Title V program has been working with Medicaid to identify and remedy barriers and policy issues that impact providers and patients alike. This includes referrals, reimbursements, and data sharing. The MCOs cover the Optum OB Homecare 17P administration, but it's only offered in two areas of the state. As part of our focus on educating and training the MCH network to provide this service it became clear that provider reimbursement across practice settings was not equitable. In the past year, KDHE worked with Health Care Finance officials to ensure that Medicaid reimbursement policies supported 17P administration in a variety of settings. Advance authorization protocols, prescribing authority, medication and administration coverage are now in place and publicized among providers. Effective June 2018, Medicaid issued a new bulletin (snapshot below) covering administration of Makena 17P by local health departments (MCH local agencies). In 2018, Optum OB Homecare expanded their service area to include Wichita, Kansas in Sedgwick County and the surrounding communities (map below). Optum is under contract with the KanCare Medicaid Managed Care Organizations to provide 17P home administration under the guidance of clinical prescribers.

Optum Service Map – Wyandotte and Sedgwick Counties plus 100 Mile Radius

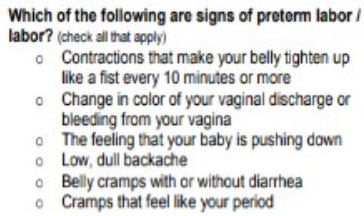


Prenatal Risk Screening in KPCC Sites: As the "Initial Survey" (pre-test) has served as a prenatal risk screen for KPCC/BaM participants, DAISEY reports have been developed and in use since July 2017 that assist program staff to easily identify participants with specific risk factors (smoking in pregnancy, previous spontaneous singleton preterm birth, lack of prenatal care, etc.). State Title V staff are working with partners to develop a more comprehensive "perinatal risk assessment" tool to be utilized in BaM as well as home visitation and other MCH programs. We hope to have this assessment developed and piloted in 2019.



Education targeting preterm labor risk reduction has been a major focus area for collaboratives utilizing the BaM curriculum in Kansas. Supplemental resources have included the following: PowerPoint slides embedding videos from the March of Dimes (MOD) on signs of preterm labor and “Is It Worth It” from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Child & Maternal Health Education Program; handouts on preterm labor and risk reduction (including the use of preventive medications like progesterone); activities, including the use of a “signs of preterm labor” magnet customized by each participant to include the date they reach 37 completed weeks of pregnancy and their provider’s phone number; repeat messaging across multiple sessions of the curriculum.

Program evaluation efforts show significant improvement in knowledge/recognition of preterm labor signs by program participants’ pre to post testing.



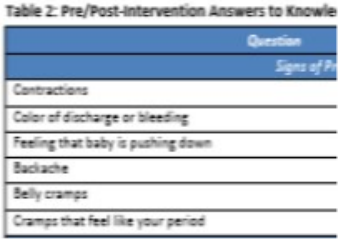
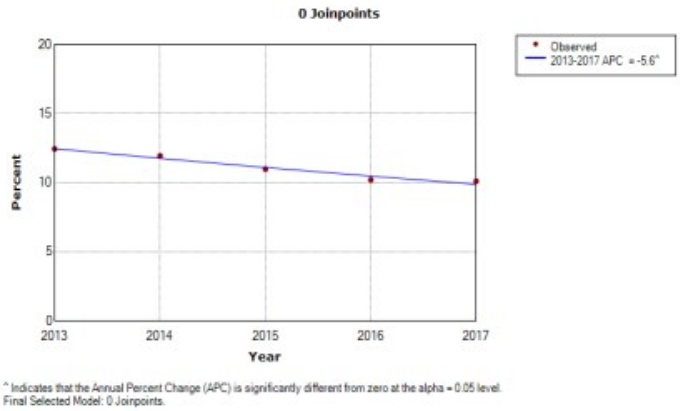


Table 2: Pre/Post-Intervention Answers to Knowle

Question
Signs of Pr
Contractions
Color of discharge or bleeding
Feeling that baby is pushing down
Backache
Belly cramps
Cramps that feel like your period

NPM14: Smoking (during pregnancy/household smoking)

Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. In 2017, 10.1% (3,860) of women reported smoking during pregnancy, a non-significant decrease from 2016 (10.2%). During 2013-2017, there was a statistically significant decreasing trend observed. The smoking rate was highest for non-Hispanic Native American women, at 15.7%, followed by non-Hispanic black women, 12.3%, and non-Hispanic white women, 11.6%. Rates for Hispanic (3.9%) and non-Hispanic Asian women (0.8%) were substantially lower. Teenagers 18-19 years and women in their early twenties had the highest smoking rates (12.4% and 14.3%, respectively). Smoking rates for women in their thirties and older were sharply lower, around 7%. In 2017, Medicaid paid for the delivery of 11,439 (31.4%) Kansas live births. Among women who reported smoking during pregnancy, 72.0% reported Medicaid as principal source of payment for this delivery. This was a slight decrease from 2016 (72.6%).



Exposure to environmental smoke—from cigarettes, cigars, or pipes—can be a serious health hazard for children. According to the Centers for Disease Control and Prevention, exposure to secondhand smoke is associated with higher rates of sudden infant death syndrome (SIDS), more frequent and severe asthma, and acute respiratory infections in young children. In the combined 2016-2017 National Survey for Children's Health, parents were asked whether anyone in the household used cigarettes, cigars, or pipe tobacco. Overall, 14.7% of Kansas children were reported to live in households where someone smokes. About 16.0% of non-Hispanic white children, 9.6% of Hispanic children, and 8.4% of non-Hispanic black children lived in households with a smoker. Rates of household smoking decline as income increases. Of children with household incomes below the poverty level 27.8% lived in a household with a smoker, of children with household incomes between 100 and 199 percent of the Federal poverty level (FPL), 17.1% lived with a smoker, of children with household incomes between 200 and 399 percent of FPL, 14.4% lived with a smoker, and of children with household incomes of 400 percent or more of FPL, only 5.7% had a smoker in the household.

Objective: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

Comprehensive Tobacco Cessation Approach: A comprehensive approach provides the most promise for addressing this tobacco cessation. In 2017, Kansas launched its first tobacco cessation program for pregnant women, Baby and Me —Tobacco Free* (BMTF) and communities continued to implement the evidence-based program through 2018. Implementation in Kansas was made possible with support from MCH and the March of Dimes. Over time, KDHE has worked closely with program sites to establish standardized processes for risk assessments, referral and program evaluation systems. This program, coupled with the state's Tobacco Quitline, represented the core of the Kansas MCH cessation approach in 2017. Since that time and throughout 2018, we moved beyond this to develop a multi-faceted campaign which includes:

- multiple evidence-based cessation programs in addition to the Quitline;
- clinical and public health provider education;
- a tobacco cessation toolkit to assist with consistent program implementation;
- patient education resources;
- integration into existing programs (Becoming a Mom/Comenzando bien, WIC, MCH, Chronic Disease Risk Reduction - CDRR); and
- Medicaid coverage for screening, counseling, and postpartum nicotine replacement therapy (NRT).

**Baby & Me Tobacco Free* (BMTF)* is an evidence-based intervention targeted to pregnant women who smoke. It continues to be implemented in four communities that have modified the delivery model in an effort to increase participation and lower attrition rates. Sites reporting success have connected the program to their prenatal education classes and added incentives to reinforce cessation during the prenatal period. The Title V program did not provide additional BMTF training during 2018.

Kansas BMTF Promo Card (all sides)

Kansas BMTF Participant Diaper Voucher

Smoking Cessation and Reduction In Pregnancy Treatment Program (SCRIPT): SCRIPT is an award-winning, evidence-based intervention known to assist women with quitting smoking. SCRIPT training was provided with support from Title V in January 2018 for 25 professionals representing 36 counties and again in March 2018 for 18 professionals representing 19 counties. Training was delivered in a train-the-trainer format enabling participants to teach additional staff and collaborative partners locally in an effort to promote the program and support broader reach. Participants included MCH local agencies and CDRR (health promotion) grantees who worked together throughout the training to develop a cooperative action plan for local implementation. Sites have been provided with training templates, a timeline and recommendations for launching SCRIPT locally with an expectation that this will occur by fall 2018. The BFH secured partial funding from the March of Dimes to cover patient education materials. CDRR grantees included education materials in their application budget as a backup. Program incentives lead to improved compliance, so sites included this in their local funding proposals/applications and are working to identify additional local resources. The BFH will continue to provide technical assistance as needed and will monitor progress as SCRIPT is launched in these initial communities. A third training is scheduled for June 2019. The BFH will continue to assess interest and readiness to determine where additional SCRIPT programming may be warranted.

With the addition of SCRIPT to the tobacco cessation arsenal, BMTF sites are looking for ways to integrate both programs and reduce staffing requirements. We will be working with them to assist with this model integration. The DAISEY evaluation system captures referral to BMTF and SCRIPT in an effort to monitor participation related to implementation and quality improvement.

Local MCH Agencies: Local agency staff, including home visitors, assess all pregnant women of smoking status and educate them about the dangers of smoking during pregnancy. Tobacco use after pregnancy is also assessed during clinic visits as well as during home visits. Information and resources are given related to smoking during pregnancy, as well as second- and third-hand smoke exposure. Referrals will be made to the Kansas Tobacco Quitline. Education regarding tobacco use and exposure to tobacco/smoking (both while pregnant and after baby is born) is provided across many of the sessions of the Prenatal Education classes utilizing the Becoming a Mom (BaM) Curriculum.

Across all programs (MCH, TPTCM, Title X, and Becoming a Mom) during SFY2018, a total of 685 referrals were made to a tobacco cessation program and 420 or 61.0% were accepted into a program. Intentional effort to increase the number of referrals across all programs is necessary.

Tobacco Cessation Integration Toolkit: In 2018, Kansas began launching programmatic toolkits designed to assist local sites with integration guidance for priority interventions. Toolkits were initially piloted/implemented with the KPCC/BaM sites but are now available for the entire MCH network via the KDHE website. A technical assistance webinar was provided to support understanding and standardized use and implementation across the state. http://www.kdheks.gov/c-f/integration_toolkits.htm

The tobacco cessation toolkit includes the following:

- Integration Guidance/Plan
- Flowchart (as applicable)
- Resource/Reference Summary
- Screening Tools
- Provider Education (as applicable)
- Medicaid Coverage Guidance
- Resource Access (provider and patient)

Essential State & Local Partnerships: The Bureau of Family Health, Women, Infants and Children (WIC) program and Bureau of Health Promotion, responsible for overseeing the state tobacco plan, have developed a long-term partnership to integrate tobacco cessation programming across programs. Cross-training (Brief Tobacco Intervention, Tobacco Treatment Specialist, Motivational Interviewing, and SCRIPT) is fully incorporated into all agency plans, and the state MCH and tobacco

plans are now aligned. In addition, the BFH has provided funding support for the Kansas Infant Death and SIDS Network and the Kansas Breastfeeding Coalition to promote safe sleep and breastfeeding practices including tobacco cessation education. The partners have worked together on messaging related to the dangers for tobacco use and smoking as well as integrated cessation resources and education into the community baby shower model. The MCH program assessed Quitline utilization among KPCC program sites in 2017 to identify both practice and patient issues. Since that time, a warm referral process was established whereby sites could directly enroll women via fax or web. Tobacco cessation education and Quitline enrollment at Community Baby Showers is now standard practice performed by Quitline staff/representatives. Monthly utilization reports are provided to KDHE and program sites with targeted pregnancy utilization data available upon request. AMemorandum of Understanding was developed between these two organizations and the Quitline that outlined commitment to the shared work and goals. Through these state and local partnerships, tobacco cessation programs and messages reach a broader audience. Bringing diverse state partners together helps leverage multiple funding streams and insures program fidelity and sustainability. Local funding and resources are leveraged more effectively, duplication is eliminated, and communities are able to create their own customized campaigns.

Objective: Implement the Vermont Oxford Network (VON) Neonatal Abstinence Syndrome (NAS) Universal training program statewide in partnership with the Kansas Perinatal Quality Collaborative (KPQC) and birthing centers (Target: 65 centers)

Neonatal Abstinence Syndrome: During the last FFY quarter of 2017, KDHE invested staff and resources toward a comprehensive approach to addressing neonatal abstinence syndrome (NAS), including the re-engagement of the Kansas Perinatal Quality Collaborative and partnership with the Vermont Oxford Network. As a result of a request from Governor's Office, BFH/Title V provided leadership for the development of a workgroup to address neonatal abstinence syndrome (NAS). In August 2017 KDHE, BFH partnered with the Governor's Office, Kansas Health Institute, and Wichita State University to host a forum on NAS. Nationally-known experts on NAS including Dr. Mark Hudak and Madge Buus-Frank participated in the event. Stakeholders who attended the meeting agreed on a shared understanding of NAS, supported a plan to re-engage the Kansas Perinatal Quality Collaborative to initially address NAS through the implementation of the Vermont Oxford Network (VON) Universal training program by purchasing a statewide subscription that all birthing hospitals/centers in the state would be able to access, and also the desire to ensure that the NAS efforts were aligned with the on-going efforts to develop a comprehensive state plan to address the opioid crisis. All meeting materials can be found on the Kansas MCH website: http://www.kansasmch.org/nas.asp.

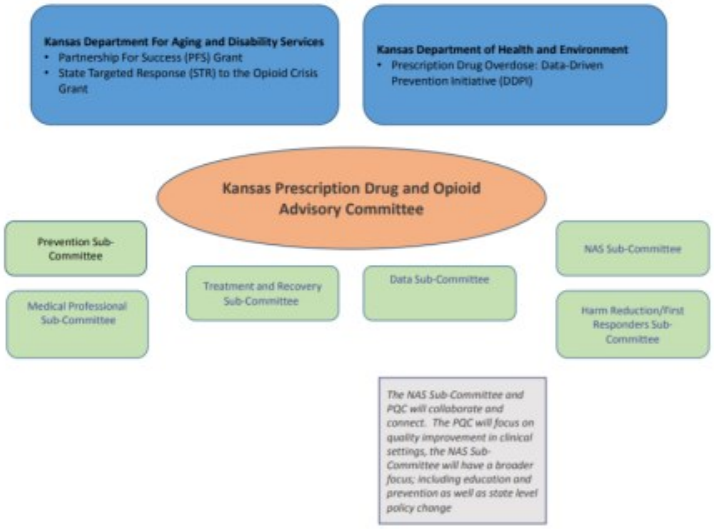
The Title V program continued partnering with the Wichita State University Community Engagement Institute (WSU) throughout 2018, to convene the Kansas Perinatal Quality Collaborative (KPQC), a panel of experts to improve the quality of care for mothers and infants in Kansas, affecting measurable improvements in statewide health care and health outcomes. The KPQC was formally convened for the first time (since stalling out in 2014) on February 26, 2018. WSU has also been charged with facilitating the first quality initiative related to addressing the impact of substance use during pregnancy, in some cases resulting in infants diagnosed with Neonatal Abstinence Syndrome (NAS). Work to date has focused on developing and disseminating best practices and facilitation of practice and policy changes in a variety of settings and at multiple levels across the state.

The NAS approach involves several levels of prevention, education, and intervention (surveillance to clinical practice improvements) as well as points of education to prevent exposure and reduce the impact when exposure occurs (lifespan approach with emphasis on the preconception, pregnancy, and infant health periods).

- Implementing the Vermont Oxford Network (VON) Neonatal Abstinence Syndrome (NAS) Universal Training Program (2-year state-level subscription) as part of the state's response to addressing NAS;
- Promoting, supporting, and implementing universal screening of all pregnant women for substance use and providing recommendations, training, and technical assistance to partners;
- Researching preconception education/initiatives to prevent substance exposed newborns; and more.

Significant interest and engagement of hospitals has steadily risen since launch in early 2018—as of July 2018, 256 subscribers were participating at some level, representing 60 birthing hospitals. Priority work involved partnering with the Kansas Hospital Association and birthing hospitals to provide education and implement quality improvement efforts (and collecting data) to improve care and for babies born exposed to substances. During 2018, 28 of the 62 birthing centers across the state enrolled in the comprehensive Vermont Oxford Network (VON) Universal NAS Training Program. VON provides a learning management system and training modules promoting, supporting and implementing standardized care for infants exposed to substances. As of 29 (represented on the map below), there are now a total of 32 birthing centers enrolled with VON; those 32 centers cover approximately 84% of all births in the state.
Efforts were expanded during the year to include the Department of Children and Families social workers and other providers that play a critical role in identifying pregnant women who may be using substances before and during pregnancy.

The KPQC NAS work is directly connected to the State Prescription Drug & Opioid Task Force work—a NAS Subcommittee is part of the Task Force and members include the Title V KPQC staff, Coordinator, and Chair (see image below). This alignment is critical to facilitate cross-agency collaboration to identify and implement best practices and advocate for policy change.



During 2018, with guidance from Title V the KPQC increased and enhanced state and local level partnerships in the interest of discussing practice and policy change to support improved health outcomes for infants exposed to substances in utero and their mothers. Current partners include the Kansas Hospital Association, Department for Children and Families, Department of Aging and Disability Services, and the American Academy of Pediatrics Kansas Chapter. Partners meet regularly to discuss prevention education and intervention. Consideration of developing criteria to standardize diagnosis codes, practices regarding reporting substance use identified prenatally and during birth, and inclusion of NAS as reportable condition to be monitored utilizing the Kansas Birth Defects Surveillance System are all ongoing and will carry forward into 2020. Key publications have been made available to guide the work:

KPQC NAS Initiative Overview Document

KPQC

Kansas Perinatal Quality Collaborative

Vision: Kansas is the best place to be born and to be a mother

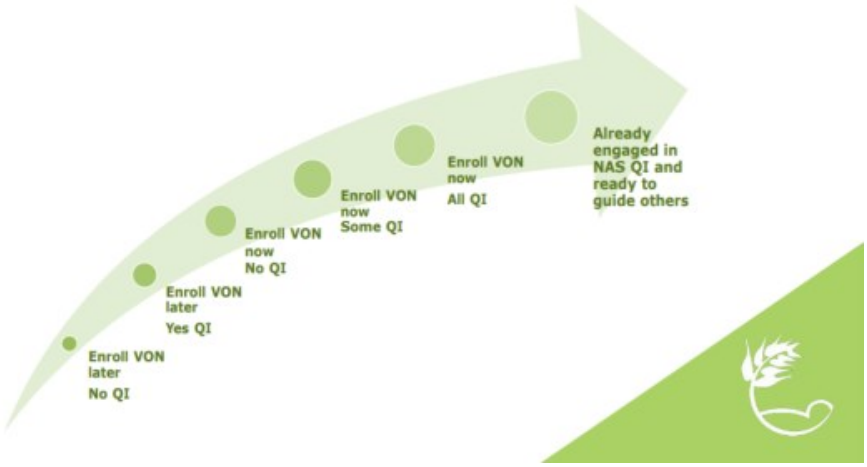
Mission: To improve Kansas' maternal and infant health outcomes by assuring quality perinatal care using data-driven, evidence-based practice, and quality improvement processes.

Goals:

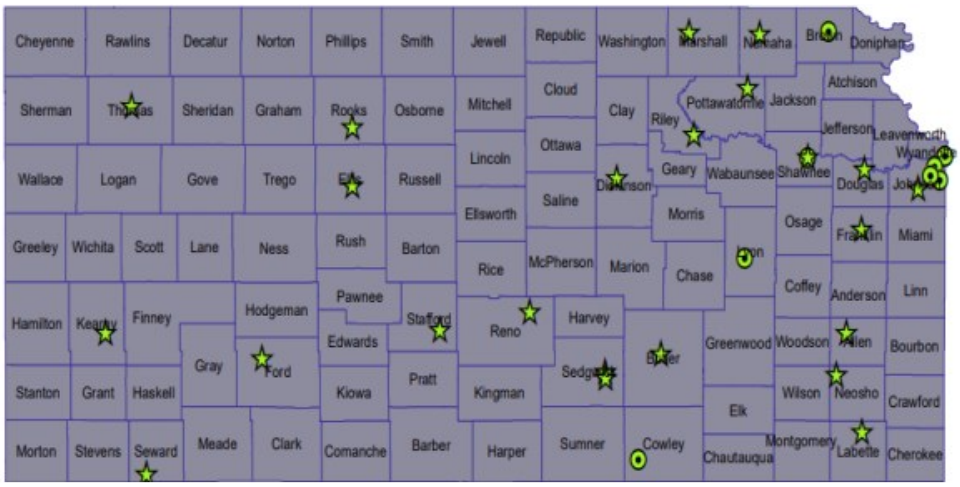
1. Establish and provide oversight for multiple state-wide quality improvement initiatives to improve birth outcomes
2. Promote system changes by gathering data resources and increasing use of evidence-based practices for perinatal health
3. Bring personalized support to Kansas communities by providing education and resources for perinatal health

Neonatal Abstinence Syndrome Kansas State Initiative *Universal education for birthing hospitals in Kansas for standardization of care in identification, evaluation, treatment and safe discharge of infants with NAS*	
IDENTIFICATION	Partner with prenatal care providers to facilitate universal screening and early identification per ACOG guidelines Standardize protocol for infant drug screening Partner with treatment centers
EVALUATION	Utilize one specific NAS scoring tool Standardize an NAS scoring education program assuring clinicians are trained upon hire with reliability checked yearly
TREATMENT	Standardize protocol directed at avoiding separation of infant and mother outlining evaluation and non-pharmacologic treatment of the substance exposed infant Standardize education for families to engage in non-pharmacologic intervention Provide Vermont Oxford Network NAS Universal Education virtual classroom access to the interdisciplinary team and all involved in creating a culture of compassion and healing for the mother and infant. Standardize protocol outlining criteria for breastfeeding which promotes and supports breastfeeding in eligible mothers Standardize protocol for pharmacologic treatment of NAS
DISCHARGE	Standardize a process to ensure safe discharge Establish appropriate follow-up for mother Liaison with child protective services to align expectations and assure that appropriate resources are available upon discharge Standardize a process for measuring and reporting NAS rates, data collection and outcome measures. Standardize a classification utilized to designate infants at risk for NAS and treated pharmacologically

Levels of Participation – Options for Birthing Hospitals (depending on readiness and resources)



Map of Kansas Counties with Hospital Participating in the NAS/VON Initiative

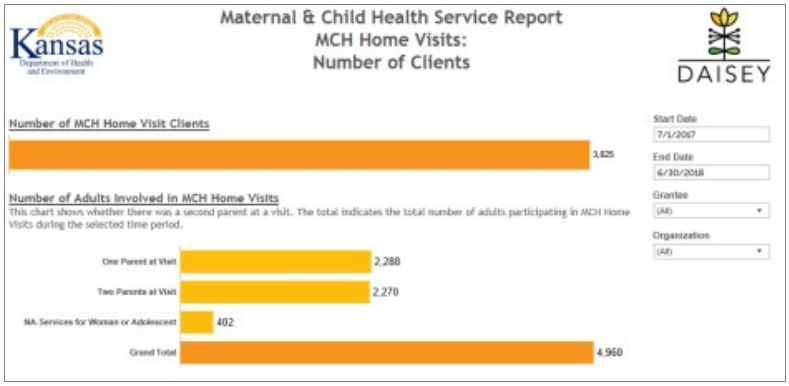


Other Activities Impacting Women & Maternal Health

Universal Home Visiting: The MCH universal home visiting program includes protocol and utilization of standard tools for smoking/tobacco, alcohol, substance abuse, and mental health, including perinatal depression. MCH Home Visitors make every effort to ensure that prenatal and post-partum mothers and their infants receive screening assessments with persons that are trained and qualified to conduct them.

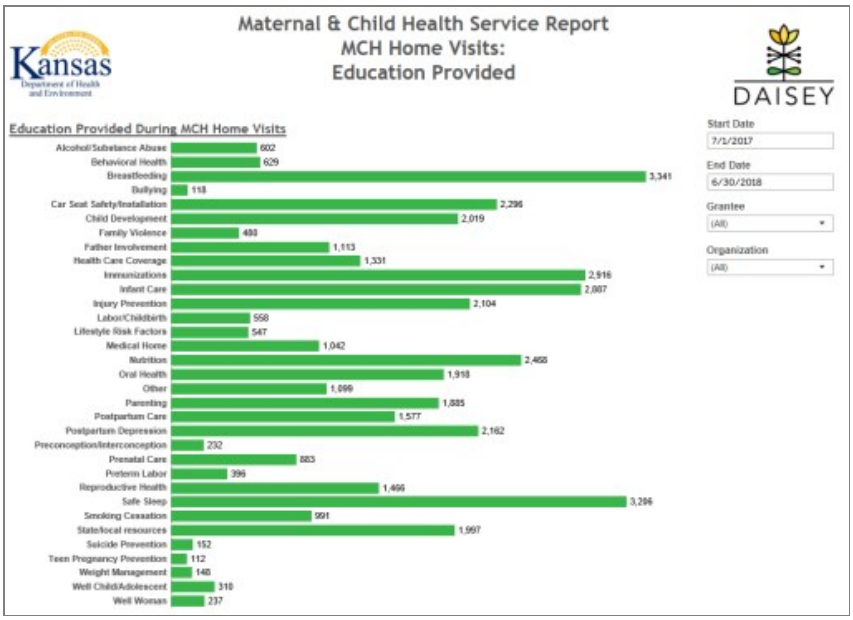
Based on data collected in DAISEY, MCH local agencies offering home visiting services provided a total of 6,475 visits, reaching 3,825 women (26% inter-conception; 27% pregnant; 47% postpartum) during FY18. Women are encouraged to have their partner/family attend the visit (see screenshot #1). Parent Education Topic Recommendations are included as part of the MCH Home Visiting redesign for 2018. MCH Home Visitors provided verbal and written education to the prenatal and postpartum mother.

Screenshot #1



For SFY18, 4,960 parents were educated on a variety of topics including breastfeeding, safe sleep, infant care, immunizations, etc. (see screenshot #2). There were 455 women who received a home visit that reported they smoked (12%) and 786 reported someone else in the household smokes (21%). A total of 74% of women reported they initiated prenatal care in the 1st trimester (see screenshot #3). Of the total women served in SFY18, 1,792 women initiated breastfeeding (67%). NOTE: This data reflects information collected from local MCH agencies related to the individuals served and services provided. Results may not be similar to state data or rates. We regularly monitor data for local MCH agencies in relation to state goals and data.

Screenshot #2



Screenshot #3

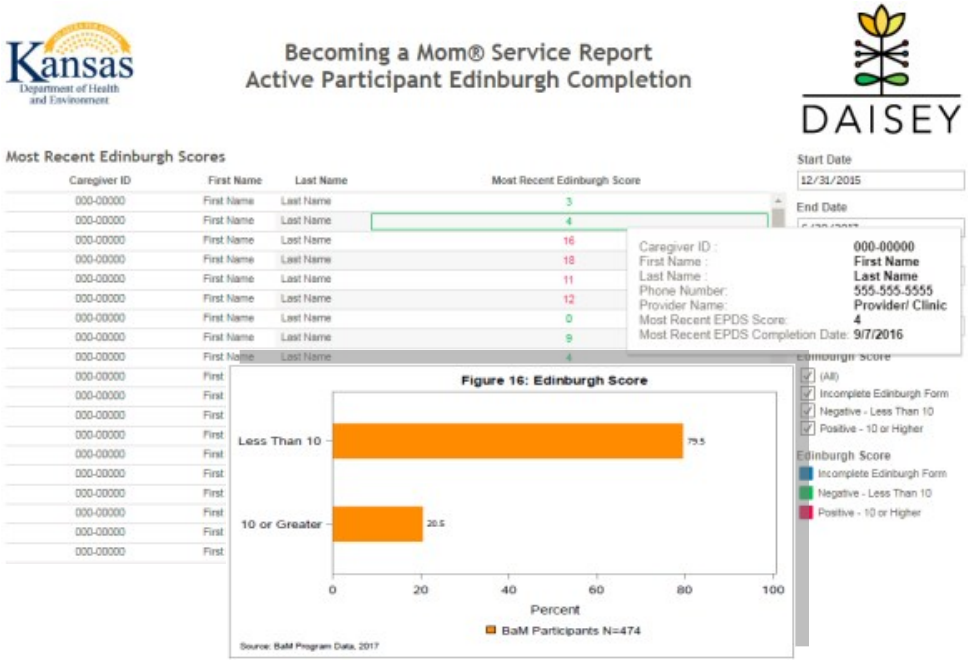
MIECHV & MCH Universal Home Visiting Partnership: The MIECHV programs continued to provide educational information, referrals, and support addressing multiple areas affecting maternal health including prenatal and postpartum care. Screenings of substance use, maternal depression, and domestic violence using standardized tools were also conducted and tracked to identify and address needs for additional information, support, and referrals as well as completed referrals. Specialized trainings regarding maternal depression and domestic violence were provided to local home visiting staff. The full-day training regarding domestic violence was offered in four regions across the state in FY18 and was open to MCH Home Visitors from local health departments and staff from all home visiting models. The MIECHV Program has partnered with the Kansas Coalition Against Sexual Assault and Domestic Violence to develop and conduct these trainings and facilitate improved collaboration and service coordination between local home visiting and domestic violence agencies. All KS MIECHV and MCH Home Visitors were invited to attend the Governor's Conference on Abuse and Neglect and the Governor's Public Health Conference. Both conferences addressed various topics regarding these performance measures.

Mental Health Integration

This Mental Health Integration Plan and associated toolkit has been created through the work of many state and local partners with a shared interest in providing coordinated and comprehensive services to women before, during and after pregnancy. It has been endorsed by the Kansas Maternal and Child Health Council (KMCHC). Information contained in the toolkit is based on sound research and recommendations from the US Preventive Services Task Force* (USPSTF) and the Substance Abuse and Mental Health Services Administration* (SAMHSA). Screening and crisis intervention algorithms have been adapted from those developed by the Minnesota Department of Health. The plan and toolkit have been developed for use by the Kansas Perinatal Community Collaboratives utilizing the March of Dimes Becoming a Mom® (BaM) curriculum in a group setting.

- Mental Health Integration Toolkit Training Webinar
- Mental Health Integration Plan Overview
- Information on Implementing Screening for Perinatal Mood and Anxiety Disorders for Kansas Perinatal Community Collaboratives utilizing the March of Dimes Becoming a Mom® Curriculum
- Mental Health Integration – Resource/Reference Guide for Providers (PDF for print purposes)
- Edinburg Prenatal Depression Scale Tip Sheet
- Screening Tool
  - Edinburgh Postnatal Depression Scale (English) (Spanish)
  - Stress Quiz – Intended for completion by both the mother and her support person
- Algorithm: Screening for Perinatal Mood and Anxiety Disorders in the Becoming a Mom® Group Setting
- Algorithm: Crisis Intervention following Screening for Perinatal Mood and Anxiety Disorders in the Becoming a Mom® Group Setting
- Templates for Local Use
  - Mental Health Resource Directory - Template for Local Adaptation and Client Use
  - Screening for Perinatal Mood Disorders Policy Template
  - Refusal of Transport for Mental Health Evaluations
  - Consent for Communication with Care Providers coming soon!
- Provider Training
  - Mental Health First Aid
  - Postpartum Support International
- Mental Health Resources

Mental Health Integration – KPCC Maternal Depression Screening: Evidence shows that maternal mental illness is a more common health concern than previously thought. Many cases of what has been called postpartum depression actually started during the pregnancy. Left untreated, this can be detrimental to the well-being of both the mother and child. As stated by Dr. Michael Pignone, a professor of medicine at the University of North Carolina at Chapel Hill and an author of recommendations issued by the United States Preventive Services Task Force, “there’s better evidence for identifying and treating women with depression during and after pregnancy”, thus “we specifically called out the need for screening during this period.” Recent published guidance such as this have led public health nurses to screen for postpartum depression in home visitation and clinical settings. Expansion of MCH services in our state to include Kansas Perinatal Community Collaboratives (KPCCs) implementing the MODs BaM curriculum has also prompted the need for such guidance on screening prenatally and in the group setting. As a result, the Mental Health Integration Toolkit (including research, guidance, screening tools, algorithms and resources) was developed and finalized with support from the KS MCH Council. The toolkit was revised following the initial pilot among BaM programs in early 2017, and in 2018 was adapted for use by all MCH programs. A DAISEY report has been designed and implemented to assist staff in follow-up on positive Edinburgh screens.



Analysis of MCH network DAISEY Edinburgh Data: July 1, 2017 – June 30, 2018

Total number of Edinburgh Screens entered in DAISEY: 2670
Total unduplicated count of caregivers who received an EPDS: 1632
Total count of screens indicating the client may be at risk: 425 (16%)
Total unduplicated count of caregivers with a concerning screen: 291 (18%)

- *Screening and related services provided during an MCH Visit*
    - 1,595 instances of Maternal Depression Screening
    - 168 instances of Maternal Depression Counseling
- *Screening and related referrals*

477 referrals for behavioral health services; 324 clients accepted services

Oral Health Integration – KPCC Education/Toolkit: As a part of the "relaunch" of the BaM curriculum by KPCCs and integration of toolkits around targeted Title V priorities, an Oral Health Integration Toolkit was developed in partnership with Oral Health Kansas (OHK) in 2018. The handout "Tips for Good Oral Health During Pregnancy" by the National Maternal and Child Oral Health Resource Center was added as a supplemental handout to the original curriculum. Additionally, partnership with Oral Health Kansas included the production of slides, video, and activity on oral health screening, all focused on the importance of good oral health in pregnancy in relation to preterm labor risk reduction. Sites received in-person training, where they were provided tool kits for completion of the guided self-exam activity and additional resources for use during the BaM sessions. Sites were encouraged to bring a partnering dental hygienist from their local community, who is partnering as a guest presenter of the session's oral health content as part of local collaborative efforts.

Title V Behavioral Health Investment & Expanded Programming: The Bureau of Family Health (BFH) including Title V recognizes that we cannot support individuals achieving whole health without integrating behavioral health practices and services. Therefore, additional investments have been focused on behavioral health interventions, healthy social-emotional development, and cross-systems collaboration related to Title V investments and the State Action Plan. To elevate coordination and increase effectiveness, Kansas MCH hired a Behavioral Health Consultant in 2018. In October 2018, the KDHE BFH was awarded HRSA's *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement* funding. Read more in the Women/Maternal Plan.

Maternal Depression Screening (MDS) Workgroup: Title V and other state and local partners came together to form a *Maternal Depression Screening (MDS) Workgroup* that leveraged state Medicaid funding to support workgroup activities. Membership includes state agencies, state universities, a child care provider, home visitors, individuals with lived experience of maternal depression, and other system partners who share interest in providing coordinated and comprehensive services to women before, during and after pregnancy. The group works on initiatives such as developing an impact paper to help advocate for the reimbursement of depression screening, and other initiatives to increase MCH local agency knowledge of screening, referral and treatment for prenatal and postpartum mood and anxiety disorders.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Workgroup: This group was established similarly to the MDS workgroup but with the focus of substance use and the evidence-based SBIRT process. The workgroup ensures collaboration across system partners to ensure existing resources are leveraged and consistent messaging occurs. Workgroup activities include creating a SBIRT Toolkit that includes information and resources about substance use screenings, interventions, motivational interviewing, referrals, treatment, implementation guidelines, crisis and non-crisis algorithms, and available training opportunities like the Kansas Department for Aging and Disabilities (KDADS) approved SBIRT training.

Count the Kicks Stillbirth Prevention Initiative: Kansas vital statistics show that 232 stillborn babies are born each year in our state. In an effort to have a positive impact, Title V entered into a formal agreement with Healthy Birth Day in August 2018, a nonprofit lead for an intervention known as Count the Kicks (CTK). CTK is a campaign to prevent stillbirth through provider and patient education that emphasizes the critical importance of monitoring fetal movements during the 3rd trimester of pregnancy. Thanks to this investment from Title V, providers statewide can order free educational materials

at www.countthekicks.org for use in their practices. Moms everywhere can download the free app, which is available in the Google Play and iTunes online stores. The app, available in English and Spanish, allows expectant moms to monitor their baby's movement, record the history, set a daily reminder, count for single babies and twins. Title V kicked off the statewide CTK initiative with a letter to all providers, educating them about CTK and inviting them to order their free educational materials. The mailing/letter portion of the campaign was followed up with by a call campaign to all providers asking them if they received their letter, had any questions, and whether they were ready to order free materials. A media release announced the initiative to the state and several news outlets across the state picked up the story. Kansas continued to promote CTK and increase awareness about stillbirth by recognizing October 2018 as Stillbirth Awareness Month with a Proclamation by the Governor of Kansas. Additionally, several infographics were created and distributed related to stillbirth awareness in general and the CTK Kansas campaign progress. The infographics were shared on social media and with the Kansas MCH Network. The statewide initiative has been very successful. Between the launch of the campaign in August of 2018 to May of 2019, over 190 total orders of free educational materials were made by providers from all corners of the state of Kansas equating to 44,735 pieces of educational materials being distributed. Over 2,400 Kansans have visited the Count the Kicks website, seeking more information about kick counting and more than 700 expectant parents in Kansas have downloaded the free Count the Kicks app to track their babies' movements! The introduction of CTK in Kansas has the potential to save 60 babies every year if Kansas' stillbirth rate decreases by 26 percent, as has happened in neighboring Iowa as a result of their campaign.

Campaign Kick-off Letter Sent to Kansas Providers & Governor's Proclamation

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Count the Kicks

Dear Healthcare Provider:

If you could help lower the number of stillbirths in Kansas this year, would you? *Count the Kicks* along with the Kansas Department of Health and Environment's Bureau of Family Health are asking you to team up with us to make a difference. *Count the Kicks* has already made a difference in Iowa, reducing the stillbirth rate every year (collectively 26%) since *Count the Kicks* began in 2008. With your help, we can spread the word in Kansas and potentially save 60 babies in our state every year.*

How do we make this happen? A study[2] published in the BioMed Central journal Pregnancy and Childbirth indicates an overall decrease in the stillbirth rate by one-third when all patients were educated on monitoring fetal movements.

That is what the *Count the Kicks* campaign is all about. This campaign helps educate expecting parents on how to monitor fetal movements during the third trimester of pregnancy. It is a SIMPLE and FREE way to self-monitor to improve the chance of delivering a healthy baby, and by doing so, reduce stillbirth rates, which occur in one out of every 167 pregnancies nationwide.

Healthy Birth Day is a nonprofit founded by five Iowa moms who each experienced a stillbirth or infant death. The organization created the *Count the Kicks* campaign to prevent other women and families from enduring this terrible loss. Through the partnership with Healthy Birth Day, we are able to offer FREE *Count the Kicks* materials to Kansas healthcare providers to help you educate your patients and save babies. You can receive materials such as those listed below, examples attached to this letter, and the enclosed brochure to educate your patients and make it easy for you to facilitate your own *Count the Kicks* campaign.

1. Brochure (available in Spanish and English)
2. *Count the Kicks* general poster for waiting rooms and bulletin boards (Spanish and English)
3. "How To" poster for exam rooms and bathrooms (Spanish and English)
4. App promotional card (business card size)
5. Sample childbirth education lesson plan
6. Implementation tip sheet
7. FAQs
8. *Count the Kicks* How-To video for internal training and patient education www.countthekicks.org/videos

Join Healthy Birth Day and me to make Kansas a safer place to have a baby. Order your free materials online at www.countthekicks.org!

Warm Regards,

Rachel Sisson

Rachel Sisson, Bureau of Family Health Director
Kansas Department of Health & Environment

P.S. ORDER YOUR FREE MATERIALS TODAY!

Count the Kicks is a project of Healthy Birth Day, a 501(c)3 nonprofit organization.
© Healthy Birth Day 2018
www.healthybirthday.org, www.countthekicks.org

STATE OF KANSAS

PROCLAMATION BY THE GOVERNOR

TO THE PEOPLE OF KANSAS, GREETINGS:

WHEREAS, more than 36,000 Kansas babies are born each year, and on average, 184 of them will be born still; and

WHEREAS, one in 218 pregnancies ends in stillbirth in Kansas; and according to the Centers for Disease Control and Prevention, families are 10 times more likely to lose a baby to stillbirth than they are to SIDS; and

WHEREAS, families who lose a baby to stillbirth are more likely to have Post Traumatic Stress Disorder, depression, loss of productivity and are four times more likely to get divorced; and

WHEREAS, the Kansas Department of Health and Environment recently launched a powerful and effective stillbirth prevention campaign called Count the Kicks to prevent loss due to stillbirth; and

WHEREAS, *Count the Kicks* educates and empowers expectant parents to track their babies' movements daily in the third trimester of pregnancy; and

WHEREAS, Count the Kicks empowers expectant parents to speak up if they notice a change in their babies' movements; and

WHEREAS, Kansas has the potential to save 60 babies a year through stillbirth prevention activities; and no family should suffer the loss of a baby; and

WHEREAS, recognizing Stillbirth Awareness Month would enable the people of Kansas to consider how, as individuals and communities, they can work to prevent stillbirths;

NOW, THEREFORE, I, Jeff Colyer, M.D., GOVERNOR OF THE STATE OF KANSAS, do hereby proclaim October 2018 as

Stillbirth Awareness Month

in Kansas and urge our citizens to commend its observance

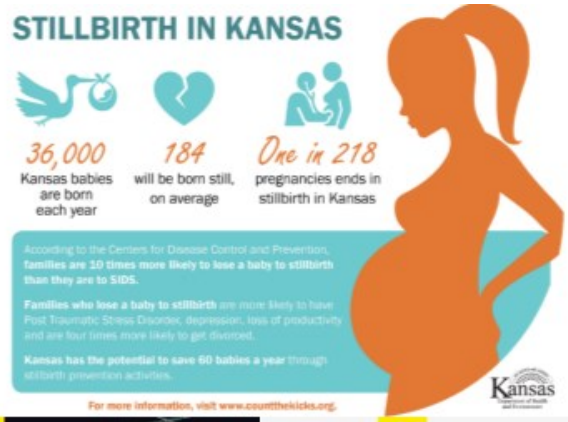
DONE: At the Capitol in Topeka under the Great Seal of the State this 1st day of October, A.D. 2018

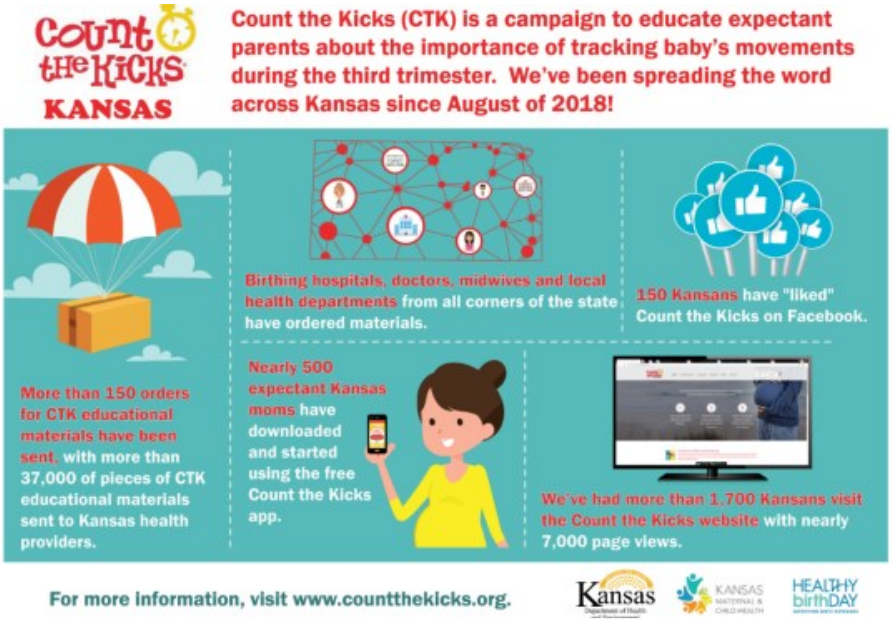
BY THE GOVERNOR:

Secretary of State

Assistant Secretary of State

CTK Infographics





Maternal Mortality Review: Within the population of women of reproductive age, maternal mortality (death of a woman during pregnancy or up to one year after pregnancy) is an indicator that is monitored by KDHE pursuant to K.S.A. 65-177. Kansas maternal mortality data are closely aligned with national trends. There are clear patterns that can be identified within the data. The following Kansas women are at greater risk of maternal death and therefore will be target populations for prevention efforts: advanced maternal age (35 years or older); Non-Hispanic black women; and women who have lower levels of education, are unmarried (separated, divorced, widowed, or never married), and live in rural areas.

Although maternal deaths have long been monitored as part of the Kansas Title V program work, it has long been a goal to formally review each pregnancy-related death. Kansas has made significant progress over the last year related to establishing a formal process for reviewing maternal and pregnancy-associated deaths. After several meetings with key partners like ACOG, the Kansas Title V Director worked with the agency's legal department and partners to draft legislation to support implementing a comprehensive review process including establishing a Kansas Maternal Mortality Review Committee (MMRC). The Kansas team worked closely with AMCHP and CDC, learned from peer states, and utilized invaluable resources available to all states on the Review to Action website (www.reviewtoaction.org). The use of tools like the Authorities and Protections Checklist were instrumental in the Kansas planning and launch.

Initially introduced during the 2018 Kansas Legislative Session as, HB 2573, the new legislation (effective July 1, 2018) amends existing public health law (K.S.A. 65-177) as necessary to strengthen efforts related to monitoring maternal health, including maternal and pregnancy-associated deaths (death of a woman during pregnancy or within one year of the end of pregnancy). Specifically, the bill grants the Department access to all necessary information to implement a comprehensive process to review each pregnancy-associated death and protects all people, records, and interviews obtained as part of each review. The bill allows for routine compilation and wide distribution of aggregate, non-individually identifiable data to further the study of causes and problems associated with deaths. This comprehensive process leads to informed, data-driven recommendations for actions that reduce death and support health and wellness during the pregnancy, childbirth, and postpartum periods. The Title V Director provided testimony for both the House and Senate hearings and met with House leadership to advance the bill. ACOG was instrumental in moving the bill through both chambers—several physicians

gathered for the Senate hearing and shared their stories about women.

The Kansas MMRC membership is diverse, including representation from every region of the state and a vast array of professionals and partners engaging with and serving women during pregnancy and the year postpartum. Currently approximately 30 members representing diverse backgrounds including obstetrics, anesthesiology, midwives, social service, local public health and law enforcement have committed to serving on the committee. The launch meeting took place June 12, 2018. Our partners from the CDC were present to provide an overview of maternal mortality committees across the US and oriented KS to best practices. We also discussed procedures, finalized the scope of cases to be reviewed, and completed a mock case review to familiarize ourselves with the process.

The first formal MMRC meeting took place on November 2018, and a total of six cases were completed as part of the initial review. An additional meeting was held in March 2019 when ten 2016 cases were reviewed, and a third review meeting was held in June 2019. The committee will meet in August and September 2019 to fast track review of all cases for 2016 and 2017 to ensure eligibility for the *Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees* CDC grant which Kansas submitted an application on May 8, 2019.

Women/Maternal Health - Application Year

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

NPM 1: Well-woman visit (Percent of women, ages 18-44, with a past year preventive visit)
SPM 1: Preterm births (<37 weeks of gestation)
NPM 14: Smoking (during pregnancy and household smoking)

Local MCH Reach: Based on SFY2020 MCH Aid-to-Local applications received, 64 of 70 grantees (91%) plan to provide services to the Woman & Maternal population.

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

Objective: Increase the proportion of women receiving a preventive medical visit annually.

State Title V staff will continue to promote the importance of women receiving a preventive medical/well-woman visit annually. Primary strategies to achieve the goal of increasing the number of women receiving education about the importance of a well visit as well as those *receiving* an annual well visit include:

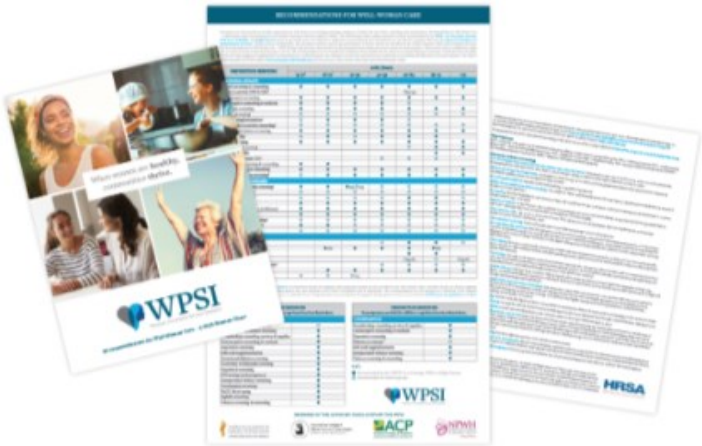
- providing education and resources to local Title V MCH local agencies, partnering with other community agencies to provide on-site assistance for accessing health care coverage in the pre/interconception period;
- developing a toolkit for use by providers across settings, not only public health; and
- promoting the development of personal health plans, including a reproductive life plan, for individuals receiving services across settings.

All of this work will be done in alignment and collaboration with Title X Family Planning. The importance of women's health and the annual visit will be highlighted at trainings and other events, and associated resources will be distributed (annual Governor's Public Health Conference, MCH Home Visiting Regional training, and other appropriate venues). Recent activities have been focused on the development of a Well-Woman Visit Integrated Toolkit (see more below) and a Reproductive Life Plan Workbook that will be inclusive of the One Key Question® approach (currently being implemented in Kansas) and existing LARC resources. This will continue to be the primary work for women of reproductive age throughout FY20. Both of these toolkits will be modeled after the same format used in development of the other MCH Integration Toolkits shared mentioned Report. Patient and provider resources will be accessed from ACOG and the Office of Women's Health and include key messages and guidance such as the Women's Preventive Services Initiative Chart. Toolkit components will include the following:

- Technical Assistance (TA) Webinar
- Integration Plan with Implementation Guide
- Screening Tools
- Flowchart with Algorithm
- Resource/Reference Guide (provider version and client version)
- Templates (including sample policies and procedures)
- Resources (includes links from webpage to documents and other websites)
    - Programs and Targeted Interventions (Promising Practices, Evidence-Based Interventions)
    - Patient Education Resources (patient handouts, online resources, etc.)
    - Provider Resources (latest research, best practice guidelines and recommendations, opinion statements; provider training opportunities)
    - Medicaid Coverage (guidelines, billing codes, inclusions in coverage)

Well-Woman Visit Integration Toolkit: Title V and Title X are collaborating to create an Integration Well-Woman Toolkit. The release is planned for May 2020 during National Women's Health Week as part of a statewide media campaign ***"Past the Pap…Why an annual preventative visit is more than a pap smear!"*** Plans are being made for a Governor's proclamation with signing ceremony to officially recognize Women's Health Week in Kansas as well as a media release announcing the toolkit and social media blasts centered on the importance of women receiving an annual well-woman visit. Ideas for celebrating National Women's Health Week in partnership with the HHS Office of Women's Health will be shared with all MCH and Family Planning public health network partners as well as other partners representing the medical setting.

Sample Resources for the Toolkit



Women's Preventive Services Initiative (WPSI) Materials

One Key Question®: To support broader MCH women's reproductive health goals, full implementation is underway of the One Key Question® (OKQ) Initiative, property of the Power to Decide, in partnership with Title V and Title X clinics. Following introduction to the initiative at the 2018 Governor's Public Health Conference, KDHE continued to promote and prepare local grantees for full implementation. The Power to Decide returned to Kansas in February and March 2019 to provide full-day training events in three locations across the state. Over 100 individuals were trained representing County Health Departments, FQHCs, Home Visitors, WIC Clinics and Community Health Organizations. Power to Decide will provide this first Kansas OKQ training cohort with additional implementation guidance and technical assistance (TA) in the form of consultation calls and webinars. We plan to build on this training by assisting cohort one with full integration of OKQ into their practices/clinics with TA from Power to Decide. Plans are underway to bring Power to Decide back to Kansas in 2020 for training cohort one. We plan to target FQHCs and Safety Net clinics around the state for the second training.

Kansas Training Flyer & OKQ Algorithm

Local MCH Agencies: Title V staff will continue to support the promotion of women receiving a well-woman visit annually, by messaging the importance of local Title V grantees partnering with other community agencies to provide on-site assistance for accessing health care coverage in the pre/inter-conception period. We will continue to target OKQ and promote the development of personal health plans, including a reproductive life plan, for individuals receiving MCH services. Local grantees either provide direct well woman preventive care or enabling services by providing resources and referrals for women to receive annual well visits. Women will be assessed for a visit in the past year and will be educated on the importance of preventive care. Referrals will be made to the local agency's family planning clinic or another provider in the community for clients that have not had a visit in the last year.

Objective: Increase the proportion of women developing a reproductive life plan annually.

Reproductive Life Plan Booklet: As noted above, the development of a Reproductive Life Plan Booklet is underway related to the Women's Health Toolkit. Several collaborative work group meetings have occurred between KDHE and local agencies in the metro Kansas City area, including the Wyandotte Health Council, Unified Government of Wyandotte County (Local Public Health Department), and Vibrant Health Care (FQHC) to develop a comprehensive Reproductive Life Plan workbook for use across agencies and sectors of the health care system in our state. The workbook will consist of several sections including:

- Your Future
- Your Choice
- Your Health Now
- The Skin You're In
- Inner Health
- Healthy Checklist

Design of the workbook has been created with the intention of it lending itself for use in a variety of settings where providers have varying degrees of opportunity to work through the workbook with a woman. The intention is that for a case management or home visitation service provider, the workbook can be revisited over the course of several visits for completion, reflection, and progress monitoring, whereas only targeted sections of the workbook might be completed by a provider in a busy medical clinic, Title X clinic, etc. While use of the workbook can be customized by each type of service provider, it provides standardized tools and a consistent approach for encouraging women of reproductive age to set life and health goals during a well-woman visit on an annual basis.

The booklet screening questions will be tied to more in-depth screening tools that a provider can access depending on how a woman answers the screening questions. For example, the "Your Health Now" section includes screening questions on tobacco, alcohol, and substance use. The appendices attached to the section will include substance exposure resources pages and more in-depth screening tools and links to SBIRT (screening, brief intervention, and referral to treatment process) resources. Currently, the workbook is being field tested with Cradle Kansas City Community Action Board. The goal is to have the Reproductive Life Plan workbook available for use by the end of 2019. The plan is to continue testing and collect community feedback to have the booklet ready for release by the end of 2019. Later in 2020 we will work with organizations to implement the booklet into practice. A training webinar will be held targeting local MCH agencies including Title X and Universal Home Visiting staff. Title V will continue to offer technical assistance to agencies as they work to implement. The importance of Reproductive Life Planning and the booklet will also be marketed several times throughout the plan period at events such as the LARC Grand Rounds event, cohort two OKQ training, and the Governor's Public Health Conference 2020.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): As part of Kansas Title V's commitment to the continued development and expansion of perinatal collaboratives utilizing the March of Dimes Becoming a Mom® prenatal education curriculum, there is continued commitment to the development and implementation of additional "integration" components that allow for the strengthening of particular priority areas within the curriculum and program delivery model. One area of focus over the next year will include training of BaM sites on the comprehensive integration of personal health plans, including greater utilization of the reproductive life plan completed by each woman participating in BaM, and greater familiarity with the OKQ initiative. Once the Reproductive Life Plan workbook development is complete, it will be integrated into the BaM curriculum, either complementing or replacing the current resource "Show Your LOVE – Steps to a Healthier me!" by the CDC. Participants will be encouraged to take their reproductive life plan to their provider for discussion during the remainder of their prenatal care and their postpartum check-up. Additionally, as a part of this "integration" component during session six of the program, sites will be encouraged to invite a Health Care Exchange Navigator from their community to participate as a guest presenter on the topic of accessing health care coverage following the loss of Medicaid coverage 60 days postpartum. Ideally, this navigator will be available before and after the session to assist participants in navigating the federal insurance exchange and enrolling in an insurance plan that will increase the likelihood of the women receiving annual well-woman exams following pregnancy. With release of the Well-Woman Integration Toolkit that is planned for summer 2020, work will be done to integrate this into the BaM curriculum as well.

Objective: Increase the number of communities utilizing the MCH collaborative model and prenatal education curriculum by at least 5 annually by 2020.

KPCC/BaM: As mentioned in the report, resources needed for regional and statewide implementation of KPCCs utilizing the MODs BaM curriculum have been under development over the past two years to insure both growth and future sustainability of the initiative, and phase two of the website development that includes redesign and expansion of the public Perinatal Community Collaboratives website as an access point to introductory information about the initiative has been completed. Final phase 2 revisions to the private BaM website will be under way in May 2019, which will provide additional training and implementation resources for communities once they have signed the MOU and are ready to begin implementation. Enhancements to the resources will include online training webinars for program coordinators and group facilitators. Additional training webinars are scheduled for production in May 2019 with state partners (Oral Health Kansas, Kansas Breastfeeding Coalition, and the Kansas Infant Death and SIDS Network) to complete enhancements to the Integration

Toolkits specific to BaM implementation of Oral Health, Breastfeeding, and Safe Sleep components. The toolkits have already been integrated, as written about in the report, but to date, training of new sites has required resources to bring in-person training to each new KPCC/BaM location. By providing all training components online, it will allow new sites to receive the training in a timely manner, at their own pace and according to their own schedule, vs. waiting on KDHE staff availability to provide training in person, further supporting long term sustainability of KPCC/BaM expansion efforts. Promotional material templates will also be expanded to include materials for provider outreach, as well as other materials developed and shared by existing sites. All efforts are aimed at decreasing burden on new sites embarking upon implementation and existing sites facing staff turnover.

Initial conversations are under way with clinical service providers in rural southwest Kansas to identify local issues and needs for the region around the KPCC model and BaM implementation. As spoken to in the report, this region has a significant Hispanic population, many of whom are undocumented and/or uninsured. Four counties provide the bulk of clinical services for women of child-bearing age in the region, requiring pregnant women to travel for services, including BaM prenatal education. Virtual implementation has been piloted in the Northcentral region of the state and is an option available for this region as well, however there is interest in possibly adapting the model in other ways that will better lend itself to access by this largely rural population. Conversations with local stakeholders are planned for early FY20.

As mentioned in the report, review of MCH Aid-to-Local applications for FY19, identified 32 communities/applicants that included BaM interest in their application. Plans are in place to engage these interested communities through an introductory email providing the URL for the recently enhanced public Perinatal Community Collaborative website. This will allow each interested community to explore the initiative and engage in conversations with community partners on their own timeline, utilizing TA resources provided online. Again, this approach is hoped to better meet the needs of local communities who are interested in enhancing perinatal services, while reducing burden on KDHE Title V staff, which will improve expansion and sustainability efforts long term.

In 2019/2020, we hope to continue preliminary discussions that began with our state's Medicaid MCOs in 2016 regarding expanded partnerships to support existing BaM programs, as well as expansion of the program in targeted areas of the state. These discussions will include: potential funding partnerships related to the development of a regional model approach to program delivery in small rural communities where birth numbers are too small to justify a full scale independent BaM program; program incentives; printing of standardized curriculum for consistency of curriculum delivery across all program sites; the idea of partnering in the implementation of telehealth for the delivery of specialized care and monitoring of high risk OB patients in rural/frontier communities across the state. Although some of this work has already begun, as described in the report section, we wish to further develop these conversations and secure commitments from all three MCOs in the next year.

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

Fiscal Years 18-19 focused on foundational issues primarily related to providers. Barriers identified in the 2017 provider assessment supported the state expansion plan. This year, systems and processes for risk identification, screening and referrals were established and promoted through provider webinars. Patient education (17P) was incorporated into existing prenatal education programs with the associated evaluation components added to the DAISEY system. Medicaid coverage and payment systems were expanded to support treatment in multiple settings and the OPTUM OB Homecare home administration program was expanded to include nine additional counties. Bringing these components together into a comprehensive package is the next step and main FY20 priority.

The FY20 emerging issues that need to be addressed focus largely on clinical and public health partnerships. Patient messaging related to preterm birth and progesterone utilization has been developed but is primarily delivered through prenatal education programs. This same messaging needs to be adopted by clinical providers to insure consistency and promote 17P utilization. Cross-referral systems between clinical and public health providers for prenatal education are in

place in most KPCC communities, but they are not 17P specific. A standardized provider referral form incorporating 17P screening has been drafted and is ready for review. A comprehensive provider algorithm will also be developed to support this cross-agency partnership. Over the last year Kansas has established a toolkit system to support implementation of programming for targeted issues. A toolkit specific to 17P is currently under development with launch anticipated in early fall 2019.

17P Toolkit Components

- Fact Sheet
- Provider Education Webinars
- Professional Resources (ACOG, ASTHO, MOD, OPTUM)
- Patient Education Resources (BaM/Cb, brochures, videos, etc.)
- Policies and procedures document
- Flow Chart/Algorithm
- Standardized Referral Form
- Medicaid (Coverage Summary, Prior Authorization, Billing Codes)
- Demonstration Models (IN, NC, SC, OH)

In order to increase 17P utilization several capacity issues must also be addressed. Providers have expressed concern about insurance coverage (public/private), medication access (Makena/compounded) and treatment efficacy. Kansas Medicaid now provides coverage for the Makena drug and administration. Private insurance carriers must be surveyed to determine coverage, processes and gap analysis. Kansas has many compounding pharmacies statewide, but these must be assessed to determine 17P inclusion. Mail order options must also be reviewed. Makena is readily available both through the OPTUM program and direct physician prescribing authority, but the expense often makes this prohibitive. Understanding what is available, how to access it and how to pay for it are fundamental questions that must be answered. The third concern is over the efficacy of prophylactic progesterone treatment. It is due primarily to conflicting endorsements and follow up studies. ASTHO, the March of Dimes and ACOG have all endorsed 17P as an effective treatment to reduce the reoccurrence of spontaneous preterm birth. Numerous states have also launched initiatives to expand utilization. That said, there is a conflicting study from the University of Texas Southwestern Medical Center published in the American Journal of Obstetrics and Gynecology in 2017. Current research has not yielded any new information; however, a more in-depth article review is warranted.

All of the strategies outlined above should be further developed with provider, patient and insurer input. We will assemble a multi-tiered workgroup to review other state strategies, medical research and state capacity issues to develop a comprehensive 17P expansion plan for Kansas. In FY20, targeted interventions will be developed with several strong Perinatal Community Collaborative sites (Sedgwick, Lyon, Saline and Reno counties) to test ideas for replication.

Local MCH Agencies: Local agencies continue to work to reduce the number of preterm births in Kansas by reducing the number of pregnant women who smoke. In addition, integrated screening tools and case management services to identify and support women eligible for progesterone therapy will be utilized. Improved prenatal care and prenatal education should decrease the risk of preterm deliveries. Local agencies will assure that women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy. Women will be screened for preterm birth history and the associated risk factors.

NPM 14: Smoking (during pregnancy and household smoking)

Objective: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

Kansas has made tremendous progress building a comprehensive tobacco cessation campaign. System linkages (state and local) are in place and will be nurtured over time. Services are available through numerous media (social media, texting, videos, peer-to peer and trained counseling support). Capacity-building to increase utilization is a priority and a key part of that is public awareness and promotion. The BHP and the BFH have aligned tobacco cessation components of their state plans. Universal promotional tools will be developed in FY19 to support communities in their efforts. Templates that can be customized to meet specific community-level needs will be developed and shared widely. Promotional materials will also be developed for MCO and Bureau use with special emphasis on cross-agency promotion.

In the last two years, KDHE BFH has developed the systems and infrastructure to launch comprehensive tobacco cessation programming statewide. This infrastructure included provider toolkits, educational resources, website access and evaluation systems (DAISEY). A new referral tool, IRIS, is being implemented in Kansas across systems including public health, health care/medical, behavioral health, oral health/dental, and early childhood. This infrastructure provides a solid foundation (plug-n-play) for program implementation on a broad scale. During the last year, emphasis was placed on provider training to promote use of the available resources in a collaborative format. Collaboration between clinical and public health providers is still an issue in many communities with numerous requests for technical assistance. One piece of this involves establishing effective referral systems for early and repeat interventions. To better understand provider issues KDHE will resurvey KPCC, CDRR, SCRIPT, and Baby & Me—Tobacco Free (BMTF) sites. This information will be compared to the initial survey conducted in 2017 and will include follow-up phone calls for personal input. In addition, a patient survey tool will be developed for all providers to use in their initial screening. This will provide information needed to meet the perinatal patient's unique needs.

Kansas has developed universal tobacco screening tools and standardized processes for the public health setting which are currently in use within BaM program sites and being spread to MCH local agencies statewide These tools are now available via the web to clinical providers and public health sites that are not part of a larger collaborative (beyond BaM). Data related to screening and referrals is tracked through DAISEY, ATL, reports and BaM reports so continuous oversight to identify successes, challenges and emerging issues is now possible. The BFH staff will continue to monitor and support local needs.

The BMTF program is currently provided in five Kansas communities. We will continue to monitor program results reported in the DAISEY system, however there are no current plans to launch additional program sites at this time, however several locations have blended BMTF with SCRIPT and their BaM program and increased the incentive timeframe to ease staffing requirements and provide a more cost-effective, sustainable program. The BFH will work with program sites making this transition and share information among these program sites to promote promising practices as they emerge.

KDHE assessed Quitline utilization among BaM program sites in 2017 to identify both practice and patient issues. Since that time, a warm referral process was established whereby sites could directly enroll women via fax, web or cell phone. Enrollment at Community Baby Showers is now standard practice as part of the tobacco cessation education provided by Quitline staff/representatives. Monthly utilization reports are provided to KDHE and program sites with targeted pregnancy utilization data available upon request. Despite these efforts, Quitline utilization among pregnant women is low. Establishing system and process credibility among stakeholders is an ongoing issue; repositioning the Quitline as one intervention in a multi-faceted arsenal is key. The direct counseling services provided through this medium can have a significant impact on patient compliance, particularly when partnered with intervention programs such as SCRIPT and BMTF. In FY20 we will launch two pilot partnerships to integrate Quitline counseling into a comprehensive cessation program thereby increasing utilization and compliance.

Nicotine replacement therapy during pregnancy is not universally endorsed among obstetricians or family practice providers and is not covered by Kansas Medicaid. In October 2017 ACOG released limited guidance on the use of NRT during the perinatal period and recommended caution when used during this time. Numerous additional randomized trials (pro and con) now exist with a wide variety of recommendations for NRT use among pregnant women. A new assessment of provider NRT utilization will be conducted in 2019 to determine statewide use during and after pregnancy. It's important to

note that NRT can be an important treatment option for women to maintain abstinence after delivery and it is covered by Kansas Medicaid postpartum. Because there are changing guidelines regarding the use of NRT, KDHE will share our provider assessment results with Kansas ACOG and ask for guidance in promoting NRT utilization prenatally.

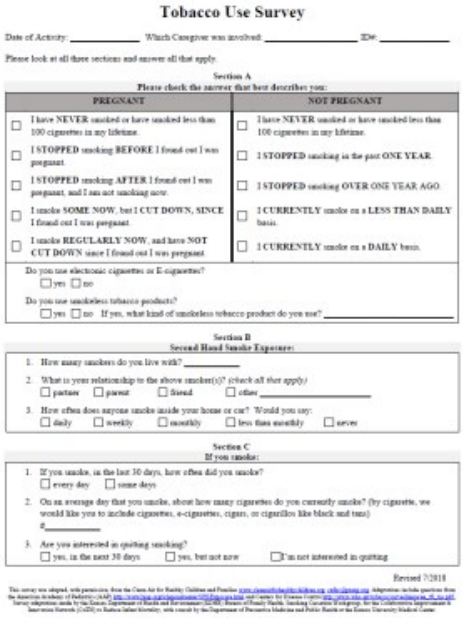
Refining our multi-tiered approach (universal screening and referral, education, counseling and medical interventions) continues to be a priority. Launching the comprehensive tobacco cessation campaign began in early 2018 with provider webinars, however this needs to be updated and used to bring new providers on board. This updated webinar will educate additional partners statewide and promote campaign resources and the new tobacco cessation toolkit throughout 2019. The new tobacco cessation toolkit will be deployed statewide as one part of integrating this comprehensive campaign. Resources will be made available to all sites interested in launching tobacco cessation programming on the KDHE BFH website.

Building state and local referral systems is a significant priority. The investment that has been put forward to create tobacco cessation initiatives will be lost if women are not participating. Referral systems and processes to be developed at the state level include the Medicaid Managed Care Organizations (MCO). Medicaid currently pays for 30% of all pregnancies in Kansas and will often receive the first notification when a woman is pregnant. This coupled with tobacco usage data provides a solid pool of potential early referrals. The BFH has established a data sharing agreement between Medicaid and Vital Stats birth record data. The next step is to create a referral system to enable MCO's to easily promote existing intervention programs (BaM, SCRIPT, BMTF, Quitline, etc.). Local referral systems that also need to be developed include public health (MCH services, WIC, home visiting), clinical providers, FQHCs and hospitals. The BFH will continue to provide technical assistance for established stakeholder groups (Perinatal Community Collaboratives, Community Coalitions, CDRR sites) to create their local systems and will share promising practices as they develop.

KDHE will work with the Kansas MCH Council and the Kansas Chapter of the American Academy of Pediatrics to identify current tobacco cessation resources that are applicable to the pediatric setting. In Kansas, Medicaid stops coverage for postpartum women 60 days after delivery however babies are covered for the long-term. Because of this, pediatricians often see postpartum women along with their new baby more frequently than primary care physicians. This may provide a vehicle to support women to stay quit.

Kansas collects a wealth of data and we are just beginning to use it on a scale that extends beyond state needs to support community level evaluation and planning. What we have started and plan to continue in FY20 is conduct surveys and focus groups to talk with individuals about what they need to help them stop tobacco use. We need to ask for their feedback on the tools, resources and programs we currently provide and need to ask what is missing. We can't miss this opportunity to ask women what motivates them to quit and if they have declined services what drivers keep them smoking. This personal evaluation/survey will be developed by KDHE and initiated in communities with existing cessation programs. Several cohorts of teens will be surveyed to capture their unique viewpoint.

Tobacco Use Survey (Screening Form in DAISEY)



Tobacco Use Survey

Date of Activity: _____ Which Caregiver was involved: _____ ID#: _____

Please look at all three sections and answer all that apply.

Section A
Please check the answer that best describes you:

PREGNANT	NOT PREGNANT
☐ I have **NEVER** smoked or have smoked less than 100 cigarettes in my lifetime.	☐ I have **NEVER** smoked or have smoked less than 100 cigarettes in my lifetime.
☐ I **STOPPED** smoking **BEFORE** I found out I was pregnant.	☐ I **STOPPED** smoking in the past **ONE YEAR**.
☐ I **STOPPED** smoking **AFTER** I found out I was pregnant, and I am not smoking now.	☐ I **STOPPED** smoking **OVER** ONE YEAR AGO.
☐ I smoke **SOME NOW**, but I **CUT DOWN, SINCE** I found out I was pregnant.	☐ I **CURRENTLY** smoke on a **LESS THAN DAILY** basis.
☐ I smoke **REGULARLY NOW**, and have **NOT CUT DOWN** since I found out I was pregnant.	☐ I **CURRENTLY** smoke on a **DAILY** basis.

Do you use electronic cigarettes or E-cigarettes?
☐ yes ☐ no

Do you use smokeless tobacco products?
☐ yes ☐ no If yes, what kind of smokeless tobacco product do you use? _____

Section B
Second Hand Smoke Exposure:

1. How many smokers do you live with? _____
2. What is your relationship to the above smoker(s)? *(check all that apply)*
   ☐ partner ☐ parent ☐ friend ☐ other _____
3. How often does anyone smoke inside your home or car? Would you say:
   ☐ daily ☐ weekly ☐ monthly ☐ less than monthly ☐ never

Section C
If you smoke:

1. If you smoke, in the last 30 days, how often did you smoke?
   ☐ every day ☐ some days
2. On an average day that you smoke, about how many cigarettes do you currently smoke? (by cigarette, we would like you to include cigarettes, e-cigarettes, cigars, or cigarillos like black and tans)
   #_____
3. Are you interested in quitting smoking?
   ☐ yes, in the next 30 days ☐ yes, but not now ☐ I'm not interested in quitting

Revised 7/2018

This survey was adapted, with permission, from the Clean Air for Healthy Children and Families www.cleanairforhealthychildren.org, info@cleanair.org. Adaptations include questions from the American Academy of Pediatrics (AAP) http://www.aap.org/tobacco/smoke/SHS/index.html and another by Kansas Center http://www.ksu.edu/ksrc/ksrcindex/ks_tf_to_all/ Survey adaptations made by the Kansas Department of Health and Environment (KDHE) Bureau of Family Health, Smoking Cessation Workgroup, for the Collaborative Improvement & Innovation Network (CoIN) in Rural Infant Mortality, with consult by the Department of Preventive Medicine and Public Health at the Kansas University Medical Center.

Local MCH Agencies: Local agency staff, including home visitors, will continue to assess all pregnant women of smoking status (through use of the screening form mentioned/shared) and educate them about the dangers of smoking during pregnancy. Tobacco use after pregnancy is also assessed during clinic visits as well as during home visits. Information and resources will continue to be given related to smoking during pregnancy, as well as second- and third-hand smoke exposure. Title V will continue to provide technical assistance to local agencies and encourage them to offer evidence-based tobacco cessation interventions in their organizations. Referrals will be made to the Kansas Tobacco Quitline, BMTF, and/or SCRIPT depending on the status and readiness of the individual. The screening, referral, and education information will be captured in DAISEY. Funding support continues in FY20 for the KIDS Network and the KBC to support Community Baby Showers where tobacco cessation education, resources, and even referral is provided on site, for example enrollment into Kansas Quitline (KanQuit). KDHE will continue to track statewide utilization of the Quitline by pregnant women and continue to solicit feedback from KPCC programs and make recommendations to the Quitline staff as appropriate.

Objective: Implement the Vermont Oxford Network (VON) Neonatal Abstinence Syndrome (NAS) Universal training program statewide in partnership with the Kansas Perinatal Quality Collaborative (KPQC) and birthing centers (Target: 65 centers).

Kansas Perinatal Quality Collaborative: In FY20 the Kansas Perinatal Quality Collaborative (KPQC) will continue supporting substance exposed babies and their mothers by working with partners to build awareness and reduce stigma outside of the birthing facilities while ensuring practices and policy changes are sustained. The KPQC will work with early childhood providers as well as substance use treatment providers to enhance supports to babies and their mothers as well as extended families. KDHE-BFH partnered with the BHP to develop an innovative prevention project for the Data Driven Prevention Opioid Grant that was submitted to CDC in May 2019; if funded, grant funds will be used to support a universal home visiting pilot targeting two locations with high substance-exposed infant births. This program will build on the current MCH home visiting curriculum and will include lessons learned from MIECHV-funded programs related to topics such as safe sleep, breastfeeding, developmental screening, and specific content that relates to supporting addiction recovery and caring for substance exposed infants.

The KPQC will work more collaboratively with the Kansas Maternal Mortality Review Committee (KMMRC) in FY20 to disseminate committee findings and identify the next QI initiative related to maternal and perinatal health. Kansas will enroll as an Alliance for Innovation on Maternal Health (AIM) state before 2020 and will identify an AIM bundle, identified by data gleaned from completed maternal mortality reviews as well as other MCH priority data for implementation.

AIM is a national data-driven maternal safety and QI initiative for states and hospitals and partners from participating states (focus on consistent obstetric practices). AIM is based on proven implementation approaches to improving maternal safety and outcomes in the U.S.
AIM works through state teams and health systems to align national, state, and hospital level QI efforts to improve maternal and perinatal health outcomes. Any state can join AIM as part of a state-level PQC quality efforts/initiatives. States that enroll in AIM receive:

- Access to 12 "safety bundles"
- Access to Patient Safety Tools
- Access to the AIM Community of States

AIM Bundles – Learn more at: https://safehealthcareforeverywoman.org/aim-program/

AIM-SUPPORTED PATIENT SAFETY BUNDLES

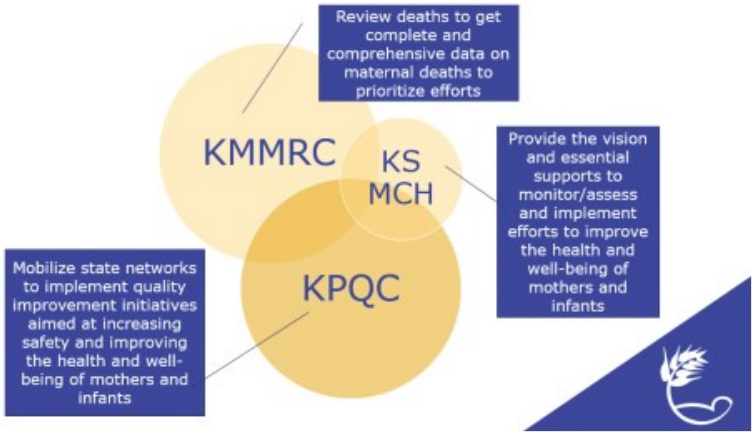
- Maternal VTE Prevention
- Postpartum Care Basics for Maternal Safety From Birth to the Comprehensive Postpartum Visit
- Postpartum Care Basics for Maternal Safety Transition From Maternity to Well-Woman Care
- Obstetric Care for Women with Opioid Use Disorder
- Obstetric Hemorrhage
- Reduction of Peripartum Racial/Ethnic Disparities
- Safe Reduction of Primary Cesarean Birth
- Severe Hypertension in Pregnancy
- Severe Maternal Morbidity Review
- Support After a Severe Maternal Event

State Perinatal Quality Collaboratives (PQCs) and MMRCs function to improve maternal and perinatal health (investing in the mother's health leads to a healthier birth/pregnancy outcomes). Roles are difference but complementary:

- PQCs: Focus on efforts during the maternal and perinatal periods intended to improve birth outcomes and strengthen perinatal systems of care for mothers and infants
- MMRCs: Focus on reviewing maternal and pregnancy-associated deaths (pregnancy through one year after delivery) to identify gaps in health services and make actionable recommendations to prevent future deaths, improving maternal and perinatal health

Lessons learned over time have resulted in the national recommendation (from CDC) for states to intentionally and strategically align the review efforts (MMRC) with the action/QI efforts (PQC), creating a "culture of safety". Kansas' enrollment in the AIM initiative (with Title V as lead) will result in statewide adoption of a "patient safety bundle". This will be done in partnership with the KPQC, MMRC, and key MCH partners at the state and local levels. The tentative date to launch a bundle is summer 2020 (or sooner if ready). It is imperative that the first KPQC initiative focused on NAS is stable and fully integrated for return on investment. KDHE/Title V applied for CDC funding in May 2019 to support this work.

Diagram Showing the Role of the KMMRC and KPQC



The KMMRC will continue reviewing cases for 2017 and 2018 with the goal of reviewing all maternal deaths that occur in the state within two years from the date of death. Data will be shared with the CDC as it is entered into the Maternal Mortality Review Information Application or MMRIA; sharing data in this way connects Kansas to other maternal mortality review committees and allows a deeper understanding of maternal deaths and opportunities for prevention.

Count the Kicks® Stillbirth Prevention Initiative: Title V entered into a formal partnership with Healthy Birth Day, a nonprofit lead for an intervention known as *Count the Kicks (CTK)* in 2018. CTK is a campaign to prevent stillbirth by educating providers and patients about monitoring fetal movements during the 3rd trimester of pregnancy. This is taking place across Kansas at no cost to providers who will have full access to videos and educational materials (including posters, brochures, and, appointment cards in English and Spanish). Kansas plans to keep the momentum of the Count the Kicks (CTK) campaign going in Kansas by continuing social media blasts and sharing data and information with the MCH network (provided by Healthy Birth Day, Inc.). We will again mark October 2019 as Stillbirth Awareness Month to encourage local MCH agencies to spread awareness in their communities and encourage moms to count those kicks! Other states such as Iowa have reduced stillbirth rates annually since implementing. Learn more at https://www.countthekicks.org. Read about Kansas' progress to date in the Women/Maternal Report.

Count the Kicks Materials (note Kansas MCH branding at bottom)

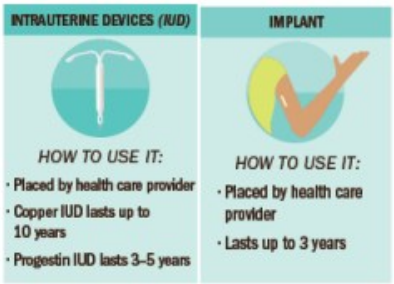
Long Acting Reversible Contraceptives (LARC): Title V will continue our collaboration with Title X and other state partners to increase access to LARCs for women. The LARC workgroup (read more in the Women/Maternal Report) is currently developing a LARC toolkit that includes:

- Case for Change (data for decision makers that approve service provision; cost of unintended pregnancy; return on investment for preventing preterm birth, low birthweight, etc.)

- Clinical Indications (LARC types/descriptions, evidence, myths, side effect, treatment)
- Billing and Coding (guidance for successful, maximum reimbursement)
- Resources (sample MOU for referral, resource guide, algorithm for workflow including OKQ)

The LARC workgroup also plans to recruit physicians for a LARC Preceptor Network (peer support) which will allow trained physicians to serve as preceptors for newly trained providers that need experience. A training event, LARC Grand Rounds, has been scheduled for September 27, 2019. This event will be a full day of learning and discussion around LARC. The training will include sessions on billing and coding and the LARC tool kit as well as an expert panel discussion with Q&A time. A live IUD and implants insertion training will also be provided.

Title V plans to continue the energy around LARC after this training event by hosting “lunch and learn” online events where organizations can call in for a short didactic session about a specific LARC topic (such as LARC myths and how to educate about them) followed by a Q&A session where participants can discuss LARC cases and get expert and peer advice. Title V and Title X will continue to offer technical assistance to organizations around LARC and assist identifying innovative ways to overcome barriers they may have to offering or referring for LARC.



Women/Maternal Behavioral Health Integration Activities:

Local MCH Agencies: Public health providers across MCH programs serve a unique role in screening, referring, and providing follow-up to our perinatal women and their infants/children. With the appropriate training, resources, and support of local clinical partners, screening for depression can be done in a caring and confidential manner within a group setting in the context of the mental health and pregnancy/postpartum discussion. With guidance, local MCH agency public health staff are increasingly screening for perinatal/postpartum depression in home visitation and clinical services. Expansion of MCH services in our state to include the BaM collaborative perinatal education and support program has prompted the need for such guidance on screening prenatally as well as in a group setting. Maternal mental illness is a more common health concern than previously thought and many cases of what has been called postpartum depression actually started during pregnancy. Left untreated, this can be detrimental to the well-being of both mother and child. Additionally, research shows correlation between untreated prenatal depression and increased risk of an infant being born preterm and at a low birth weight.

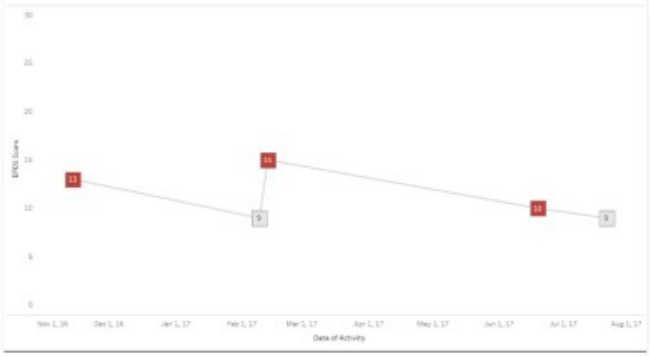
The mental health integration toolkit, with guidance and resources, was developed and finalized with support from the KS MCH Council for the Perinatal Community Collaborative utilizing the BaM curriculum. The toolkit has been adapted and shared with MCH ATL grantees across the state. Title V will continue to update and revise this toolkit to make sure it contains the most recent recommendations and resources around prenatal and postpartum mood and anxiety disorders. We will continue to market the toolkit for use in local organizations and continue to offer technical assistance to organizations who want to utilize the toolkit to integrate depression screening, referral and treatment into their organizations.

Edinburgh Report: The Edinburgh Report went live May 2019 and was designed to allow users to quickly identify clients with

positive screening scores and track their scores over time. Data in these reports come from Edinburgh screenings in DAISEY, and focus over the next year will remain on utilizing these types of reports to ensure referrals and connections are made to address the needs of MCH populations, specifically mothers experiencing depression. The Most Recent Activities Report can be filtered by Start and End Date, Organization, Score Classification, and Completeness Classification.

The Most Recent Activities dashboard displays the most recent screening data for all caregivers who have an Edinburgh entered in DAISEY with a Date of Activity within the selected Start and End Date. It includes an overall visualization of positive vs negative scores for your organization, and a table showing each caregiver's most recent Edinburgh score, the response left for question 10, and whether or not the questionnaire was completed.

As noted on the report, a result of positive means that a score of 10 or higher and/or thoughts of self-harm were indicated on the client's most recent screening. All positive scores are highlighted in red in the client data. Screenings in which one or more questions were not answered (incomplete) are highlighted in purple in the client data.



The All Activities for Client Report includes one filter to view all screenings for a particular client. This filter can be used by scrolling through the client list or typing the client's name or ID in the white search bar that appears at the top of the dropdown. Once a client is selected, the chart will show all screenings completed for that client. Positive screenings will continue to be highlighted in red. Furthermore, hovering over each score box will provide additional information including the exact date of the screening, Q10 response, completeness, and the organization that completed the screening.

Kansas Connecting Communities: As mentioned in the Women/Maternal Report, the KDHE BFH was recently awarded the HRSA's Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement funding. The funding/project provides the opportunity to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders. This project is titled Kansas Connecting Communities (KCC) and is directed/managed by the BFH/Title V Behavioral Health Consultant.

This work is critical, resulting in universal assessment and linkages across the MCH domains through expanded community support networks. The project has five overarching goals centered around increasing capacity and improving mental health and substance use screening and services for pregnant and postpartum women. Goals include:

1. Develop and Disseminate Trainings and an Integration Toolkit for the Edinburgh Postnatal Depression Scale (EPDS) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) process;
2. Utilize Telehealth and/or Community Resources (e.g., Community Mental Health Centers (CMHCs) and behavioral health telehealth providers) to deliver real-time psychiatric consultation and access to care;
3. Develop linkages and care coordination across providers;
4. Provide services through telehealth or community providers following initial consultation; and
5. Enhance alignment of state and local partnerships including peer support groups.

The initiative can create an immediate impact not only for Kansas' mothers but also for their children and families. Maternal

depression has significant influence on children, even from the moment a woman becomes pregnant. During pregnancy, a mother's physical and mental health impacts both the immediate and long-term health of her child. For example, it has been found that children whose mothers are depressed while pregnant are at an increased risk for being born preterm and at a low birth weight. The percent of preterm births is an MCH state performance measure. By taking a more holistic or whole-person approach to maternal health care, Kansas anticipates a reduction in these risks and related performance measure rates and an improvement in children's developmental health as indicated through developmental screenings and school readiness assessments over time.

KCC will increase statewide access, using a regional phased approach, to screening, assessment, and treatment for maternal depression, anxiety, and substance use disorders. The project is initially targeting ten counties in Southeast Kansas. The need in this region is the highest in Kansas, with three of the five maternal depression risk factors between 7 and 9 percent higher than the state average. While grant activities will be focused in this region for the first three years of the award, all resources and capacity building opportunities will be made available to the statewide MCH network.

According to the Kansas PRAMS 2017 Surveillance Report, approximately 1 in 8 Kansas mothers (12.4%) exhibited signs of postpartum depression. This further demonstrates the importance of leveraging the resources and opportunities created by Kansas Connecting Communities to advance Title V MCH work in these areas. Some of these opportunities include:

- *Mental Health Integration Toolkit* (mentioned above): The toolkit includes resources for both families and providers and is available for download here: https://www.myctb.org/wst/KansasMCH/tools/Pages/default.aspx. The toolkit also includes algorithms for crisis and non-crisis situations, sample policies, and information about the Edinburgh Postnatal Depression Screen (EPDS), which is the recommended screening tool by both the BFH and the MDS Workgroup. The toolkit has been shared and discussed with Title V MCH local agencies/grantees on several occasions: as part of a webinar/TA event, the Kansas Governor's Public Health Conference, and Regional Public Health Meetings. The toolkit will also be introduced at an upcoming regional event (details below).
- *Regional Training Event:* The KCC regional training event will be held July 23, 2019, in Southeast Kansas. The theme is: *Kansas Connecting Communities: Every Mom Thrives!* The KCC project is partnering with two subject matter experts to facilitate the training. First, Melissa Hoffman, DNP, APRN, PMHNP-BC is the founder of Build Your Village and President of Postpartum Support International's Kansas Chapter. Melissa will provide information related to maternal mental health. Second, Christina Boyd, LSCSW, LCAC, is the CEO of Hope and Wellness Resources and the Western Kansas MSW Program Director at the University of Kansas School of Social Welfare.
- *Project ECHO* (Extension for Community Healthcare Outcomes) uses subject-matter experts and video conferencing technology to mentor, expand capacity, and promote consistency in care and practice. KCC is partnering with the University of Kansas Medical Center for Telemedicine and Telehealth Project ECHO team to sponsor four ECHO sessions in September 2019; any medical or social service provider in Kansas can participate in the sessions at no cost. The sessions will cover the importance of screenings, brief interventions, referrals and treatment, implementation strategies, and problem solving to address implementation barriers.
- *Maternal Depression Work Group:* As mentioned in the Women/Maternal Report, Title V and other state and local partners came together to form a *Maternal Depression Screening (MDS) Workgroup* that leveraged state Medicaid funding to support work group activities. This workgroup serves as an advisory council for the KCC project by reviewing resources and tools such as the Mental Health Integration Toolkit and providing feedback on training and

promotion activities. Overall, the workgroup works to increase knowledge about prenatal and postpartum mood disorders and topics including screening, referral, and treatment. The group is also presently focused on policy change to allow for reimbursement of depression screening in the public health setting as well as at well-child checks in the pediatric setting. Conversations with Medicaid are underway, and KAAP is actively engaged/supporting the proposals. The work of this group will continue in FY20.

- *Screening, Brief Intervention, and Referral to Treatment (SBIRT) Work Group:* Also mentioned in the Report, the SBIRT work group was formed with Medicaid dollars to support activities and initiatives to increase knowledge of substance use disorders and the evidenced based SBIRT process. This group also serves in an advisory role to the KCC project. The group's current efforts are focused on the development of an SBIRT Toolkit for MCH programs. The SBIRT Toolkit will include information about substance use screenings, interventions, motivational interviewing, referrals, treatment, implementation guidelines, crisis and non-crisis algorithms, and available training opportunities like the Kansas Department of Aging and Disabilities (KDADS)/Medicaid-approved SBIRT training.

Perinatal/Infant Health

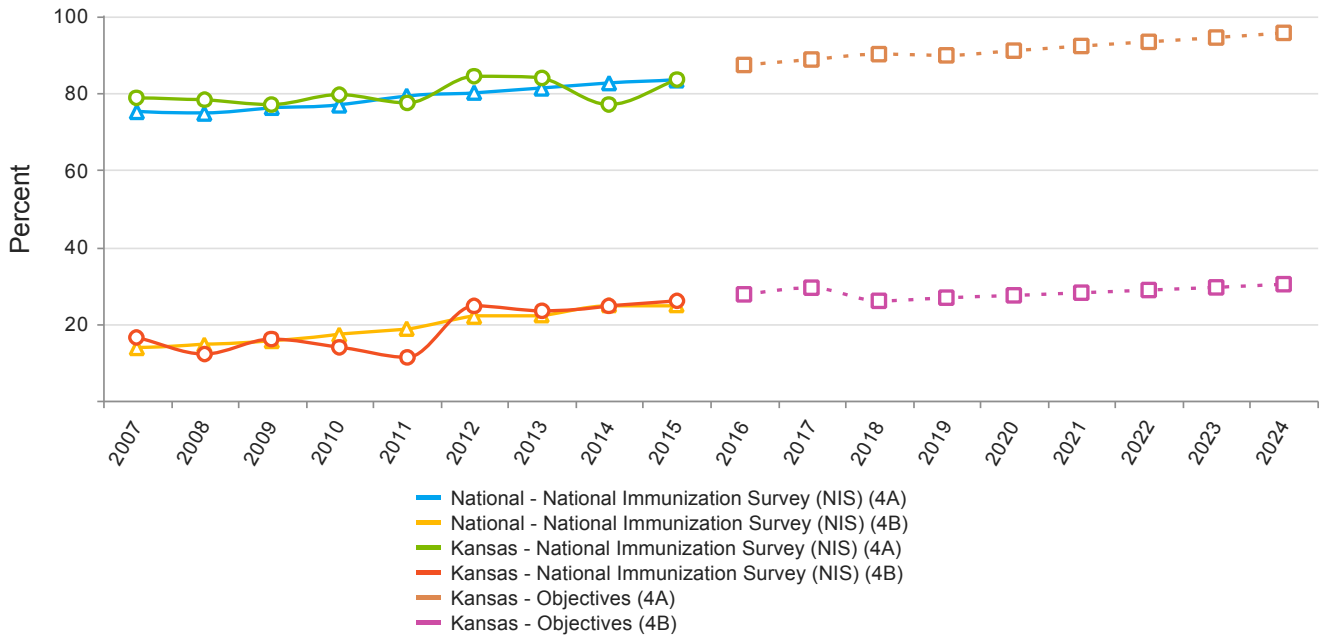
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	6.0	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.1	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	128.8	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	87.2	88.6	90
Annual Indicator	83.8	77.1	83.6
Numerator	32,783	29,183	30,314
Denominator	39,126	37,866	36,276
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

State Provided Data			
	2016	2017	2018
Annual Objective	87.2	88.6	90
Annual Indicator	87.4	88.1	88.5
Numerator	34,078	33,429	32,162
Denominator	38,998	37,937	36,331
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	89.7	90.9	92.1	93.2	94.3	95.5

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	27.7	29.4	26
Annual Indicator	23.4	24.5	26.1
Numerator	9,025	9,095	9,159
Denominator	38,643	37,166	35,100
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	26.8	27.4	28.1	28.8	29.5	30.3

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		22.5	15
Annual Indicator	14.1	13.9	13.7
Numerator	943	990	966
Denominator	6,671	7,121	7,075
Data Source	KWIC	KWIC	KWIC
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.5	20.0	22.5	25.0	27.5	30.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			55
Annual Indicator	36	50	93
Numerator			
Denominator			
Data Source	KIDS Network	KIDS Network	KIDS Network
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	105.0	110.0	115.0	120.0	125.0

State Action Plan Table

State Action Plan Table (Kansas) - Perinatal/Infant Health - Entry 1

Priority Need

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

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

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

3.2 Increase the proportion of live births delivered in birthing facilities that provide recommended care for breastfeeding mothers by 2020.

3.3 Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020.

Strategies

3.1.1 Support capacity to expand the number of communities that achieve criteria for the Community Supporting Breastfeeding designation. 3.1.2 Partner with the Kansas Breastfeeding Coalition (KBC) and WIC in their efforts to promote and support breastfeeding with businesses through the Breastfeeding Welcome Here and Business Case for Breastfeeding initiatives. 3.1.3 Develop standard curriculum for prenatal parent education about infant feeding for use by local communities across the state, integrating it into education sessions. 3.1.4 Increase access to professional and peer breastfeeding support, including Certified Lactation Consultants and Breastfeeding Peer Counselors, through training, referrals, and linkages between birthing facilities and community resources. 3.1.5 Partner with Medicaid and MCOs to increase awareness of and access to breastfeeding support benefits such as lactation consults and breastfeeding supplies as recommended by the US Preventive Services Task Force.

3.2.1 Partner with WIC and KBC to expand the High 5 for Mom and Baby program by increasing the number of hospitals implementing the program. 3.2.2 Support the Kansas hospitals seeking to achieve the Baby-Friendly Hospital designation in partnership with United Methodist Health Ministries Fund (UMHMF), KBC and WIC. 3.2.3 Provide access to education to hospital and maternity care/OB staff to support implementation of evidence-based maternity care policies and practices known to increase breastfeeding initiation and duration rates.

3.3.1 Deploy evidence-based breastfeeding education tools through WIC and Home Visiting programs, hospitals, and provider offices to support an accurate, consistent message about infant feeding for women and families. 3.3.2 Align and strengthen optimal infant feeding education and support through existing programs, including Maternal & Child Health, Home Visiting, and WIC. 3.3.3 Increase the number of referrals to WIC and WIC Breastfeeding Peer Counselors for breastfeeding support and education, including the expansion of WIC Breastfeeding Peer Counseling sites.

ESMs	Status
ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Kansas) - Perinatal/Infant Health - Entry 2

Priority Need

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

SPM

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

Objectives

3.4 Implement a multi-sector (community, hospitals , maternal and infant clinics) safe sleep promotion model by 2020.

Strategies

3.4.1 Enhance safe sleep instructor skill sets to include training home visitors and health care providers and facilitating community baby showers expanding to address safe sleep, smoking cessation, and breastfeeding. 3.4.2 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need. 3.4.3 Expand promotion of the American Academy of Pediatrics' (AAP) Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention and the Safe Sleep Toolkit for outpatient clinics. 3.4.4 Increase the number of Safe Sleep instructors by approximately 5 per year through targeted recruitment in areas with identified need for instructors, high rates of sleep-related injury or mortality, and low levels of related resources.

Perinatal/Infant Health - Annual Report

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

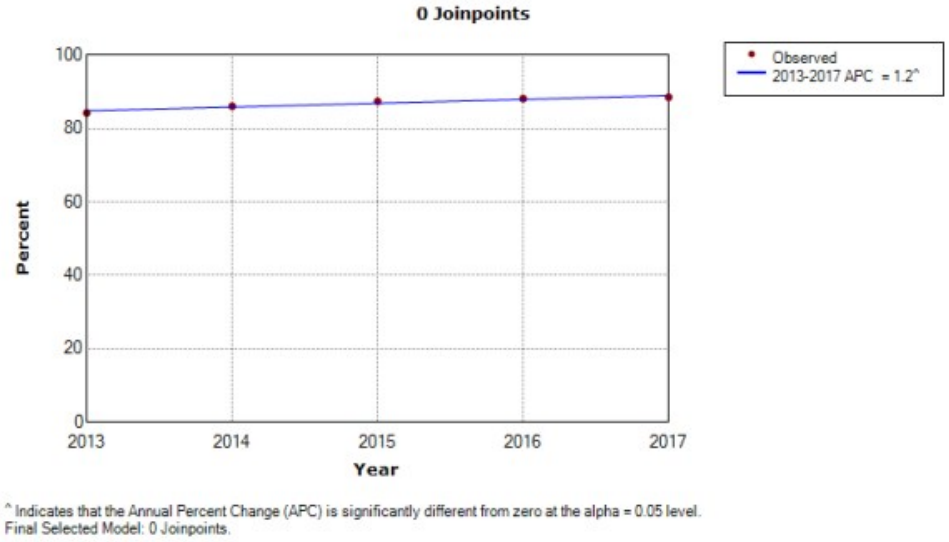
NPM 4: Breastfeeding (ever breastfed; breastfed exclusively through 6 months)
SPM 3: Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

Local MCH Reach: During SFY2018, 66 of 70 grantees (94%) and during SFY2019, 62 of 71 grantees (87%) provided services to the Perinatal & Infant population.

NPM 4: Breastfeeding [ever, exclusively through 6 months] and breastfeeding at 6 months

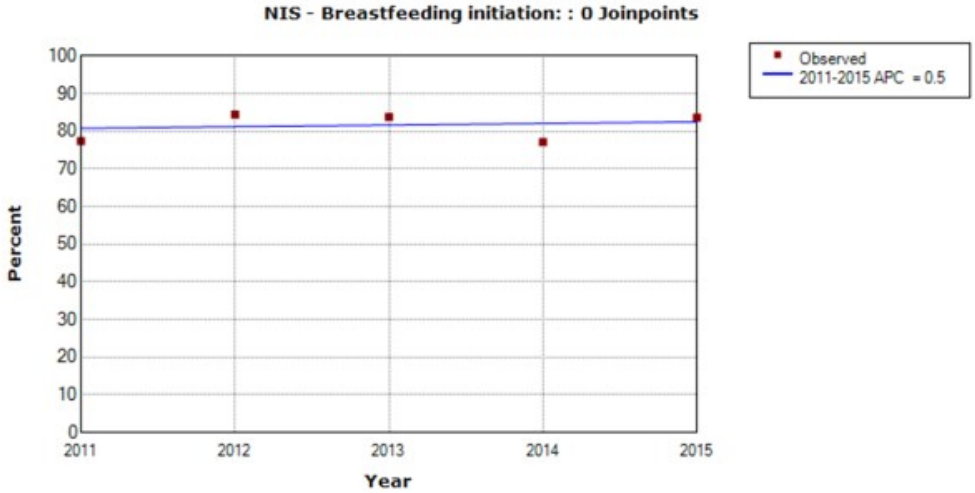
In 2017, **Kansas birth certificate data** showed that mothers initiated breastfeeding in 88.5% of resident live births. This was an increase from the 88.1% reported in 2016 and exceeded the Healthy People 2020 target of an 81.9% breastfeeding initiation rate. Non-Hispanic Asian mothers had the highest breastfeeding initiation rate (92.5%), followed by non-Hispanic white (89.7%) and Hispanic (87.7%) mothers. Non-Hispanic black mothers had the lowest breastfeeding initiation rate (79.0%). The overall breastfeeding initiation rate has been significantly increasing by 1.2% per year (95% Confidence Interval: 0.6% - 1.9%) for the past five-year period (2013-2017).

Breastfeeding Initiation/Ever Breastfed (Source: KDHE, Kansas Birth Certificate Data)



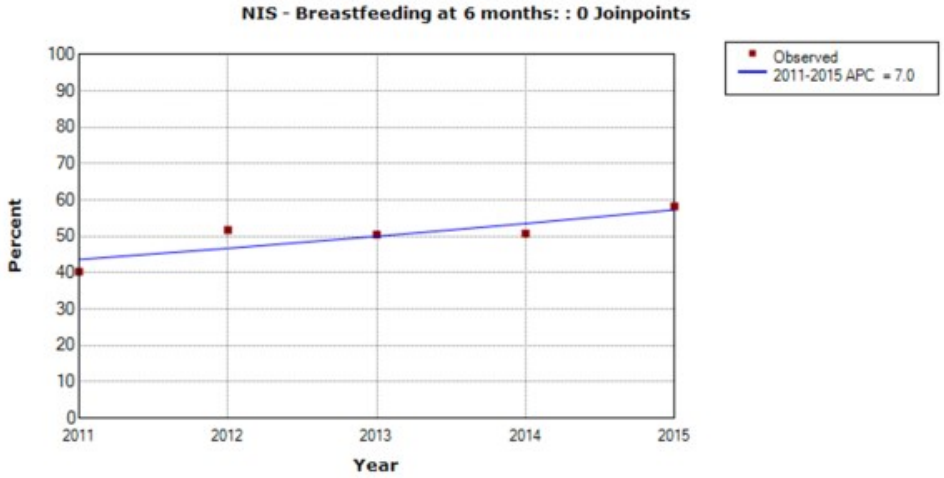
According to the most recent **National Immunization Survey** (NIS), for infants born in 2015, 83.6% of mothers reported ever breastfeeding, 58.2% reported breastfeeding at 6 months, and 26.1% reported exclusive breastfeeding at 6 months. From 2011 to 2015, essentially no change in the proportion of infants who were ever breastfed was observed. A pattern contrary to the trend observed in the birth certificate data. However, during the same period, the proportion of infants who were breastfed at 6 months increased by 7.0% per year (95% confidence interval: -0.9%, 15.7%) and the proportion who were exclusively breastfed at 6 months increased by 13.5% (95% confidence interval: -11.2%, 45.2%). While there has been an improvement in breastfeeding at 6 months and exclusive breastfeeding at six months, more work is needed to meet the Health People 2020 goals. While Kansas has exceeded the Healthy People 2020 goal for breastfeeding initiation rate (81.9%) and surpassed the goal for exclusive breastfeeding rate at 6 months (25.5%), the goal for the breastfeeding rate at 6 months (60.6%) has yet to be met. Babies who are breastfed exclusively for six months receive the most benefits from breastfeeding as do their mothers. Preventative health through exclusive breastfeeding can save health care dollars through reduction in acute illnesses and chronic disease.[1,2]

Breastfeeding Initiation (Source: National Immunization Survey)



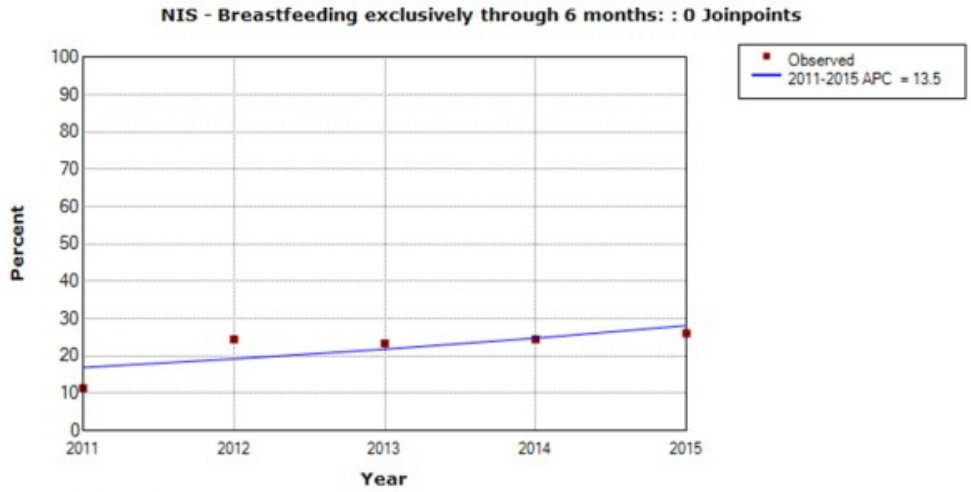
* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

Breastfeeding at 6 months (Source: National Immunization Survey)



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

Breastfeeding exclusively through 6 months (Source: National Immunization Survey)



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

Based on the most recent 2015 Maternity Practices in Infant Nutrition and Care Survey, known as the mPINC, 64 Kansas hospitals (93%) that deliver babies participated in the survey. Kansas scored 76 and ranked 36th out of 53 in the nation.[3] Kansas hospitals are doing well in teaching prenatally about breastfeeding and teaching breastfeeding techniques which results in early initiation. However, there are few policies to support these measures to assure that all staff is trained in assisting breastfeeding families. This may be reflected in the flattening rates of exclusive breastfeeding at 6 months in Kansas.

1. U.S. Department of Health and Human Services. Healthy People 2020. www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf
2. Centers for Disease Control and Prevention. National Immunization Survey. www.cdc.gov/breastfeeding/data/NIS_data/
3. Centers for Disease Control and Prevention. Kansas 2015 Report, CDC Survey of Maternity Practices in Infant Nutrition and Care. Atlanta, GA. September 2016. https://www.cdc.gov/breastfeeding/pdf/mpinc/states/2015/kansas-2015-mpinc-report.pdf

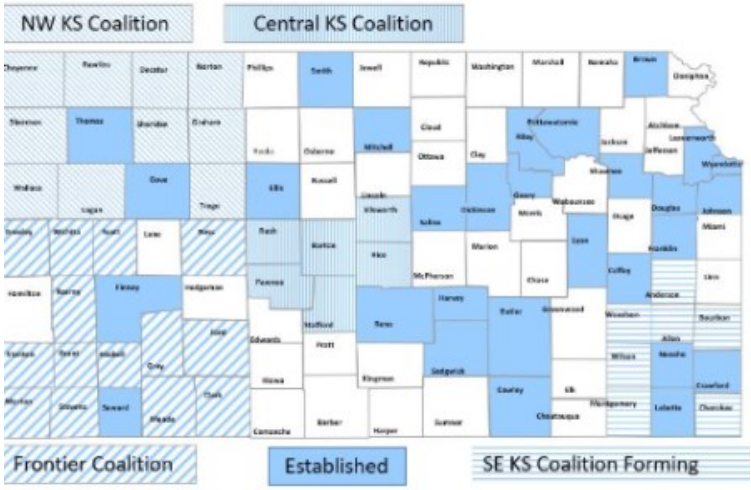
Objective: Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020.

Communities Supporting Breastfeeding (CSB): Kansas Title V has a strong partnership with the state breastfeeding coalition. The Kansas Breastfeeding Coalition (KBC), with support from Kansas MCH for the past several years, continued launch and sustain/develop CSB communities. CSB is a designation from the KBC that recognizes communities that have demonstrated a culture of supporting breastfeeding across settings including public spaces, work sites, birthing facilities, child care setting through partnerships with local breastfeeding coalitions and breastfeeding support peers. The goal of a CSB community is to improve exclusive breastfeeding rates for infants at six months of age by integrating six breastfeeding initiatives across sectors. As of October 2018, 19 communities had achieved the CSB designation with support from the KDHE Bureau of Family Health MCH program, KBC, the Kansas Health Foundation and the Prime Health Foundation. The African-American community in Wyandotte County achieved CSB designation in March 2019. The Prairie Band Potawatomi Tribe achieved the designation on June 6, 2019. The MCH program and KBC continue to be committed to addressing the disparities in breastfeeding. The KBC adapted the CSB criteria to define “community” as a *cultural community* rather than a geographical community which allowed the African-American community in Wyandotte County to achieve the CSB designation. An African American BWH window cling/table tent logo was developed in March of 2018. This project will create tools and models for use in other African American Communities in Kansas. The CSB criteria was also modified to define a community as a tribal reservation. The KBC is worked actively with the Prairie Band Potawatomi Tribe to help them achieve the CSB designation. The KBC also promoted the CSB model at the 2018 Tribal Summit and is engaging three other

Kansas Tribes in conversation about working towards the CSB designation.

Designated Communities Supporting Breastfeeding as of October 1, 2018

Map of Local Breastfeeding Coalitions & Status



Having a local breastfeeding coalition is one of the six required CSB criteria. Over the past 10 years, the number of local breastfeeding coalitions in Kansas has risen from 8 to 33, covering 68 counties or 65% of the state. A list of local breastfeeding coalitions and their contacts can be found at: http://ksbreastfeeding.org/coalitions/

Local breastfeeding coalitions are supported, and formation of new coalitions is fostered by the KBC through the following activities, all of which took place during the reporting period:

- Quarterly conference calls with local coalition leaders.
- Annual "Kansas Breastfeeding Coalitions Conference." In 2017 this conference drew 84 attendees from 30 communities. In 2018 the conference was expanded to a two-day format and included a clinical day of "hot topics in lactation." 154 participants attended the 2018 conference, representing 57 communities.
- Provide resources such as sample coalition documents, project ideas for local coalitions, community engagement ideas and tools for local coalitions on the KBC "Tools for Coalitions" webpage.
- Awarded $5,000 in mini-grants to 10 local breastfeeding coalitions to fund projects improving breastfeeding support in their communities through April of 2019.

A second CSB breastfeeding initiative includes training a minimum of 20 child care providers to support breastfeeding families using evidenced-based practices. Over 3,300 child care providers have completed the training since its launch in June 2013, most through an online course hosted by Kansas Child Care Training Opportunities (KCCTO). MCH funds granted to Child Care Licensing support the KBC instructor for this online course, allowing the course to be offered to child care providers at no cost each month. In addition to CSB criteria efforts, Child Care Licensing also collaborated with the KBC to support breastfeeding friendly online training for 625 child care providers, face-to-face training to 136 child care providers and provided technical assistance to 15 individuals, including child care providers. Funds used to support access to training at no cost was made possible with MCH funds.

The Kansas CSB program has received state and national attention. The program has been selected as an Emerging Practice for AMCHP's Innovation Station (2016) and will be featured in AMCHP's NPM 4 toolkit to be developed in Spring 2019. The CSB project has been recognized at the following during this reporting period:

- NACCHO Exchange Summer 2018 Breastfeeding Issue
- 2018 National Health Outreach Conference, May 4, 2018, Minneapolis, MN
- International Lactation Consultant Association Conference, July 19-21, 2018, Portland OR
- National Breastfeeding Coalitions Convening, U.S. Breastfeeding Committee, Aug. 3-5, 2018, Atlanta GA
- National WIC Assoc. Nutrition Education & Breastfeeding Promotion Conference, Sept. 24-27, 2018, New Orleans, LA

Other CSB Designation Criteria – Businesses & Employers: Other CSB breastfeeding initiatives include *Breastfeeding Welcome Here (BWH)* and *the Business Case for Breastfeeding*, which are supported by MCH partner The United Methodist Health Ministry Fund (UMHMF). As of December 2018, 870 public establishments enrolled in KBC's "Breastfeeding Welcome Here" program which recognizes establishments who support public breastfeeding in their facilities. These establishments make a commitment to support breastfeeding by taking a Business Pledge and displaying the "Breastfeeding Welcome Here" window decal and table tents as well as educating staff on the Kansas law protecting breastfeeding in public. All Breastfeeding Welcome Here materials are available in English and Spanish including a Breastfeeding Welcome Here tool kit that was created for advocates to promote the BWH program. BWH materials have also been translated to Potawatomi and Kickapoo languages. An African American version of the BWH logo was created in March of 2018. The "Business Case for Breastfeeding" assists employers in providing worksite support for breastfeeding employees and creating a breastfeeding friendly worksite through education and resources. As of December 2018, 339 employers had received the "Breastfeeding Employee Support Award" which recognizes employers in Kansas that provide workplace levels of support for breastfeeding employees: Gold, Silver, and Bronze.

Read more about CSB here: http://ksbreastfeeding.org/cause/communities-supporting-breastfeeding/.

The CSB is also included in the Kansas Health Matters database of promising practices here: http://www.kansashealthmatters.org/promisepractice/index/view?pid=30307.

Local MCH Agencies: MCH local agencies provide breastfeeding education and support in many ways and utilize DAISEY to report the number of mother's who are breastfeeding. During the reporting period, 62% of all mothers receiving services reported breastfeeding. In addition, 67% of all home visit clients giving birth during the report period reported breastfeeding.

Examples of MCH local agency work impacting breastfeeding and CSB designation:

- Southeast Kansas Multi-County Health Department have been working with local hospitals in their community to implement the "High 5 for Baby" program which includes community-based efforts among employers, hospitals, and community partners. MCH staff collaborated with local community members to start breastfeeding coalitions. The coalition promotes breastfeeding awareness within the community and recruiting businesses to make a pledge to be breastfeeding friendly businesses.
- Hays Area Children's Center participated in the Communities Supporting Breastfeeding initiative through the Kansas Breastfeeding Coalition and are working to get local businesses to participate in supporting breastfeeding for their employees as well as customers.
- Reno County Health Department staff worked with the Reno County Breastfeeding Coalition to make community members and businesses more aware of the policy and practices regarding the benefits of breastfeeding. MCH nursing staff and home visitors offer the follow-up visit for all breastfeeding mothers to ensure successful transitions from hospital to home and support in those first few critical days at home.
- University of Kansas Medical Center Research Institute School of Medicine staff are members of the breastfeeding coalition and attend events to support efforts including the "Community Supporting Breastfeeding" designation. MCH program staff have also attended the Continuity of Care workshop presented by the Kansas Breastfeeding Coalition.

Objective: Increase the proportion of live births delivered in birthing facilities that provide recommended care for breastfeeding mothers by 2020.

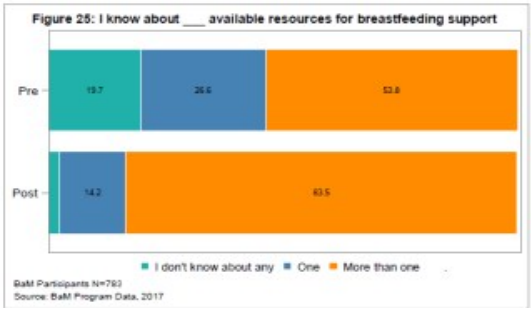
Kansas Breastfeeding Coalition Partnership Activities: Title V partnered with the KBC and WIC to expand the High 5 for Mom and Baby program by increasing the number of hospitals trained and number implementing the program. As of April of 2019, 60 Kansas hospitals and 2 birthing centers demonstrated their commitment to supporting breastfeeding success by participating in High 5 activities. A total of 37 Hospitals have achieved full High 5 program recognition.

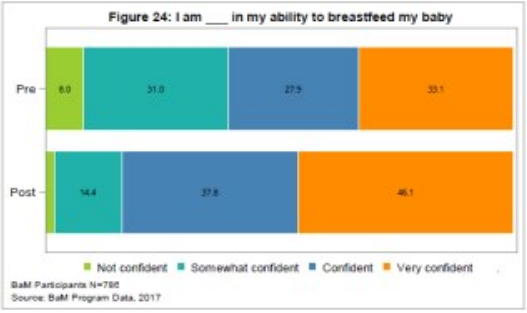
United Methodist Health Ministry Fund (UMHMF) Partnership – Baby Friendly Hospital Initiative: The MCH program established a formal partnership with the United Methodist Health Ministry Fund (UMHMF) to support up to six hospitals seeking to work towards Baby-Friendly Designation. An invitation to apply via a funding proposal was disseminated to hospitals in January 2017 for a three-year period beginning July 1, 2017. The maximum funding per hospital during the three-year period was $25,000. The grants assisted hospitals with successfully implementing the Ten Steps to Successful Breastfeeding, a collection of evidence-based practices shown to increase breastfeeding initiation and duration rates, and a requirement for attaining Baby-Friendly designation. An abundance of scientific evidence has demonstrated lower risks for certain disease and improved health outcomes for both mothers and babies who breastfeed. Hospitals that received the grants were Hays Medical Center; Lawrence Memorial Hospital; Pratt Regional Medical Center; Ransom Memorial Hospital, Ottawa; Saint Luke's South Hospital, Overland Park; and Salina Regional Health Center. More information about the ten steps can be found at https://www.babyfriendlyusa.org/.

Objective: Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020.

MCH-WIC-Becoming a Mom® (BaM) Program Collaboration: Working together collaboratively across WIC, MCH, and BaM, as well as with community partners such as local hospitals and birthing centers, breastfeeding coalitions, and La Leche League groups, much progress is being made to improve breastfeeding initiation and continuation rates in Kansas, as is evident by the above presented data. MCH 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. All the above-mentioned entities are also working collaboratively to implement *Coffective* materials, promoting familiarity with the tools and repeat messaging of the same guidance across different access points in the community (see information provided about Coffective in this section). Numerous local MCH, WIC, BaM, and hospital birth center staff from across the state were fortunate to be able to participate in Certified Lactation Counselor (CLC) training provided by the Healthy Children Project, Inc., Center for Breastfeeding, which is the premier National Certification in Lactation Management for the United States. After being brought to the state for the first time in 2017, the abundant attendance and desire for training of additional staff prompted the Geary County Healthy Start Project *Delivering Change* to sponsor a second training opportunity in April 2018, with registrations reaching maximum capacity. Between these two training opportunities, our state's capacity to support breastfeeding women at a much higher level has increased dramatically, with just over 120 individuals earning certification. A third training will be hosted in Geary County in July 2019 with plans for bringing the training back to Kansas in the western part of the state, as well as other rural and high need locations are in the works for 2020 and beyond.

Through the work of the Kansas Perinatal Community Collaboratives (KPCC) BaM Integration Pilot in 2016, Kansas Title V contracted with the Kansas Breastfeeding Coalition (KBC) for the development of a two-hour evidence-based breastfeeding curriculum component. This evidence-based curriculum utilizes the U.S. Department of Health and Human Services' "Your Guide to Breastfeeding" to supplement the original MOD BaM curriculum handout that was determined to not be near extensive enough to cover this priority topic. Primary focus of this infant feeding session is to get 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. Following piloting of the curriculum in 2016 and feedback gathered from program sites, updates and changes to the curriculum were made in the spring of 2017 and shared back with program sites for implementation starting July 2017. The curriculum has also been made available to WIC/MCH programs in counties across the state where KPCC are not in place, through the work of the KBC and translated into Spanish along with other translation efforts that occurred in the last quarter of 2018. The Kansas Breastfeeding Coalition updated the 2-hour infant feeding curriculum and aligned it with the new "*Your Guide to Breastfeeding*" released by the Office on Women's Health in March 2017. Alignment with our state's Baby Friendly efforts has also occurred, assuring the curriculum meets Baby Friendly requirements. As mentioned under the Women/Maternal domain, work is underway to produce a recorded training webinar for the Breastfeeding Integration Toolkit that will be provided as part of the online resources on the BaM private website, in order to do away with the need for continued in-person training, promoting greater sustainability of efforts.





According to the 2017 BaM Aggregate Report for KPCC, initiation rates rose to 94.1% (over the 88.1% state rate, according to Kansas Birth Certificate data, 2016), which we feel is reflective of efforts by KPCC to provide extensive education and support around this priority. See data below reflecting the significant improvement in confidence of BaM participants in their ability to breastfeed and their knowledge of available breastfeeding support resources pre to post intervention, two significant variables effecting breastfeeding initiation and continuation rates.

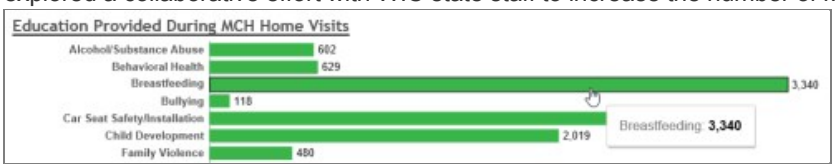
Additionally, data consistently show the BaM session focused on infant feeding as the highest ranking related to "helpfulness of the session", with 93% rating it between very (31.5%) and extremely (61.5%) helpful. Although breastfeeding initiation rates across the state have improved steadily in recent years, there is continued work to be done to improve continuation and exclusivity rates at six months. KPCC and local MCH programs around the state have acknowledged a lack of a structured follow-up process for the offering of support at targeted points following the initial postpartum home visit as well as lack of a system for data collection related to tracking continuation rates.

All BaM resources (curriculum handouts, slides, lesson plans, activity plans) have recently been translated to Spanish to complete the buildout of session components necessary for full implementation of Comenzando bien® (Cb) (Spanish version of BaM). All infant feeding session materials (as well as materials for the other 5 BaM sessions) were fully translated and piloted in the Sedgwick Co. community (with input being reflective of 5 Spanish dialects). Following focus group feedback and final edits and adaptations, these Spanish resources were provided to all BaM sites via the KDHE supported private website for use in local implementation of Cb in late 2018. This has most certainly increased the number of pregnant women receiving education related to optimal infant feeding, especially in largely Spanish speaking areas of the state like SWK.

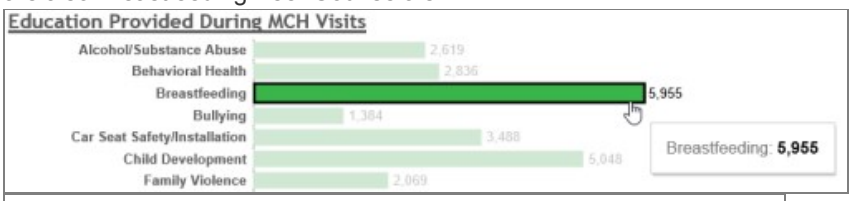
Educational Materials – Promotion and Distribution: Coffective system of counseling/education tools (http://www.coffective.com/) were distributed in 10 communities in 2016-2017 as part of their technical assistance for the *Community Supporting Breastfeeding* (CSB) program. These counseling tools were provided to all community programs who serve mothers and infants in the 10 selected CSB communities. The widespread use of the high-quality tools increased consistent messaging about breastfeeding and supported the hospital's maternity care practices that support breastfeeding, such as skin-to-skin and rooming-in. The Coffective tools "We're Prepared Checklist" and "Build Your Team", encourage families to contact WIC. The Coffective tools are being implemented in all KS WIC agencies, MIECHV programs and in 10 CSB communities in an effort to increase the number of referrals to WIC and breastfeeding peer counselors for breastfeeding support and education. In April 2018, MIECHV hosted two Coffective Breastfeeding Trainings that were offered to both MIECHV and MCH Home Visitors. Both trainings addressed: an overview of Coffective tools and content, implementation of Coffective tools in the home visitor setting, interactive activities to promote participate involvement and practice using Coffective tools, and PDSA (Plan, Study, Do, Act) examples. There were 69 home visitors that attended this training in the Wyandotte County and Southeast Region. Materials were provided in English and in Spanish, (see below), and many of our home visitors have reported utilizing the information with families and expectant mothers.

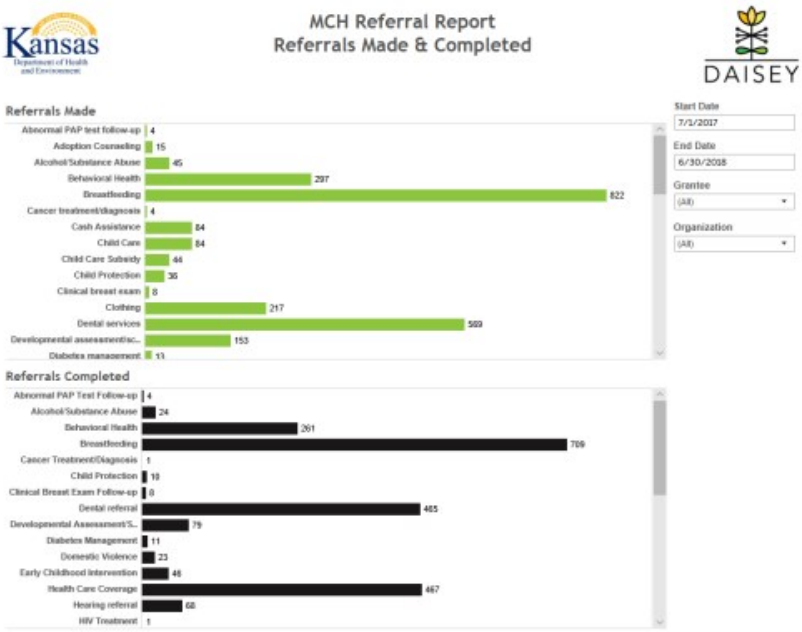
Local MCH Agencies: Local MCH agencies provided education to many prenatal and postpartum clients about breastfeeding. Referrals for breastfeeding assistance were made by local MCH staff, including MCH Home Visitors. Breastfeeding support was the top referral made and completed among MCH clients. In SFY18, of the 822 referrals made for breastfeeding, 709 clients accepted the referral.

Many MCH staff and home visitors are Certified Breastfeeding Educators (CBE), breastfeeding peer counselors and/or a few are International Board-Certified Lactation Consultants (IBCLC). Additionally, many local agency staff members participated in breastfeeding coalitions in their communities/regions. Local MCH agencies collaborate with WIC, hospitals, child care providers and local physicians to provide consistent messaging about breastfeeding. The MCH Universal Home Visiting program provides education and support related to breastfeeding initiation and duration. MCH state staff have explored a collaborative effort with WIC state staff to increase the number of MCH Home Visitors who



are also Breastfeeding Peer Counselors.





Several communities in the state hosted community baby showers, using the Kansas Infant Death and SIDS (KIDS) Network model, to promote **breastfeeding**, safe sleep, and to connect pregnant women and their support persons with community resources. Some agencies collaborate with coordinated outreach and referral (central intake) programs and the states MCOs to host a baby shower open to residents who were pregnant or had an infant less than a month old. Participants enter drawings for prizes donated by various businesses, agencies, organizations and local citizens.

Workforce Development: The KBC provides ongoing education to communities, including the MCH workforce. The following are activities supported through expanded capacity funded by MCH.

- Provided information about breastfeeding support and resources to the KS Birth Defects staff.
- Coordinated a 1.5-hour webinar addressing insurance reimbursement for lactation support services featuring Susanne Madden, with the National Breastfeeding Center and author of the "Model Payer Policy" and Sunee Mickle with Blue Cross Blue Shield of Kansas.
- Updated KBC's online database "Breastfeeding Support by KS County" which has 12 indicators of breastfeeding support and breastfeeding data.
- Presented "Breastfeeding's Impact on Mental Health" at the Governor's Conference on the Prevention of Child Abuse and Neglect and the Kansas Association of Women's Health Obstetrics and Neonatal Nurses Conference.
- Attended and supported the reforming/start-up meeting for Mitchell County, MO/KS Black and Dodge City/Ford County Breastfeeding Coalitions.
- Entered into a MOU with the Kansas Infant Death and SIDS Network to incorporate breastfeeding into community baby showers and Safe Sleep Instructor training. The KBC encourages local breastfeeding coalitions to participate in Community Baby Showers where possible and provide breastfeeding materials for the showers.
- Collaborated with the Kansas Farmworkers Program to educate their regional outreach workers about the availability of local breastfeeding resources and to encourage the program to educate their regional outreach workers about the availability of local breastfeeding support services in their client voucher program.
- Participates in the Community Health Worker Coalition and attends meetings regularly to identify opportunities to incorporate breastfeeding support into CHW roles and training.
- Participated in Kansas Health Foundation Health Symposium
- Presented a full one-day breastfeeding training in Colby, KS.
- Provided input to KDHE MCH to align breastfeeding measures and improve consistent vocabulary within the

breastfeeding questions within the DAISEY and PRAMS survey tools.

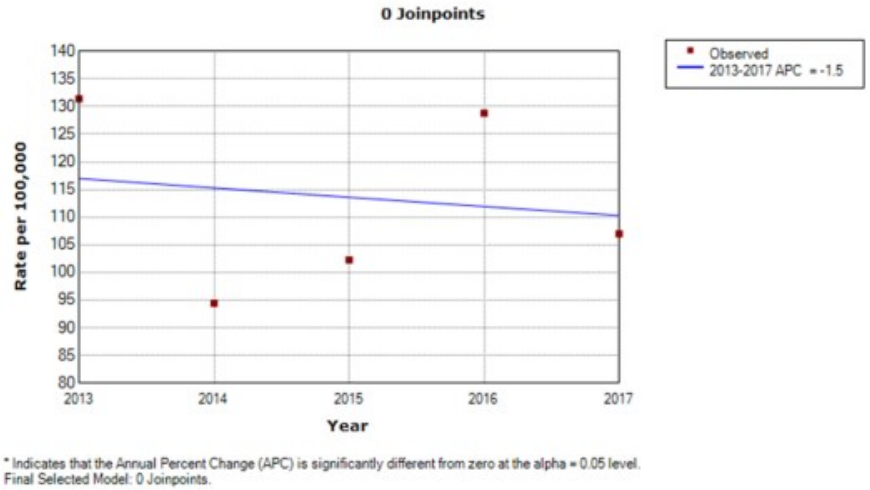
- Maintained statewide "Local Resources Directory" to allow families and health care providers to find local breastfeeding support by entering their zip code. A Google map is populated with breastfeeding resources from a wide variety of sources to include health departments, hospitals, private practice, lactation consultants, peer breastfeeding support groups and walk-in clinics. The rage of the search can be enlarged to encompass a large area if the family is willing to travel. This resource is promoted through a business card with a QR code and full URL to the page. Thousands of these cards (see image to the right) have been distributed to hospitals and local health departments.

- Disseminated breastfeeding information to the public and the breastfeeding field through an active social media presence on Facebook and Twitter and through the KBC website.

SPM 3: Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

A sleep-related infant death is the death of an otherwise healthy infant with no obvious trauma or disease process present, birth to one year of age, where elements of an unsafe sleeping environment were present. This encompasses infant deaths classified as Sudden Infant Death Syndrome (SIDS, ICD10 code: R95), Accidental Suffocation and Strangulation in Bed (ASSB, ICD10 code: W75) and Undetermined (ICD10 code: R99). Unsafe sleep environment includes soft bedding, articles in the crib or bed, infant sleeping in an adult bed or on other sleep surfaces such as a couch or chair, infant sleeping with another adult or child, and infant sleeping in a non-supine position (i.e. on the stomach or side).[1] The Sudden Unexpected Infant Death (SUID) rate is the combination of SIDS, ASSB, and unknown cause deaths.

During the five-year period (2013-2017), overall SUID rates in Kansas decreased by 1.5 per year (95% CI: -16.5, 16.3), from 131.4 deaths per 100,000 live births in 2013 to 107.0 deaths per 100,000 live births in 2017. This decrease was not statistically significant.

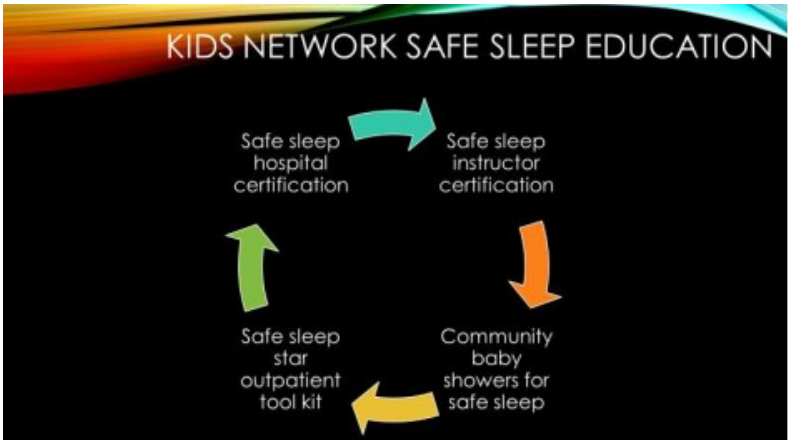


During 2013-2017, 216 Kansas infants died due to sleep-related deaths. Sleep-related deaths are the third most common cause of infant deaths in Kansas (18.4%), behind deaths due to prematurity or low birthweight (19.0 %) and congenital anomalies (23.5%). Non-Hispanic black infants (33 cases, 259.4 deaths per 100,000 live births, 95% CI: 178.6, 364.3) died at a significantly greater rate than non-Hispanic white (127 cases, 93.5 deaths per 100,000 live births, 95% CI: 77.3 – 109.8), and Hispanic infants (35 cases, 113.6 deaths per 100,000 live births, 95%CI: 79.1 – 158.0) where the cause of death was SUID.

According to the 2018 Kansas State Child Death Review Board Annual Report (2016 Data), there were 25 SIDS deaths and seven Unclassified Sudden Infant Deaths (undetermined) in Kansas in 2016. Based on the 25 SIDS deaths reviewed, 4% were sleeping on a couch; 60% were sleeping in an adult bed (73% of whom were co-bedding); 76% occurred at the decedent's residence; 52% were not placed on their back to sleep (recommended position); and 76% were not sleeping in a crib/bassinet (84% of whom had one available in the home).

Objective: Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotions model by 2020.

Kansas Infant Death & SIDS (KIDS) Network – Safe Sleep Expansion Initiative: Kansas Title V continued with the formal (contractual) partnership with the KIDS Network of Kansas during 2018 to reduce infant mortality. The primary work focuses on continued implementation of a comprehensive statewide safe sleep approach. Components include the KIDS Network Safe Sleep Instructor (SSI) Project (including the Community Baby Shower initiative), the Hospital Safe Sleep Certification and the Provider Safe Sleep Star Program (including the Provider Outpatient Toolkit).



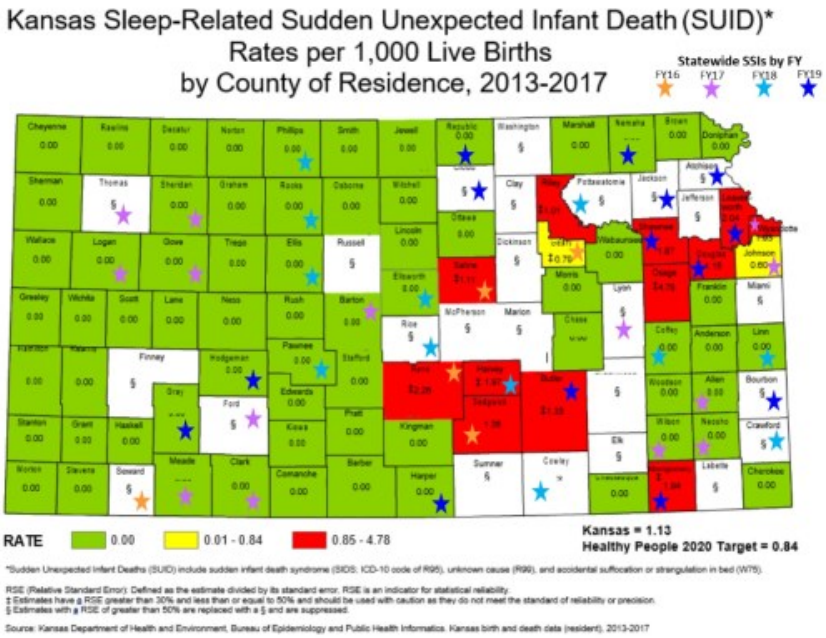
Safe Sleep Instructor Project

Annual Safe Sleep Instructor Training: Each year, KIDS Network hosts a Safe Sleep Instructor Training to certify professionals and caregivers as educators on safe sleep best practices. The curriculum was developed based on American Academy of Pediatrics (AAP) guidelines and the ABC's of Safe Sleep, and updated each year based on current research and recommendations. Topics discussed in this training include diagnosis and disparity of sleep-related deaths, including sudden infant death syndrome (SIDS); safe sleep location, environment, position, and messaging strategies; risks of smoking and protective quality of breastfeeding; and recommended practices related to temperature regulation, pacifiers and tummy time. Following training, SSIs are certified (three levels – Gold, Silver, Bronze) to educate parents/caregivers, childcare providers, health care providers and other members of their communities about safe sleep practices.

A total of 84 SSIs were certified as of March 31, 2019. Each SSI is tasked with the following goals:

- Train at least 10 professionals in their local community
- Facilitate/co-facilitate a safe sleep community baby shower/crib clinic
- Implement the National Safe Sleep Hospital Certification and/or the Safe Sleep Outpatient Toolkit in at least one pediatric, OB, and family medicine clinic.

From July 1, 2017 to June 30, 2018 SSIs conducted 93 safe sleep trainings across the state. From June 30, 2018 to March 31, 2019 SSIs have conducted 46 safe sleep trainings across the state.
Annual SSI training was held October 25-26, 2018, in Wichita. Day one was required for both new and returning SSIs. There were 47 new trainees and 37 returning SSIs for a total of 84 attendees at the training. The map below indicates SUID Rates by county of residence with SSI instructor locations. SUID rates for locations with SSI instructors are not increasing and rates are improved when compared to 2008-20012. Further analysis is being conducted by the KIDS Network and MCH Epidemiologist to determine targeted interventions for counties with the highest rates.



Community Baby Showers: The Community Baby Shower model mentioned above in the breastfeeding report goes beyond the traditional health fair to an education and service access focus. In January of 2018, the KIDS Network, The Kansas

Breastfeeding Coalition and the Kansas Quitline/KDHE Bureau of Health Promotion and the KDHE Bureau of Family Health signed a memorandum of understanding to jointly support Community Baby Showers statewide through staffing, education and the provision of resources. The three-pronged approach includes safe sleep, breastfeeding and tobacco cessation. This is a significant step forward as it brings together these key agencies to provide consistent safe sleep messaging and comprehensive services reaching a greater number of women during the perinatal period. The Community Baby Shower goals for each of these priority areas are:

- Safe Sleep – back position only; safe location; no unsafe items in bed
- Tobacco Cessation – Identify 3 or more ways to avoid 2nd hand smoke; identify at least one local tobacco cessation resource
- Breastfeeding – confidence in ability to breastfeed at least 6 months; identify at least one local resource for breastfeeding support.

As of March 31, 2019, 28 Community Baby Showers have taken place across the state with 15 more scheduled to occur.

Hospital Safe Sleep Certification Program

The Safe Sleep Hospital Certification initiative was developed by Cribs for Kids to identify and recognize hospitals that demonstrate a commitment to community leadership for best practices and education on infant sleep safety. The certification program identifies three designations:

- Bronze
  - Develop and maintain a safe sleep policy that is consistent with the AAP recommendations.
  - Hospitals must provide all staff working on units serving infants with safe sleep training.
  - Hospitals must provide and document provision of safe sleep education to parents of infants before discharge.
- Silver
  - All of the above Bronze activities
  - Implement the use of wearable blankets in neonatal intensive care unit and well-baby nursery.
  - At least two instances of PDSA cycles of new interventions or audits of safe sleep modeling must be done each calendar year.
- Gold
  - All of the above Bronze and Silver activities
  - Hospitals must conduct at least two community outreach activities (e.g. health fair, public service announcement regarding safe sleep) per year.
  - Hospitals must readily display safe sleep education materials (e.g. poster) and must include safe sleep information on their hospital website.
  -

  Hospitals must affiliate, support, or partner with either local or national Cribs for Kids program.

As of March 31, 2019, two hospitals have reached gold level in the National Safe Sleep Hospital Certification Program and two are in the process of applying to become hospital certified.

Provider Safe Sleep Star Program + Outpatient Toolkit

The Safe Sleep Star Outpatient toolkit was launched in FY18 to address infant mortality by providing tools to help outpatient maternal and infant healthcare providers improve safe sleep promotion utilizing evidence-based or evidence informed best practices, including the Medical Society of Sedgwick County's Safe Sleep Toolkit targeted to health care providers, child care providers, and parents. The certification program identifies three designations:

- Bronze
  - Provides annual safe sleep training to employees
  - Has a safe sleep policy regarding educating all appropriate patients/parents on safe sleep and includes information on referral for patients/parents to further safe sleep education, cribs or safe sleep resources and bereavement services
  - Utilize the Safe Sleep Star Outpatient QI toolkit with appropriate patients, at minimum embedding the safe sleep quiz and brief provider script into practice.
- Silver
  - All of the above Bronze activities
  - Provides patients/parents with take-home materials on safe sleep, such as brochures, door handers, "this side up" onesies or wearable blankets.
- Gold
  - All of the above Bronze and Silver activities
  - Engages in safe sleep education at the community level through health fairs, community baby showers or other community outreach at least twice a year.

In order to maintain the earned stars, practices must continue to report compliance on an annual basis. Practices may upgrade their status at any time a higher level is reached. As of March 31, 2019, four outpatient clinics have reached gold level, one has reached silver and two are at bronze. Six more clinics are in the process of achieving a level.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Integration efforts written about in the Women/Maternal Report, have also included standardization of the SIDS/Safe Sleep component of the BaM curriculum, led by state MCH staff and the KIDS Network. An updated Power Point presentation was built for consistent use across all KPCC program sites. During the February 2016 "BaM Integration Training, Part II" training day, all KPCC staff were trained on presentation of the slides and associated resources from the KIDS Network. Additionally, staff were trained on the demonstration of an "unsafe sleep environment" and a "safe sleep environment" that is to be incorporated within the presentation as part of the "Infant Care" session of the BaM program. Updates to the slides and associated supplemental resources were made again in late 2017 and were reviewed in a monthly TA webinar for all KPCC sites. Updates are scheduled again for May 2019, in partnership with the KIDS Network.

In preparation for launch of a KPCC in SWK in late 2017, in-person training was provided for all new facilitators. This component of the integration training was exceptionally well received by program staff, as many of the new group facilitators were feeling inadequate in presenting this component of the curriculum, as their areas of expertise were more clinical than public health. Recent investments included translation of the SIDS/Safe Sleep component of the BaM curriculum and all related resources (as described under the Women/Maternal domain report section). In addition to curriculum content having a SIDS/Safe Sleep focus, program incentives across every site include the pack-n-play crib which provides a safety approved crib for expectant mothers with limited resources. The image below shows 2017 BaM outcome data shows significant improvement in knowledge and intentions for safe sleep position and location, following provided education (based on pre and post-tests).

I will put my baby to sleep on his/her: (check all that apply)

- Back
- Side
- Stomach

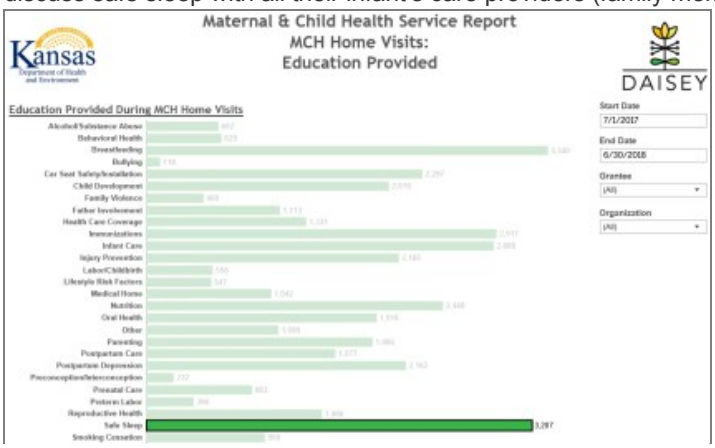
At home, my baby will sleep: (check all that apply)

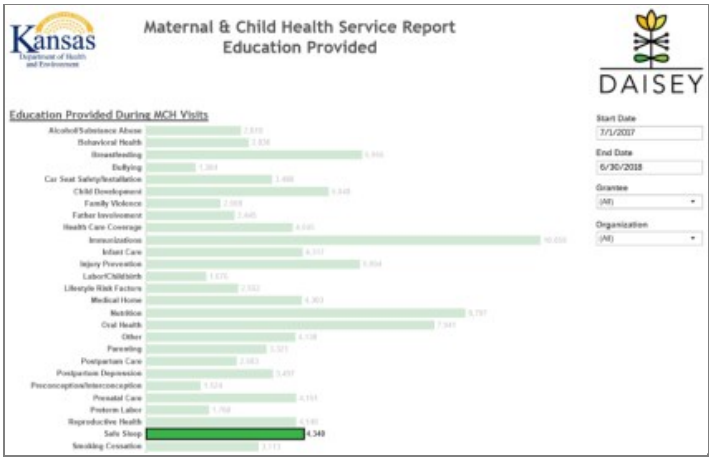
- In a crib, bassinet or portable crib
- In an adult bed, couch or recliner with me
- In a car seat, carrier, bouncer or swing

Safe Sleep		
Baby sleep position (back)	82.7	95.2*
Baby sleep location (crib, bassinet or portable crib)	88.2	98.5*
*The differences between pre- and post- survey results were statistically significant (P<0.05). The participant needs to have a response in both the pre and post survey to be included in the table.		

Training on the SIDS/Safe Sleep integration component, along with the other comprehensive integration components, will be provided to new KPCCs preparing to implement the BaM curriculum. This training, along with the breastfeeding and oral health components, will be provided via recorded TA webinars to be housed on the private BaM website, as are current TA webinars on tobacco
cessation and mental health integration components. The training webinar for the safe sleep component will be recorded in partnership with the KIDS Network and is scheduled for June 2019. This will allow new BaM facilitators to receive comprehensive training on all integration components in a timely manner that fits their local timeline rather than waiting on the schedules of state partners to allow for group travel to the location to provide in-person training. This will support expansion and sustainability efforts long-term.

Local MCH Agencies: According to DAISEY data for SFY2018, safe sleep education was provided more than 4,300 times during MCH clinic/office visits and more than 3,200 times as part of home visits provided to pregnant and postpartum women during the reporting period. Local MCH agency staff educated and encouraged pregnant and postpartum women to discuss safe sleep with all their infant's care providers (family members, friends, childcare providers).





Local agencies collaborate with community partners and other health care providers to promote safe sleep in their community in a consistent manner. MCH home visitors evaluate sleep environments when providing home visiting services for pregnant/parenting moms. This may include a safe sleep demonstration and providing a sleep sack for the infant. MCH home visitors attend the "Wrestling with Safe Sleep" instructor training provided by the KIDS Network. Certified Safe Sleep instructors have provided safe sleep education to women and their families across the state.

Child Care Licensing (CCL) Safe Sleep Efforts: KDHE Care Licensing collaborated with Kansas Infant Death & SIDS Network to update the English version of the online Safe Slumber training and to create a Spanish online version. The training was made available on KS-TRAIN and at no cost to providers (made possible with MCH funds). The number of participates completing the training between October 1, 2017- March 31, 2019 was 656 (655 English and 1 Spanish).

Child Care Licensing attended 5 Baby Jubilee events held by Stormont Vail Hospital. The events are attended by expecting mothers and families. CCL distributed on average 50 Safe Slumber DVDs (English and Spanish) at each event as well as information regarding attaining licensed childcare and other topics such as oral health. Child Care Licensing also participated at the 2018 Safe Kids Kansas Day at the Zoo in Shawnee County. CCL distributed safe slumber DVDs at the event as well as information regarding finding quality licensed child care.

Special Health Care Needs: The Kansas Special Health Care Needs (KS-SHCN) programs offers infants with special needs and their families a holistic care coordination service. This includes sharing information, education and referral, when needed. All families with infants are referred to WIC, home visiting programs, educated about safe sleep practices and encouraged to breastfeed. The care coordinators work to educate and empower families to be able to navigate the systems of care regarding topics such as, medical, insurance, developmental milestones, self-care etc. It is the goal of the KS-SHCN program to provide assistance in navigating these complicated systems, so that over time, the family will be able to do it independently as they advocate for the needs of their child.

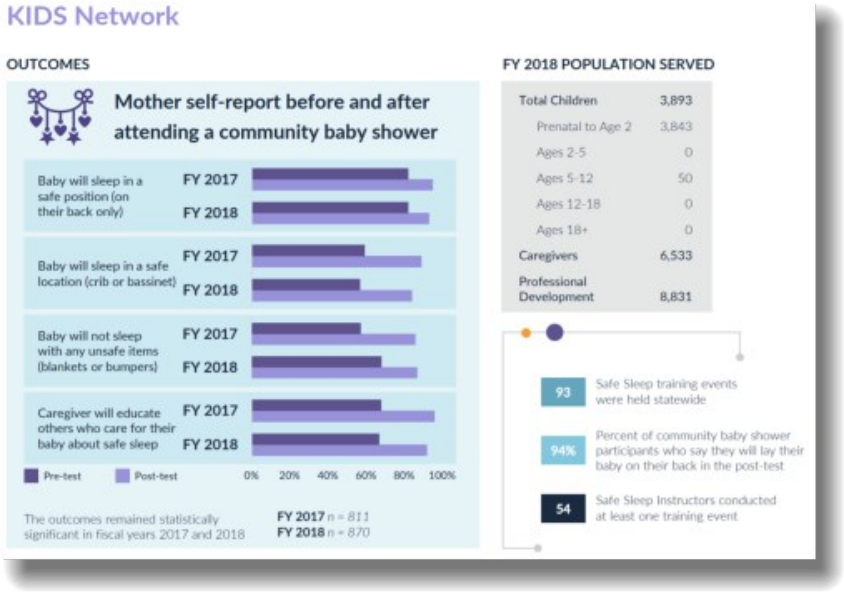
Safe Sleep Infrastructure & Support for Families: The Title V program (with support from the Kansas Children's Cabinet) contracted with the KIDS Network during FY18 to provide a statewide support system to assist families, relatives, friends, caregivers and all others who are affected by the sudden death of an infant. Objectives of the partnership/agreement include:

- Enhance referral network and protocols to enable a minimum of 75% of referred families affected by the unexpected or sudden death of an infant receive initial contact and/or support services;
- Finalize a statewide network for families to assure parents and extended family members access to follow-up and support services based on individual/family needs;
- Utilize an organizational structure to include an executive director and, as appropriate, support staff to fulfill agreement provisions;
- Provide organizational structure to include professional and parent/family representation on the KIDS Network, Inc.

Board of Directors; and

- Implement a public information initiative to inform professionals, families, and other Kansas citizens of the KIDS Network, Inc. services, resource center, and infant safe sleep education.

2018 KIDS Network Impact Report



Other Safe Sleep Activities

Safe Sleep Parent Education – Home Visiting & Hospitals: The Title V program purchased copies of the book "Sleep Baby Safe and Snug" from Charlie's Kids Foundation in English and Spanish. The books are an advocacy tool for SUID prevention and were provided to Kansas Birthing Hospitals, Kansas Perinatal Community Collaboratives, and MCH Universal Home Visitors. The hope is that these books will help bring the message of safe sleep home to caregivers as they read the book to their baby. This will not only allow for repeat safe sleep messaging, reading and talking to babies fosters early literacy and increases the bond between infant and caregiver as well. Kansas Title V provided 11,092 English books and 1,405 Spanish books in the report period. Title V partnered with The KIDS Network to develop an impact survey to report any caregiver behavior change after using the book. Preliminary data shows a 14% increase in caregivers reporting that they would lay their baby down to sleep on its back from pretest to posttest.

Other Perinatal/Infant Health Activities

Early Childhood Literacy: Research shows a direct connection between early reading and high school graduation rates. Grade-level reading, especially in the third grade, is a key indicator of whether children will go down a road to success or face a lifetime of challenges. The window for early learning closes early and if kids don't start building reading skills before they enter school, it could be too late for them to catch up. The Title V program purchased copies of the book "Cuddle" in the Happy Heathy Baby series by Spirit Publishing. A total of 5,145 books were shipped to home visitors and perinatal collaboratives to share with parents to encourage reading, talking, and playing with their baby as early as possible. The books are also sent to moms who complete the PRAMS survey. These books serve to promote early childhood literacy and strengthen the bond between infant and caregiver.

safe sleep

Sleep Baby Safe and Snug Caregiver Survey

Pretest

1. How will you lay your baby down to sleep?
   ☐ On the back ☐ On the tummy ☐ On the side ☐ Not sure
2. Where will your baby sleep at home?
   ☐ In a bassinet next to my bed ☐ In a crib in the baby's room ☐ Don't know/not sure
   ☐ In a portable crib next to my bed ☐ In a big bed ☐ Other (specify) _____
   ☐ In a crib in my room ☐ In my bed
3. Please check the items that are already in your baby's sleeping area at home, or that you plan to get for your baby's sleeping area.
   ☐ Firm Mattress ☐ Blanket ☐ Pillow ☐ Sleep Positioner
   ☐ Fitted Sheet ☐ Bumper Pad ☐ Stuffed Toy ☐ Other_____
4. Will you talk about Safe Sleep with others who may put your child down to sleep? ☐ Yes ☐ No

Date: _____

Posttest

1. How will you lay your baby down to sleep?
   ☐ On the back ☐ On the tummy ☐ On the side ☐ Not sure
2. Where will your baby sleep at home?
   ☐ In a bassinet next to my bed ☐ In a crib in the baby's room ☐ Don't know/not sure
   ☐ In a portable crib next to my bed ☐ In a big bed ☐ Other (specify) _____
   ☐ In a crib in my room ☐ In my bed
3. Please check the items that are already in your baby's sleeping area at home, or that you plan to get for your baby's sleeping area.
   ☐ Firm Mattress ☐ Blanket ☐ Pillow ☐ Sleep Positioner
   ☐ Fitted Sheet ☐ Bumper Pad ☐ Stuffed Toy ☐ Other_____
4. Will you talk about Safe Sleep with others who may put your child down to sleep? ☐ Yes ☐ No

Date: _____

Visit kidsks.org for more safe sleep information.

Pregnancy Risk Assessment Monitoring System (PRAMS): Since October 2017, Kansas PRAMS has achieved several milestones. The first year of data collection wrapped up, achieving a 62.9% weighted response rate. The minimum threshold set by CDC PRAMS is 55%. With this first year of data, KS PRAMS has been able to report information not available in Kansas before, such as prevalence of postpartum depression. KS PRAMS is in the process of releasing reports, as well as fulfilling data requests from stakeholders. Along with the standard PRAMS topics, KS PRAMS has collected information on issues that were of immediate interest, such as: mothers' perceptions about the Zika virus (in the Zika supplement, 2017 study), any physical challenges that mothers may have (in the Disability supplement, beginning in the 2018 study), and opioid use and perceptions (in the Opioid supplement, beginning with the 2019 study). With the additional federal funding from these supplements, KS PRAMS increased the reward amount for Moms from $15 to $25, which will hopefully bolster response rates. Finally, KS PRAMS hired a bilingual interviewer, which will allow a greater reach to Hispanic mothers for participation in the study.

Timeline of Kansas PRAMS Activities (during reporting period)

- October 2017
  - Continued first year of data collection, which included supplemental questions on Zika virus
- April 2018
  - Began 2018 data collection; moved to internal phone operations through KDHE's BEPHI
  - Discontinued collection of Zika virus questions
- July 2018
  - Submitted 2017 data to CDC for weighting and analysis
- September 2018
  - Hired Brandi Markert, KS PRAMS Epidemiologist
  - Awarded funding for two new sets of supplemental questions (one on Disability and one on Opioid Use)
- October 2018
  - Received Year 1 (2017) data from CDC, achieving a 62.9% weighted response rate
  - Exhibited at Kansas Public Health Association conference, to network with potential stakeholders

Perinatal/Infant Health - Application Year

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

NPM 4: Breastfeeding (ever breastfed; breastfed exclusively through 6 months)
SPM 3: Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

Local MCH Reach: Local MCH Reach: Based on SFY2020 MCH Aid-to-Local applications received, 62 of 70 grantees (89%) plan to provide services to the Perinatal & Infant population

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NPM 4: Breastfeeding (ever breastfed; breastfed exclusively through 6 months)

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

Objective: Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020

Capacity Building & Systems Development to Support Breastfeeding Goals & Objectives: KDHE works with partners across the state to increase breastfeeding rates (initiation, exclusivity, and duration) as a strategy to improve maternal and infant health and reduce infant mortality.

Direct support for local coalitions and communities will continue to be provided by the Kansas Breastfeeding Coalition (KBC) made possible with support through an agreement for FY20 funded by MCH and WIC. The purpose of the agreement is to:

1. Increase the capacity of the KBC to facilitate broad cross-sector statewide collaboration to sustain long-term systemic change;
2. Build capacity within the KBC to provide breastfeeding resources and organize cross-sector partners to transform the approach to improving breastfeeding rates in Kansas; and
3. Scale up interventions to increase breastfeeding rates by stimulating action across the state and among many partners.

The KBC provides capacity to support the overall direction and policy strategy for breastfeeding in Kansas across the Bureau of Family Health (BFH), ensuring alignment with the Title V Maternal and Child Health (MCH) and Women, Infants, and Children (WIC) priorities and measures. The KBC is expected to utilize a collective impact model and public health intervention approach to create the conditions needed to decrease disparities and increase overall breastfeeding rates. Focus is on structural and social determinants that create systemic barriers and assure conditions where all mothers can choose to breastfeed their infants, targeting African American and low-income families as well as high-risk women. Specifically, the KBC-BFH/MCH partnership focuses on the following efforts and activities.

- Align and support breastfeeding across BFH programs - MCH, WIC, Child Care Licensing, home visiting programs, Reproductive Health, and other BFH programs as needed. Specifically, working in partnership with the WIC State Breastfeeding Coordinator and WIC Breastfeeding Peer Counselor Coordinator, providing mutual support and shared learning; supporting implementation of Coffective materials; support for new employee breastfeeding training platform and staff breastfeeding education.
- Assist BFH staff to prepare the breastfeeding content for federal and state reports.
- Support and align breastfeeding across BFH state partners such as Kansas Medicaid, KIDS Network, Kansas Perinatal Quality Collaborative (currently focusing on Neonatal Abstinence Syndrome), Child Care Aware of Kansas (especially related to the breastfeeding friendly child care designation), and Kansas Child Care Training

Opportunities (KCCTO) related to child care provider training and education.

- Serve as a clearinghouse for breastfeeding information and a point of contact for national, state and local organizations to improve the consistency of messaging and the utilization of current research and resources.

The FY20 BFH-KBC agreement will focus specifically on the following efforts.

1. Increase capacity and strengthen support at the community level through local breastfeeding coalitions.
   - Create a "Toolkit for Breastfeeding Coalitions" – both as a document and webpage – to include the following resources:
     - Library of governance documents
     - Community partner engagement strategies
     - Coalition management strategies
     - Action plan templates and instructions
     - Fiscal resources and grant writing tips
     - Breastfeeding data
   - Provide technical assistance to communities to include:
     - "Continuity of Breastfeeding Care" meeting facilitation to assist communities in mapping local breastfeeding support and identifying strengths and opportunities
     - "Start-up" meeting facilitation to foster the growth of new breastfeeding coalitions
     - KBC Local Breastfeeding Coalition Member Section to provide regular opportunities through virtual meetings for networking, support and sharing. The Section will inform the creation of the Toolkit mentioned previously and the content of the KBC annual conference and the quarterly "Building Local Breastfeeding Coalitions" virtual meetings. The Section as will also continue to identify additional resources and support needed by local breastfeeding coalitions.
     - Annual KBC Breastfeeding Conference to provide education and resources in additional to in-person networking, support and sharing. Conference sessions will include session by state and national speakers on the following topics:
       - Action planning
       - Community partner engagement
       - Leadership development
       - Equity
       - Grant writing
       - Project examples
2. Technical assistance (TA) to existing CSB communities to help identify "next steps" to continue building a community supporting breastfeeding. Activities will be community and data driven. The KBC will provide guidance and tools to address breastfeeding barriers across sectors with a goal of increasing rates of exclusive breastfeeding at 6 months. County-level WIC breastfeeding data will be used as a measure of success and adjustments in strategies will be made according to measured improvement in WIC breastfeeding rates (MCH ESM for NPM 4 is based on CSB rates – WIC as data source). TA will include:
   - Create an action plan informed by data and the local community's identified barriers and gaps in breastfeeding support, using the "Breastfeeding Support by Kansas County" database and needs assessment
   - Implement suggested strategies to move to the next level of community breastfeeding support such as:
     - Targeted outreach to large employers or those who employ low-wage workers
     - Assisting physician practices to achieve the "Breastfeeding Friendly Practice" designation from the KS AAP *(if funded)*
     - Assisting child care providers to achieve the "Breastfeeding Friendly Child Care Provider" designation from Child Care Aware of KS
     - Improving coalition governance and partner engagement
     - Strengthening peer breastfeeding support through use of social media to reach more families

- Supporting hospitals in their work to achieve the "High 5 for Mom & Baby" or "Baby-Friendly Hospital" designation

3. Child care provider education will continue to be offered. Activities to sustain and expand the opportunity will focus on: Maintaining and updating course curriculum and resources; providing instructor/instruction for monthly online course hosted by KCCTO; providing technical assistance to child care providers and state partners as needed.
4. Participate in planning for Community Baby Showers* led by the Kansas Infant Death and SIDS Network and assist with connecting local breastfeeding coalitions.
5. Maintain and update *Infant Feeding Session* for Becoming a Mom curriculum, to include providing 10 toolkits for existing KPCC/BaM sites.
6. Breastfeeding education for home visitors and WIC staff – six (6) regional 2-hour presentations of "Breastfeeding Basics for the Home Visitor & WIC Staff", supported in part by MIECHV funding for SE KS and Wyandotte County. Emphasis on utilization of Coffective tools.

*The Community Baby Shower is an interactive event that invites new and expectant parents, their support people, and community service providers to get together for an educational "baby shower." At the shower, participants learn about infant safe sleep and maternal child health in order to improve health and infant birth outcomes. The central focus of the Community Baby Shower for Safe Sleep is to teach all participants about infant safe sleep. This includes educating parents and their support people on the ABCs of Safe Sleep, which is that all babies should sleep Alone, on their Backs, and in a safety approved Crib. Participants will know the ABCs of safe sleep and will intend to follow the AAP guidelines for safe sleep utilizing the tools.

Communities Supporting Breastfeeding Model Diagram

More information about CSB is online at http://ksbreastfeeding.org/cause/communities-supporting-breastfeeding/. CSB Designation criteria is online at http://ksbreastfeeding.org/wp-content/uploads/2014/08/CSB-Criteria-Guidelines.docx.

Beyond the specific activities agreed upon under the formal agreement for FY20, the KBC will continue to maintain and promote the "Local Breastfeeding Resource Directory" to enable BFH staff, partners, health care providers and families to locate local breastfeeding support through a database searchable by zip code. The directory includes WIC Breastfeeding Peer Counselors. "Breastfeeding 911" cards are used to promote the directory and provide to community partners across the state. KBC will also maintain and analyze "Breastfeeding Support by Kansas County" database of breastfeeding support indicators to determine their impact on breastfeeding duration rates, either alone or in combination. Further analysis will provide direction to local breastfeeding coalitions and partners to help them focus their resources on the most effective interventions to increase the rates of exclusive breastfeeding at 6 months of age. More information about all KBC breastfeeding initiatives can be found here: http://ksbreastfeeding.org/.

The Kansas Breastfeeding Support Network

MCH-WIC-Becoming a Mom® (BaM) Program Collaboration: Partnership with the Kansas Breastfeeding Coalition (KBC) will continue in SFY20 to annually update the BaM Infant Feeding curriculum component. Recent contract drafting with this state partner includes recording of a training webinar for the Breastfeeding Integration Toolkit that will be provided as part of the online resources on the BaM private website, in order to do away with the need for continued in-person training, promoting greater sustainability of efforts. The KBC will also be providing 10 additional toolkits for new sites implementing in SFY20 that include all the supplies needed for activities and visual aids as part of the Infant Feeding session.

KDHE Title V staff have committed to assisting local partners, including public health departments and BaM sites, with the development of a comprehensive follow-up process and data collection system. This will likely be in the form of additional tools and resources being added to the existing Breastfeeding Integration Toolkit that was implemented in 2017. A flow chart/algorithm will be developed with follow-up calls, home visitation, and support/educational resources being offered at targeted points when mothers are most likely to stop breastfeeding (i.e. in the first week following birth and upon return to work). These tools will likely be co-developed by a work group consisting of the KPCC state coordinator, state MCH Consultants, KBC, and BaM/MCH/WIC consumers in late 2019 / early 2020.

As capacity is available to build additional data collection fields and reports within our state data collection system (DAISEY), both will be built in an effort to support local Title V program staff in tracking breastfeeding status and follow-up efforts. Work will be done with KPCC to develop plans for targeted outreach to disparity populations. As experience with DAISEY reports and exports increases, sites will be encouraged to compare participant demographic data to identified high-need/-risk groups in their individual counties to assess if the targeted population is being appropriately served. This will support improved breastfeeding rates among the teen and non-Hispanic black populations in our state. Planning is also in the works with KDHE BFH Epidemiologist to develop a “dashboard” that will assist BaM program sites and their collaborative partners in more easily identifying trends in data such as this, promoting responsive and strategic planning around targeted efforts and interventions.

Coordinated efforts and collaboration across initiatives at the state level will also target outreach to all KPCC’s, encouraging each to achieve designation as a *Community Supporting Breastfeeding*. Additionally, as mentioned in the report, plans are in the works for bringing the CLC training back to Kansas in 2020 and beyond, targeting the western part of the state as well as other more rural and high need locations of the state.

Local MCH Agencies: All MCH grantees that chose the Perinatal/Infant Health domain in their FY2020 MCH Aid-to-Local (ATL) grant application will provide breastfeeding education, support, and services in their community. Local agency nurses and home visitors will educate families on the benefits of breastfeeding infants exclusively for the first six months. They will collaborate with local hospitals and physicians to develop and/or adapt policies to support initiation and continuation of breastfeeding infants in their community. Collaboration between local agency staff, employers and childcare providers in their communities to support the continuation of breastfeeding after the mother returns to work will continue. Local agencies

will continue to participate in local breastfeeding coalitions along with the Kansas Breastfeeding Coalition.

Jefferson County Health Department plans to encourage initiation and exclusivity of breastfeeding to all pregnant women receiving MCH services. All daycare providers in Jefferson County will be encouraged to support nursing clientele, educated on the importance of breastfeeding and educate on proper handling and storage of breast milk provided for infants in their care.

Lawrence-Douglas County Health Department will begin educating women prenatally on the benefits of breastfeeding. They will utilize an evidence-based curriculum to promote and assist women to overcome any barriers to breastfeeding. Women will be connected to the breastfeeding peer support counselor and informed on local breastfeeding support groups.

Mitchell County Health Department now has a Certified Lactation Counselor (CLC) at the health department. They will be working on strengthening their breastfeeding coalition and actively working with the local hospital to become a High 5 hospital and to refer women after delivery to meet with the only CLC in the county.

SPM 3: Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

Objective: Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2020.

Kansas Infant Death & SIDS (KIDS) Network Partnership: Kansas MCH will continue our partnership with the KIDS network in FY20. KIDS Network will to provide the following activities supported by Title V:

- Continue to implement the statewide Safe Sleep Strategy including the Safe Sleep Instructor (SSI) train-the trainer project and embed regional leads in the six health regions of the state. If a new safe sleep instructor regional leader separates from employment, the position will be replaced with a new regional leader. The KIDS Network will maintain an official list of at least 40 safe sleep instructors approved to train professionals at the community level.
- Provide technical assistance for SSIs related to facilitation of professional trainings to home visitors, health care providers, and child care providers to ensure consistent infant safe sleep messages statewide.
- Continue expanding the Community Baby Shower model in partnership with local communities to provide direct education to families at high risk for adverse outcomes. Continue planning around the model, events, expansion, and improvements with KDHE BFH, KBC (and local coalitions/leagues) and the KDHE Bureau of Health Promotion State Tobacco Program (and local grantees). Local coalitions and organizations leading efforts for breastfeeding promotion/support and tobacco use prevention must be invited to all local events; Implementation of the Safe Sleep Star Outpatient Toolkits Program which ensures family practice, obstetrics and pediatric clinics share consistent safe sleep messages.
- Continue implementation of the national Cribs for KIDS Hospital Safe Sleep Certification program.

Read more about the structure of the statewide safe sleep strategy, programs, and activities, including progress to date, in the Perinatal/Infant Report. Review contents of the Safe Sleep Toolkit online.

Other Safe Sleep Activities

KIDS Network Infrastructure & Family Support: The Title V program will continue to contract with the KIDS Network during FY20 to provide a statewide support system to assist families, relatives, friends, caregivers and all others who are affected by the sudden death of an infant. A 100% funding match will be required of the KIDS Network. They plan to continue to find ways to most effectively disseminate information across the state. The network is planning for evaluation efforts to be revised to include findings by parents and/or professionals, as well as developing assessment tools by caregivers, safe

sleep instructors and professionals.

Objectives of the partnership/agreement include:

- Enhance referral network and protocols to enable a minimum of 75% of referred families affected by the unexpected or sudden death of an infant receive initial contact and/or support services;
- Finalize a statewide network for families to assure parents and extended family members access to follow-up and support services based on individual/family needs;
- Utilize an organizational structure to include an executive director and, as appropriate, support staff to fulfill agreement provisions;
- Provide organizational structure to include professional and parent/family representation on the KIDS Network, Inc. Board of Directors; and
- Implement a public information initiative to inform professionals, families, and other Kansas citizens of the KIDS Network, Inc. services, resource center, and infant safe sleep education.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Training on the SIDS/Safe Sleep integration component, along with the other comprehensive integration components, will be provided to new KPCC preparing to implement the BaM curriculum. This training, along with the breastfeeding and oral health components, will be provided via recorded TA webinars to be housed on the private BaM website, as are current TA webinars on tobacco cessation and mental health integration components. The training webinar for the safe sleep component will be recorded in partnership with the KIDS Network and is scheduled for June 2019. This will allow new BaM facilitators to receive comprehensive training on all integration components in a timely manner that fits their local timeline rather than waiting on the schedules of state partners to allow for group travel to the location to provide in-person training. This will support expansion and sustainability efforts long-term.

Local MCH Agencies: Information will continue to be provided to all pregnant and postpartum women regarding the importance of safe sleep practices. Local agency staff will continue to educate and encourage pregnant and postpartum women to discuss safe sleep with all their infant care providers (family members, friends, childcare providers). They will also continue to collaborate with community partners and other health care providers to promote safe sleep in their community in a consistent manner.

- Geary County Healthcare Foundation Delivering Change ensures all mothers have Safe Sleep education at a minimum once in the antepartum period and at least once in the immediate postpartum period. They also hope to increase the number of Safe Sleep Champion outpatient clinics in Geary County. Delivering Change also hosts two community baby shower events that focus on safe sleep and community resources.
- Pottawatomie County Health Department plans to provide safe sleep education to providers in Pottawatomie County to ensure there is a consistent message no matter where families receive services.
- Riley County Health Department plan to host an annual Safe Sleep/SIDS training for clients, community members and health professionals in Riley County,
- Saline County Health Department plans to host Safe Sleep Community Baby Showers to all pregnant and new mothers in Saline County and their support people on an annual basis as part of a community collaborative. Health department staff that provide services to both prenatal and postpartum women will be educated about safe sleep through a formal education session with local safe sleep instructors.
- Shawnee County Health Department plans to have a staff member remain certified through the Kansas Infant Death and SIDS Network (KIDS Network) to be a Safe Sleep Instructor.
- In Seward County, the health department has three staff members trained on Safe Sleep, they will continue to teach Safe Sleep practices during prenatal Becoming a Mom classes as well as at a community baby shower planned for SFY2020.

Safe Sleep Parent Education: As noted in the Report, Title V provided board books, *Sleep Baby Safe and Snug*, to birthing

hospitals and home visitors as a tool to educate new parents/care givers on safe sleep as well as encourage early childhood literacy and bonding between infant and parent. Title V will continue to provide the books and monitor the impact with the safe sleep pre and posttest until our current inventory is depleted. New in FY20 is a partnership with the Kansas Department for Children and Families. Title V will encourage local MCH agencies and hospitals to create a sustainability plan if they would like to continue providing the books to new parents/caregivers. This will include educating hospitals and local agencies on how they can purchase the books direct from the manufacturer for a low cost as well as innovative funding streams for the books such as writing the expense into their ATL applications.

Other Perinatal/Infant Health Activities

Infant Mental Health/Social-Emotional Development/Early Childhood Literacy: As noted in the Report, Title V purchased copies of the *Cuddle* board book for home visitors to encourage parents to read and hold/interact with their infants. Title V will continue to provide the books to home visitors and the PRAMS team until our current inventory is depleted. Title V will encourage MCH local agencies that want to continue to provide the books or other appropriate books to identify funding to purchase them, including writing the expense into their MCH budget requests or working within the early childhood partners in their communities to promote health development and literacy.

Pregnancy Risk Assessment Monitoring System (PRAMS): Moving forward in 2019 and 2020, KS PRAMS (http://www.kdheks.gov/prams/index.htm) will continue data collection, including questions from the CDC Disability and Opioid supplements. PRAMS will also integrate new strategies for promoting the survey/questionnaire to hard-to-reach populations (such as low-income minority mothers). Finally, KS PRAMS plans to strengthen their ties with MCH partners across the state to ensure that they have the data they need to improve the health of mothers and babies in Kansas.

The Title V Director, MCH Epidemiologist, and primary team have been activity engaged in the PRAMS work since before launch and will continue to be closely involved over the next year. Title V staff meet with the PRAMS coordinator and data manager on at least a monthly basis to review and discuss data, assist with media questions and interviews related to the first PRAMS report with findings based on 2017 births (released March 2019) and consider revisions to the next Questionnaire. The Kansas MCH Council meetings often involve PRAMS updates, sharing of data and stories/input from mothers, and requests for more information. The Women/Maternal and Perinatal/Infant workgroups from the Council will continue to serve in an advisory capacity for PRAMS.

Below is a timeline of PRAMS activities for the planning period.

- October - November 2019
  - PRAMS staff attend Regional Public Health Meetings to present findings and promote the project
- December 2019
  - Proposed discontinuation of Disability supplement data collection
- April 2020
  - Proposed discontinuation of Opioid supplement data collection
- Present/2019 – 2021
  - Development of next questionnaire
  - Continue data collection

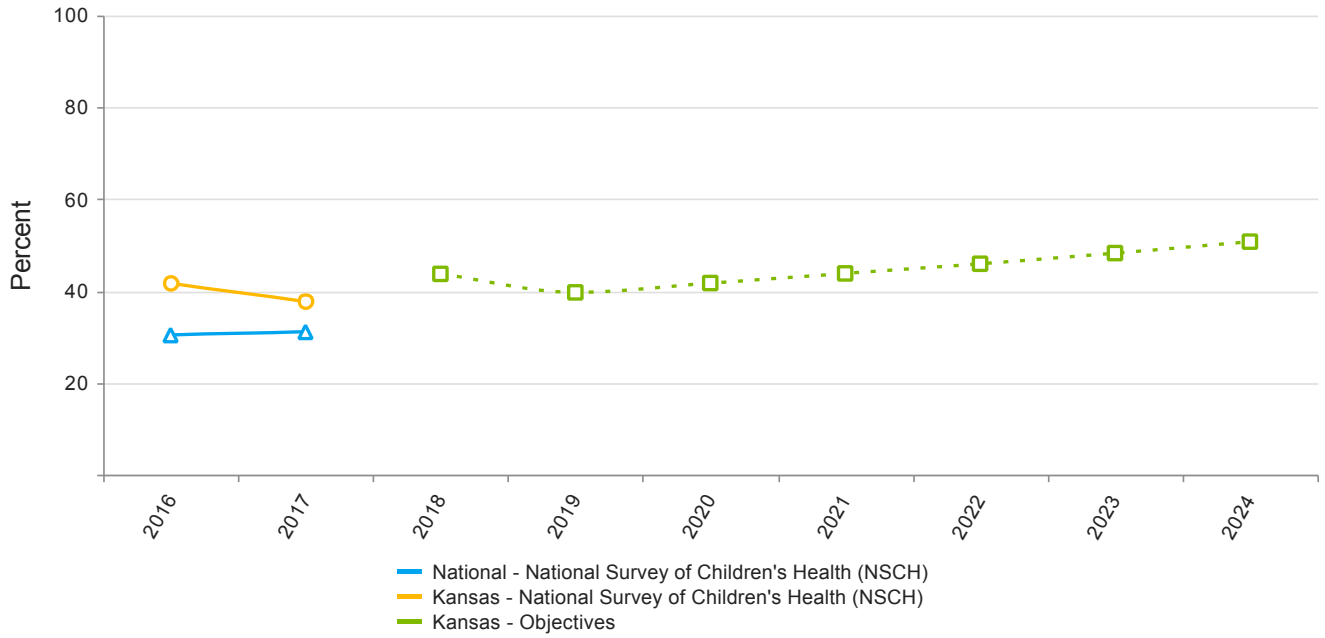
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2017	19.4	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	40.4	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	14.3	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	14.5	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	91.0 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			43.7
Annual Indicator		41.6	37.8
Numerator		33,290	30,554
Denominator		79,958	80,931
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	39.7	41.7	43.8	45.9	48.2	50.7

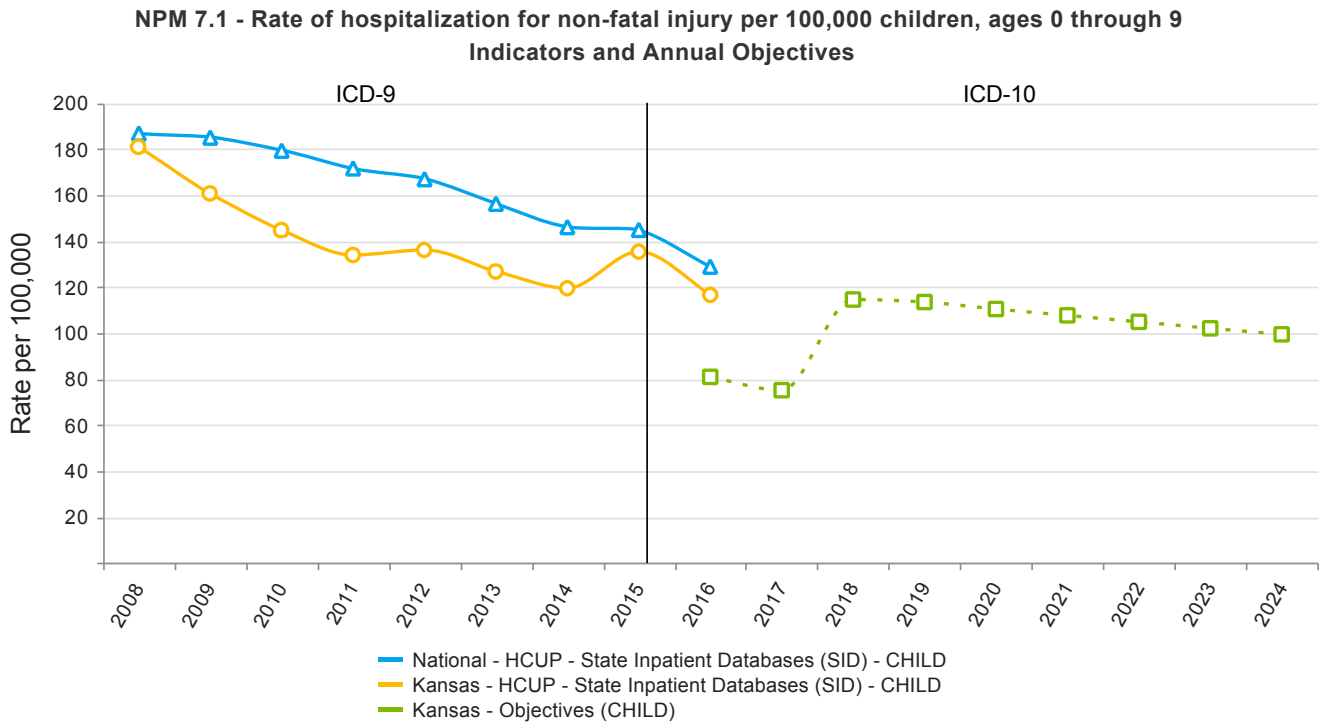
Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program (9-35 months)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		90	72.7
Annual Indicator	12.7	21.4	22.3
Numerator	243	347	340
Denominator	1,907	1,621	1,524
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	27.5	30.0	32.5	35.0	37.5



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data			
Data Source: HCUP - State Inpatient Databases (SID) - CHILD			
	2016	**2017**	**2018**
Annual Objective	80.9	75.1	114.5
Annual Indicator	80.8	135.5	116.4
Numerator	325	406	461
Denominator	402,420	299,709	395,930
Data Source	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	113.4	110.4	107.6	104.8	102.0	99.4

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		1,050	1,100
Annual Indicator	969	1,094	961
Numerator			
Denominator			
Data Source	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,000.0	1,050.0	1,100.0	1,200.0	1,250.0	1,300.0

State Performance Measures

SPM 3 - Percent of children ages 6 through 11 who are physically active at least 60 minutes per day

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		29.6	35.4
Annual Indicator	28.2	32	26.7
Numerator	133,276	77,678	60,041
Denominator	473,426	242,379	224,657
Data Source	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2016	2016-2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	28.0	29.4	30.9	32.5	34.1	35.8

State Action Plan Table

State Action Plan Table (Kansas) - Child Health - Entry 1

Priority Need

Developmentally appropriate care and services are provided across the lifespan.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

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

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

Strategies

2.1.1 Conduct an environmental scan to identify providers conducting developmental screening and determine the tools being utilized to maximize resources and eliminate duplicate screening. 2.1.2 Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention. 2.1.3 Build MCH capacity for screening and follow-up through complete referrals to providers and community-based services. 2.1.4 Provide training to MCH grantees on messaging the importance of ongoing developmental screening and use of Ages and Stages Questionnaires (e.g., ASQ-3; ASQ:SE2).

2.2.1 Develop a standard and consistent message to communicate importance of developmental screening among child care programs. 2.2.2 Make available and provide training to child care providers on social-emotional development, milestones, and age-appropriate activities using the Kansas Early Learning Standards. 2.2.3 Build child care provider capacity to support coordination and referrals with other providers and community-based services. 2.2.4 Partner with statewide networks such as Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs.

ESMs	Status
ESM 6.1 - Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program (9-35 months)	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Kansas) - Child Health - Entry 2

Priority Need

Developmentally appropriate care and services are provided across the lifespan.

NPM

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Objectives

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

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

Strategies

2.3.1 Increase the number of MCH grantees, as a lead for or partner of local Safe Kids Coalitions, providing education and installation of car seats. 2.3.2 Increase the number of trained car seat technicians, support additional check lanes for MCH, and incorporate information and check lane locations into prenatal and postpartum education and information. 2.3.3 Provide targeted training and technical assistance to child care providers related to regulatory and transportation requirements.

2.4.1 Enhance home safety information and education provided as part of prenatal and postnatal visits/sessions 2.4.2 Provide education and support through use of online systems and tools to assist parents with selecting a child care setting that meets health and safety requirements. 2.4.3 Develop a standard home visiting tool for MCH home visitors to assess environments for potential harm or injury in the home environment. 2.4.4 Track changes to the home environment between visits in response to education and consultation provided by MCH home visitors to reduce the potential for harm or injury.

ESMs	Status
ESM 7.1.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Kansas) - Child Health - Entry 3

Priority Need

Developmentally appropriate care and services are provided across the lifespan.

SPM

SPM 3 - Percent of children ages 6 through 11 who are physically active at least 60 minutes per day

Objectives

2.5 Increase the percent of children participating in at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

Strategies

2.5.1 Provide training and resources to child care providers related to healthy practices and regulatory requirements to encourage and support implementation of daily routines involving physical activity. 2.5.2 Increase the number of community programs, including early care settings, collaborating with MCH programs to promote participation in regular physical activity including engaging and educating families. 2.5.3 Support local health departments, early care settings, schools, and community centers in local initiatives to promote physical activity and utilization of safe walking and biking trails (Ex. Walking School Bus).

Child Health - Annual Report

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

NPM 6: Developmental Screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)
NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9)
SPM 3: Physical Activity (Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day)

Local MCH Reach: During SFY2018, 57 of 70 grantees (81%) and during SFY2019, 59 of 71 grantees (83%) provided services to the Child population.

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

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

Kansas has made strides in its ability to provide developmental screenings to the child population. According to the 2016-2017 National Survey of Children's Health (2 years combined), 37.8% (95% confidence interval [CI], 26.6% - 50.3%) of Kansas parents reported they completed a standardized screening tool during a health care visit, compared to 31.1% (95% CI, 28.9% - 33.4%) nationally. However, the difference was not significant. In FY2018 (10/01/2017-09/30/2018), according to the Kansas Medical Assistance program, Annual EPSDT Report, 47,327 (91.8%) of the 51,573 eligible children, under 1 through 2 years old, received at least one initial or periodic screen. This data only reflects a portion of the children Kansas is targeting—rather than focusing only on birth to 3 years/35 months, the initiatives are focused on all children birth to 5 years.

Help Me Grow Kansas: Kansans recognize the need for early identification of children at risk for developmental and/or behavioral challenges and for improved links between families and the services and supports they need. The Help Me Grow Kansas effort is not exclusively about health care or developmental screening alone even though developmental screening is a key component, rather it is focused on forging partnerships to collectively address issues families face in the context of their communities. The areas of focus for this project include access to quality care and services, social determinants of health, enhanced education and training, sustainability and accountability, and vulnerable populations.

Help Me Grow (HMG) is a national framework that promotes integrated, cross-sector collaboration in an effort to build efficient and effective early childhood systems that mitigate the impact of adversity and support protective factors among families. In essence, HMG is a comprehensive approach to early childhood systems building. Successful implementation of HMG leverages existing community resources, maximizes opportunities, and advances partnerships working collaboratively through the implementation and cooperation of four core components: family and community outreach, provider outreach, a centralized access point, and data collection and analysis. In February of 2017, Title V convened a Core Leadership Team comprised of key program staff and partners from early childhood agencies to discuss how HMG fit into the existing early childhood vision for Kansas. In December 2017, the Kansas HMG summit was held in Wichita. Attendees totaled 113 individuals from 33 state and community organizations across 14 counties. Participants heard HMG National Center representative and had the opportunity to dialogue with one another about what HMG should look like in Kansas. With the support of the Core Leadership Team and other key stakeholders, Kansas became a HMG national affiliate state.

The mission of HMG Kansas is: Kansas families have informed and equitable access to seamless, comprehensive supports and services that ensure the well-being and lifelong success of all. As mentioned above, the Help Me Grow website has been developed which offers family and provider resources as well as information on how to get connected to the statewide centralized access point, The Parent Helpline (1-800-CHILDREN). Other statewide tools are currently being developed for communities interested in implementing the framework including a community implementation tracking tool as well as a community implementation guide.

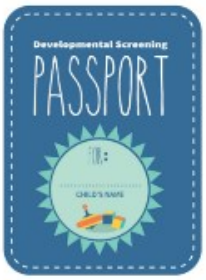
Currently there are three HMG pilot communities in Kansas that are in different stages of implementing the four core components of HMG.

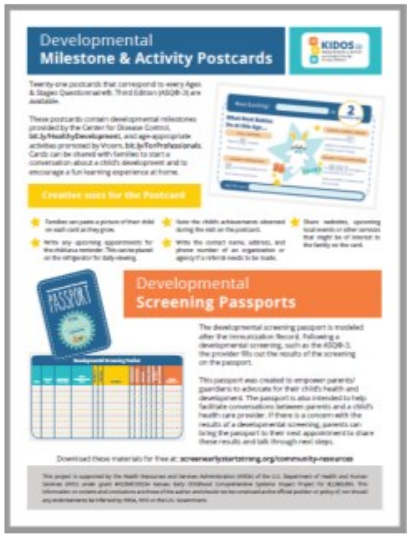
MCH—Early Childhood Comprehensive Systems (ECCS/KIDOS 2.0) Partnership: The Bureau of Family Health is in the third year of a 5-year Early Childhood Comprehensive Systems: (ECCS) Impact grant. The Title V priority and measure for child health is directly aligned with the ECCS Impact project work. This alignment has allowed for focus and expansion on communities beyond the two primary target areas under the grant (Geary and Montgomery counties). Furthermore, Title V provides the overall "umbrella" vision for this work. Due to this broad, systems level thinking and view, critical systems improvements have been realized (Help Me Grow Kansas framework, IRIS integrated referral system, state early childhood systems building, and more).

The ECCS Impact project, known in our state as the Kansas Initiative to Develop and Optimize Systems for early childhood (KIDOS 2.0), expands upon existing efforts and infrastructure in order to effectively coordinate, improve, and promote developmental health for infants and toddlers across a variety of health and early childhood support systems. Kansas is one of 12 states that received an ECCS Impact grant. The overall aim for the grant is to show a 25% relative increase in children birth through age 3 that are achieving age appropriate developmental health in all five developmental domains by July 31, 2021.This grant aligns perfectly with Title V National Performance Measure 6, Developmental screening, as well as ESM 6.1 – Percentage of program providers using a parent-completed developmental screening tool during an infant or child visit (9-35 months) in which rates have risen from 48.6% in the first quarter of 2017 to 55.9% in the fourth quarter. The ECCS grant has allowed Kansas to increase the work of providing developmentally appropriate care and services across the lifespan.

The ECCS Impact project work is focused in two place-based communities: Montgomery and Geary counties. In these communities, efforts are underway to build, pilot, and strengthen systems and coordination for developmental screenings and referrals across sectors in ways that meet the needs of both families and programs. Partners in both communities drive the Collaborative Improvement and Innovation Network (CollN) work that is central to ECCS Impact. As part of this CollN work and CQI efforts, community partners carry out Plan-Do-Study-Act (PDSA) cycles - rapid-cycle, small-scales tests of change ideas to learn if these changes will bring about improvement. This community work is being done in tandem with a state advisory team, which utilizes the place-based communities' findings to scale these efforts statewide. Highlights of work being done in the communities and across the state thanks to Title V capacity and investments/resources are below. The distribution and spread of best practice resources including the Developmental Screening Passports,

Developmental Milestone Activity Cards, and the newly created “Implementation Tips for Developmental Activity Cards and Passports” to reach statewide.





Below is documentation captured by Title V that shows how we are utilizing and building from ECCS in Kansas to impact the broader MCH work around developmental screening. More than 18,000 pieces of developmental screening materials developed through ECCS were distributed by Title V.

Event	Agency Lead/Partner	Materials Distributed	Number of Materials
MCH Home Visiting Training	KDHE Title V MCH	Passports, Activity Cards, and Implementation Tips	Passports 9,500 Milestone Cards 2,775 Tip Sheets 102
Child Care Quality Initiative Participants	Child Care Aware	Passports	300
PRAMS Incentives (mailing)	KDHE PRAMS Team	Milestone Activity Cards	427
Child Care Provider Mailings	KDHE Child Care Licensing	Passports, Milestone Activity Cards	Milestone Cards 4,695 (renewing and licensing providers serving up to 96,261 children)
KDHE Legislative Luncheon	KDHE Bureau of Family Health (BFH)	Passports, Milestone Activity Cards	Passports 30
Early Learning Advocacy Day at the Capitol	Kansas Head Start Association	Passports, Milestone Activity Cards, Implementation Tips	Passports 25 Milestone Cards 10 Tip Sheets 20
Care Coordination Satellite Sites Training	KDHE Title V SHCN	Passports, Milestone Activity Cards, Implementation Tips	Passports 300 Milestone Cards 100 Tip Sheets 100

ASQ Trainings & ASQ Screening Data: KIDOS 2.0 builds on the work of KIDOS 1.0 regarding the strategy to increase the number of health and early childhood practitioners who have received formal training on administering ASQ screening instruments. With support from the United Methodist Health Ministry Fund (a Title V partner), the BFH currently partners with the University of Kansas to coordinate and provide ASQ training on an ongoing basis. Several trainings have been provided since 2016. The training is designed for any professional from a community agency that works with parents and young children under age 6, such as home visitors, public health professionals, clinical health providers, and early childhood educators. MCH local agencies are strongly encouraged to attend the training when offered. Between the timeframe of August 1, 2017 to July 31, 2018, 337 professionals attended an ASQ training. Between July and December 2017 (SFY 2018 Quarters 1 and 2), ECCS partner KCCTO subcontracted to provide ASQ qualified trainers for 9 training sites across Kansas: Girard, Topeka, Eudora, Salina, Hays, Clearwater, Oakley, Sublette, and Hutchinson. Over 600 school district administrators, kindergarten teachers, social workers, and others were trained on the ASQ-3, 70-month questionnaire and ASQ: SE-2, 60-month questionnaire with parents of kindergarten children in Kansas to determine school readiness.

ASQ Screening data shows that through the KIDOS 2.0 project 6,469 screening assessments were completed during the 2017-2018 project year. Of these screenings, 618 were conducted on infants (< 1 year) and 5,851 were children between the ages of 1 year through 5 years old. 75.7% were Caucasian, 8.3% were Black or African American, 1.6% were Asian, and 8.5% reported more than one race. From the completed ASQ screens, 673 referrals or care coordination activities were conducted through early childhood providers, health care providers, and other local community organizations.

An exciting development occurred with the state partners and KU-CPPR during the 2018 reporting period. Conversations have been taking place with Brooke's publishing about Kansas' use of the ASQ Enterprise. For years, funding from KDHE and the Children's Cabinet has made it possible for programs and individuals across the state to enter ASQ screening results into ASQ Enterprise, a secure online database for tracking ASQ screenings. Under the work of KIDOS 2.0 and Help Me Grow (HMG) Kansas, KDHE with partners seek to expand data entry into ASQ Enterprise but not increase the number of Enterprise accounts in the state (bring all the ASQ online data together from Brookes into another possible data warehouse —hub). In theory, we would like to have a Kansas ASQ data pull across all online/pro/enterprise accounts. This all relates to the desire of all partners to move to an Early Childhood Integrated Data System (ECIDS). This is not a new goal for the early childhood partners, but one that has been discussed with renewed hope considering the alignment work and collaboration brought about with the work around HMG and the Preschool Development Grant (PDG) activities (statewide early childhood needs assessment and development of a state action plan). The bigger vision is being able to connect dots for parents, inform services, and move the needle towards wider spread/reach of screening to all kids for intervening as early as needed.

Developmental Screening Promotion – Screen Early Start Strong Website: Throughout the KIDOS 2.0 work, community and state MCH and early childhood partners identified the need for resources around children's developmental health and screening among three audiences: families, communities, and providers. The screenearlystartstrong.org website originally developed during the KIDOS 1.0 project, was redesigned and updated to reflect the interests and needs of these three groups. From October 2017 through September 2018, the website provided families, providers, and community members access to resources and tools regarding early childhood developmental health. Information on the Ages and Stages screening tool, trainings, resources and quality web links to developmental milestones were available, as well as downloadable resources such as the developmental screening passports, milestone activity cards, and implementation tip sheets. During this timeframe, there were a total of 8,888 page views. There were also unique page views that indicated where viewers navigated. It's very promising to see that the highest number of hits were on the "Family Page". This means

Screen Early Start Strong Website Views	
Family Page	739
Community Page	598
Provider Page	596
Information about the ASQ	253
Community Resource Page	239

either parents are visiting the site—promotion and outreach is having an impact—and/or providers are accessing information important for and targeted to families.

As mentioned in the Child Plan, the *Screen Early Start Strong* website has since been redesigned as the Help Me Grow Kansas website. In addition to all the resources and tools that the other website offered, this site offers information about the HMG Framework, where the pilot HMG communities are located, and information on how to contact the statewide centralized access point (The Parent Helpline at 1-800-CHILDREN) more details are in the Help Me Grow section.

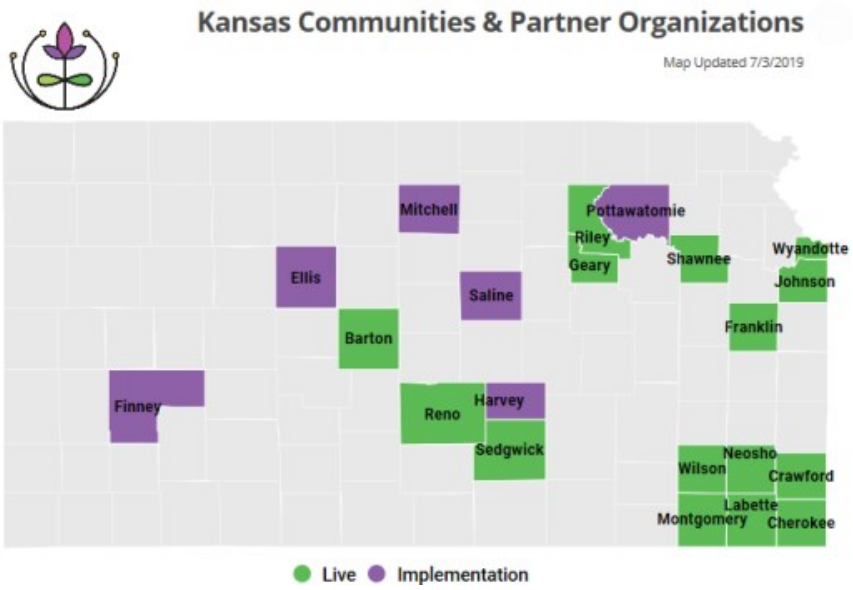
Aligning Developmental Screening Efforts: KIDOS 2.0 continued to align with MCH and Healthy Start efforts in Geary and Montgomery counties and MCH and MIECHV work in Montgomery County during the reporting period. In addition, Geary County partners are a part of the Lifting Young Families Towards Excellence (LYFTE) project (administered by the Bureau of Family Health). In Montgomery County, the overlap in KIDOS 2.0, MCH, and MIECHV priorities facilitates collaborations, with many common partners committed to across projects. KIDOS 2.0, MCH, and MIECHV worked to integrate efforts around IRIS testing and implementation in Montgomery County. KIDOS 2.0 project staff attend and provide project updates at monthly meetings of the *Montgomery County Coalition for Children, Families, and Communities*, a group including all partners. By identifying overlapping activities and aims, KIDOS 2.0 has been able to capitalize on and expand existing work, further strengthen relationships with partners, and broaden reach across these communities.

Resource and Referral System – IRIS: The Integrated Referral and Intake System (IRIS) is a web-based communication tool, developed by KU-CPPR and supported in part by Kansas Title V that helps organizations connect the families they serve to the right providers, services, and supports in their community. IRIS empowers communities to build a family-centered network supported by common expectations. IRIS enables service providers in a community to make, receive, and track referrals. In addition to serving as a means to close the referral loop, IRIS allows communities to collect and track data related to coordination and referral. This allows communities to identify where connections are not being made and where there are gaps in services or no services at all.

In coordination with Kansas MIECHV and Healthy Start projects, the two ECCS Impact and MCH communities have implemented IRIS, to support best practices in social service referral and coordination. Community conversations have brought partners together to agree upon a common referral form and a set of community standards around IRIS use. Ongoing training and technical assistance are being provided to organizations to ensure that IRIS is successfully incorporated into staff workflow. Data available for two IRIS communities is below to demonstrate reach and impact.

- Southeast Kansas includes 65 programs offered by 25 organizations. There were 1,448 referrals between February 2017 (launch) and June 2019.
- Geary County includes 22 programs offered by 9 organizations. There were 1,117 referrals between February 2018 (launch) and June 2019. In Geary County, 95% of referring agencies knew the final status of the referral made and approximately 68% resulted in families being enrolled in services. Reasons for non-enrollment could include: families declining services, family already receiving similar services through another agency, inability to contact families.

The Title V program continues to promote and support the use of IRIS at the community level. Several Local MCH agencies are a part of an IRIS community and MCH funds are used in some areas to support ongoing use and expansion. Below is the most current map of communities.



Learn more about IRIS at: http://connectwithiris.org/what-is-iris/. Read more about the history of IRIS below; read more about the future IRIS work in the Child Plan. NOTE: MCH took a lead role in expanding IRIS to the behavioral health system during the reporting period in partnership with the KDHE Bureau of Health Promotion related to the CDC opioid response funding.

IRIS Background/History: KDHE received the MIECHV Innovation Award for the period of December 1, 2016 through November 30, 2018. The project engaged multi-sector partners, developed a shared vision, and leveraged an innovative web-based tool: IRIS – Integrated Referral and Intake System. IRIS facilitates communications around outreach, referrals and warm hand-offs; and, supports and encourages family participation in their own engagement process with community partners. IRIS (pilot) was launched in the MIECHV communities February to May 2017. Piloting occurred in Southeast Kansas MIECHV and MCH communities testing implementation of referrals from the MIECHV/MCH-funded coordinated outreach and referral (central intake) programs to the home visiting programs.

Local MCH Agencies: Local agencies provided developmental screenings to children served, birth to age six. Many agencies use the Ages and Stages Questionnaire (ASQ-3; ASQ-SE/ASQ-SE2) for developmental screenings for ages 2-60 months old. For ages above 60 months, agencies use the Bright Futures Pediatric Symptoms Checklist (PSC). Local MCH agencies provided health screenings in accordance with the KAN-Be-Healthy (KBH)/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines during well visits/screenings. Developmental screening is a vital component to the continuum of care for children. The ASQ parent-completed questionnaire is intended to screen children for developmental delays in the areas of communication, gross motor, fine motor, problem solving and personal-social skills. Educational material is provided to parents regarding developmental milestones during the visit.

SFY2018 - Local MCH Agencies (client level & aggregate) Providing Education on Child Development
ALL MCH Visits (including MCH Home Visits)
6,284
MCH Home Visits ONLY
2,086

Local agency Child Health programs use an outline and multiple screening assessment tools to determine the needs of the child through direct services and indirectly through making appropriate referrals. The DAISEY data system collects data related to child development education provided during an MCH visit as well as referrals for developmental screening and/or early childhood intervention services that are appropriate to the needs of the child.

Feedback from local agencies emphasized their need to receive additional training on KanBeHealthy visits and the Bright Future guidelines. In response to this need, a taskforce was formed to update the current KBH training to include up-to-date information, and more helpful tools and resources. The taskforce is made up of the Title V Child and Adolescent consultant as well as partners from KDHE Bureau of Community Health Systems, KDHE Medicaid, KDHE Special Health Care Needs, Kansas Chapter of American Academy of Pediatrics, Wichita State University, and three representatives of local health departments from Crawford and Linn counties.

Through polls and phone interviews it was uncovered that key topics to include in the KBH training were: hands-on head to toe exam with an experienced clinician; vision and hearing training; guidance on forms (Bright Futures); Developmental Screening (i.e. ASQ); and referral and resource list information. Others expressed an interest in learning to screen for autism and mental health. Another ask was that training be available to parents in their communities regarding the length, comprehensive care and level of screening that is included in a KanBeHealthy visit.

MCH home visitors started providing child development and child social-emotional development screenings for families they serve. This new FY18 requirement is related to the implementation of the redesign of the MCH home visiting program. Universal Home Visiting provided developmental screening for participants who have continued to receive services and are not eligible for other community-based home visiting programs. Technical assistance and training were provided to local agencies regarding the protocol and expectations for incorporating the developmental screening (parent completed tool) into child well visits. Distinctions between use of Bright Futures and the ASQ (intent, purpose, use together) were provided to ensure local agencies were not using one or the other, but both per intent and standards related to monitoring and improving child health. Read more about the MCH Universal Home Visiting Program online at: http://kshomevisiting.org (click on Resources – Universal Home Visiting).

Beyond the Developmental Screen - Special Healthcare Needs: It was anticipated that as the Kansas HMG work continued there would be an increased need for additional developmental evaluations to occur; therefore, the KS-SHCN program has collaborated with a variety of partners to conduct a four-part ECHO series entitled, “Beyond the Developmental Screen”. This series is designed to assist providers (medical, educational and community) to understand what to do after a developmental screening indicates, that a child might need additional help. Waiting for an appointment with a developmental pediatrician is not always the answer. There are many things that can be done immediately, that might or might not involve an appointment with a developmental specialist. This series will begin with raising awareness of the benefits of early screening, assessment and referral. The second session will focus on the implementation with part of this session devoted to raising awareness of the importance of working across systems to reduce duplication and assure screenings occur. The third session will be centered on communication to help providers gain strategies when helping families understand the screening results using a culturally competent manner. The fourth and final session will focus on resources and identifying specialty care or medical service referral points and next steps when a developmental delay or concern is noted. Each

session will allow time for participants to ask question and have discussion around the topics presented. The ECHO team consists of a developmental pediatrician, two social workers, a parent of a child with special health care needs, a nurse, and an ASQ screening expert. Each member of the team has experience with children who have special health care needs, so therefore, are a valuable resource to all EHCO participants. This ECHO series will occur each Tuesday during the month of June 2019. The goal is to increase the system's capacity to provide additional developmental evaluations by increase the number of providers trained to do developmental assessments, decrease evaluation wait time for children and increase the ability to begin treatment immediately following a diagnosis. By increase the system's ability to meet the needs of children who show possible developmental delays and being able to access services or an evaluation, if needed, more providers will feel comfortable doing regular developmental screenings.

Kansas Family Engagement and Partnership Standards for Early Childhood: Title V is currently leading a lot of work around early childhood to streamline services and supports and improve early screening and identification, so services can begin early in a child's life. As part of this alignment work, it was determined that the Kansas Family Engagement and Partnership Standards for Early Childhood needed to be reviewed and updated to better align with all early childhood systems across the state. The KS-SHCN Program Manager/Family Engagement Liaison was part of the original core team and is now participating in the work to update these standards. The standards are designed to 1. Recognize the importance of the families in the early learning years. 2. Serve as a guide for appropriate family engagement and partnership practices. 3. Serve as a guide for creating quality interactions and partnerships with families. The standards focus on families as: Foundation, Communicators, Advocates, Partners, and Community Members. The goal of this project is to identify and implement evidence-based practices for each standard and to make sure the standards are reflective of all early childhood systems in Kansas.

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

Child Care Licensing Partnership: The MCH Child and Adolescent Health consultant met with the child care program director to discuss what components of the *Screen Early Start Strong*/*Help Me Grow* resources are appropriate for child care providers. *Screen Early Start Strong* is part of Kansas Initiative to Develop and Optimize Systems for early childhood (KIDOS 2.0). In addition to gathering information about the KIDOS work and how it aligns with the MCH plan strategies, the MCH consultant attended the Association of Maternal & Child Health Programs (AMCHP) Conference in Kansas City and participated in a session on supporting and enhancing developmental screening initiatives through, family, professional, and state partnerships. At this session, the CDC's *Learn the Signs. Act Early* program was promoted. The program aims to improve early identification of children with autism and other developmental disabilities, so children and families can get the services and support they need. The program/content is appropriate for child care providers. An inquiry was also sent to CDC to gain access to the GroupSpaces site to begin customization of the materials to tailor them to Kansas. The Track Your Child's Developmental Milestones brochure was printed in English and Spanish. Approximately 4,700 licensed facilities serving 90,000 children between the ages of 0 and 4 years of age received the Milestones brochure with child care facility renewal licenses. The distribution began in July 2017 and will be completed June 2018. The brochures are also provided the child care licensing health department surveyors to be distributed during the licensing required orientation for a prospective child care facility.

In addition to the child care licensing program participating in the ECCS/KIDOS 2.0 initiative with a focus on typical development and developmental screening, including social emotional health, the program has partnered with training organizations in the state to ensure training tailored for child care providers is made available. The Plan section details efforts related to this objective, specifically a list of available courses child care providers can complete. Hours do apply toward annual in-service training requirements. Title V partners with KDHE Child Care Licensing, Child Care Aware of Kansas, and Kansas Children Service League to ensure that up-to-date quality training opportunities are provide for child care professionals across the state both in-person and online.

Examples of courses are listed below.

- Behavior & Guidance (ways to encourage positive behavior in young children)
- FLIP IT! (steps to help young children identify their feelings, learn healthy self-control, and reduce challenging behavior-feelings, limits, inquiry, and prompts)
- Understanding Temperaments of Young Children
- Supporting Relationships through Engaging Environments
- Play: Problems and Interventions
- Infant and Toddler Social-Emotional Development Series (three courses)
    - Social Emotional Development within Relationships
    - Responsive Routines, Environments and Targeted Strategies to Support Social Emotional Development
    - Individualized Intervention: Determining the Meaning of Behavior and Appropriate Responses

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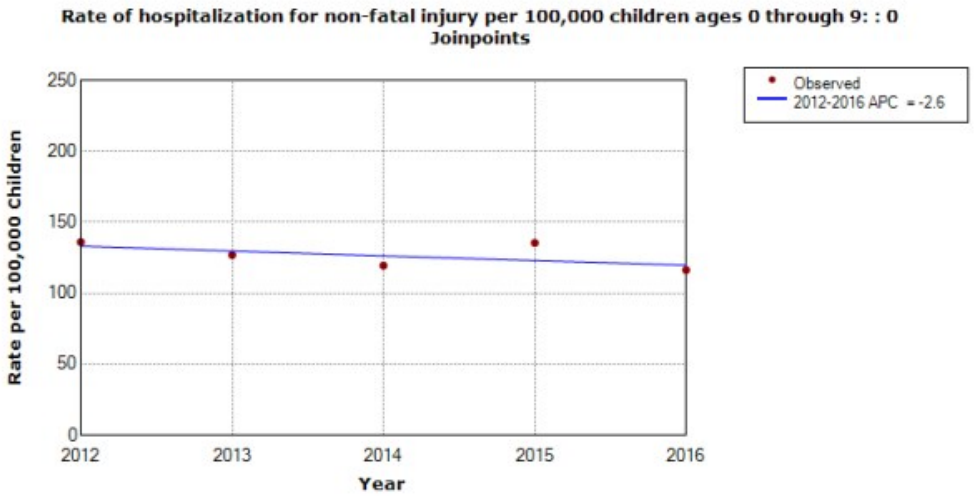
NPM 7: Child Injury (0 to 9 years)

During 2012 and 2016, rates of non-fatal injuries (hospital admissions with a primary diagnosis of unintentional or intentional) have decreased from 136.1 to 116.4 injuries per 100,000 children ages 0 through 9. (Annual Percent Change=-2.6%, 95% Confidence Interval=-8.7, -3.9)

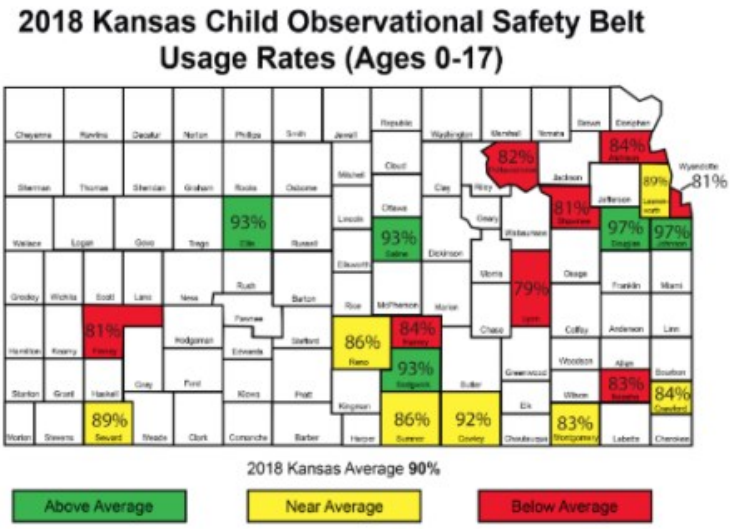


^ Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

In 2016, rates of non-fatal injuries were highest among infants less than a year old (251.3 per 100,000), followed by children ages one to four (126.2 per 100,000), and children ages five to nine (83.3 per 100,000). Non-Hispanic black children had the highest rate of non-fatal injury hospitalizations at 230.3 per 100,000, which was nearly double the rates among non-Hispanic white (110.9 per 100,000) and Hispanic (92.6 per 100,000) children. Male children are more likely than female children to sustain non-fatal injuries (128.3 per 100,000, versus 103.5 per 100,000, respectively).

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

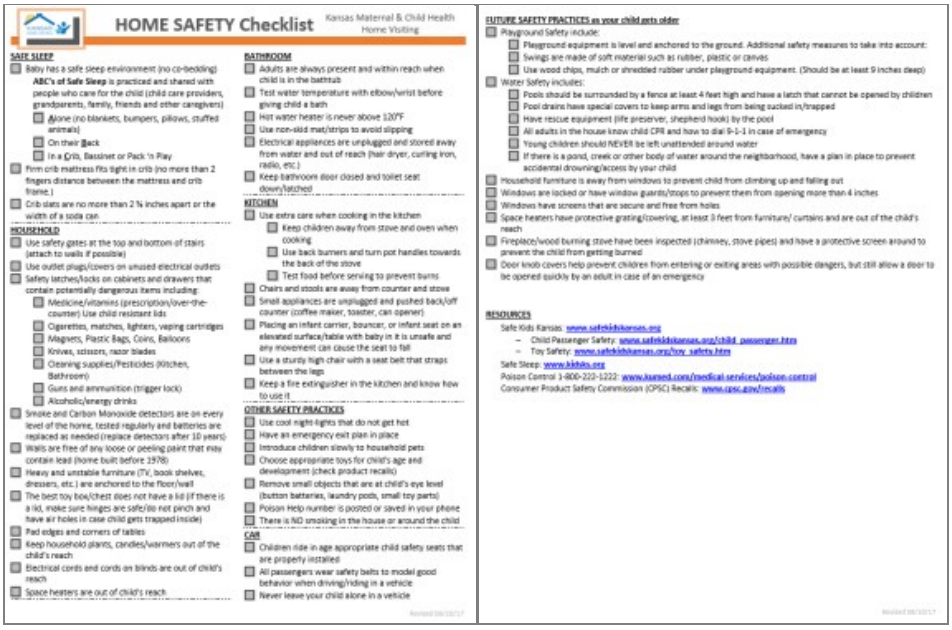
State and Local Partnerships: Title V has a close partnership with Safe Kids Kansas which is a network of partners and local coalitions across the state dedicated to preventing childhood injury. The Safe Kids Kansas Director sits on the Kansas MCH Council and provides Safe Kids technical assistance to local MCH agencies on activities such as coalition development and building a car seat program which includes training of potential car seat technicians. There are currently 13 local MCH agencies that are the Safe Kids Coalition Coordinators for their counties (City-Cowley County, Dickinson County, Doniphan County, Elk County, Geary County, Johnson County, Marshall County, Mitchell County, Montgomery County, Morris County, Pottawatomie County, Republic County, Riley County). These agencies are members of their community Safe Kids coalition, have trained car seat technicians on staff, and/or assist in the community at car seat check and education events. Title V is currently working with Safe Kids Kansas to uncover where there are gaps in coverage of Safe Kids Coalitions. Coordinated recruiting efforts to establish new Safe Kids coalitions and car seat programs will be intentional in these areas for the FY2020 Plan. Curricula used for car seat safety education is from the Kansas Traffic Safety Resource Office. Data from the Kansas Traffic Safety Resource Office reveals potential areas MCH can target over the next year to increase safety for children. Safety belt usage rates are below average in multiple regions and counties.



Local MCH Agencies: Many local MCH agencies have staff that are Child Passenger Safety Technicians and many grantees and home visitors provide education on car seat installation and safety. During the report period, 5,832 families served through MCH local agencies were educated on motor vehicle safety. One local agency is Morris County Health Department. They continue to have a strong Safe Kids Coalition. The MCH program staff provide education and equipment/devices recommended by Safe Kids Kansas. There is also a Certified Car Seat Technician that installs and checks car seats. Information regarding car seats was provided to attendees. Children were weighed and measured by the certified car seat technician and advised what type of car seat is recommended for each child. During the reporting period Saline County provided a certified car seat safety technician to train on car seat safety during prenatal visits.

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

Home Safety Checklist/Tool: To enhance home safety information and education provided as part of prenatal and postnatal visits/sessions during infancy and early childhood, MCH staff developed a standard tool for MCH home visitors to assess environments for potential harm or injury in the home environment. Information was compiled to develop a Home Safety Checklist reflective of input from the Injury Prevention Program, Safe Kids Kansas, and local MCH programs. The end result was inspired by resources from the American College of Preventive Medicine, Massachusetts Department of Health, and Safe Kids. The checklist was shared for input with MCH staff and home visitors of our local grantees at the 2017 Governor's Public Health Conference. All input was captured and incorporated into the final version of the Home Safety Checklist (screenshot 1). The Home Safety checklist, MCH Universal Home Visiting tools and resources are available on the Kansas Home Visiting website at www.kshomevisiting.org.



HOME SAFETY Checklist

Kansas Maternal & Child Health Home Visiting

SAFE SLEEP

- Baby has a safe sleep environment (no co-bedding)
  - **ABC's of Safe Sleep** is practiced and shared with people who care for the child (child care providers, grandparents, family, friends and other caregivers)
    - Alone (no blankets, bumpers, pillows, stuffed animals)
    - On their Back
    - In a Crib, Bassinet or Pack 'n Play
- Firm crib mattress fits tight in crib (no more than 2 fingers distance between the mattress and crib frame.)
- Crib slats are no more than 2 ⅜ inches apart or the width of a soda can

HOUSEHOLD

- Use safety gates at the top and bottom of stairs (attach to walls if possible)
- Use outlet plugs/covers on unused electrical outlets
- Safety latches/locks on cabinets and drawers that contain potentially dangerous items including:
  - Medicine/vitamins (prescription/over-the-counter) Use child resistant lids
  - Cigarettes, matches, lighters, vaping cartridges
  - Magnets, Plastic Bags, Coins, Balloons
  - Knives, scissors, razor blades
  - Cleaning supplies/Pesticides (Kitchen, Bathroom)
  - Guns and ammunition (trigger lock)
  - Alcoholic/energy drinks
- Smoke and Carbon Monoxide detectors are on every level of the home, tested regularly and batteries are replaced as needed (replace detectors after 10 years)
- Walls are free of any loose or peeling paint that may contain lead (home built before 1978)
- Heavy and unstable furniture (TV, book shelves, dressers, etc.) are anchored to the floor/wall
- The best toy box/chest does not have a lid (if there is a lid, make sure hinges are safe/do not pinch and have air holes in case child gets trapped inside)
- Pad edges and corners of tables
- Keep household plants, candles/warmers out of the child's reach
- Electrical cords and cords on blinds are out of child's reach
- Space heaters are out of child's reach

BATHROOM

- Adults are always present and within reach when child is in the bathtub
- Test water temperature with elbow/wrist before giving child a bath
- Hot water heater is never above 120°F
- Use non-skid mat/strips to avoid slipping
- Electrical appliances are unplugged and stored away from water and out of reach (hair dryer, curling iron, radio, etc.)
- Keep bathroom door closed and toilet seat down/latched

KITCHEN

- Use extra care when cooking in the kitchen
  - Keep children away from stove and oven when cooking
  - Use back burners and turn pot handles towards the back of the stove
  - Test food before serving to prevent burns
- Chairs and stools are away from counter and stove
- Small appliances are unplugged and pushed back/off counter (coffee maker, toaster, can opener)
- Placing an infant carrier, bouncer, or infant seat on an elevated surface/table with baby in it is unsafe and any movement can cause the seat to fall
- Use a sturdy high chair with a seat belt that straps between the legs
- Keep a fire extinguisher in the kitchen and know how to use it

OTHER SAFETY PRACTICES

- Use cool night-lights that do not get hot
- Have an emergency exit plan in place
- Introduce children slowly to household pets
- Choose appropriate toys for child's age and development (check product recalls)
- Remove small objects that are at child's eye level (button batteries, laundry pods, small toy parts)
- Poison Help number is posted or saved in your phone
- There is NO smoking in the house or around the child

CAR

- Children ride in age appropriate child safety seats that are properly installed
- All passengers wear safety belts to model good behavior when driving/riding in a vehicle
- Never leave your child alone in a vehicle

FUTURE SAFETY PRACTICES as your child gets older

- Playground Safety include:
  - Playground equipment is level and anchored to the ground. Additional safety measures to take into account:
    - Swings are made of soft material such as rubber, plastic or canvas
    - Use wood chips, mulch or shredded rubber under playground equipment. (Should be at least 9 inches deep)
- Water Safety includes:
  - Pools should be surrounded by a fence at least 4 feet high and have a latch that cannot be opened by children
  - Pool drains have special covers to keep arms and legs from being sucked in/trapped
  - Have rescue equipment (life preserver, shepherd hook) by the pool
  - All adults in the house know child CPR and how to dial 9-1-1 in case of emergency
  - Young children should NEVER be left unattended around water
  - If there is a pond, creek or other body of water around the neighborhood, have a plan in place to prevent accidental drowning/access by your child
- Household furniture is away from windows to prevent child from climbing up and falling out
- Windows are locked or have window guards/stops to prevent them from opening more than 4 inches
- Windows have screens that are secure and free from holes
- Space heaters have protective grating/covering, at least 3 feet from furniture/ curtains and are out of the child's reach
- Fireplace/wood burning stove have been inspected (chimney, stove pipes) and have a protective screen around to prevent the child from getting burned
- Door knob covers help prevent children from entering or exiting areas with possible dangers, but still allow a door to be opened quickly by an adult in case of an emergency

RESOURCES

Safe Kids Kansas: www.safekidskansas.org
- Child Passenger Safety: www.safekidskansas.org/child_passenger.htm
- Toy Safety: www.safekidskansas.org/toy_safety.htm

Safe Sleep: www.kkhks.org
Poison Control 1-800-222-1222: www.kumed.com/medical-services/poison-control
Consumer Product Safety Commission (CPSC) Recalls: www.cpsc.gov/recalls

Safe Kids Kansas Collaboration: Title V staff continue to work closely with the Bureau of Health Promotion, Injury Prevention Program and Safe Kids Kansas to implement strategies in partnership with MCH grantees across the state. As part of the "shared work" across the MCH Action Plan and Safe Kids Kansas Strategic Plan, Title V staff work to increase the number of MCH grantees that lead or partner with local Safe Kids Coalitions. Local MCH agencies provided child injury education and information based on age and development of the child. Child injury education and installation of car seats is provided during developmental screenings, immunizations and home visits. Local MCH agencies collaborate with Safe Kids Kansas for injury prevention and program guidance on topics including water safety, sun safety, poison control, car seat safety, choking, fire, carbon monoxide, and prevention falls. Local agencies collaborate with local school districts to provide presentation to students regarding injury prevention. Safe Kids staff presented during a MCH Technical Assistance webinar to all MCH local agencies to educate about Safe Kids, discuss additional partnerships at the local level, where local Safe Kid coalitions are located and how to become a coalition in their community.

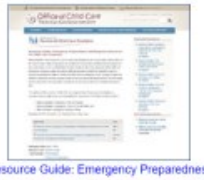
Poison Control Center Partnership: MCH and child care staff contributed to a collaboration with the University of Kansas and other partners to develop poison control resources, including the *Poison Diaper Bag* (available in English and Spanish http://www.kumed.com/medical-services/poison-control/info-for-families). During Fall 2017 (FY2018), updates were made to the Kansas prenatal education curriculum to standardize content across the state for all sites working with the Kansas MCH program and utilizing the supplement curriculum developed to be used with the March of Dimes Becoming a Mom® curriculum. As part of the update, the Poison Diaper Bag handout was incorporated, along with a handout on infant choking for child safety and injury prevention. State Title V staff met with the Kansas Poison Control Center to discuss partnerships and ways to collaborate with local MCH agencies providing home visits to increase awareness of the Poison Helpline (1-800-222-1222), the Poison Center services, and the poison prevention strategies. The poison control center has developed two postcards, available in English and Spanish that home visitors can use as resources for families they serve: the "Congratulations on your New Baby" postcard with a Poison Help magnet attached and a "Medication Safety" postcard with metric medicine dosing syringes with the Poison Helpline number. Staff at the Kansas Poison Control Center presented at the 2018 Governor's Public Health Conference breakout session on "Poison Prevention: A Prescription for a Safer Home". The session provided education about poison prevention and poison safety, specifically related to the safety of children their homes. Participants that attended the session also learned about free resources (including both

postcards) to help spread the message of poison safety to the children and families they serve.

Child Care Licensing Emergency Preparedness: The child care licensing program developed content and gathered resources from reliable sources to establish a website for providers and families: *What's The Plan? Emergency Preparedness Planning in the Child Care Setting.* The site was launched in an effort to support "ready" early care settings and prevent injuries that could result in an emergency. Content on the site reads, "Child care providers are responsible for the health, safety and welfare of the children in their care. Providers need to know how to respond quickly and calmly in an emergency. Developing a written emergency plan and reviewing it frequently helps to prepare and reduces the likelihood of poor judgments made under the stress of an actual emergency situation. There are a number of resources available to help in the development of an effective plan. Below is a look at some of the resources provided on the website: http://www.kdheks.gov/bcclr/emergency_preparedness_planning.htm.

Child Care Emergency Preparedness Website Resources

Kansas Department of Health and Environment: Preparedness


Resource Guide: Emergency Preparedness and Response Resources for Child Care Programs | CCTAN

Disaster Planning & Recovery Basics | Child Care Aware of America

Child Care Aware of Kansas

Save the Children: Get Ready. Get Safe

Save the Children: Disaster Check List for Early Childhood Professionals

Kansas Child Care Training Opportunities (KCCTO)

Smoke Detectors for the CYSHCN Program: In partnership with Safe Kids Kansas the KS-SHCN program has been offering free smoke and carbon monoxide detectors to all families on the program. Each family is asked if they currently have these devises in their home and if not, we offer to have someone come to their house and install the detectors. When a custom installation is required due to the individual's health needs the KS-SHCN program covers the installation expense through the Special Bequest fund and the smoke and carbon monoxide detectors are covered by Safe Kids Kansas. All families who request a detector complete a safety survey at the time the request is made and a second survey during the care coordination follow up call after installation has occurred. Additional collaboration has occurred between the two programs to secure appropriate car seats for children. Information is shared with families on where they can go to have car seats installed safely.

The KS-SHCN care coordinators continue to share safety tips with families per the Safe Kids Kansas recommendations. Both programs are committed to working together to keep all Kansas children safe and healthy and to developing additional partnership projects in the future. Safe Kids Kansas presented safety information to all care coordinators during an in-person training in October of 2018. One of the topics discussed was car seat safety and where to refer families to the nearest car seat check lanes. Care coordinators share the information they learn with CYSHCN families, and if appropriate, add child injury prevention goals to the child's Action Plans.

Continuation of the Safe Kids Kansas and KS-SHCN smoke and carbon monoxide detectors project will continue in FY20. At this time, Safe Kids Kansas provides the funding for the detectors and the KS-SHCN program provides funding for the installation, for those families who need specialized detectors requiring installation by a trained electrician. Both programs are committed to securing funding sources, as needed, to continue the program in the future.

Healthy Homes Essentials Home Visiting Training: The Fall 2018 MCH Universal Home Visitor training was planned and delivered in partnership with the Children's Mercy team. The training educated home visitors on the connection between health and housing—how to identify basic housing hazards and educating home occupants on practical solutions. The goal of healthy homes training was to take a holistic approach to identify and resolve problems that threaten the health and well-being of residents. Discussion on the latest knowledge about how to manage lead-based paint, moisture and mold, pests, allergens and dust, chemical hazards, radon and asbestos was had. The training focused on utilizing the eight principles of healthy housing; Keep it Dry, Clean, Pest-free, Ventilated, Safe, Contaminant-free, Maintained and Thermally Controlled. Through interactive exercises and lots of discussion, home visitors had the opportunity to get their questions answered about how to make homes safe and healthy for children and their families. There were 112 local agency staff that attended this training.

SPM 2: Physical Activity (children 6 through 11)

Objective: Increase the percent of children participating in at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

The 2018 Physical Activity Guidelines for Americans recommend that children and adolescents ages 6-17 get 60 minutes or more of physical activity daily with most of the 60 minutes being either moderate- or vigorous intensity aerobic physical activity. The overall finding from the 2016*-2017 combined National Survey of Children's Health, based on parent-reported data, was that 26.7% of Kansas children ages 6-11 were physically active for at least 60 minutes seven days a week. There were no significant disparities by gender, race/ethnicity, special health care needs, parental educational attainment, health insurance, household income-poverty ratio, household structure, or nativity.

Local MCH Agencies: Local agencies worked on initiatives to increase children's physical activity. Local MCH agencies provided and distributed information on the importance of daily physical activity to clients regarding the American Academy of Pediatrics' (AAP) Healthy Habits. Local MCH agencies promoted and encouraged physical activity among children and youth through counseling during developmental screenings, well child visits, home visits, immunization and WIC appointments. Families were educated at each visit about physical activity the entire family can focus on. Families were encouraged for children and adolescents to have at least 60 minutes of physical activity daily. Some local MCH agencies provided presentations to students in elementary and middle schools regarding physical activity. Other examples of local agency activities are below.

- Neosho County Health Department provided parents and child care providers with education and information on ways to get children their daily physical activity, including ideas and activities to help parents and day care providers get children moving during inclement weather.
- Jefferson County Health Department worked in collaboration with the local school district to educate youth on the importance of daily physical activity. They jointly purchased the "Adventures to Fitness" subscription, which is an evidence-based tool used to take students on a fun exercise adventure. This program is based on research showing that physically active children perform better academically socially, and behaviorally. Adventure to Fitness is the nation's #1 educational fitness program, used by over 120,000 teachers across more than 22,000 schools, and the nation's top children's hospitals and organizations. Students engaged in moderate to intense physical activity for 20-30 minutes in the school gymnasium before classes begin. A school committee was formed to plan and organize the morning activities, and middle/high school students, teachers and support staff assisted with leading and supervising wellness activities. The overall goal is to incorporate lifelong wellness into the students' everyday lives. Another goal was to gauge whether students were more attentive in class and if they were more eager to learn on

the days they exercised compared to days they did not exercise. Students, administrator, teachers, and students were given questionnaires at the end of the year regarding success of the program. Overall responses were overwhelmingly positive. The school district and local health department are planning to launch the program every fall.

- Nemaha County Community Health Services collaborates with local schools on their annual Family Run/Walk to promote family fun and fitness as well as teaching young children the importance of lifetime physical activity.
- Rooks County Health Department promotes nutrition and physical activities including walking/biking trails, recreation centers, and fitness centers in their community. They also encourage families to participate in the Walking School Bus in the community.
- Wilson County Health Department addresses physical activity through collaboration with community partners such as the Healthy Living Action Team (HLAT) and the Community Health Improvement Planning group. They are working to provide new trails, a bike/skate park, and Every Child Deserves a Bike. Through Every Child Deserves a Bike, 2nd graders from families that qualify for free/reduced lunches can receive a bike and helmet after the child completes a bicycle safety course provided by the local police department.
- Ford County Health Department collaborates with their local school district to encourage students to walk or ride their bikes to school..
- Barton County Health Department and Thomas County Health Department held Bike Rodeos in their communities.
- Meade County Health Department collaborates with the county Safe Kids program in providing kids safe routes to and from school.
- Ottawa County Health Department is the director of the local Wellness Center and involved in the high school health fair. Information about the importance of adding physical activity into their day as they graduate high school as well as some examples of physical activity students can do in their dorm or apartment with a small piece of equipment like a fit band or jump rope to assist them in physical activity.

Child Care Licensing: Child Care Licensing collaborated with the Bureau of Health Promotions to update a Physical Activity training available to child care providers. *Let's Move!* Child Care is a national, web-based initiative that support child care providers to help kids get off to a healthy start. Participating child care providers who meet all 5 *Let's Move!* Child Care goals can earn recognition. This training focuses on increasing children's physical activity. Children ages 3-5 years should have two or more hours of active play time throughout the day. Children ages 1-2 years should have at least one hour of active play time throughout the day. Non-crawling infants should have short periods of "tummy time" every day. Training is offered to child care providers at no cost. The training was completed by 107 child care center staff and 203 in-home child care providers during the 2018 reporting period.

Objective: Implement collaborative oral health initiatives to expand oral health screening, education, and referral by 2020.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM) Program: As a part of the "relaunch" of the BaM curriculum by KPCC, as described elsewhere in this report, the handout "Tips for Good Oral Health During Pregnancy" by the National Maternal and Child Oral Health Resource Center has been added as a supplemental handout to the original curriculum. The partnership with Oral Health Kansas has led to the production of PowerPoint slides, video, and activity, all focused on the importance of good oral health in pregnancy, to be integrated into session one. Sites received in-person training June 2017, where they were also provided toolkits for completion of the guided self-exam activity and additional resources for use during the BaM sessions. Sites were encouraged to bring a partnering dental hygienist from their local community, who will serve as a guest presenter of the session content as available.

Child Care Licensing Healthy Smiles Initiative: Nearly 1 in 3 preschoolers are already affected by tooth decay, despite the fact that good oral health early supports the overall health of a child. Child Care Licensing partnered with Title V MCH and the Bureau of Oral Health in addition to other partners including Kansas Child Care Training Opportunities and Oral Health

Kansas to launch the *Healthy Smiles* initiative, focused on reducing decay prior to school entry. For *Healthy Smiles* phase 2 work during 2018, Child Care Licensing purchased 19 training/instructor sessions for the course *Oral Health in the Child Care Setting – Whole Tooth and Nothing but the Tooth*. A total of by 484 providers attended the trainings. This course assists early care professionals in understanding the importance of good oral health: importance of keeping children cavity free, the prevention of bacterial transmission, healthy snacking, and how to keep teeth clean and strong. Participants were provided numerous resources to assist them in promoting oral health in the child care setting and in the home setting for families. The breakdown of attendees by facility type is: 44% licensed and group day care home, 53% center/preschool, and 3% other (including foster parents, relative care providers, clinic staff, etc.).

A new oral health online training was developed titled, *How Teething, Weaning and Oral Habits Impact Oral Health*. This training was offered beginning January 2019, and three offerings have been attended by 50 providers. The breakdown of attendees by facility type is: 65% licensed day care home, 62% licensed and group day care home, 35% center/preschool, and 3% other. This training addresses three events that can have a big impact on the child's oral health. The lesson on teething provides the child care provider information on when to expect baby teeth and permanent teeth to erupt; typical symptoms children may experience when teething and choosing safe ways to relieve symptoms. The weaning lesson is designed to share reasons for weaning, guidance on how to wean, and the proper use of a sippy/training cup. Oral habits are discussed in the final lesson. Topics include: the advantages and disadvantages of non-nutritive sucking as well as ideas for discontinuation of oral habits such a thumb sucking and pacifier use.

Child Health - Application Year

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

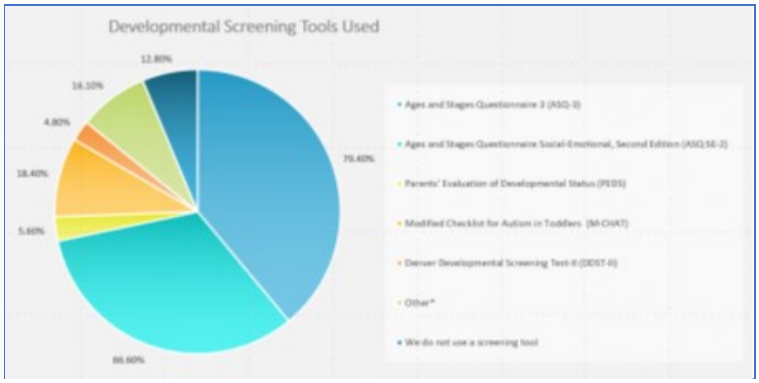
NPM 6: Developmental Screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)
NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9)
SPM 3: Physical Activity (Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day)

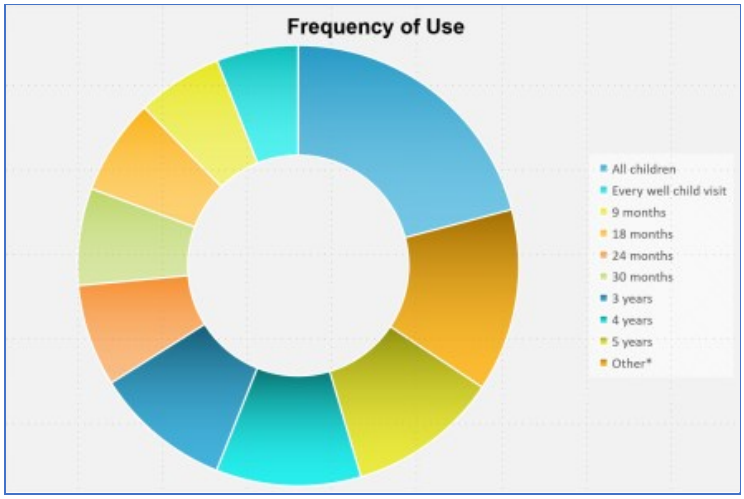
Local MCH Reach: Based on SFY2020 MCH Aid-to-Local applications received, 56 of 70 grantees (80%) plan to provide services to the Child population.

NPM 6: Developmental Screening (9 to 35 months)

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

Developmental Screening Environmental Scan: The coming year will involve applying results from a statewide developmental screening scan that took place through April 2019. The survey/scan was conducted in collaboration with other projects such as Help Me Grow (HMG) work, Part C Infant-Toddler Needs Assessment, and Early Childhood Comprehensive Systems (ECCS) Impact. The results will be incorporated into the Title V needs assessment as well as the Preschool Development Grant needs assessment to inform the state action plans for MCH and early childhood. Title V partnered with the University of Kansas Center for Public Partnerships (KU-CPPR) and the Kansas State Department of Education (KSDE) to conduct the scan which is intended to reveal: who is screening in what setting(s), when screening is occurring, what tools are being used across the state, how the results are being stored, how referrals and connections are made, and much more. Other state partners such as the Department for Children and Families (DCF) and Kansas Children's Service League (KCSL) are involved with this effort; they provided feedback on the survey tool and dissemination efforts. The environmental scan survey consisted of 21 questions and was given to child care providers, home visitors, healthcare professionals, etc. around Kansas. Data was collected from November 6, 2018 to April 30, 2019. A total of 461 de-duplicated surveys were received. Results are being analyzed at this time. Note: More than one screening tool could be selected.





Help Me Grow (HMG) Kansas: Help Me Grow is the broader context in which Kansas is working to promote developmental screening as a means to monitor children's developmental health and connect families and children in need to intervention, services and supports as early as possible when the need is indicated by the screening. Title V will continue to partner with the State of Kansas Early Childhood Leadership Team, which includes representation from KDHE (Title V/Bureau of Family Health Director), KSDE, DCF, and the Kansas Children's Cabinet & Trust Fund (KCCTF), to focus on children's developmental health and emphasize the importance of early and ongoing developmental screening. This work is one of four key components of the Help Me Grow (HMG) framework that Kansas adopted in 2017. Progress has been made with implementing HMG in communities across the state, and the use of existing developmental screening materials has been integrated (read more about the history of HMG Kansas/national affiliation in the Child Report). The team will continue to develop resources and tools for HMG communities and promote existing resources such as the statewide centralized access point (CAP) which launched in May 2019. The Parent Helpline (1-800-CHILDREN) serves as the CAP for HMG as well as the Title V 1-800 line; Title V contracts with the KCSL to support the phone line, website, and app. The work is funded with Title V and PDG dollars. Over the next year, all the agencies will continue working in a highly collaboratively manner to implement HMG by leveraging the Preschool Development Grant (PDG) funds awarded to Kansas. Read more about the Kansas PDG activities later in this section.

Help Me Grow Kansas Website (https://helpmegrowks.org/)

Spread of Developmental Screening Tools & Resources: Title V staff have encouraged the statewide use of the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire—Social Emotional (ASQ-SE) for many years. The KSDE recently established a requirement for all preschoolers or pre-kindergarten students that enter a public-school district be screened at enrollment. This coming year is the time to provide strong recommendations to local MCH grantees and other state and local partners such as pediatricians, home visitors, child care providers, health clinic nurses, and clinicians about using the ASQ and ASQ-SE for early and ongoing developmental screening. A unified recommendation message will be created and will be energized with the work through HMG and PDG work.

Title V staff will continue to express the importance of early developmental screening, detection of additional services, and early intervention. Existing resources that have been developed and utilized with Kansas providers, families and communities will be promoted and spread during the next year as they relate to several early childhood initiatives (ECCS, HMG, PDG/Systems Building, and more). The developmental screening passport, milestone activity cards and implementation tip sheet are already available through the Help Me Grow Kansas website and are referred to at the local level. The ongoing collaboration with state agencies and organizations including the Department for Children and Families, State Department of Education, Children's Cabinet and Trust Fund, Kansas Children's Service League, fatherhood initiatives, local school districts, and faith-based communities will support this effort and increase reach. Dissemination of materials through the MCH team will continue, targeting home visitors, child care providers, public health/health center providers, and pediatricians. Currently the passports, developmental milestones, and implementation tip sheets are only available in English. In FY2020 Title V staff plan to have the resources translated into Spanish and other languages as necessary.

Local MCH Agencies: The ASQ parent-completed questionnaire is intended to screen children for developmental delays in the areas of communication, gross motor, fine motor, problem solving and personal-social skills. Local agencies will continue to provide a developmental screening at least once a year to children they serve. Many local agencies use the Ages and Stages Questionnaire (ASQ-3; ASQ-SE/ASQ-SE2) for developmental screenings for ages 2 to 60 months and use the Bright Futures Pediatric Symptoms Checklist (PSC) for children over 60 months of age. Local MCH agencies will

continue to provide required ASQ screenings during KBH well child visits. Developmental screening is a vital component to the continuum of care for children. Educational material is provided to parents regarding developmental milestones during the visit. Local agency service highlights are below.

- Geary County Healthcare Foundation, also known as Delivering Change, plans to increase the number of Geary county providers using the ASQ/ASQ-SE developmental screenings during well child visits. They will leverage the KIDOS 2.0 Place Based Coalition to provide free ASQ kits and training opportunities to medical providers, daycares, and community agencies.
- Nemaha County Community Health Services plans for all children (ages 9 months through 35 months) to receive KBH assessments at the clinic using the ASQ-3 as the required developmental screening tool.
- Riley County Health Department plans to use the Ages and Stages Questionnaire to provide evidence-based outcome measures for developmental milestones. Interventions and referrals to community partners (Parents as Teachers, Infant and toddler services) will be made as needed utilizing Riley County's Integrated Referral and Intake System (IRIS) community.

Home Visiting: MCH home visitors will continue to provide child development and child-social emotional development screenings for families they serve. This requirement is related to the redesign of the MCH home visiting program. Universal Home Visiting will provide developmental screening for participants who have continued to receive services and are not eligible for other community-based home visiting programs. Technical assistance and training will be provided to local agencies related to distinguishing between the use of the Bright Futures Pediatric Symptoms Checklist and the ASQ (intent, purpose, use together), as well as the protocol and expectations for incorporating the developmental screening into the child well visit. Billing procedures for the screenings and/or the comprehensive well visit will be clarified as well.

KanBeHealthy & Bright Futures as Standard of Care for Child Well Visits/Screening: The Child & Adolescent Health Consultant will continue to represent the Title V program on a team working to review and update the KanBeHealthy (KBH) training. KBH is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. Kansas Medicaid utilizes Bright Futures$_{TM}$ as the EPSDT/KBH standard of care, so all services must be provided in accordance. Correspondence with the regional Bright Futures representative for Kansas has been underway and will continue to identify free resources, trainings, or membership opportunities for state purposes and for local grantee access. Kansas is looking into state licensing to support full access at no cost for public health providers.

Over the next year, regional, in-person trainings will be held for MCH grantees and other public health partners providing KBH visits (following Bright Futures$_{TM}$ guidelines), and online training modules will be available through KS-TRAIN as well as other online early childhood training platforms. Additionally, the Local Public Health Program (LPHP), with capacity support from Title V, will continue to partner with MCH staff and external partners to plan and develop the KBH training to be available as a pre-conference at the annual Kansas Governor's Public Health Conference in April 2020. This provides insight into what's to come related to KBH training for MCH partners statewide. The training will not only increase access to comprehensive well visits and screenings but improve the quality of services children receive.

The LPHP will continue to utilize the Regional Public Health meetings and other communication venues for local public health administrators as an avenue for communicating updated changes on KBH visits and exams/EPSDT and other important issues related to child health. The program will also work to increase access to training and resources for local health departments related to developmental screenings.

Special Health Care Needs: During FY19 the KS-SHCN program contracted with a Medical Director to advise and assist with a variety of tasks, but primarily to lead an ECHO (Extension for Community Healthcare Outcomes) project referred to as "Beyond the Developmental Screen" to help all providers across the state, not just those provider care to children with special health care needs, understand the importance of doing developmental screenings and evaluations, if needed.

Planning for the ECHO is currently underway, with the ECHO taking place in June 2019. Once the ECHO has been completed and evaluations reviewed by the SHCN program a determination will be made to identify if there is a need for future ECHO's around developmental screenings and evaluations or other training options that need to be considered. Through FY20, the Medical Director will be available to provide assistance and support through the use of telehealth for those conducting developmental evaluations across the state, as well as assistance for future ECHO/trainings, as needed.

The KS-SHCN program will continue collaborating with all early childhood systems in the state to assure that any trainings around developmental screenings and evaluations align with other ongoing efforts. SHCN staff participate in many of the early childhood workgroups to provide insight for those with special health care needs, collaborate in planning and implementation of services and supports, and avoid duplication of effort and to assure that children are being identified early so services can begin quickly.

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

Partnership with Child Care Aware: Title V will continue to partner with KDHE Child Care Licensing, Child Care Aware of Kansas (CCA), and KCSL to ensure that up-to-date quality training opportunities are provided for child care professionals across the state both, in-person and online. The Title V-CCA partnership was expanded in 2019 and a formal agreement will continue through FY20 with focus on the following MCH state action plan activities.

- Complete a Child Care Provider Training Needs Assessment inclusive of children and youth with special health care needs, collaboratively with DCF, KDHE, Kansas Child Care Training Opportunities (KCCTO) and other key Kansas early care and education partners.
- Develop a training package (available face to face and online) for child care providers to include a 4-part training series to increase knowledge of social emotional development. This training will draw from and incorporate the Kansas Early Learning Standards* (KELS) and Family Engagement and Partnership Standards (FEPS). The package will be offered at least two times annually.
- Develop a professional development training curriculum/series focused on Special Health Care Needs for child care providers.
- Develop a training webinar for child care providers to become more informed about postpartum depression, symptoms to watch for in the mothers of the children they care for, how to approach a conversation with them, and what resources they might be able to provide to the mother and family. Provide related resources/toolkits as part of the training.
- Produce content for Kansas Child magazine focused on MCH priorities/goals with emphasis on how child care providers support Kansas in advancing efforts and reaching those goals for children and families (Highlights related to oral health, breastfeeding, child development, infant safety (safe sleep), parent engagement, maternal/postpartum depression, etc.)

In addition to the above activities, CCA in partnership with Title V and KCCTO, will host a virtual, multi-day school age conference that will consist of virtual exhibits, networking opportunities via chat boards, resource sharing, and real-time/online/live professional development. Topics will include the following: summer literacy, nutrition, physical activity, STEAM, family engagement, mindfulness, and more. CCA will also partner with Title V will promote and expand the use of a Healthy Lifestyles Toolkit (previously developed in partnership between CCA and Children's Mercy Hospital). A professional development event will be planned that focuses on the use and implementation of the toolkit.

*The guiding document for developmentally and age-appropriate activities is the Kansas Early Learning Standards (KELS) located here: KELS. The standards are a shared vision of what children should know and be able to do. The current KELS document is the third revision of the Kansas Early Learning Standards and is aligned with the K-12 College and Career Ready Standards. The purposes of the Kansas Early Learning Standards are:

1. To create a continuum that links early development to school readiness and later learning in school and life;

2. To provide a clear statement of what young children should know and be able to do as a result of experiencing quality early learning opportunities.
3. To provide guidance for early learning professionals that enhance and support their abilities to create experiences that promote early learning opportunities and support families; and
4. To show that during the early years, children acquire skills, knowledge and abilities in all developmental areas (e.g., social-emotional, physical, early literacy, mathematics, music) critical to future learning.

Other Activities Related to Children's Developmental Health

Preschool Development Grant Birth through Five (PDG B-5): Kansas received a Preschool Development Grant – Birth through Five (PDG B-5) in January 2019. PDG B-5 is a funding stream that will support building and/or enhancing infrastructure that enables the delivery of high-quality services to children. The one-year planning grant (January 2019-December 2019) will transition into an opportunity to apply for additional funding for implementation of a state action plan for early childhood. KSDE was the state agency selected by the Governor's Office to make application; however, development of the proposal and implementation of the grant is highly collaborative. KDHE along with KSDE, KCCTF, DCF, and other early childhood stakeholders are partnering to carry out this work. Every agency has shared responsibility for the processes, decisions, activities/work, and outcomes.

As the collaborative group that has developed this proposal, our Kansas vision for early childhood is: *Connected Families, Connected Communities – Every Child Thrives*! The PDG proposal is completely aligned with the Help Me Grow framework! Our mission for PDG is for Kansas families to have informed and equitable access to seamless, comprehensive supports and services that ensure the wellbeing and lifelong success of all. When the Early Childhood Care and Education (ECE) system engages and connects families in a meaningful, coordinated way that supports choice, best practices, and quality, communities are poised to ensure the success of each child. Connected communities become catalysts for connected families, and connected families have better opportunities to thrive. Early childhood stakeholders in Kansas have been building this foundation for nearly two decades and are positioned to leverage existing work to align funding streams, enhance shared measurement, and expand the seamless continuum of services so that families have access to what they want and need.

Screenshot of Early Childhood Systems Building Website (PDG landing page)

The remainder of 2019 and 2020 will be spent actively working on the key activities this funding stream supports. The Bureau of Family Health/Title V Director represents KDHE. Kansas is taking this opportunity with new federal grant funding to engage in a collaborative effort to shape our state's future direction for early childhood. In addition to a needs assessment

and development of a state action plan, funding will also support activities to maximize parental choice and knowledge of early care and education options, the sharing of best practices among early childhood providers, and improvement of the overall quality of early childhood services.
As a result of these efforts, our early childhood system will be optimized through meaningful engagement of families and stakeholders to support all children and families, particularly those who currently face a variety of risks that impede thriving.

The leadership team is currently traveling to communities across Kansas hosting community engagement sessions to learn what is needed and desired for early childhood. Family and partner voices are critical to this process, so we've developed a number of options for local communities to share their input if they can't attend an in-person session. These options allow individuals to contribute input every step of the way and follow the journey. Here are the five ways Kansans can share their voice.

1. Participate in a Community Engagement Session*. The calendar of communities is HERE. The sessions are about one hour with small table discussions.
2. Share What's Happening in the Community Online. Individuals can provide input on the same questions asked at a community engagement session at http://kschildrenscabinet.org/share/.
3. Share a Personal Story. We are collecting personal stories from parents, caregivers and providers through the *Our Tomorrows* initiative to better understand what families are experiencing and learn more about how we can improve systems and supports. http://kucppr.org/ourtomorrows/
4. Participate in Webinars. The webinars are held every other week. Individuals can register to join us live. All webinars are recorded and can be accessed anytime online.
5. Email. Anyone with ideas, questions, suggestions, or comments, are welcome to email.

Example of the Community Engagement Sessions Flyer (developed for May, June and July)

As of July 9, 40 sessions have been held in 27 communities since launch in May. More than 1,048 participants have attended, and more than 1,700 stories have been shared by families through the Our Tomorrows initiative. The original goal for Our Tomorrows story collection was 1,000 stories. We've surpassed that, so the goal has been adjusted to collect at least one story from every county in Kansas. Below is a map that reflects story collection to date.

IRIS, a web-based coordinated intake and referral communication tool mentioned earlier in this section and detailed in the Child Report, is a major component of the PDG work (including HMG). Communities have developed informal means of coordinating early childhood services, but there are opportunities to strengthen and refine more structured referral protocols and to monitor effectiveness of the early childhood system. The user-friendly application and email notification system will connect partners within a community to better serve families no matter which 'door' they enter. IRIS uses a consistent referral and acceptance protocol to facilitate family outreach and enrollment. Common intake forms and needs assessment tools developed collaboratively translate into minimal data collection requirements. IRIS gives communities a clear, data driven picture of service capacity and partnership, allowing them to mobilize resources based on need. This approach is designed to support family-focused referrals within a community context to streamline the way families navigate and connect to services. The PDG leadership team is currently working on an IRIS strategy and work plan. IRIS implementation continues to expand in Kansas, across sectors and systems. Many more communities have shown an interest in implementing IRIS and Title V MCH will continue to be a lead partner in the development and expansion of IRIS across Kansas.

Learn more about the early childhood systems building journey here (https://kschildrenscabinet.org/early-childhood-initiatives-in-kansas-2019/#journey). Visit the Early Childhood Systems Building site housed on the KCCTF website for additional information, including a statewide community engagement tour, biweekly webinars (registration and recordings), weekly updates, opportunity to share input, contact information, and more. http://kschildrenscabinet.org/early-childhood/

Find all the Kansas PDG application materials are available online. http://kschildrenscabinet.org/wp-content/uploads/2019/06/Kansas-2018-Federal-Planning-Grant-Materials-Preschool-Development-Grant-Birth-through-Five.pdf

Kansas Family Engagement & Partnership Standards for Early Childhood: Related to the early childhood systems building/PDG work, the KS-SHCN Program Manager/Family Engagement Liaison will continue to participate in the review and updating of the Kansas Family Engagement and Partnership Standards for Early Childhood. This individual was part of the core team to develop the initial standards a few years ago, but now, with all the new early childhood initiatives that are occurring across the state it was determined that these standards need to be reexamined and reworked to better align with all early childhood systems. The goal is to identify and implement evidence-based practices for each standard and to make sure the standards are reflective of all early childhood systems in Kansas. The work is being facilitated through KSDE in collaboration with agencies and early childhood partners with PDG funds. The standards focus on families as: Foundation, Communicators, Advocates, Partners, and Community Members.

Special Health Services (SHS) Referral Processes: During FY20, the KS-SHCN program will continue its referral processes with all Special Health Services programs (genetic/metabolic and hearing screening programs, Birth Defect Program and Infant-Toddler Program). Currently when an infant is identified at birth with a genetic/metabolic/hearing or qualifying birth defect condition they are sent a letter explaining the KS-SHCN program and an application. After one month,

if the application has not been received by the SHCN program a call is placed to the family to answer questions and further explain the program. All referrals are tracked and monitored in the Welligent system.

Currently, the KS-SHCN holistic care coordination training is being modified, so that training can occur with the Newborn Hearing Screening partners (deaf and hard of hearing specialists), so they will be able to implement the care coordination model for all infants born in Kansas who have been identified with a hearing loss. This will allow the hearing specialists to address all hearing related issues for the infant immediately. The hearing specialists will receive support and assistance from the SHCN Lead Care Coordinator, when needed. Once the infant reaches six months of age and their hearing needs have been addressed, the infant and their families will be transitioned to a KS-SHCN Care Coordination within their geographic location for continuous supports and services from the SHCN program. As part of the agreement the hearing specialists will continue to provide ongoing advice, support and assistance to the care coordinators regarding all hearing issues.

As soon as a new Birth Defects Coordinator is hired, work will continue on the referral process. At that time, the referral process will be reviewed, and if needed, revised to meet the expectation of the new coordinator and the KS-SHCN program. The KS-SHCN Decision Schema will be provided to the new coordinator to use when determining medical qualification for the program. A tracking log for non-qualifying medical conditions will be kept and reviewed regularly by the Birth Defects Coordinator and the SHCN Program Manager, to determine if those conditions can be added to the SHCN program to receive care coordination services and supports. It is the intent of the KS-SHCN program to offer care coordination services to all infants and their families identified with a birth defect, even if they do not meet program eligibility criteria.

When a child from birth to three years of age is identified on the KS-SHCN program the family will be referred, if appropriate, to the Infant-Toddler Program. The KS-SHCN Care Coordinator will work in collaboration with the child's family and Infant-Toddler services provider to make sure that the child and family's needs are being met and that there is no duplication of services between programs. During the next year all Infant-Toddler providers will receive the KS-SHCN Decision Schema to help them determine who to refer to the SHCN program. During the FY 2020, an Interagency Agreement will be developed between the KS-SHCN and the Infant-Toddler programs to improve the referral process and to conduct some collaborative training opportunities for staff from both programs to work together and gain a better understanding of what each program offers for children and their families.

NPM 7: Child Injury (0 to 9 years)

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

Partnership Efforts with Safe Kids: Title V MCH staff will continue to partner with Safe Kids Kansas to cover gaps in Safe Kids Coalition areas and to increase car seat technicians and seatbelt usage throughout the state. Title V MCH will continue to be in support of and market Safe Kids Kansas resources and community events to local MCH agencies. Many local MCH agencies are certified technicians qualified to conduct car seat checks, and Home Visitors provide car seat safety/installation education. Parents are referred for car seat installation and provided education from Safe Kids worldwide. MCH local agencies are encouraged to partner at the community level and share information with all participants. MCH agencies and Universal Home Visitors will continue to offer these services as well as provide child injury education and information based on age and development of the child. Child injury education will continue to be provided during developmental screenings, immunizations and during home visits. Local agencies will continue to collaborate with Safe Kids Kansas for injury prevention and program guidance on topics including water safety, sun safety, poison control, car seat safety, choking, and falls prevention. Local agencies will collaborate with local school districts to provide presentations to students regarding injury prevention.

Safe Kids Kansas continues to present information both written and verbal to the SHCN team in an effort to help them

understand how to work with families on preventing childhood injury. Care Coordinators share information and safety tips with clients and their families to help reduce childhood injuries. One topic that comes up frequently with families is around car seat safety. Care Coordinators refer families to the nearest car seat check lane to make sure the child's seat is correctly installed. Safe Kids Kansas has also assisted the SHCN program in accessing the appropriate car seat needed for a child with a disability. Ongoing communication will occur between the two programs over the next year to continue to strengthen the partnership and reduce child injuries in the state of Kansas.

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

Local MCH Agencies & SHCN: Child injury education will continue to be provided as part of developmental screenings, immunizations, health assessments and MCH Home Visiting services. The MCH program is working to enhance home safety information during infancy and early childhood to reduce the risk of child injury. The program recently developed a standard tool for MCH home visitors to assess environments for potential harm or injury in the home environment, in partnership with parents. A "home safety checklist" has been shared with MCH local agencies and home visitors and is available for use by parents to assess whether the home is safe for young children. The checklist provides a space for the parent and/or home visitor to identify needed changes to make the home safer. This tool will provide an opportunity for the home visitor to reassess at subsequent visits. There is discussion to develop an electronic version for programs that want to tie the checklist with a visit record and track changes to the home environment between visits in response to education and consultation to reduce the potential for harm or injury. The Home Visiting checklist and other MCH Universal Home Visiting tools and resources are available on the Kansas Home Visiting website here: www.kshomevisiting.org.

The KS-SHCN program will continue its partnership with Safe Kids Kansas to provide smoke and carbon monoxide detectors to clients free of charge. This has been an ongoing program now for several years. Safe Kids Kansas provides the detectors and the SHCN program funds any customized installation costs due to the client/family special health care needs, such as, a strobe detector for those with hearing impairments.

SPM 2: Physical Activity (children 6 through 11 years)

Objective: Increase the percent of children participating in at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

Physical Activity Awareness Events: Information regarding monthly physical activity awareness months/days with awareness event resources will be available to the Title V MCH local agencies. Agencies will be encouraged to hold physical activity awareness events in their local communities. Collaboration with be enhanced with the KDHE Bureau of Health Promotions who administers healthy lifestyle grants such as the Farmers Market initiatives, Kansas Governor's Council on Fitness, Get Active Kansas, and bicycle/pedestrian resources and events.

Local MCH Agencies: Local MCH agencies will continue to work on initiatives to increase children's physical activity. MCH providers discuss and provide information on the importance of daily physical activity as well as encourage, promote, and evaluate physical activity among children and youth at developmental screenings, well child visits, immunizations, and WIC appointments. Families are educated at each visit about physical activity for the entire family. Families are encouraged to take part in at least 60 minutes of physical activity daily. Some local agencies will provide presentations to students in elementary/middle schools.

Child Care Licensing: KDHE Child Care Licensing will continue the partnership with the Bureau of Health Promotion to update and offer a physical activity training to all child care providers using the CDC standards and *Let's Move!* model. In 2019 and 2020 the physical health training will continue to be available online at no charge. Read more in the Child Report.

Other: Child Behavioral Health Activities

KSKidsMAP to Mental Wellness: The Title V Behavioral Health Consultant will serve as project director for the newly funded HRSA Pediatric Mental Health Access Program. The project, KSKidsMAP to Mental Wellness, will establish an expert pediatric mental health care team to support Primary Care Physicians within a statewide network. In-person evidence-based clinical training will be provided via the REACH Institute's Patient-Centered Mental Health in Pediatric Primary Care Mini-Fellowship program. A telementoring learning community will be established using the case-based Extension for Community Healthcare Outcomes (ECHO) platform. Trainings will occur alongside development of an online database of pediatric mental health providers across Kansas and a telephone/email support line (Warm Line), providing access to consultation with the expert team or referral through the database. Additional training, including clinical evidence and toolkits aligned with ECHO session content, will be available via webinar or similar events. The goals of this project are to:

- Increase Primary Care Clinicians' capacity to screen, diagnose, and treat children and adolescents with uncomplicated mental illness, such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD);
- Support PCPs in the treatment of children and adolescents with behavioral health conditions through development of a centralized access point of "Warm Line" for consultative and referral services;
- Improve access through telehealth for treatment and referral, especially for those in rural and underserved areas;
- Establish and sustain the use of telehealth technologies, modalities and care models.

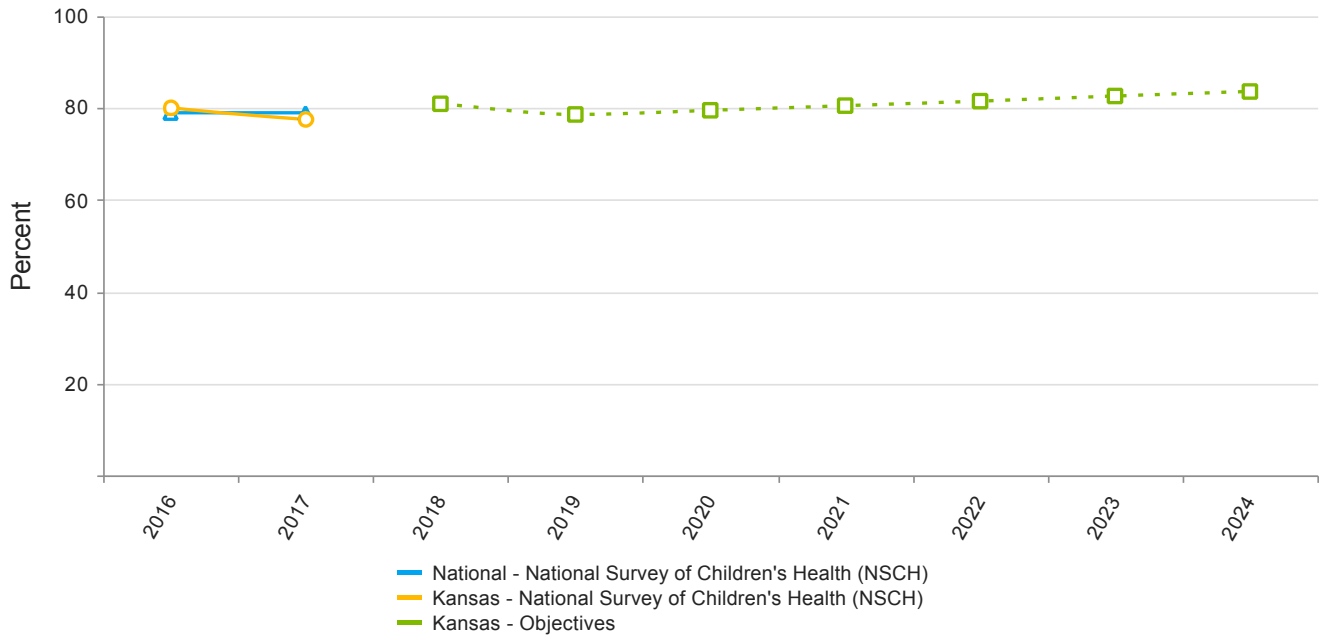
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	40.4	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	14.3	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	14.5	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	51.7 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	91.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016_2017	13.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	12.8 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	13.1 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2017_2018	53.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	52.4 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	89.7 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2017	72.1 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	21.3	NPM 10

National Performance Measures

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



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			80.8
Annual Indicator		79.8	77.5
Numerator		185,414	184,888
Denominator		232,249	238,418
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.5	79.4	80.4	81.4	82.5	83.5

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		30	40.3
Annual Indicator	24.4	32.6	30.3
Numerator	1,098	1,318	1,118
Denominator	4,492	4,042	3,690
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	32.5	35.0	37.5	40.0	42.5	45.0

State Action Plan Table

State Action Plan Table (Kansas) - Adolescent Health - Entry 1

Priority Need

Communities and providers support physical, social and emotional health.

NPM

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

Objectives

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

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

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

Strategies
4.1.1 Engage health care providers, Medicaid and Managed Care Organizations to promote annual well-child visits through adolescence into adulthood. 4.1.2 Partner with KAAP and KAFP to provide professional development events on using the Bright Futures Guidelines. 4.1.3 Increase accessibility to preventative care and well visits by piloting School Based Health Centers in at least 2 school districts. 4.1.4 Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan (IHP) who have not had a well visit in the past year.
4.2.1 Partner with state Department of Education Family and Consumer Science (FCS) Coordinator and local FCS teachers to update the Personal & Wellness Curriculum, including supplemental teaching tools on adolescent health topics (i.e. bullying, suicide prevention, distracted driving, healthy relationships, contraceptive choices, etc.). 4.2.2 Partner with schools and existing groups to set up youth focus groups to determine their views on health, what services are available, and what tools they need to navigate the health care system. 4.2.3 Develop standardized toolkits and educational materials for local MCH grantees on adolescent empowerment and health promotion. 4.2.4 Partner with other HRSA and SAMHSA initiatives to provide events and programs, including those related to bullying and suicide prevention, that promote protective factors and empower youth to reduce risky behaviors. 4.2.5 Identify methods to increase adolescent awareness of services and programs available to them in
4.3.1 Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received. 4.3.2 Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment. 4.3.3 Partner with KU Pediatrics, Kansas Department of Aging and Disability Services, and Kansas Association for the Medically Underserved to provide mental health fellowship training opportunities to pediatric primary care providers through the REACH Institute. 4.3.4 Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

ESMs	Status
ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Adolescent Health - Annual Report

PRIORITY 4: Communities and providers support physical, social and emotional health

NPM 10: Adolescent preventive medical visit (12 through 17)
SPM 3: Physical Activity (Percent of children 6-11 and adolescents 12-17 physically active at least 60 minutes/day)

Local MCH Reach: During SFY2018, 47 of 70 grantees (67%) and during SFY2019, 55 of 71 grantees (77%) provided services to the Adolescent population.

The focus and activity around the Kansas Title V adolescent population has increased dramatically over the last several years. Based on data provided by MCH local agencies, a total of 1,220 adolescents were served by Kansas Title V local MCH agencies in 2016. In 2017, that total was 6,447 and 6,312 in 2018. This indicates an increase of more than 5,000 adolescents being reached through Title V compared to past years. The implementation of the state action plan in 2016 with greater emphasis on adolescent health is likely the reason for this. The 2016 plan was associated with an adolescent health needs assessment that emphasized the voice of youth, parents, and partners related to the priority needs of adolescents.

The 2016-2017 National Survey of Children's Health (2 years combined) showed that 77.5% of Kansas adolescents, 12-17 years of age, had a preventive medical visit in the past year. Of those who had health insurance, adolescents covered by public health insurance (Medicaid) were less likely to have received a preventive medical visit than those with private insurance (72.0% and 84.9%, respectively). Hispanic adolescents were less likely than non-Hispanic white adolescents to receive a preventive medical visit. About 59.3% of Hispanic children received a preventive medical visit, compared with 81.7% of non-Hispanic white adolescents. Adolescents with special health care needs were significantly more likely to have received a preventive medical visit than adolescents without special health care needs (93.5% and 72.7%, respectively). Adolescents with parents who had more education were more likely to receive a preventive medical visit. Adolescents whose parents had a bachelor's degree or more were most likely to have received a preventive medical visit (85.9%), followed by those whose parents had some college and adolescents whose parents had only a high school diploma (81.4% and 60.6%, respectively). Adolescents living in low-income families were less likely to receive a preventive medical visit than adolescents living in higher-income families. The lowest percent of adolescents who had received a preventive medical visit were adolescents living in households with incomes below 100 percent of poverty (64.6%), followed by adolescents from households with incomes of 100-199 percent of poverty (65.6%), adolescents in households with incomes of 200-399 percent of poverty (84.8%), and adolescents in households with incomes 400 percent or more of poverty (87.0%).

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

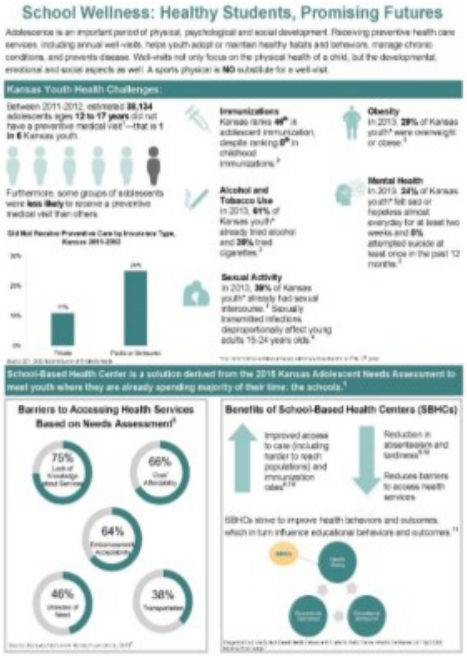
School Based Health Center Initiative: The data summary included in this narrative provides solid rationale for MCH being involved in launching school-based health centers as a key strategy to increase access to the annual adolescent preventive medical visit, including comprehensive screening in accordance with Bright Futures guidelines. Phase 1 of this project involved partnering with schools and medical providers along with community providers to evaluate the capacity and infrastructure to provide school-based services, followed by development of best practices, existing policies, and effective procedures that address components identified as key to successful development and implementation of a school-based health center. During this reporting period, a school-based health center guide was developed, and the first school-based health center pilot began the journey to development. The Kansas MCH team strived to consider disparities in adolescent health as we developed a model for school-based health. Partnerships with local health departments and FQHCs as medical sponsors will be key to reaching those most in need (Hispanic, low income, less educated). Initial and ongoing outcome goals of this initiative include:

- Develop a model or structure to provide well visits for youths in school settings
- Reduce barriers in obtaining preventative services

- Provide opportunities for adolescents to obtain routine yearly exams; and
- Increase youth/family understanding of the importance of making a well medical visit a yearly routine.

Background: The initial phase of the Kansas School-Based Health Center initiative launched in April 2017 with technical assistance provided by the National Maternal & Child Health Workforce Development Center (WDC), University of North Carolina (UNC), Chapel Hill as part of the National MCH Workforce Development Center's Cohort 2017.

Original School-Based Health Initiative Flyer & Adolescent Health Fact Sheet (page 1 of 2)



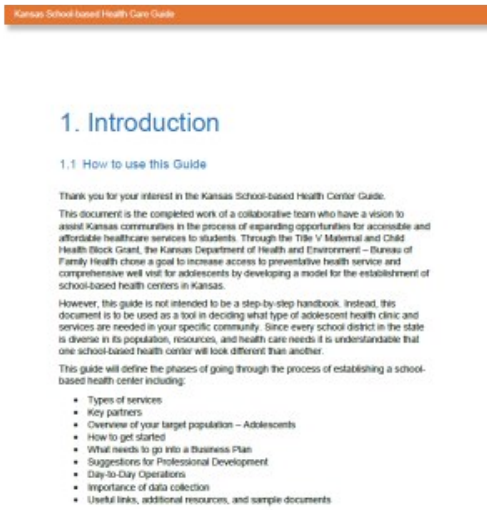
<u>*School Based Health Center (SBHC) Guide & Pilot*</u>: The school-based health center Project Core Team worked to develop a comprehensive SBHC Guide this reporting period. The guide was developed to assist Kanas communities in the process of expanding opportunities for accessible and affordable health care services to students. The guide is not intended to be a step-by-step handbook, but rather a document to be used as a tool in developing a school-based health clinic that meets the needs of the specific community. The guide defines the phases in the process of establishing a school-based health center including:

- Types of services
- Key partners
- Overview of target population - adolescents
- How to get started
- What needs to go into a Business Plan
- Suggestions for Professional Development
- Day-to-Day operations
- Importance of data collection
- Useful links, additional resources, and sample documents

This guide was sent to the 1st pilot site to be used throughout the process of establishing their school-based health center. Feedback from the pilot site will be provided to determine modifications to the guide.

Screenshots of the KS School-based Health Guide Cover & Intro (available electronically soon)

Kansas School-based Health Care Guide
2018



Kansas School-based Health Care Guide

1. Introduction

1.1 How to use this Guide

Thank you for your interest in the Kansas School-based Health Center Guide.

This document is the completed work of a collaborative team who have a vision to assist Kansas communities in the process of expanding opportunities for accessible and affordable healthcare services to students. Through the Title V Maternal and Child Health Block Grant, the Kansas Department of Health and Environment – Bureau of Family Health chose a goal to increase access to preventative health service and comprehensive well visit for adolescents by developing a model for the establishment of school-based health centers in Kansas.

However, this guide is not intended to be a step-by-step handbook. Instead, this document is to be used as a tool in deciding what type of adolescent health clinic and services are needed in your specific community. Since every school district in the state is diverse in its population, resources, and health care needs it is understandable that one school-based health center will look different than another.

This guide will define the phases of going through the process of establishing a school-based health center including:

- Types of services
- Key partners
- Overview of your target population – Adolescents
- How to get started
- What needs to go into a Business Plan
- Suggestions for Professional Development
- Day-to-Day Operations
- Importance of data collection
- Useful links, additional resources, and sample documents

The first Title V School Based Health Center Pilot is in the development phase. Valley Center USD 262 serves around 3,000 students from the communities of Valley Center, Park City, Kechi, and Wichita. The district includes one Pre-K-3 building; two K-3 schools; an intermediate school (4th & 5th grades); a middle school (7th & 8th grades) and a 5A high school. The USD 262 Superintendent and a community champion Pediatrician presented to the current Health and Wellness Task Force and the Administration Cabinet (consisting of 18 principals) and received approval to move forward in establishing a school-based health center. UDS 262 is utilizing the Title V School Based Health Center Guide in the development process and will provide feedback and any recommended modifications on the guide. As the selected pilot site, Valley Center also receives additional technical assistance from the Child and Adolescent Health Consultant. Resources available through the School-Based Health Alliance staff and their Blueprint directory have been used as best practice examples. Fifteen resources have been provided to the pilot site in preparation for discussions between the school district and potential medical partners including: Partnership Action Plan, Guiding Questions for MOUs, MOU templates, contract templates, sample letters of agreement, town hall/public meeting tips, communication guide, and marketing strategies.

Local MCH Agencies: Local MCH agencies provided adolescent well-visits utilizing the KanBeHealthy screening form (which includes behavioral health screening). During this report period 1,865 well visits were provided by MCH agencies, and 2,608 clients were provided information and education on the importance of well visits. Information regarding adolescent well-visits from Bright Futures is provided as a resource to the client. Many local MCH agencies educate parents and adolescents about the importance of a yearly preventative visit and refer clients to their Title X Family Planning clinic or local providers in their community.

The majority of the local MCH agencies that provide adolescent services collaborate with the local school districts and/or school nurses to provide school-based services for physical, social and emotional health of their adolescents in their communities. Greeley County Health Department sends letters to the parents of 11-year old's and high school seniors that provides immunization education, schedules, and encourages parents to have their children vaccinated. The letters target Tdap, MCV4, and HPV vaccinations; the high school senior letters target MCV4 booster, MenB series, and any catch-up of vaccinations they may need before heading to college.

The MCH Program plays a key role in assuring preventive interventions such as immunizations to improve the health and quality of life for women, infants, children, and adolescents. MCH programs promote routine health screenings for all children and adolescents as part of well visits that include assessment of immunization status, assure administration of immunizations and establish systems and referral networks that link low-income children and adolescents to state immunization programs. In addition to serving as Vaccines For Children (VFC) sites, local MCH agencies provide education about the importance of well visits and immunizations during all services, including home visits.

Objective: Increase the number of adolescents aged 12 through 17 years accessing positive youth development,

prevention, and intervention services and programs by 2020.

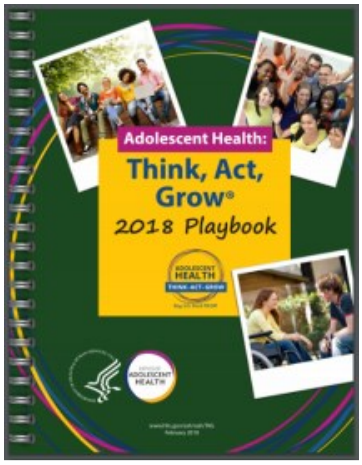
Kansas State Department of Education Family & Consumer Sciences Partnership: Ongoing conversations have been taking place with the KSDE Family and Consumer Sciences (FCS) Consultant who has access to more than 400 FCS teachers in school districts across Kansas. During FY18 we explored new partnership opportunities with FCS teachers and engaging youth in Family, Career and Community Leaders of America (FCCLA). Family and Consumer Sciences Education body of knowledge is focused on improving the quality of life of the individual who in turn influences family strength and community wellness, ultimately impacting our society's wellness.

The FCS philosophy and practice is based upon the theories of Maslow's Hierarchy of Needs and Bronfenbrenner's Ecological Model, both focusing upon the needs of the individual. In Kansas, the term "life literacy" has been adopted to explain the knowledge and skills every individual needs to hold to make intelligent life decisions. Standards have been set for the FCS classroom which focuses upon the younger adolescent (middle level) and the older adolescent (secondary level). Each comprehensive standard has content which better illustrates the knowledge and skills to be addressed. Local coursework aligns to these standards. The middle level courses are usually designed to meet local needs in the life literacy arena. The secondary level FCS offerings includes courses which specify course competencies as part of the Career and Technical Education program as these life literacy skills are the foundation to human services and family and consumer sciences careers. We hope to insert and/or create curricula related to Title V measures and priorities based on the needs of the students and community.

An alignment of the FCS Standards/FCCLA activities and the Title V Adolescent Health priorities/objectives revealed an abundance of opportunity for the future. As a result of the FCS partnership, the following strategies have been incorporated into the Adolescent Health Consultant' vision for a 3-year initiative discussed in the Plan Section. Activities are ongoing versus "one time" events and targeted to different schools, districts, or communities based on resources, capacity, readiness, and need.

- Training students and teachers in Youth Mental Health First Aid and training FCS Sciences teachers in Positive Youth Development
- Adding Adverse Childhood Experiences (ACES) and Mental Health First Aid training to the annual Kansas School Nurse Conference
- Presenting information at the annual Kansas School Nurse Conference related to strategies for partnership between nurses and FCS teachers/FCCLA leaders (on prevention education and planning to improve health outcomes and advance the MCH state action plan)
    - Understand how the Family and Consumer Sciences (FCS) Body of Knowledge, real work experiences and inquire based strategies of the FCS classroom promote healthy decision making in today's youth.
    - Learn how FCS teachers are collaborating with school nurses.
    - Identify how partnerships with your local FCS teacher can assist your work.

Read more about the partnership with FCS planned for 2020 in the Adolescent Plan.



Youth Engagement & Youth-Friendly Environments: The Child and Adolescent Health Consultant (CAHC) developed and shared a youth engagement and a youth friendly clinic environment toolkit on the MCH WorkStation. The youth engagement toolkit includes: HHS Office of Adolescent Health's: Think, Act, Grow (TAG) materials such as the TAG one-pager, 2018 Playbook, 2018 toolkit, 8 Steps to Engage Youth, Act for Youth's "Preparing for Youth Engagement: Youth Voice, Youth-Adult Partnership, Youth Organizing, Being Youth-Adult Partnership Savvy Primer; Search Institute's "Relationships First", and the scale of Youth Participation. The youth friendly toolkit includes: Adolescent Health Institute's SPARK trainings which provides mini staff meeting trainings on topics such as Adolescent Brain Development, Being an Askable Adult, Being Youth-Friendly, Cultural Responsiveness, Nonverbal Communication Bias and Strength-based Approaches to Adolescent Sexual Health; Wisconsin Department of Health's 2017 PATCH Planning Guidebook; Vermont Adolescent and Young Adult Clinical Tour Tool; Adolescent Health Initiative's Youth-Friendly Starter Guide and Youth Led Health Center Assessment Tool.

To gather feedback from the resources posted on the Workstation, the Adolescent Health Consultant began a discussion thread to ask local grantees if the resources were helpful. One responded "I like the teen assessment idea. Our High School Seniors will be coming through for their government class activity. We could have them do a targeted assessment of facility/services. Thanks for the resources." Later the same respondent posted this message: "So we used our Work Study High School senior to do a walk thru this morning. Pretend STD client. Gained some useful info. Some quick fixes, such as shutting doors to cut down on confusion about where to go. Also just observing the process, we noticed things we could improve. It was a great exercise."

Title V made visiting with youth across the state a priority in 2018 and the commitment is strengthened in 2019. On August 7, 2018, the CAHC met with the Kansas State Department of Education (KSDE) Family, Career and Community Leaders of America (FCCLA) Program Director, Peer Education Director, and two Peer Educators for the Student Body National Program to discuss statewide adolescent health initiatives. During this meeting, the CAHC was briefed on the youth-led events that are presented under the "Student Body" Program. The "Student Body" Program covers activities that deal with:

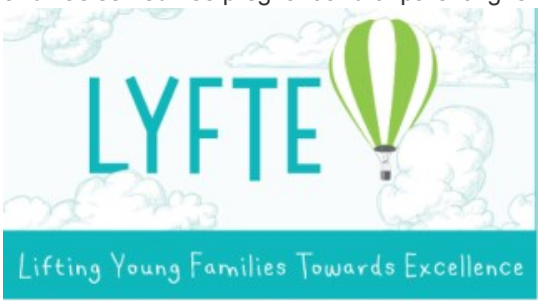
- *The Healthy You*: Empowering teens to make wise food and lifestyle choices
- *The Fit You*: Empowering teens to take charge of their health and their level of fitness
- *The Real You*: Empowering teens to maintain positive mental health
- *The Resilient You*: Empowering teens to live in ways that build emotional health

The CAHC was invited to be a guest speaker at the state-wide FCCLA kickoff Conference "Take Aim" on August 28, 2018. Discussion was held around how Title V could support FCCLA regarding Student Body Projects and other technical assistance that could be provided around adolescent health.

The CAHC (far right in picture at left) presented at the 2018 District E-West FCCLA Fall Leadership Conference on adolescent health (*The Teen Years Explained: A guide to healthy adolescent development*) and provided an interactive activity and group discussion with middle school and high school students. Over 200 students from 12 schools across the NE region of Kansas attended. Presentations were made to 40 students across 4 sessions. The CAHC also provided one-on-one technical assistance to four FCCLA students to assist them with information and resources for their FCCLA projects. Three students needed information for a Family First Presentation at a fall conference on what adults can do to help youth feel empowered and raise self-value/esteem. One student will be coordinating a school assembly event on mental health awareness.

Teen Pregnancy Targeted Case Management (TPTCM): During FY18, ten local programs received Teen Pregnancy Targeted Case Management (TPTCM) funding and served 361 pregnant and/or parenting teens. One of the objectives of the program is that all adolescents served, and their children, will access well child/adolescent programs such as EPSDT screenings and immunizations. In addition to ensuring adolescents receive prenatal medical care, TPTCM case managers educate adolescents on routine healthcare services, prevention of illness and injury, and available healthcare resources in the community. When an adolescent does not have an identified healthcare home the TPTCM case managers provide linkages to community healthcare providers. Other services the participants receive through the program either directly or through referral to other providers, include behavioral health assessment and treatment, substance abuse assessment and treatment, and domestic abuse services. All adolescents served in TPTCM programs are Medicaid eligible. If an adolescent loses Medicaid eligibility when their pregnancy and post-partum period ends, TPTCM case managers assist them in identifying and accessing other healthcare coverage options. Helping ensure these adolescents have adequate healthcare coverage increases their ability to access needed health services, including adolescent well visits and behavioral health services on an ongoing basis.

Lifting Young Families Toward Excellence (LYFTE): KDHE continued the Lifting Young Families Toward Excellence (LYFTE) project funded by an Office of Adolescent Health (OAH) Pregnancy Assistance Fund Grant. LYFTE is an innovative youth/young adult-centered program providing case management with wrap-around services to evidence-based programs focusing on connecting clients to regular perinatal and preventive health services, parental education/support, healthy family relationships, completion of educational goals and career development. Currently, LYFTE is in seven counties in the state and has served 188 pregnant and/or parenting females and 34 males to date.



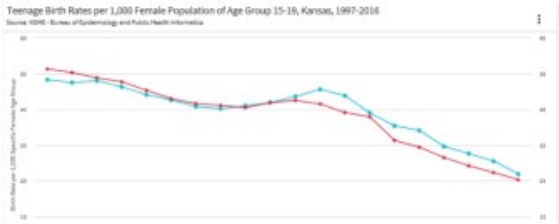
KEY Summit (Kansas Empowering Youth and Young Adults): The Bureau of Family Health (BFH) hosted the KEYSummit (Kansas Empowering Youth and Young Adults) June 19-20, 2018. This event is supported by Title V MCH and our Lifting Young Families Toward Excellence (LYFTE) project (funded by the Federal Office of Adolescent Health). In total, 72 participants attended. The event was an exciting opportunity to learn and share about how—collectively—we can be the keys that empower and lift up youth and young adults in Kansas, helping them to improve their lives and expand their vision of what is possible. Sessions on Mind Positive Parenting, Ensuring Adolescent/Youth Friendly Access to Services, Lessons Learned on Youth Engagement, Career Preparedness/Readiness and Youth Development and Developmental Relationships Framework were offered. A post-conference survey was administered with online and paper options. Results showed that

91% of participants felt high and very high comfort levels working with youth and young adults and 82% of participants reported that the summit provided information regarding items or topics they wanted to learn

more about.

Teen Pregnancy—Using Data to Tell Stories: The MCH program partnered with the Bureau of Epidemiology and Public Health Informatics in March 2018 to publish a live story about teen pregnancy. Data showing the decline over time along with program and intervention highlights provided an interesting way for partners and the public to learn more about the issue as well as what the agency is doing to prevent and support. View the live story online here: https://insight.livestories.com/s/v2/kansas-teenage-pregnancy-birth-rates-age-group-15-19/a5631dc6-cf85-421b-a5a6-d8930e47743f/

In 1997 the Kansas teen birth rate was 48.3 per 1,000 girls between the ages of 15 and 19. That rate has declined steadily since then for both the state and nation. As of 2016, the Kansas teen birth rate was 21.9. This is a decrease of 54.7%! Below is a look at the latest data on teen pregnancy in Kansas.



Title V Abstinence Education Program: KDHE continued the Abstinence Education Project funded by an ACF Title V Abstinence Education grant. The KDHE contracted partner, Children's Alliance of Kansas, coordinated abstinence education training to foster/adoptive/kinship parents and children/youth in foster care and out-of-home placement (residential care) as well as other at-risk youth through partnerships with Kansas child welfare providers and foster and adoptive family organizations. The education and training utilize abstinence-based, evidence-informed curricula regarding healthy relationships, decision-making, and youth development in accordance with federal grant requirements. From October 1, 2017-September 30, 2018, trained providers conducted All Stars, Choices, HEART (Healthy Empowering Adolescent Relationship Training) and Healthy Relationships (HR) trainings and programs reaching 889 youth ages 10-19 years and 236 parents/adults statewide.

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

Trauma-informed Practices/Systems of Care: Title V Child & Adolescent Health Consultant (CAHC) reviewed trauma-informed best practices and existing implementation tools. From this review, the Health Consultant created a Trauma Informed Care toolkit that is shared on the MCH WorkStation which is a password-protected online portal for local MCH agency use. Materials were provided from the Trauma-Informed Care Implementation Resource Center through the Center for Health Care Strategies: (https://www.chcs.org/resource/trauma-informed-care-implementation-resource-center/). The toolkit includes: "Trauma Informed Care Ideas" which lays out the resources in the toolkit and the weblinks where resources are housed; an infographic entitled "10 Key Ingredients for Trauma Informed Care"; a 12-page brief entitled "Key Ingredients for Successful Trauma-Informed Care Implementation"; a 9-page brief entitled "Laying the Groundwork for Trauma-Informed Care"; and the Trauma Informed Care Implementation Resource Center weblink that has additional resources such as fact sheets, videos, journal articles, briefs, infographics, presentation slides, and additional helpful websites and trainings. One local grantee posted on the Workstation: "Laying the Groundwork for TIC was very informative. Several ideas to implement there. Breakfast for staff and clients or for client attended meetings, was interesting."

Local MCH Agencies: Local MCH agencies provided education and counseling related to mental health (ex: bullying and suicide) during physicals and adolescent well visits from Bright Futures and the CDC. Referrals were made to mental health services, crisis centers and suicide hotlines for additional resources and to report bullying. Some local MCH agencies worked in collaboration with their local school districts and local law enforcement agencies on educating students on bullying prevention during Red Ribbon Week as well as throughout the school year. Many local MCH agencies offered educational awareness about healthy relationships as defining what constitutes a healthy relationship is critical to understanding physical, social and emotional health. Relevant MCH program activities are highlighted below.

- Riley County Health Department offers educational awareness about healthy relationships and defining what constitutes a healthy relationship. Riley County also focuses on the persistent inequalities in the health and well-being of adolescents and how the interplay of risk and protective factors at critical points of time can influence the adolescent's health across his/her lifespan.
- Nemaha County Community Health Services provides materials from the Kansas Children's Service League to parents during KAN Be Healthy assessments on bullying: "Is Your Child Bullying Others," "Cyberbullying," and "Is Your Child Being Bullied?"

Lemonade for Life (LFL): The BFH is committed to supporting physical, social, and emotional heath, and addressing adverse childhood experiences (ACEs) is a key to supporting broad health and well-being in the state. Multiple trainings were provided between May and June 2018 in locations across the state to provide *Lemonade for Life* training (lemonadeforlife.com), a trauma-informed, hope-infused approach to using ACEs research in our work to improve outcomes for children and families. The training was supported by our Lifting Young Families Toward Excellence (LYFTE) project so the targeted audience was community professionals providing services (health, education, career, etc.) to adolescents. The training was provided at no cost. Attendees committed to completing the following: pre-work online; full day training; and a follow up coaching call. The MCH program continues to promote Lemonade for Life as an approach, and it has been implemented in the Geary County Community Healthy Start project.

Lemonade for Life
Using ACEs to Build Hope and Resilience

4 Trainings to choose from:

LAWRENCE | May 22, 2018, 8:30-4:30
Register **bit.ly/2vHL4zy**

WICHITA | June 6, 2018 *Training is Full*
Date Added!! June 7, 2018 - 8:30-4:30
Register **bit.ly/2Gip26P**

HAYS | June 28, 2018 - 8:30-4:30
Register **bit.ly/2I0UkSb**

CONTACT: Stefanie Olson, saolson@ku.edu
www.facebook.com/LemonadeForLifeKU

www.LemonadeForLife.com

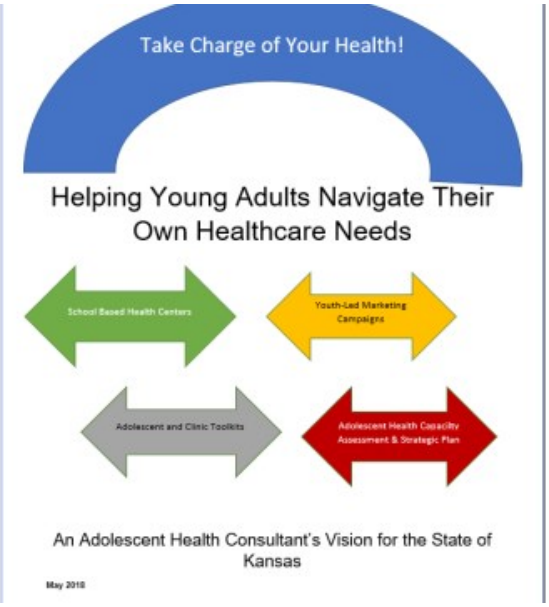
Adolescent Health - Application Year

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

NPM 10: Adolescent preventive medical visit (12 through 17)

Local MCH Reach: Based on SFY2020 MCH Aid-to-Local applications received, 44 of 70 grantees (63%) plan to provide services to the Adolescent population.

The Adolescent Health Consultant created a 3-year plan based on the belief that every young adult deserves the best life possible—happiness and health. The plan, depicted through the image provided below, is intended to expand on the adolescent well visit performance measure. The focus is on youth empowerment and puts the voice and decision-making of youth in the forefront of all activities under four distinct areas: School-based Health Centers, Youth-Led Marketing Campaigns, Toolkits (to assist youth in navigating the healthcare system and to assist the healthcare system in becoming more youth friendly in their services), and conducting an adolescent health capacity assessment at the local level to identify gaps in services.



To advance the vision around adolescent health, Kansas MCH will continue to build and maintain statewide health partnerships to promote adolescent health and well-being. The Title V program is currently soliciting bids (request for proposals) for a contractor to provide facilitation, create resources inspired by youth, and assist with gathering data specific to the adolescent population statewide. The contract will allow MCH to support 12 youth focus groups (two in each of the six public health regions in Kansas) to be held across the state to gather perceptions and youth voice on: health care needs for their population, the supports and services that are currently in place (being utilized), and the gaps that exist. Feedback will be especially important from youth with special health care needs, those currently or previously in the child welfare/foster care system, and those who receive services through the state juvenile justice system. The contractor will develop messaging and resources (based on evidence and promising practices) for the health care sector from the feedback gathered by youth and young adults as well as provide recommendations specific to adolescent health priority needs that will be incorporated into the comprehensive statewide MCH needs assessment currently underway (priorities for the period 2021-2025). A social media campaign will be created and utilized on the KDHE and MCH websites. The social media campaign will also be disseminated to the MCH local grantees as a tool to use in their communities.

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

Health Providers and Medicaid: Health care providers and representatives from Kansas Medicaid and Managed Care Organizations will continue to attend quarterly Kansas MCH Council meetings and participate in the adolescent domain group discussions on ways to promote well visits across the state. Discussions this year will include strategic ways to promote annual well visits through social media outlets and how to get youth and young adults involved in creating and disseminating messaging to peers; promoting strategies, resources, and the GotTransition website to health care providers, schools, families, and communities. The website and materials will be provided on the MCH online Workspace platform (the web-based portal for all local MCH agencies developed and launched in 2019) as a recommended best practice resource.

Local Agencies: Local MCH agencies will continue to provide adolescent well visits along with behavioral health screening in accordance with Bright Futures standards and guidelines. Smaller agencies that do not provide clinic-based services will educate parents and adolescents about the importance of a yearly preventative visit and refer them to their Family Planning clinic or local providers in their community. The Title V MCH and Special Health Care Needs staff will create a discussion board on the Workstation to receive feedback and technical assistance needs from the local grantees.

KS-SHCN Care Coordinators will continue to work with adolescents to ensure they receive their routine KAN Be Healthy (KBH) exams per the Kansas Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program. They will also continue to work with youth to assist them with transition goals. Care Coordinators will begin the discussion with parents/caregivers early in a child's life about transition and request that the youth participate in the transition conversations on or before the youth reaches a developmental age of 14 years. Each youth over the age of 14 will continue to have a transition goal listed on their Action Plan per SHCN program requirements.

Standards & Guidelines – Appropriate Practices with Bright Futures: The Title V MCH Child & Adolescent Health Consultant (CAHC) will continue to participate in a workgroup that is updating the KBH manual and training, along with the Executive Director of the American Academy of Pediatrics Kansas Chapter (KAAP). During FY20, KBH trainings will be offered online and regionally face-to-face for local agencies. The Title V MCH program will continue to partner with KAAP, Kansas Academy of Family Physicians (KAFP), and Community Care Network of Kansas* (CCN), to promote Bright Futures as the recommended standard of care across sectors and settings. This is the standard of care for Kansas Medicaid and required to be utilized by local agencies receiving MCH funds. The ongoing collaboration will also work to provide access to Bright Futures resources and toolkit at low or no-cost at the local level. Discussions will be conducted to review the process of integrating Bright Futures interfacing abilities into various electronic health records (EHRs) utilized across the state. Related work with KAAP involves creating a chart that depicts the differences between a sport physical and an adolescent well visit to educate parents of the differences and inform parents of the need of an annual well visit in addition to an adolescent's sport physical. The anticipated release of this tool is summer of 2019.

**Statewide association made up of a network of community care clinics dedicated to ensuring the best medical, dental and behavioral care available to all*

School-based Health Centers: Adolescence is a crucial time for preventive interventions because it's a period of significant physical, behavioral and emotional growth. In an effort to increase access to preventive health services and comprehensive well visits for adolescents, Title V and key partners are committed to increasing the number of school-based health centers (SBHCs) in Kansas. The plan to do this involves building community capacity to provide preventive health services in school, reducing the need for transportation, and improving access to services. With an emphasis on prevention, early intervention, and risk reduction, school-based health centers are intended to provide the support youth need to transition to a healthy adult. Furthermore, SBHCs can bridge the divide between health and education by incorporating public health approaches to achieve population health and equity. The goal is for expanded school-based services to result in increases

in the percent of well visits or prevention services received by adolescents.

Title V is hosting an intern from the University of Kansas during the summer of 2019 to prepare for ramp up around school-based health centers during 2020. By September, the intern will plan to have an updated electronic SBHC guide and toolkit to provide to communities that request assistance with establishing a SBHC. Through recommendations and show of interest, Title V plans to establish SBHCs in at least two new school districts in the future. This is foundational work that can be done in partnership at the state and local levels as we prepare for a budget initiative/proposal to be introduced during the 2020 legislative session. The KDHE Bureau of Family Health, Title V Director and staff have been involved in conversations with the CCN related to a budget proposal for the Kansas Legislature to fund a school-based health center initiative, resulting in at least 10 new or expanded sites. The proposal under development expects local school districts and clinics to work together to submit a proposal for funding. Focus during FY20 will remain on promoting flexible models for Kansas communities. Rural areas of the state may want to focus on part-time centers offering comprehensive well visits, including screening and guidance in accordance with Bright Futures guidelines while urban areas may wish to provide a full array of health services, including medical, behavioral health, and dental.

The future KS MCH Council chair and member of the adolescent domain group is a pediatrician and adolescent health expert. She has been a member of the KS planning team since Title V participated in the National MCH Workforce Development Center Cohort in 2017 and will continue to provide guidance and direction related to the comprehensive health needs of adolescents and how we can increase access to services and supports. Read more about history and progress of SBHCs in the Adolescent Report.

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

Partnership with Family & Consumer Sciences: Title V has been partnering with the Kansas State Department of Education (KSDE) Family and Consumer Sciences (FCS) Coordinator for several years. Providing youth-friendly materials and information will be an emphasis in FY20. Read more about the Title V-FCS alignment in the Adolescent Report.

Over the next year, the shared work will focus on supporting local FCS teachers with addressing issues that matter to adolescents in the classroom. This is an opportunity to “meet youth where they are at” and embed MCH messaging related to healthy decision making into the schools. The health of adolescents in Kansas is a concern of FCS Education and has been for many years. Their mission “to prepare students for family life and work life” uses methodology based in the biological and social sciences which strengthens the well-being of individuals, promotes optimal wellness, uses critical and creative thinking to address problems and promotes taking responsibility for one’s actions. KDHE is currently working with a selection of Kansas FCS teachers conducting a comprehensive review and revision/update to the existing Personal & Wellness Curriculum (originally developed in 1990) utilized by more than 400 FCS teachers across the state. Supplemental teaching tools on adolescent health topics (i.e. bullying, suicide prevention, distracted driving, healthy relationships, contraceptive choices, etc.) will also be developed and provided. By the beginning of the 2019-2020 school year, the updated FCS curriculum will have been completed and ready to provide at Train-the-Teachers events. We will work with the KSDE FCS Coordinator to select training dates, times, and locations that best meet FCS teachers’ needs. Conversations will occur to determine if the training can be recorded and provided online to those who cannot attend in person.

Teen Pregnancy Targeted Case Management: For FY20 ten local agencies across the state, including eight agencies who also provide MCH services, will provide services to pregnant and parenting teens up to age 21 years through the Teen Pregnancy Targeted Case Management program (TPTCM). Based on proposals received, the projected number of TPTCM participants to be served is 489, very similar to previous years. The co-location of both programs within an agency increases opportunities to collaborate to ensure adolescents receive coordinated care and support across programs. One of the objectives of the program is that all adolescents served, and their children, will access well child/adolescent programs such as early and periodic screenings and immunizations. In addition to ensuring adolescents receive prenatal medical care, TPTCM case managers educate adolescents on routine healthcare services, prevention of illness and injury, and

available healthcare resources in the community. When an adolescent does not have an identified healthcare home, the TPTCM case managers provide linkages to community healthcare providers. Other services the participants receive through the program either directly or through referral to other providers, include behavioral health assessment and treatment, substance abuse assessment and treatment, and domestic abuse services. All adolescents served in TPTCM programs are Medicaid eligible. If an adolescent loses Medicaid eligibility when their pregnancy and post-partum period ends, TPTCM case managers assist them in identifying and accessing other healthcare coverage options. Helping ensure these adolescents have adequate healthcare coverage increases their ability to access needed health services, including adolescent well visits and behavioral health services on an ongoing basis.

Lifting Young Families Toward Excellence (LYFTE): The LYFTE project (which expands on the Kansas Teen Pregnancy Targeted Case Management model) was established in July 2017 with funding from the Office of Adolescent Health. Based on the Title V vision, LYFTE improves the lives of young families, parents and children, through an integrated approach to life-skills development that focuses on health, education, and employment. Case management with wrap-around services to evidence-based programs such as Early Head Start are provided. The project is delivered through a youth-driven approach incorporating technology-based mentorship and incentives. LYFTE expands their ideas of what is possible for them, while simultaneously rewarding them for taking the steps needed to become self-sufficient members of the community. In 2018, KDHE received two years of additional funds to continue and expand LYFTE, a program targeted to providing supports (parent, education, career, etc.) for pregnant and parenting teens. Funding is expected through June 30, 2020. Continued efforts toward overall project sustainability in each of the communities will continue. Because LYFTE builds on the TPTCM model, lessons learned and resources developed will be incorporated into the TPTCM model for dissemination across the state. In addition, lessons learned and resources developed will be shared with other providers working with adolescent populations to better support their needs. *Target Communities:* 6 counties in the SC, SE, and NE regions of the state based on teen pregnancy rates.

Special Health Care Needs Family Care Coordination & Transition: Youth with special health care needs will continue to be encouraged to participate in the Family Care Coordination Trainings held by the KS-SHCN team. Youth participation will continue to be monitored and evaluated to see if a training for youth needs to be conducted separately from parents/caregivers. This training covers a wide variety of topics such as communicating with providers, self-care, transition and advocacy. Information about the Kansas Youth Empowerment Academy (KYEA) and the services they provide will also continue to be shared with youth. Youth will be encouraged to participate in leadership programs such as the Kansas Youth Leadership Summit and the FACES of Change program through KYEA. They will also be encouraged to attend transition

workshops conducted by Families Together, Inc. and the KS-SHCN Family Care Coordination Trainings to continue to improve their self-awareness and self-advocacy skills (refer to the CYSHCN Report for more details) which are important to knowing when and what to access when it comes to their health and well-being.

Local Public Health (LPH) Partnership: Kansas Title V will continue our partnership with the KDHE Local Public Health Program to advance our work around adolescent health when it comes to ensuring local/community services and programs are available to youth. In the coming year, the LPH team will continue to:

- Coordinate with leadership to identify partnership opportunities with USD 501 to better address needs related to adolescent health, particularly related to adolescent preventive medical/well visits and physical activity;
- Ensure there are meaningful sessions related to adolescent health at the 2020 Governor's Public Health Conference and other training venues;
- Provide information about adolescent health through the Public Health Connections electronic newsletter; and
- Support partnerships for school-based health initiatives (including specific efforts with USD 501).

Local Agency Highlight—Human Trafficking: Barton County Health Department has found there are exorbitant amounts of interest in their Human Trafficking Efforts. Agency staff is planning to provide education to adolescents and the public on human trafficking using the "8 Days" movie. Barton County staff will have conversations with teens after the movie, to help identify other needs of teens in the community. They will also partner with the Juvenile Justice Agency to offer Sex Education 101 to teens. They will host classes for the Hispanic population and the Girls and Boys Homes to provide a safe, non-judgmental place for discussions so that the health department can become a Safe Haven for teens in the community.

KEY (Kansas Empowering Youth & Young Adults) Summit: A number of professional development events such as trainings and conferences as well as resources and materials for providers and youth will take place. Several of the events for the coming year are already scheduled and planning is underway. The Title V MCH CAHC will continue to participate in planning and conducting the annual Kansas Empowering Youth (KEY) Summit as well as the annual adolescent empowerment conference (refer to the Adolescent Report for more details). The CAHC will provide ideas on keynote speakers, breakout session topics, potential youth-led initiatives, and the most current data on attitudes and risky behaviors. The second annual KEY Summit was held June 17-21, 2019, as a virtual, week-long event during the lunch hour.

Social-Emotional Learning & Development – Middle Schoolers: Title V will partner with other HRSA and SAMHSA initiatives to provide events and programs, including those related to bullying and suicide prevention, that promote protective factors and empower youth to reduce risky behaviors. One example of this plan involves partnering with the KDHE Bureau of Health Promotion's Sexual Violence Prevention and Education (SVPE) Coordinator who oversees the local school programs and coordinates the Committee for Children's Second Step program. Plans are underway to replicate the program currently

being implemented in 12 elementary schools across the state. The Second Step Middle School Program for Grades 6-8 is new and now available. The new curriculum is web-based and responsive to the needs of today's students and educators, based on the latest research in adolescent brain development and social psychology. The goal is to support youth with doing better in school and life. The Title V Adolescent Health Consultant will work closely with the SVPE Coordinator to establish a strong, valid program for middle schools. The Adolescent Health Consultant will also work closely with schools (teachers and administrators), the Kansas School Nurse Organization, and Kansas State Department of Education (KSDE) School Counseling Consultant and Social-Emotional Character Development Coordinator on this effort to ensure support.

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

Local MCH Agencies: Local agencies (70%) are focusing efforts on the positive youth activities and programs to support healthy social-emotional development. For example, they collaborate with local school districts in providing anti-bullying campaigns, information, education, and counseling. Local agencies are also participating in local coalitions that provide education to first-line providers, educators and parents on mental health including bullying. Mental health is also addressed during adolescent well visits conducted in local MCH clinics using Bright Futures materials. Screening guidelines and anticipatory guidance is utilized.

Cross-agency Collaboration for Improved Adolescent Health & Well-being: Title V will continue to partner with the Kansas Department for Aging and Disability Services (KDADS) Behavioral Health Commission to create a unified multiple state department standardized list of best practices to be disseminated to health care providers, county mental health centers, schools, and community youth-serving organizations to support whole adolescent health in their communities. Youth engagement and active youth participation in planning and conducting local resources and events will be highly encouraged. MCH grantees will be encouraged to partner with the community mental health center, health care providers, schools, and other community youth-serving organizations to provide education, resources, and events for youth. Additionally, the Title V CAHC and Title V Behavioral Health Consultant will create monthly awareness event calendars and coordinating awareness event materials for local communities to utilize for special events and creating new partnerships within the community. The monthly awareness event calendars will be provided on a quarterly basis in order to provide enough planning time for the MCH grantees.

The Title V program (Director, CAHC and team) will continue to build collaborations with the KDADS Behavioral Health Commission staff, KDHE Bureau of Health Promotion (injury prevention and violent death reporting system staff), Office of the Attorney General, Suicide Prevention Resource Center (SPRC), State Department of Education (KSDE), Department for Children and Families, Department of Corrections-Juvenile Services, community mental health centers, suicide prevention coalitions across Kansas, health care providers, schools and others will continue to work together to support youth and young adults with mental health initiatives and services.

We are also striving to improve partnerships with the Department of Children and Families (DCF), specifically seeking to engage foster care youth/adolescents in MCH programs. With the upcoming initiation of the Families First Program in the state DCF is seen as a critical partner to improve programming for youth and adolescents at the community level.

Ongoing highly collaborative work with the above-named agencies and organizations specifically will focus on creating a unified cross-agency standardized list of best practices to be disseminated to health care providers, community mental health centers, schools, and community youth-serving organizations to support whole adolescent health in their communities. In addition, the KS MCH Council is working on a "call to action" in the form of an infographic or action alert related to youth suicide prevention. There is something everyone can do "right now". Promoted strategies will be based on/drawn from the CDC Technical Package of Policy, Programs and Practices. Youth engagement and active youth participation in planning and conducting local resources and events will consistently be highly encouraged. MCH grantees will be encouraged to partner with the local prevention coalition/collaborative, community mental health center, health care

providers, schools, and other community youth-serving organizations to mobilize/take action and provide education, resources, and events for youth. Mental health will also be addressed during adolescent well visits conducted at local MCH agencies using Bright Futures materials.

Youth-driven/centered Approaches: Increasing youth voice related to planning to address youth mental health across the state is a top priority. Title V MCH, along with the other partners mentioned above, will coordinate a calendar of youth-led or youth-centered events across the state to collect youth-designed messages for their peers to be used in a statewide marketing campaign. The image below shows the result of Title V partnering with the KDHE Bureau of Health Promotion (BHP) and the Shawnee County Youth Suicide Prevention Coalition to develop an activity for the annual Youth Resiliency Conference on April 9, 2019. This activity encouraged young adults to write messages to their peers about what they would want them to know: that they matter. The messages were sent to KDHE Communications to create a visual graphic and prepare social media messages. The youth-created messages were distributed to the KDADS, KSDE, SPRC, and local MCH agencies. Collaborations will be expanded to conduct this activity to other counties across the state in the future. We will focus on more activities like this one over the next year.

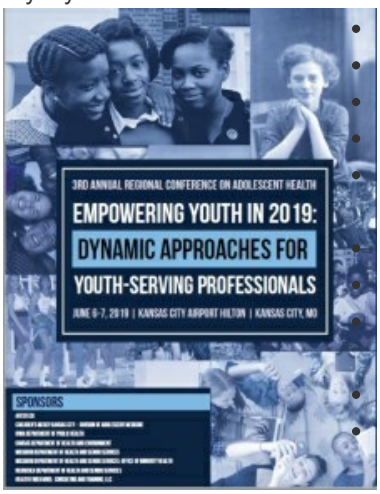
Working with the KS-SHCN program staff who led development of the Supporting You peer to peer network platform, we hope to expand to include programs serving adolescents. Phase one of Supporting You is targeted to connecting parents of children with disabilities to others who share their experiences; it's possible that phase two could focus on connecting youth in need of peer support related to anxiety, depression, and thoughts of suicide. The desire to utilize the existing platform/infrastructure developed and supported by Title V stemmed from youth input—they want to talk to other peers who can understand what they are going through.

Increasing Awareness & Equipping the Workforce: The Title V CAHC and the Behavioral Health Consultant created a toolkit for Child Mental Health Day (May 6, 2019) and National Mental Health Prevention Week (May 12-18, 2019) that included SAMHSA resources and an *Awareness Event Tips and Guidelines* guide. This guide included special event task timelines and how to obtain and maintain new partnerships in local communities. MCH local agencies were encouraged to share messages on social media with pre-scripted messages from SAMHSA and/or contact their community mental health center to support their local efforts in recognizing these national awareness events. We will continue to promote and utilize/spread the toolkit over the next year. Many of the available resources are underutilized by local MCH agencies. The Title V program will provide targeted support to assist communities with understanding how to apply tools and resources available to them.

Title V is a sponsor for the 2019 Empowering Youth Conference to be held in Kansas City, MO June 6-7, 2019. The Title V CAHC also served on the planning committee for this conference. The conference message is: "Adolescence is a critical time when youth adopt behaviors that will follow them throughout the rest of their lives. It is important that youth learn to take

healthy risks and develop healthy behaviors. Adults must learn how to work with youth to ensure they are creating the proper environment and providing the best resources and opportunities to help the youth of our region as they journey through this important stage of life." Session topics include:

- Youth + Sexuality: What We Can Do
- Understanding and Addressing the Opioid Crisis: Focusing on Youth
- An exploration of Teen Health and Media Literacy in an Online World
- Awareness of Potential Trauma Induced Behaviors and Finding the Most Effective Way to Help our Community
- Reason to Hope, Reasons to Mope: Health Behavior Trends in Kansas and Regional High School Students
- They Myths and Truths of Adolescent Nutrition



- Youth + Identity + Sexuality: A Deeper Dive
- Encouraging Youth Activism, As Told by a Youth Activist
- Understanding How Human Trafficking Affects Youth Today
- 13 Minutes: A Suicide Awareness and Prevention Campaign
- The Vulnerability and Threats to Today's Youth and What We Can Do to Prevent the Fall
- Exploring Sexual Orientations, Identity Development and LGBTQ Youth
- JUUL, Vape, E-Cigarettes: Unifying the Tobacco Prevention Approach
- All Roads Lead to Stress…How Effects of Stress Impact Us on Multiple Levels and How We Can Empower Our Students to Make Health Changes
- Understanding Self-Injury and How to Help
- Below the Surface: Eating Disorders and Transgender Youth

Mental Health First Aid (MHFA) – Youth: The MCH program has been involved in ongoing discussions related to increasing access to mental health first aid training, specifically Youth Mental Health First Aid. MHFA has already been provided to MCH home visitors, but plans are underway to expand reach to school personnel, teachers, nurses, other MCH local agency staff, and any other community level partners providing services for adolescents. Local MCH agencies are starting to consider incorporating this training into their local budgets and taking action on their own to equip their teams and partners at the community level.

REACH Institute Mental Health in Pediatric Primary Care Fellowship Program: The 2018 State of Mental Health in America report indicates that 62% of female youth reported moderately severe depression or severe depression on depression screening tools. This was the case for 52% of male youth. According to the CDC, as of 2014, one in seven children in the United States – almost 20% of all boys – will receive a diagnosis of A.D.H.D. by the time they turn 18. The national shortage of child psychiatrists has placed much of the burden for evaluating children's behavioral and mental health disorders on general family practitioners and pediatricians. Because A.D.H.D. and other mental disorders such as severe depression have become widespread national health concerns in youth only in the past few decades, many family practitioners and pediatricians have received little formal instruction on the disorders and how to treat them. Undiagnosed and/or poorly managed pediatric behavioral health problems can cost the pediatric primary care system in several ways, including increased ambulatory medical costs, increased ER visits and hospitalizations (behavioral and emotional crises, accidents, injuries, suicide attempts), and overuse of expensive psychiatric medications.

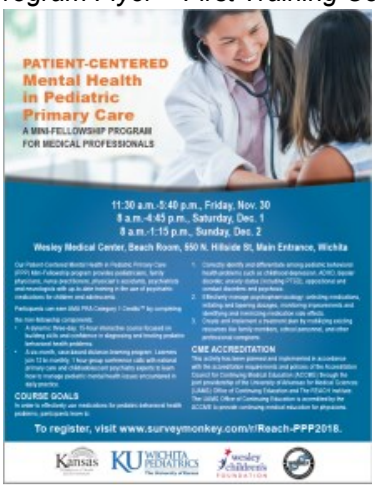
The Title V Program is partnering with the University of Kansas Medical Center – Wichita (KU Med) Departments of Pediatrics and Psychiatry and Behavioral Health to bring the REACH Institute Patient-Centered Mental Health in Pediatric Primary Care Mini Fellowship Program (PPP) to Kansas. The first training was held November 30-December 2, 2018, in Wichita (sponsored by KU Med). It was targeted to pediatricians in the urban (northeast and southcentral) areas of the state, and the training reached capacity with 34 providers attending. A second training will be supported by Title V and take place September 13-15, 2019, in Hays, Kansas, a rural area in the western region of the state. Focus is not only on pediatricians in private practice but also family physicians and public health professionals providing services to adolescents.

REACH programs are the only national clinical practice transformation programs that use evidence-based change methods to help primary care providers adopt proven, more efficacious clinical practices related to assessing for and treating behavioral health needs of children. The training includes a three-day, 15-hour interactive course focused on building skills and confidence in diagnosing and treating pediatric behavioral health problems. It also includes a six-month, case-based distance-learning program where learners join 12 bi-monthly, 1-hour, group conference calls with national primary care and child/adolescent psychiatry experts to learn how to manage pediatric mental health issues encountered in daily practice.

The course goals of the REACH PPP training include:

1. Correctly identify and differentiate among pediatric behavioral health conditions such as depression, ADHD, bipolar disorder, anxiety (including PTSD), oppositional and conduct disorders, and psychosis.
2. Effectively manage psychopharmacology: selecting medications, initiating and tapering dosages, monitoring improvements, and identifying and minimizing medication side effects.
3. Create and implement a treatment plan by mobilizing existing resources like family members, school personnel, and other professional caregivers.

Kansas REACH Mental Health Fellowship Program Flyer – First Training Cohort



Kansas REACH Mental Health Fellowship Program Flyer – Second Training Cohort

Children with Special Health Care Needs

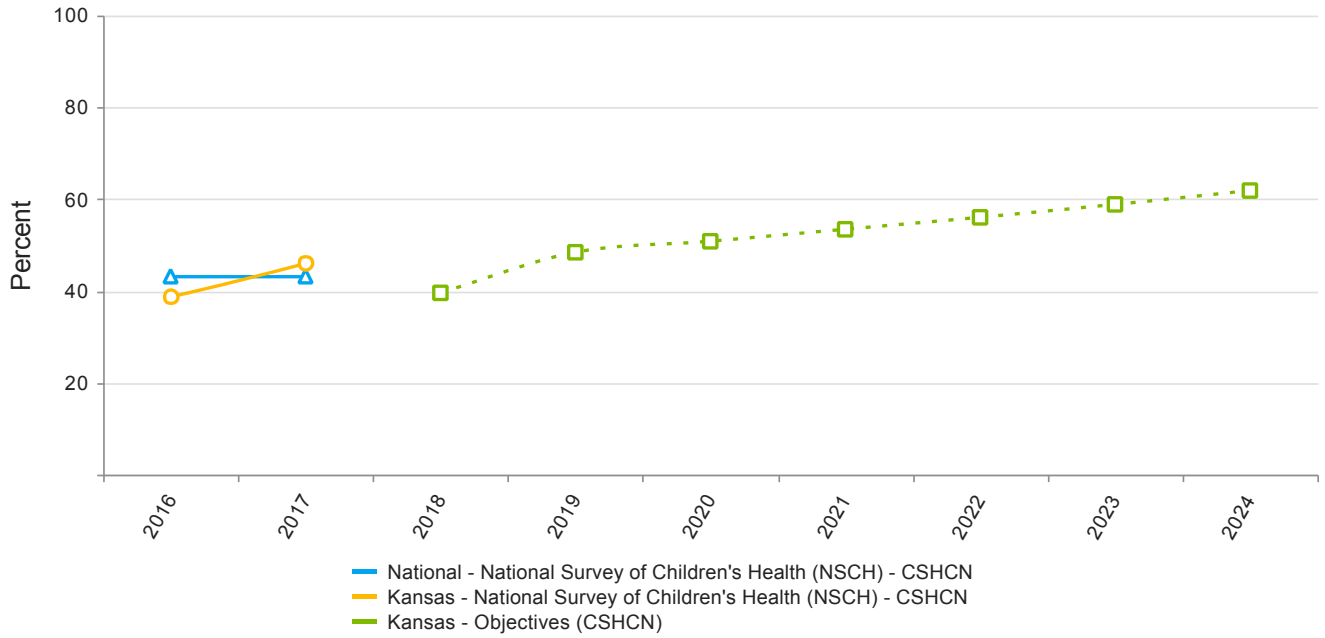
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016_2017	15.9 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	51.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	91.0 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016_2017	2.1 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			39.6
Annual Indicator		38.6	46.1
Numerator		56,808	68,059
Denominator		147,272	147,776
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	48.4	50.8	53.4	56.0	58.8	61.8

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		5	5
Annual Indicator	0	0	66.7
Numerator			18
Denominator			27
Data Source	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	70.0	75.0	80.0	85.0	90.0	95.0

State Action Plan Table

State Action Plan Table (Kansas) - Children with Special Health Care Needs - Entry 1

Priority Need

Services are comprehensive and coordinated across systems and providers.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

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

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

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

Strategies

6.1.1 Support family-centered medical homes through increased awareness among families, including communicating with their doctors and building effective health advocacy skills. 6.1.2 Provide professional development opportunities to health care providers to increase family-centered medical home supports. 6.1.3 Implement communication and referral protocols for SHCN Care Coordinators and providers.

6.2.1 Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers. 6.2.2 Expand KS-SHCN to have care coordinators located in all six Kansas public health regions. 6.2.3 Engage Managed Care Organizations and primary care providers in collaborative coordination for SHCN clients. 6.2.4 Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care. 6.2.5 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients and perinatal community collaborative participants.

6.3.1 Complete the online navigational toolkit to provide resources and services, including expansion to Help Me Grow. 6.3.2 Increase access to primary and specialty care in underserved areas. 6.3.3 Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals. 6.3.4 Connect SHCN care coordinators with foster care and Managed Care Organization case managers to provide technical assistance and support for SHCN clients. 6.3.5 Ensure SHCN providers have access to care coordinators for support and assistance in their community (in-person or remote access).

ESMs	Status
ESM 11.1 - Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

PRIORITY: Information is available to support informed health decisions and choices

SPM 4: Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them.

Local MCH Reach: During SFY2018, 47 of 70 grantees (67%) and during SFY2019, 37 of 71 grantees (52%) provided services to the Cross-Cutting/Systems Building population.

Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate decisions regarding their health.[1] According to the most recent 2016 Kansas Behavioral Risk Factor Surveillance System (BRFSS) CDC optional module data, three screening questions measure health literacy: 1) ***Find information***: "How difficult is it for you to get advice or information about health or medical topics if you needed it?", 2) ***Understand oral information***: "How difficult is it for you to understand information that doctors, nurses and other health professionals tell you?" and 3) ***Understand written information***: "You can find written information about health on the Internet, in newspapers and magazines, and in brochures in the doctor's office and clinic. In general, how difficult is it for you to understand written health information?".

About 4.7% of Kansas adults reported that it is somewhat difficult or very difficult to get advice or information about health or medical topics if they need it; 7.2 % reported that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them; and 7.0% reported that it is somewhat difficult or very difficult to understand written information about health on the Internet, in newspapers and magazines, and in brochures in the doctor's office and clinic.

[1]Institute of Medicine, Health Literacy: A Prescription to End Confusion. Editors, Lynn Nielsen-Bohlman, et al., Committee on Health Literacy, Board on Neuroscience and Behavioral Health. https://www.nap.edu/catalog/10883/health-literacy-a-prescription-to-end-confusion

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

Local MCH Agencies: "What to do when your child gets sick" books are easy to read and use for all literacy levels. The book and curriculum are discussed with families during clinic visits, home visits and/or after completion of the KPCC prenatal education classes. Local agency nurses recognize health literacy is essential to promote healthy individuals, families, and communities. Local agency staff acknowledge that health literacy is a primary factor behind health disparities. Local MCH staff routinely assess materials for the level of health literacy and attempt to simplify information and illustrations, encourage a client's questions, and determine if a client can verbalize knowledge and understanding of the information presented. Some local agencies provide a Spanish translator at MCH and WIC services as needed to enable and strengthen communication between staff and the client. Local MCH staff realize that social, economic, environmental, and cultural factors may be underlying contributors to health and social outcomes. Educating and empowering clients is the best method to help support informed health decisions and choices. Local agencies offer to help explain medical information with clients and parents if they report not understanding something. Staff make sure all written literature is an appropriate reading level for all clients.

MCH-Affiliated Programs – Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI): Case management in the TPTCM and PMI programs allows the opportunity to provide health information education to clients through one-on-one sessions and in group settings to increase health literacy. Case managers identify individual educational needs in targeted areas through use of goal planning tools and clients are connected to classes available

through the agency or though supportive community partners. TPTCM educational activities are deigned to increase client self-sufficiency which in part will aid in their knowledge and ability to obtain quality care for themselves and their children after program completion. Case managers encourage client participation in quarterly agency Advisory Group meetings to provide leadership opportunities, a platform to be a positive role model to peers and to provide feedback on program evaluation.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom (BaM) Program: Assuring accurate information is available to support informed health decisions and choices was a major focus of the KPCC "relaunch" initiative that occurred in 2017. As a result of focus groups and the work of the curriculum review committee, numerous supplemental handouts were added to the original curriculum in an effort to better inform participants and better prepare them as advocates for their care and the care of their baby. As a reoccurring theme throughout each of the six sessions, participants are guided through an activity "what questions will you ask your provider." During the activity they are encouraged and assisted in preparing questions they might ask their provider related to the information they learned during the session. This has been an ongoing theme that we have carried forward with annual updates made to the curriculum and its associated resources.

SHCN Care Coordination: Three years ago, the KS-SHCN program developed and implemented a holistic care coordination program to meet the needs of their clients. KS-SHCN Care Coordinators assist clients/families in making informed health decisions by assisting them in learning about their options, making informed decisions, and assisting in problem solving solutions. All information, written or oral, is presented to families with the health literacy of the family in mind. All KS-SHCN Care Coordinators are encouraged to participant in health literacy trainings. During care coordination training, health literacy is discussed, and all coordinators participate in role playing activities to help them identify the families/client's literacy abilities and modify their assistance, so the families/clients' needs are properly being addressed. KS-SHCN program has also provided Family Care Coordination Training (FCCT) to families across the state over the last few years. The goal of this training is to help families learn how to better communicate with their medical providers and advocate for their child's health needs. *Training flyer: http://www.kdheks.gov/shcn/care_coordination.htm*

Navigating Kansas Medicaid and the Insurance System: Local MCH clients often have a hard time navigating the insurance system and/or Kansas Medicaid. To address this issue, local agencies facilitate the on-site enrollment of MCH clients into insurance and Kansas Medicaid. All agencies will screen clients for insurance status at every visit encounter. If the client does not have insurance, clients are also screened for Medicaid income eligibility. If the client meets Medicaid income guidelines, applications are given to clients and assistance is offered in completing the application and submitting it to Medicaid. For clients who do not qualify for Medicaid, Marketplace health insurance information is provided along with contact information to a Navigation Specialist.

Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

The KS-SHCN program continues to support, through Aid-to-Local grant process, the Kansas Youth Empowerment Academy (KYEA) Faces of Change program for youth across Kansas. Faces is a program designed to build strong leadership skills for youth with disabilities. This program began in 2016, with the conclusion of the first session in the spring of 2017. The program has completed three, 7-month sessions and is currently recruiting for its 4th session. For the first time in the program's history, they are opening recruitment for both youth with and without disabilities. Each youth completed a community project to learn the importance of community services and to further build their leadership skills. Follow-up evaluations were sent to those who have graduated from the program to see how they have continued to use their leadership skills. Alumni from the previous sessions are featured as guest speakers for subsequent sessions. The SHCN Program Manager and MCH Adolescent Health Coordinator participated in a FACES session to get to know the participants, learn about their community projects and to become more familiar with the work occurring.

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

Special Health Care Needs State Plan: The KS-SHCN program continues to build infrastructure and capacity for increased services for all CYSHCN in Kansas. KS-SHCN has been aligning program services and contractual supports with the "Standards for System of Care for Children and Youth with Special Health Care Needs". This began with the strategic planning in 2015, however, was enhanced with the KS-SHCN 5-Year Plan and the completion of the D-70 Systems Integration Grant. As a requirement of the grant, a "state plan" was developed. Rather than developing a plan specific to the grant, the team decided it would be more worthwhile, to develop a plan around the overall system of care in place for CYSHCN.

This plan encompasses much more than the KS-SHCN or Title V systems and is being used to create a plan for the 10 system standard domains. The plan was developed in five stages over the course of two years, allowing for sufficient review and assessment of each domain and related standards, utilizing a community engagement process and engaging the most appropriate partners for each domain. The process included six regional meetings (one in each public health region of the state), a statewide survey, and a full-day planning meeting with key stakeholders. Through the qualitative data received through the regional meetings, the quantitative data received through the survey, and the strategies presented at the planning meeting, a shared vision was achieved for the domains discussed, as outlined in the State Plan for Systems of Care for Children and Youth with Special Health Care Needs.

2018 Governor's Public Health Conference: Title V staff provided extensive support for the Annual Kansas Governor's Public Health Conference which included pre-conference session that focused on advancing public health priority issues through universal screening, brief intervention, and referral. Focus was on building skills for specific evidence-based interventions and valid screening related to: smoking and substance use, perinatal/maternal depression, reproductive life plan counseling, and increased access to Long Acting Reversible Contraceptives (LARC). Opportunities for participants to gain hands-on practice, share, and learn was provided. Significant concepts related to successfully implementing public health interventions and enhancing programming was also discussed including family and consumer engagement, community coordination/collaboration, quality improvement, and policy/procedure development. A wide selection of breakout sessions tailored to meet the changing needs of the populations served through public health programs were offered during the general session of the conference. The preconference on April 3, 2018 drew 131 attendees and was targeted to MCH local agencies. It promoted data-driven planning, evaluation and quality improvement. Focus was on building competence and confidence in utilizing data to inform program development including opportunities for participants to gain hands-on practice and share stories.

MCH Local Agency Monitoring Visits: Technical assistance and training was provided directly to local MCH agencies/grantees by KDHE MCH staff through 25 check-in meetings and 8 on-site visits. KDHE MCH staff offer technical assistance to local agency staff on their MCH work plan as well as discuss their strengths, challenges and any other technical assistance needs they may have. During a review of quarterly progress reports, if KDHE MCH staff identify a local MCH agency needing assistance or if an agency requests additional assistance, a site visit may also be conducted. KDHE MCH staff are working towards being more available to local agencies to develop relationships and assist in strengthening their MCH programs to show the impact they are making in their communities. Staff are utilizing DAISEY data and discuss any issues they find with local agencies during check-in meeting and on-site visits. Copies of the MCH monitoring visit tools and materials are available upon request.

Date	Check-In Meetings	Date	On-Site Visits
09/06/18	Thomas County Health Dept.	11/01/18	Lawrence-Douglas County Health Dept.
09/07/18	Dickinson County Health Dept.	11/16/18	NEK Multi-County Health Dept.
09/10/18	Ellsworth County Health Dept.	02/07/19	Cloud County Health Dept.
09/12/18	Riley County Health Dept.	02/07/19	Republic County Health Dept.
09/13/18	Morris County Health Dept.	02/27/19	NEK Multi-County Health Dept.
09/13/18	Johnson County Dept. of Health & Env.	03/05/19	Rooks County Health Dept.
09/14/18	Saline County Health Dept.	03/06/19	Lincoln County Health Dept.
09/17/18	NEK Multi-County Health Dept.	03/07/19	Morris County Health Dept.
09/18/18	Clay County Health Dept.		
09/19/18	Pottawatomie County Health Dept.		
09/19/18	Shawnee County Health Agency		
09/20/18	Lawrence-Douglas County Health Dept.		
09/24/18	Phillips County Health Dept.		
09/25/18	Mitchell County Health Dept.		
09/25/18	Unified Govt of Wyandotte County		
10/18/18	Sheridan County Health Dept.		
10/18/18	Leavenworth County Health Dept.		
11/27/18	Barton County Health Dept.		
12/11/18	Sheridan County Health Dept.		
01/08/19	Franklin County Health Dept.		
01/16/19	Rooks County Health Dept.		
01/28/19	Riley County Health Dept.		
02/04/19	Riley County Health Dept.		
02/27/19	Barton County Health Dept.		
03/28/19	Mitchell County Health Dept.		

MCH Local Agency Technical Assistance Webinars: KDHE MCH staff provide technical assistance and training webinars throughout the year to local MCH agencies. Topics are identified based on emerging issues identified by state or local staff; identified need for reporting changes in the health care/public health system; need for increased collaboration with other partners (EX: Safe Kids); and/or identified need for assistance with screening, intervention, education, referral or other service or support provided at the local MCH grantee level. Several webinars were provided about KGMS, the application and reporting system for local agencies. A wide variety of topics were presented during FY18 (see table below).

Date	Title/Topic	Attendees
3/18/2019	DAISEY Learning Collaborative Technical Assistance Webinar	2
2/21/2019	SFY19 MCH Technical Assistance Webinars	101
2/15/2019	DAISEY Learning Collaborative Technical Assistance Webinar	5
1/30/2019	Open-Mic - SFY20 KGMS Application & Budget	47
1/24/2019	Open-Mic - SFY20 KGMS Application & Budget	58
12/18/2018	DAISEY Advisory Group Meeting	6
12/17/2018	DAISEY Learning Collaborative Technical Assistance Webinar	5
10/18/2018	SFY19 MCH Technical Assistance Webinars	54
10/8/2018	Kearny County Hospital Introduction to MCH	1
9/26/2018	SFY19 MCH Progress Report in KGMS	18
9/20/2018	SFY19 MCH Progress Report in KGMS	25
9/17/2018	Kansas Medicaid Overview	9
9/12/2018	Kearny County Hospital - DAISEY Forms	1
8/29/2018	DAISEY Advisory Group Meeting	5
8/21/2018	Reno Co. Conversation Re: MOD Grant Proposal	1
7/24/2018	SFY19 MCH Technical Assistance Webinar - Count the Kicks	44
7/23/2018	BaM Monthly Webinar - July 2018 Program Updates	20
7/19/2018	SFY19 MCH Technical Assistance Webinars	45
6/19/2018	Kearny County Hospital Introduction to MCH	4
6/5/2018	SBHC Team Conference Call	8
5/17/2018	SFY18 MCH Technical Assistance Webinar - Local MCH Data Trends on Kansas Measures	69
5/8/2018	DAISEY Aggregate User Meeting	11
3/12/2018	Tobacco Free: Partnerships to Improve Birth Outcomes	8
2/26/2018	Tobacco Free: Partnerships to Improve Birth Outcomes	15
2/26/2018	Tobacco Free: Partnerships to Improve Birth Outcomes	13
2/20/2018	SFY19 MCH Application Open-Mic Q&A	45
1/29/2018	BaM Monthly Webinar	30
1/24/2018	SFY19 MCH Grant Application	45
1/16/2018	SFY19 MCH Grant Application	48
11/16/2017	SFY18 MCH Technical Assistance Webinar - Collaborations & Partnerships (SHCN, Safe Kids, WIC)	78
11/9/2017	BaM DAISEY Data TA with Riley Co.	1
9/28/2017	SFY18 MCH Progress Report	14
9/26/2017	BaM Reports in DAISEY - getting started as a new program site	1
9/25/2017	BaM Monthly Webinar - Safe Sleep Integration Update	18
9/20/2017	SFY18 MCH Progress Report	23
9/5/2017	MCH Technical Assistance Webinar - DAISEY Direct Entry Users	13

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

Supporting You: 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 Special Health Services (SHS) programs worked with the Special Health Services –Family Advisory Council (SHS-FAC) to develop "Supporting You". A support/connected peer data system, "Supporting You" was developed 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. "Supporting You" was designed as a global support network for a variety of peer support program options.

The mission of Supporting You is: Connecting parents who share experiences to support the health of their family through a system of support. The network strives to assure every family in Kansas has the opportunity to connect with a trained parent who can provide emotional support, referrals to relevant resources and a listening ear for those in need of help to support their family and caregiver health needs.

The Supporting You network is designed to be a:

- Connecting point for parents who share experiences to support the health of their family.
- Support system that uses personal or multi-disciplinary communication forums to allow parents to share experiences.

Referred parents can be connected to supporting parents, caregivers, or siblings who have similar experiences or needs. A web-based system supports matching parents based on a questionnaire about experiences and desired supports. The system can match on any criteria asked on the questionnaire.

Two SHS-FAC workgroups formed: Data System/Evaluation Measures and Policies/Training. The Data System and Evaluation Measures group has developed measures to identify the utilization of the system, but more importantly the quality of the experience. Evaluation of the network will revolve around favorable experiences, successful matches, relationship-building, and mutual benefit, among other quantitative data. This group has also focused on creating work flows and processes around evaluation and data collection and informing the development of the web-based matching system. The Policies and Training group has focused on the development of the Supporting You Handbook, the guiding document for those who sign up to provide support to a referred parent. This handbook will provide the outline and content of the supporting parent trainings, with the addition of special topics such as active listening, motivational interviewing, and compassion and empathy. Additional trainings on specific resources or population needs (such as the deaf/hard of hearing culture) will also be provided by some of the participating programs.

Currently, "Supporting You" consists of three pilot programs, School for the Deaf, SHS-FAC (behavioral health focused) and the KS-SHCN program. The program launched in December of 2018 for Supporting Peer enrollment and will open for Connected Peers in the coming months. Matches will occur once there is a large enough pool of trained Supporting Peers. Extensive work has been done to develop the data system, trainings, promotion, protocols, policies and onboarding criteria.

KS-SHCN Care Coordinators have continuously, over the past few years, reported that families frequently request this type of support and they are very excited to be sharing "Supporting You" with the families they work with. A part-time Parent Support Administrator was hired by the KS-SHCN program to support both the Supporting Peer and the Connected Peer, make the matches, monitor matches, provide training to Supporting Peers, if they are unable to attend one of the monthly webinar training (held the third Tuesday of each month at 12:00 and 7:00 pm), recruit Supporting Peers and to conduct program promotion. More information can be found in the

CSHCN Report.

Objective: Implement collaborative oral health initiatives to expand oral health screening, education, and referral by 2020.

Partnership with Oral Health Kansas: Title V and Oral Health Kansas (OHK) are working with other partners to create a state that values oral health as a part of overall health for Kansans of all ages, cultures and resources. A number of activities have been completed in an effort to improve awareness of the importance of good oral health to overall health and wellbeing. The following activities were completed in FY18.

- Launching biannual oral health awareness campaigns. These include hidden picture oral health posters and social media toolkits.
- Incorporating oral health information into the "Becoming a Mom" perinatal classes offered across the state.
- Creating on-line and in-person workshops for child care providers. Workshops include an opportunity for a site visit for technical assistance as well as oral health education and screening services for the site's children.
- Evaluating oral health materials MCH partners use to ensure they are up-to-date and accurate. Follow up will include creating a user-friendly tool to locate oral health handouts, books, and videos that offer consistent and evidence-based information.

In addition to advocacy efforts, OHK is working with the Geary County early childhood community to add oral health screenings to their developmental screening events. The dental community in Geary County has also been invited to participate in the Geary County IRIS community/referral network (http://connectwithiris.org/).

Care Coordination: KS-SHCN Care Coordinators will continue working with families to assure they have a dental health home and are receiving preventive oral health care services. For program participants with Cleft Lip/Cleft Palate, KS-SHCN will work with Medicaid, dentist, oral surgeons, and community partners invested in oral health care in Kansas to assure children receive the care they need to support optimal health.

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

SPM 5: Number of MCH grantees, families and partners that participated in a state sponsored workforce development event.

Local MCH Reach: During SFY2018, 47 of 70 grantees (67%) and during SFY2019, 37 of 71 grantees (52%) provided services to the Cross-Cutting/Systems Building population.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

The Title V program provides many opportunities on an annual basis for MCH professionals, partners, and grantees, including family members and consumers, to receive training, technical assistance, and consultation.

Local Public Health Program: Title V continues to have a strong partnership with KDHE's Local Public Health Program (LPHP). With direct support from Title V, LPHP staff led the following activities related to workforce development and capacity/systems building (not a comprehensive list).

- Developed and distributed the monthly newsletter, *Public Health Connections*, sent to all local health departments as well as other public health system partners. *Public Health Connections* provides Kansas public health professionals,

including the MCH workforce, with information on upcoming training opportunities, funding opportunities, recent public health research, and updates on changes in the state public health system. It often features information that allows the MCH workforce to increase their knowledge and skills to better address the needs of their communities.

- Facilitated and participated in monthly population health webinars for local health department staff and other public health system partners each month during the reporting period. The webinars include disease updates/outbreak information, training opportunities, STI updates, and other timely information.
- Continued to offer the course, Health in 3D: Diversity, Disparities and Social Determinants of Health, which focuses on specific cultures present in Kansas and includes the importance of cultural awareness and competence.
- Continued efforts to support local health departments in providing school sanitary inspections, which are required by statute to be conducted by local health departments but only 10% are currently meeting this requirement. LPHP staff presented at the 2018 Kansas Environmental Health Association conference about the statute and the expectations related to inspections at a day-long pre-conference session focused on school inspections. Approximately 50 people attended. An online training was developed using content from the conference.
- Convened and conducted 39 regional meetings for local public health agency administrators (and/or staff). These live regional public health meetings were held in the six KDHE public health regions of Kansas for the purpose of furthering statewide collaboration on public health topics and providing workforce development to the public health system. Each meeting provided, at a minimum, an update on state MCH activities and an opportunity for KDHE MCH staff to deliver relevant content in face-to-face settings details.
- Led the development and implementation of the 2017 Kansas Public Health Workforce Assessment based on the Council on Linkages Core Competencies. The assessment was distributed to state and local health department staff in the fall of 2017. Data collection and analysis began in early 2018. Reports were distributed to local health departments actively seeking accreditation. 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. The results of the assessment were used to identify training topics for the 2019 Governor's Public Health Conference and the Regional Public Health Meetings.
- Developed and delivered the 2018 and 2019 Governor's Public Health Conference.
- Coordinated training held April 26, 2018, with a national speaker, Jerry Moe from Hazelden Betty Ford Foundation who is the director of Children's Programs. The training focused on best practices for working with children who are impacted by parental substance abuse. Approximately 200 professionals attended.
- Leadership of and collaboration with the Kansas Public Health Workforce Development Coordinating Council. Developed and delivered content to further knowledge and understanding related to MCH best practices, Core Public Health Functions, Essential Services, and PHAB Standards and Measures to entry-level and advancing public health professionals and governing bodies.

Objective: Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.

Local MCH Agencies: Strengthening family resilience has been a common goal among all MCH related programs at the state level. Great effort has been made by KDHE to create an awareness among local grantees of the need for focused initiatives in this area. The 2018 Governor's Public Health Conference included breakout sessions supporting increased knowledge of Adverse Childhood Experiences (ACEs) and trauma-informed approaches. Many local grantees have been partnering with other community agencies as well as making referrals to early childhood and parenting support programs. Focus on kindergarten readiness, centering on the social emotional health of the child, is a part of collaborative efforts at the community level, as highlighted by partnerships in the KPCC collaborative models in Saline and Reno counties. Kansas Title V staff participated in ACEs 101 and Lemonade for Life trainings to gain insight into ways ACEs and resiliency tools can be provided to local MCH agencies.

NOTE: Refer to other domain narratives within the application to read more about workforce development opportunities specifically related to mental health targeted to women, pregnant women, children, and adolescents.

Other Cross-cutting Activities

Shared Measurement Systems in MCH: DAISEY: The Bureau of Family Health worked with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) (https://cppr.ku.edu/) to: 1) implement and support a secure, HIPAA compliant web-based shared measurement data system (DAISEY); 2) train and provide technical assistance to DAISEY users to capture MCH services at the individual level and use data to inform MCH practice and service delivery; and 3) provide analytics to improve accountability and continuous quality improvement at the state and local levels. KDHE's vision for integrated and coordinated community-level maternal and child health initiatives requires high quality, reliable data from all local MCH providers across the state. KDHE uses DAISEY to support Title V system transformation through a phased approach involving input and communication with local providers throughout the process.

KDHE and KU-CPPR staff provided extensive training and technical assistance through webinars, individual phone instruction, on-site training and recorded navigational videos of forms in the DAISEY system. A DAISEY Helpdesk email is available to provide direct technical support for system users. To provide a central access point for all DAISEY-related information, a website was developed for use by local agency users (http://daiseysolution.com/kdhe/). Information available on the website includes user request templates, data security forms and policies, an implementation guide, user manual, instructional videos, printable versions of forms, report guides, Data Dictionaries and a calendar of upcoming scheduled trainings. In addition to the extensive TA and support that is provided, a DAISEY Advisory Group was developed in 2017 and met quarterly throughout FFY2018. The Advisory Group is made of local agency users representing multiple programs in both rural and urban areas. Their role is to provide input into local needs regarding data collection and measurement and also provide feedback regarding requested form and report changes and other technical elements of the DAISEY system.

Aid-to-Local Process: In addition to partnerships with state-level organizations working directly with communities, Title V contracted with more than 70 local agencies providing MCH services across the domains for FY18. Most local programs funded by the Block Grant are delivered by local health departments and safety net clinics (independent entities). These agencies are positioned to provide core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The services delivered by local agencies are designed to address ongoing needs and those identified by the most recent needs assessment. For a number of years, local agencies used the web-based Catalyst system for a single point of access, allowing local applicants/potential grantees to view and actively manage all Aid-To-Local (ATL) grants with KDHE. SFY18 was the last year ATL grantees used the Catalyst system. The Kansas Grant Management System (KGMS) was developed by KDHE IT staff for use effective July 2018. KGMS replaced Catalyst for all ATL grants, including MCH. Local MCH agencies utilized KGMS to submit the FY19 MCH grant applications and budgets. Grantees currently provide progress and financial reports through KGMS quarterly.

MCH Application Review & Award Process: In SFY18, we had 70 applicants apply for the MCH grant, 61 of the applicant agencies (87%) provided home visiting services, and 14 agencies served as a Special Health Care Needs Satellite Office. After the applications and budgets are submitted, proposals are reviewed by KDHE MCH staff, program staff in the Bureau of Family Health, other KDHE Division of Public Health Bureaus (Health Promotion and Community Health Systems/Local Public Health section), MCH council members, and family/consumer representatives (when available). Reviewers used a scoring rubric to assess each application and budget. Each application is reviewed by two reviewers. We have also developed a funding formula that considers a five-year average of: 1) children under 18 years of age in poverty; 2) the number of children 0-22 years of age; and 3) females 22-44 years of age in their county. We tried to align all applicants with their funding formula amount as well as their application average scores. If an applicant is over funded based on the formula, we considered previous performance, services provided, and the total population served to determine if a decrease needs to be made. We tried to not reduce applicants more than 10% of their previous award amount if possible. Applicants were given additional funds if they are providing home visiting services and/or serving as a special health care needs satellite office. KDHE MCH staff create progress reports in KGMS for local MCH agencies to report progress complete each

quarter. KDHE MCH staff review all progress reports to verify grantees are completing the work outlined in their applications as well as review Financial Status Reports (FSR) grant expenditures, including program revenue, related to their approved budget.

Local MCH Workforce Development: The MCH Navigator and online MCH Assessment are utilized and fully integrated into the professional development planning and performance reviews for all local MCH staff. All local MCH program staff and supervisors must complete MCH training via the online MCH Navigator. Two courses must be completed within three months of grant award or hire, whichever applies (MCH 101 and MCH Orientation). In addition to basic training and orientation, local program staff delivering certain messages or services, including education, are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination, etc.). Annual/ongoing training requirements for all local MCH staff include technical assistance calls/webinars throughout the year led by the state MCH team and the annual Governor's Public Health Conference. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing the online MCH Navigator Self-Assessment.

Local Public Health Listening Tour: KDHE held its first listening tour in 2018 to seek feedback from local health departments (LHDs) about KDHE's strengths as well as weaknesses/opportunities for improvement. The listening tour was conducted by Kendra Baldridge and Cristi Cain (Local Public Health Program director), Bureau of Community Health Systems, during the regional public health meetings held across the state. Regional meetings occurred in Chanute (July 12), Topeka (July 26), Hutchinson (August 1), Garden City (August 8), Oakley (August 9), and Beloit (August 22). Feedback was gathered from 90 attendees representing 69 counties across Kansas. A report summarizing the information gathered was developed. It was shared with KDHE leadership and the appropriate staff to review and create actionable steps to address needs and concerns. This information will also inform the agency's upcoming strategic plan. Program/employee specific concerns and compliments were shared with appropriate leadership immediately.

Public Health Accreditation – State: The Local Public Health (LPH) staff is responsible for leading the accreditation process. Efforts included organizing planning meetings, conducting a mock site visit, and hosting an actual PHAB site visit for the state healthy agency (KDHE). The agency was accredited in November 2017, and the Kansas Title V Director is a member of the State "A" Team. The accreditation process works towards strengthening health departments by advancing the quality and performance of the agency. Health literacy and cultural competency are key components of a high-performing health department that are recognized in the accreditation standards. Made possible with support from MCH, a number of advances were made to strengthen the agency's protocols and processes related to health literacy and cultural competency through KDHE's accreditation work. Health literacy was identified as an area for improvement; LPH staff have since worked closely with Communications and other KDHE staff to improve the readability of agency's communications and resources. LPH staff helped develop and submit an annual report to the PHAB Board on the improvements that have been made since KDHE achieved accreditation.

Children with Special Health Care Needs - Application Year

PRIORITY 6: Services are comprehensive and coordinated across systems and providers

NPM 11: Medical home (Percent of children with special health care needs having a medical home)

Local MCH Reach: Based on SFY2020 MCH Aid-to-Local applications received, 12 of 70 grantees (17%) plan to provide services to the Children with Special Health Care Needs population 9 agencies plan to serve as a Special Health Care Need Satellite Office.

In preparation for the Title V Needs Assessment in the coming year, the KS-SHCN program staff will be reviewing progress towards the objectives and strategies within the 2016-2020 SHCN Action Plan and developing individual and program goals for the next five years. A timeline will be developed for the coming year based on program priorities and a collective staff vision. A review of the current Care Coordination processes, Direct Assistance Programs (DAP's), data system needs, and other program areas will be reviewed, discussed and updated/changed, if needed. This process is being designed to give everyone an equal voice and promote their buy-in on programmatic changes. It takes a team effort to make the program function properly and give the greatest benefit to clients. It is anticipated that this will be an annual activity within the program to assure ongoing progress towards program and Title V objectives is being monitored by all program staff, with inclusion of Satellite Offices (SO's) in the future.

In addition to preparing for the needs assessment, the KS-SHCN program will be engaging in efforts to assure alignment across the Title V CYSHCN expectations, the recent evolution of the program, and the future direction in which the program is heading. As the program has evolved significantly over the past several years, it makes good sense for a complete statutory and regulatory review. This may result in state-level legislative initiatives, formal regulation changes, or policy change. As this work progresses the Special Health Services Family Advisory Council (SHS-FAC) will be asked to review and give feedback.

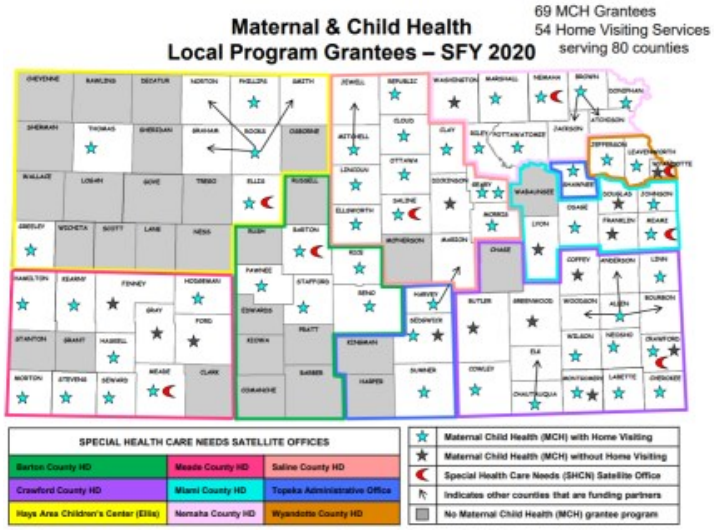
The KS-SHCN program has experienced a reduction in the number of clients served on the program in recent years, despite programmatic changes to better support families and address the needs identified through extensive assessment and planning processes. A common theme identified across the program and SO's is that that the program is not widely known – and those that are familiar with the program, are familiar with the program the way it used to be. Additionally, there is still significant confusion that the program is not the same as Medicaid (KanCare) and therefore families think they have already applied when referred, or providers do not feel like there is a reason to apply to KS-SHCN, if the client is already on Medicaid. To counter this, the KS-SHCN Program will be developing a marketing campaign that can be shared by all SO's to assist them with promotion of the program. The overall goal is to see a steady increase in the number of clients served by the program by 5% each year for the next five years.

Transformation of The Title V CYSHCN Program: The KS-SHCN program will continue to align with the MCH programs and services across the state, as well as, build new partnerships to better support the CYSHCN population. The program will continue to share the message that "CYSHCN are children first" and need all the same services and supports that are provided to infants, children, and adolescents, generally.

Throughout the coming year, much effort will be put into building partnerships with mental health agencies, Federally Qualified Health Centers (FQHC's), medical providers and non-profit agencies across the state. By building these partnerships, the KS-SHCN program will increase its referral connections, increase the number of providers connected to the program willing to take the KS-SHCN reimbursement rate, and improve services for the CYSHCN population. The KS-SHCN program will learn about the services and supports offered to all children and what these agencies are doing to accommodate those with special needs. Where gaps are noted the program will identify possible gap filling measures and collaborate with partners to address those gaps.

The KS-SHCN five priorities (Care Coordination, Behavioral Health, Caregiver Health, Training and Education, and Direct Services), objectives, and activities will continue to be advanced with guidance and assistance from the SHS-FAC. The focus for the coming year is on review and revision of objectives and related evaluative measures, and assuring progress is made on the highest priority areas. Objectives and activities that have not begun, or have not made progress, will be evaluated to determine if they should remain, or be reconsidered in the upcoming needs assessment process. Of those objectives in which progress has been slow, key factors and drivers noted include staff changes, lack of partner interest or support, and competing priorities not anticipated at the time of the plan development.

Satellite Offices: The KS-SHCN program has found great value in partnering with MCH grantees throughout the state to serve as KS-SHCN Satellite Offices (SO). Each year, the work load and capacity of each office and the program needs are evaluated to determine the number of SO needed and the amount of time and effort being requested by the SHCN program. Based on this information and the reality that some of the existing SO's are in rural and frontier areas with a very small SHCN clientele, SO will be reduced to eight for SFY20. See screenshot of the service map below (original/full-page version available in supplement documents). All SO's will continue to provide holistic care coordination services. All the SO's are located in local health departments, except one which is located within an Infant-Toddler/MCH partner program (Ellis county).



Each year, KS-SHCN hosts an annual SO training held in July, followed by bi-monthly webinars and "brain trust calls." During the webinars, guest speakers will present on services and supports available across the state that might be helpful for care coordination clients. Speakers are determined based on feedback from SO staff and input from the Topeka Administrative office who provides oversight and support for all SO. "Brain Trust Calls" allow the care coordinators to present client cases that they need assistance with for help brainstorming ideas and solutions to address the problem. This has been very effective for identifying resources and allowing the Care Coordinators to think critically around their work and assistance to families. Additionally, this has assisted with unifying state (Topeka) staff with staff located in the SO's. KS-SHCN will continue to provide daily assistance to SO staff and conduct yearly site visits to each SO.

CYSHCN Systems Alignment and Integration: The CYSHCN Director and KS-SHCN Program Manager will be focusing efforts this year on partnerships among the behavioral health and foster care systems. In partnership with the Child/Adolescent Health and Behavioral Health Consultants, the program will be collaboratively building partnerships across agencies and providers in these systems across Kansas. While traditionally, behavioral or mental health was viewed separately from physical health, Title V and public health recognize the importance of an integrated approach for optimal health outcomes. Therefore, learning about services offered across the state and building partnerships is critical to meeting the needs of the CYSHCN population. Additionally, the needs of CYSHCN in the foster care system are great, however SHS-

FAC members report great concern with the lack of dedicated training, supports, and consideration or the specialized needs of the CYSHCN population in the foster system.

In the coming year, KS-SHCN will collaborate with the Infant-Toddler Services (ITS) program to develop an Interagency Agreement (IAA) that can be used as foundational support for local ITS programs, providing guidance around referral processes and training opportunities for both programs. Historically, program staff have reported concerns or challenges around referrals due to the protections of personal health and educational records, an additional goal of the IAA is to reduce concerns through education, remove barriers through system-level policies, and mitigate future challenges in supporting appropriate cross-system referrals. This will also serve as a model for how KS-SHCN may be able to engage in these system-level agreements to improve bi-directional referral access and help assure families receive timely, appropriate, and complete referrals for services and supports.

To further support a stronger integration among Title V and ITS services, the ITS and KS-SHCN Program Managers will collectively work together for informational presentations for the others' staff, local/field staff, and key partners to learn of the respective programs. The goal is to assist staff in understanding the services and supports families can receive and how they can work collaboratively across systems to make sure the family and child are getting what they need, with no duplication of effort by either program.

Many partners have shared that they are uncertain when to refer families to the program. Therefore, a resource/tool is under development to help partners and providers understand when to refer a family to the program. This tool will be added as part of the marketing campaign materials and disseminated among all KS-SHCN partners, SO staff, physicians, home visitors, and local ITS programs to help them identify when to refer a child to the KS-SHCN program for assistance.

Direct Assistance Programs: Direct Assistance Programs (DAPs) will be reviewed by the SHCN Administrative Team in May 2019. Based on information gathered by the KS-SHCN staff and grantee partners, the team will determine if additional DAP's need to be developed or if service gaps can be addressed in already existing DAP's. Staff are encouraged to think outside of the box when looking at DAP needs. Once the determination for changes are made, policies revisions or creation will be made, effective July 1, 2019. By thinking broadly and identifying gaps in services for the CYSHCN population, the program will continue to meet client needs now, and in the future, as the health care systems change.

KS-SHCN and Medicaid Partnership: The KS-SHCN program will continue to work collaboratively with Medicaid and MCO partners to assure clients are receiving appropriate services, including review of the monthly MCO reports, sharing of KS-SHCN summary sheets, and filling gaps in the services and supports provided by the MCO case managers. Partnerships between the MCO case managers and the KS-SHCN care coordinators will continue to be nurtured and grown over the next year, in order to provide quality services for the special health care needs population. This will also include intentional efforts with the assigned KS-SHCN Medicaid Liaison and MCO partners during periods of staff turnover and present to each MCO regarding the KS-SHCN program, so they have a better understanding of the program and how complimentary the programs can be, while reducing duplication.

In January 2019, KanCare brought on a new MCO, Aetna Better Health, and for the coming year, KS-SHCN will be reaching out to share more information about the program and ways to partner to make services for dually enrolled clients smooth and seamless. Additionally, KS-SHCN has identified several opportunities to engage with the MCO's and the Medicaid policy team to streamline service authorization processes and had shared with Title V Leadership in hopes of reducing the amount of time necessary to obtain authorization for certain services, such as orthodontia services for cleft lip/cleft palate for dually enrolled clients. KanCare lacks providers across all MCO's for medically necessary orthodontia work required, however they have worked with the program to support single case agreements with individual providers. However, recently these single case agreements have been increasingly more challenge to obtain, therefore the program will be taking steps to engage in a collaborative quality improvement pilot project in the future.

Aid-To-Local Funding Process: The KS-SHCN program will continue to use the Kansas Grant Management System

(KGMS) Aid-to-Local (ATL) system for SFY20. The application and review process will be evaluated and updated to improve the system for the applicants, reviewers and the KS-SHCN staff in the fall of 2019. Changes to the application, guidance, and review process are anticipated to further streamline processes and support successful applicants. As in past year, project proposals will be required to directly align with the KS-SHCN priorities AND meet certain criteria to be considered for funding. This includes the applicant receiving an overall "score," which is an average of all reviewers' scores, of 75% or more to be considered for funding. More weight will be placed on applications with identified sustainability plans for long-term funding needs, beyond the KS-SHCN funding and multi-year proposals will be expected to incrementally reduce the funds requested by KS-SHCN each year.

In the coming year, grantees will be provided additional training and guidance on budget development and the establishment of setting SMART goal. The invoice and reporting timeline will be shortened to 30 days after the end of each quarter, to align with MCH ATL criteria. Each quarter, grantees will continue to receive a written report from the SHCN Program Manager regarding strengths, questions and comments for additional partnership opportunities, as noted during a review of each grantee's quarterly report.

The KS-SHCN ATL Annual Report will be completed for the third year in a row, for SFY2019. This report outlines programmatic activities throughout the year and reports on ATL projects, goals and objectives obtained, yearly expenses for each project and data required by KS-SHCN. After review by the grantees and the SHS-FAC, the report is disseminated to grantees and key partners and posted on the KS-SHCN website. Additionally, beginning in SFY20, a quarterly newsletter will be established, featuring success stories from grantees.

KS-SHCN Enhanced Data System: Work will continue to make sure that the new data system meets all program expectations. While the system has not been fully operational to date, it has already proven to improve service delivery, tracking and monitoring of client activities, and allowed program staff the ability to report on a variety of outcomes measures. Customized reports are being developed to assist the Program Manager in tracking and monitoring direct and indirect care coordination activities, referral sources, outcomes, client improvement levels, DAP's, budget, Action Plan results, and a variety of other data points that will be used to improve services and supports for clients and the KS-SHCN staff. Once all components are working effectively a family portal will be added so families can access their Action Plans, Authorizations, update their application and send message directly to their care coordinator.

NPM 11: Medical home

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

Increasing family satisfaction with the communication among their child's doctors and others health providers continues to be a key focus of the KS-SHCN care coordination model. Care Coordinators will continue to assist families in communicating their hope, dreams and concerns about their child with their providers, so providers are better informed and equip to make health care decisions for the child, in collaboration with the family. KS-SHCN Care Coordinators will continue to assist family's in preparing for medical appointments by helping them to identify what information they need/want to share with their child's provider and what questions they want to ask the provider to gain a better understand of their child's medical needs and how to care for them.

Family Care Coordination Training: A train-the-trainer curriculum will be developed in the coming year, in partnership with the SHS-FAC. This will allow interested SHS-FAC members to be trained to facilitate the trainings across the state. Facilitators will be provided training, tools, resources, and compensation in this role, but this further extends the capacity of the KS-SHCN program while supporting family professional development and allowing a peer-to-peer model to learning. The KS-SHCN bi-lingual staff has begun work to translate all materials, tools and the PowerPoint presentation modules into Spanish. Once complete, trainings will be offered in Spanish also.

The KS-SHCN program is committed providing quarterly trainings anticipated in SFY20. Locations include: Fort Scott (late summer), Hays (fall), and Junction City (winter). A couple of other locations have been considered for the spring training possibility. KS-SHCN staff continue to work with community partners, grantees, partners, and Satellite Office staff to plan and implement these trainings at different location across that state.

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

Holistic Care Coordination: The KS-SHCN program will continue with providing holistic care coordination and will continue refining outcome metrics for this service. To date, 47% of clients/families receiving care coordination through this model has experienced and improvement in their ability to navigate the various systems of care after only their first year participating in the care coordination program. A care coordination expansion plan will be developed in SFY20. This plan is expected to be done in phases, with monitoring to assure the program has the staffing capacity to meet the needs of additional clients. Data will continue to be used to drive the expansion plan and used as implementation occurs to track and monitor progress, changes and next phase options.

Part of a holistic care coordination approach is to make sure the KS-SHCN Care Coordinators are helping caregivers become empowered and equipped to navigate the various systems of care. To strengthen the caregiver's abilities, the KS-SHCN program will complete the Family Caregiver Assessment modified from the University of Kansas Beach Center on the Disability Family Needs Assessment (developed and researched as a model for the Kansas Early Intervention/Part C program). Once the assessment is competed and has been reviewed and approved by the SHS-FAC, they will assist in the development if next steps and any tools or resources that are needed. This assessment will be incorporated into the KS-SHCN care coordination model with training developed and provided to care coordinators, prior to implementation of the pilot. Tracking and monitoring structures will also be developed for the pilot, with PDSA cycles implemented to determine where change might be needed.

Care Coordination through Clinical Models: Existing partnerships with the Community Health Center of Southeast Kansas and the University of Kansas Pediatrics Cerebral Palsy/Medical Complexity clinic will continue and more robust outcome measures/metrics will be established to support a cost analysist and evaluation during SFY20 in an effort to improve efficiencies and identify the long-term sustainability needs of the clinic.

A long-term vision for the KS-SHCN care coordination program is to assist medical providers in establishing a care coordinator in their practice to help providers establish a medical home for the CYSHCN population they serve. During SFY20, the KS-SHCN Program Manager will formalize this plan and propose to the Title V Leadership, including a funding structure with a tiered cost-sharing component, training protocols, administrative and job descriptions, template for a contract and reporting requirements, evaluation tools, and recruitment materials for interested providers. The goal is to begin provider recruitment for a pilot in July 2021.

Families as Care Coordinators: Another partnership that will continue into SFY20, is with the independent family contractor to provide care coordination services in Wichita, serve as the KS-SHCN Supporting You Peer Support Administrator (PSA), and will assisting with the Family Care Coordination Trainings (FCCT). As a parent of a child with special health care needs, she understands first-hand what the families she is working with are experiencing, which has been incredibly beneficial to the program.

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

Cross-System Coordination: The Title V CYSHCN Director continues to be heavily involved with the Help Me Grow (HMG)

efforts in Kansas and attended the HMG National Forum in May 2019 to assist with planning, implementation, and long-term planning for HMG. The HMG Framework has been heavily integrated to broader early childhood and MCH efforts and will continue to be heavily focused on the broader MCH population needs, rather than how it began several years ago with the CYSHCN population under the HRSA Systems Integration Grant.

Additionally, the focus of the coming year with the Title V CYSHCN Director and the KS-SHCN Program Manager will be to engage, along with the Title V Needs Assessment Team, in cross-system coordination efforts, as related to specialized care, insurance, and strengthening families, specifically around the Standards of Quality for Family Strengthening and Support. A proposal was developed by the Title V CYSHCN Director on inclusion of the Standards, and related implementation tools, within the Needs Assessment process. Additionally, the Standards are being heavily integrated within the framework for Supporting You, which will be more formalized in the coming year, following attendance at the National Family Support Network national forum and certification training related to the Standards by the KS-SHCN and SHS-FAC Peer Support Administrators for Supporting You.

Peer-to-Peer Network: To meet the needs of the "Supporting You" program, two SHS-FAC member were contracted to be the Peer Support Administrator (PSA) for the KS-SHCN and SHS-FAC programs. Their responsibilities include: recruitment and training of Supporting Peers (those providing support to others), making matches, following up and providing support for both the Support and Connected Peers, promotion of the program and monitoring and tracking of all matches.

The primary focus of Supporting You in the coming year revolves around marketing/branding, recruitment, enhancing the website/data system, and formalizing the training protocol and requirements for Support Peers. As part of the network support offered to any program associated with Supporting You, KDHE is offering one-hour training webinars for any Support Peer across the entire network. The Network Administrator, Title V CYSHCN Director, and KS-SHCN Program Manager will host two trainings each month (3rd Tuesday at 12 and 7 pm). A standard training curriculum was developed that consists of a "100 Series" and a "200 Series" of training materials. The "100 Series" consists of three training modules:

- Supporting You 101: Supporting You Basics
- Supporting You 102: Confidentiality
- Supporting You 103: Communication

The "200 Series" consists of program-specific training needs and expectations. The current "200 Series" consists of two training modules:

- Supporting You 201: Families of Children Who Have Special Health Care Needs/Disabilities
- Supporting You 202: Families of Children with Hearing Loss

Each program is allowed to determine which specialized training they would like their Support Peers to take. As mentioned, all Support Peers are expected to complete the "100 Series." The "200 Series" is available to all Support Peers, however the participating program determines which trainings are required. All KS-SHCN Support Peers will be required to complete each training module and sign a confidentiality agreement prior to providing support to a Connected Peers. Additional trainings will be developed as a need is identified, to increase the Supporting Peers capacity and knowledge to support others.

The KS-SHCN Program Manager will be assisting in developing a formal PSA training prior to any new programs being onboarded.

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:		Active	
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		44.7	7
Annual Indicator	47	7.2	7.2
Numerator	987,775		
Denominator	2,101,649		
Data Source	Kaiser Family Foundation	BRFSS	BRFSS
Data Source Year	2008	2016	2016
Provisional or Final ?	Provisional	Final	Provisional

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	6.8	6.6	6.4	6.2	6.0	5.8

SPM 6 - Number of MCH grantees, families and partners that participated in a state sponsored workforce development event

Measure Status:				Active		
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	1,000.0	1,500.0	2,000.0	2,500.0	3,000.0	3,500.0

State Action Plan Table

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 1

Priority Need

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

SPM

SPM 6 - Number of MCH grantees, families and partners that participated in a state sponsored workforce development event

Objectives

5.1 Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

5.2 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 (SHCN) population into adulthood.

5.3 Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.

5.4 Implement collaborative oral health initiatives to expand oral health screening, education, and referral by 2020.

Strategies

5.1.1 Increase knowledge of providers, partners, and consumers, including families, as it relates to Kansas Maternal and Child Health: purpose, scope, target populations, programs, services, and more. 5.1.2 Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment. 5.1.3 Incorporate MCH competencies more intentionally into MCH position descriptions. 5.1.4 Incorporate health equity, disparities, and cultural appropriateness/competence concepts into all workforce development activities.

5.2.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN. 5.2.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course. 5.3.3 Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

5.3.1 Increase MCH state staff and partner awareness and knowledge of trauma-informed care and hope-infused approaches. 5.3.2 Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it. 5.3.3 Provide training for MCH grantees including home visitors on trauma-informed care and mental health first aid. 5.3.4 Train professionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.

5.4.1 Integrate oral health education, services, and referral into MCH, SHCN, and WIC clinic visits; dental visits; and home visits. 5.4.2 Promote and support on-site oral health screenings at child care facilities through the Healthy Smiles initiative. 5.4.3 Continue offering the existing training and develop level 2 and 3 courses to build on education through Healthy Smiles. 5.4.4 Educate health care professionals regarding consistent messaging and the need for ongoing screenings and oral health education.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Information is available to support informed health decisions and choices.

SPM

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

Objectives

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

7.2 Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

7.3 Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

7.4 Increase opportunities to empower families and build strong MCH advocates by 2020.

Strategies

7.1.1 Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education. 7.1.2 Provide resources to increase education and knowledge of healthy decision making. 7.1.3 Work with partners to ensure that well visits incorporate best practices.

7.2.1 Implement the youth leadership program, Faces of Change. 7.2.2 Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution to children and adolescents as part of orientation. 7.2.3 Explore opportunities for increased youth leadership.

7.3.1 Identify opportunities to optimize changes in the health care system to maximize service delivery to families. 7.3.2 Provide training and technical assistance to local health departments on MCH service planning and delivery. 7.3.3 Support connection between local health departments and Navigators to increase families' access. 7.3.4 Review and identify steps to incorporate information from the Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the Affordable Care Act (ACA). 7.3.5 Review and incorporate Standards for Systems of Care for CYSHCN.

7.4.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others). 7.4.2 Conduct Care Coordination: Empowering Families trainings for parents of CYSHCN. 7.4.3 Increase the number of fathers and male support persons that are engaged in family health activities. 7.4.4 Provide opportunities for parents to improve their skills in seeking out quality health-related information.

Cross-Cutting/Systems Builiding - Annual Report

PRIORITY: Information is available to support informed health decisions and choices

SPM 4: Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them.

Local MCH Reach: During SFY2018, 47 of 70 grantees (67%) and during SFY2019, 37 of 71 grantees (52%) provided services to the Cross-Cutting/Systems Building population.

Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate decisions regarding their health.[1] According to the most recent 2016 Kansas Behavioral Risk Factor Surveillance System (BRFSS) CDC optional module data, three screening questions measure health literacy: 1) ***Find information***: "How difficult is it for you to get advice or information about health or medical topics if you needed it?", 2) ***Understand oral information***: "How difficult is it for you to understand information that doctors, nurses and other health professionals tell you?" and 3) ***Understand written information***: "You can find written information about health on the Internet, in newspapers and magazines, and in brochures in the doctor's office and clinic. In general, how difficult is it for you to understand written health information?".

About 4.7% of Kansas adults reported that it is somewhat difficult or very difficult to get advice or information about health or medical topics if they need it; 7.2 % reported that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them; and 7.0% reported that it is somewhat difficult or very difficult to understand written information about health on the Internet, in newspapers and magazines, and in brochures in the doctor's office and clinic.

[1]Institute of Medicine, Health Literacy: A Prescription to End Confusion. Editors, Lynn Nielsen-Bohlman, et al., Committee on Health Literacy, Board on Neuroscience and Behavioral Health. https://www.nap.edu/catalog/10883/health-literacy-a-prescription-to-end-confusion

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

Local MCH Agencies: "What to do when your child gets sick" books are easy to read and use for all literacy levels. The book and curriculum are discussed with families during clinic visits, home visits and/or after completion of the KPCC prenatal education classes. Local agency nurses recognize health literacy is essential to promote healthy individuals, families, and communities. Local agency staff acknowledge that health literacy is a primary factor behind health disparities. Local MCH staff routinely assess materials for the level of health literacy and attempt to simplify information and illustrations, encourage a client's questions, and determine if a client can verbalize knowledge and understanding of the information presented. Some local agencies provide a Spanish translator at MCH and WIC services as needed to enable and strengthen communication between staff and the client. Local MCH staff realize that social, economic, environmental, and cultural factors may be underlying contributors to health and social outcomes. Educating and empowering clients is the best method to help support informed health decisions and choices. Local agencies offer to help explain medical information with clients and parents if they report not understanding something. Staff make sure all written literature is an appropriate reading level for all clients.

MCH-Affiliated Programs – Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI): Case management in the TPTCM and PMI programs allows the opportunity to provide health information education to clients through one-on-one sessions and in group settings to increase health literacy. Case managers identify individual educational needs in targeted areas through use of goal planning tools and clients are connected to classes available

through the agency or though supportive community partners. TPTCM educational activities are deigned to increase client self-sufficiency which in part will aid in their knowledge and ability to obtain quality care for themselves and their children after program completion. Case managers encourage client participation in quarterly agency Advisory Group meetings to provide leadership opportunities, a platform to be a positive role model to peers and to provide feedback on program evaluation.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom (BaM) Program: Assuring accurate information is available to support informed health decisions and choices was a major focus of the KPCC "relaunch" initiative that occurred in 2017. As a result of focus groups and the work of the curriculum review committee, numerous supplemental handouts were added to the original curriculum in an effort to better inform participants and better prepare them as advocates for their care and the care of their baby. As a reoccurring theme throughout each of the six sessions, participants are guided through an activity "what questions will you ask your provider." During the activity they are encouraged and assisted in preparing questions they might ask their provider related to the information they learned during the session. This has been an ongoing theme that we have carried forward with annual updates made to the curriculum and its associated resources.

SHCN Care Coordination: Three years ago, the KS-SHCN program developed and implemented a holistic care coordination program to meet the needs of their clients. KS-SHCN Care Coordinators assist clients/families in making informed health decisions by assisting them in learning about their options, making informed decisions, and assisting in problem solving solutions. All information, written or oral, is presented to families with the health literacy of the family in mind. All KS-SHCN Care Coordinators are encouraged to participant in health literacy trainings. During care coordination training, health literacy is discussed, and all coordinators participate in role playing activities to help them identify the families/client's literacy abilities and modify their assistance, so the families/clients' needs are properly being addressed. KS-SHCN program has also provided Family Care Coordination Training (FCCT) to families across the state over the last few years. The goal of this training is to help families learn how to better communicate with their medical providers and advocate for their child's health needs. *Training flyer: http://www.kdheks.gov/shcn/care_coordination.htm*

Navigating Kansas Medicaid and the Insurance System: Local MCH clients often have a hard time navigating the insurance system and/or Kansas Medicaid. To address this issue, local agencies facilitate the on-site enrollment of MCH clients into insurance and Kansas Medicaid. All agencies will screen clients for insurance status at every visit encounter. If the client does not have insurance, clients are also screened for Medicaid income eligibility. If the client meets Medicaid income guidelines, applications are given to clients and assistance is offered in completing the application and submitting it to Medicaid. For clients who do not qualify for Medicaid, Marketplace health insurance information is provided along with contact information to a Navigation Specialist.

Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

The KS-SHCN program continues to support, through Aid-to-Local grant process, the Kansas Youth Empowerment Academy (KYEA) Faces of Change program for youth across Kansas. Faces is a program designed to build strong leadership skills for youth with disabilities. This program began in 2016, with the conclusion of the first session in the spring of 2017. The program has completed three, 7-month sessions and is currently recruiting for its 4th session. For the first time in the program's history, they are opening recruitment for both youth with and without disabilities. Each youth completed a community project to learn the importance of community services and to further build their leadership skills. Follow-up evaluations were sent to those who have graduated from the program to see how they have continued to use their leadership skills. Alumni from the previous sessions are featured as guest speakers for subsequent sessions. The SHCN Program Manager and MCH Adolescent Health Coordinator participated in a FACES session to get to know the participants, learn about their community projects and to become more familiar with the work occurring.

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

Special Health Care Needs State Plan: The KS-SHCN program continues to build infrastructure and capacity for increased services for all CYSHCN in Kansas. KS-SHCN has been aligning program services and contractual supports with the "Standards for System of Care for Children and Youth with Special Health Care Needs". This began with the strategic planning in 2015, however, was enhanced with the KS-SHCN 5-Year Plan and the completion of the D-70 Systems Integration Grant. As a requirement of the grant, a "state plan" was developed. Rather than developing a plan specific to the grant, the team decided it would be more worthwhile, to develop a plan around the overall system of care in place for CYSHCN.

This plan encompasses much more than the KS-SHCN or Title V systems and is being used to create a plan for the 10 system standard domains. The plan was developed in five stages over the course of two years, allowing for sufficient review and assessment of each domain and related standards, utilizing a community engagement process and engaging the most appropriate partners for each domain. The process included six regional meetings (one in each public health region of the state), a statewide survey, and a full-day planning meeting with key stakeholders. Through the qualitative data received through the regional meetings, the quantitative data received through the survey, and the strategies presented at the planning meeting, a shared vision was achieved for the domains discussed, as outlined in the State Plan for Systems of Care for Children and Youth with Special Health Care Needs.

2018 Governor's Public Health Conference: Title V staff provided extensive support for the Annual Kansas Governor's Public Health Conference which included pre-conference session that focused on advancing public health priority issues through universal screening, brief intervention, and referral. Focus was on building skills for specific evidence-based interventions and valid screening related to: smoking and substance use, perinatal/maternal depression, reproductive life plan counseling, and increased access to Long Acting Reversible Contraceptives (LARC). Opportunities for participants to gain hands-on practice, share, and learn was provided. Significant concepts related to successfully implementing public health interventions and enhancing programming was also discussed including family and consumer engagement, community coordination/collaboration, quality improvement, and policy/procedure development. A wide selection of breakout sessions tailored to meet the changing needs of the populations served through public health programs were offered during the general session of the conference. The preconference on April 3, 2018 drew 131 attendees and was targeted to MCH local agencies. It promoted data-driven planning, evaluation and quality improvement. Focus was on building competence and confidence in utilizing data to inform program development including opportunities for participants to gain hands-on practice and share stories.

MCH Local Agency Monitoring Visits: Technical assistance and training was provided directly to local MCH agencies/grantees by KDHE MCH staff through 25 check-in meetings and 8 on-site visits. KDHE MCH staff offer technical assistance to local agency staff on their MCH work plan as well as discuss their strengths, challenges and any other technical assistance needs they may have. During a review of quarterly progress reports, if KDHE MCH staff identify a local MCH agency needing assistance or if an agency requests additional assistance, a site visit may also be conducted. KDHE MCH staff are working towards being more available to local agencies to develop relationships and assist in strengthening their MCH programs to show the impact they are making in their communities. Staff are utilizing DAISEY data and discuss any issues they find with local agencies during check-in meeting and on-site visits. Copies of the MCH monitoring visit tools and materials are available upon request.

Date	Check-In Meetings	Date	On-Site Visits
09/06/18	Thomas County Health Dept.	11/01/18	Lawrence-Douglas County Health Dept.
09/07/18	Dickinson County Health Dept.	11/16/18	NEK Multi-County Health Dept.
09/10/18	Ellsworth County Health Dept.	02/07/19	Cloud County Health Dept.
09/12/18	Riley County Health Dept.	02/07/19	Republic County Health Dept.
09/13/18	Morris County Health Dept.	02/27/19	NEK Multi-County Health Dept.
09/13/18	Johnson County Dept. of Health & Env.	03/05/19	Rooks County Health Dept.
09/14/18	Saline County Health Dept.	03/06/19	Lincoln County Health Dept.
09/17/18	NEK Multi-County Health Dept.	03/07/19	Morris County Health Dept.
09/18/18	Clay County Health Dept.		
09/19/18	Pottawatomie County Health Dept.		
09/19/18	Shawnee County Health Agency		
09/20/18	Lawrence-Douglas County Health Dept.		
09/24/18	Phillips County Health Dept.		
09/25/18	Mitchell County Health Dept.		
09/25/18	Unified Govt of Wyandotte County		
10/18/18	Sheridan County Health Dept.		
10/18/18	Leavenworth County Health Dept.		
11/27/18	Barton County Health Dept.		
12/11/18	Sheridan County Health Dept.		
01/08/19	Franklin County Health Dept.		
01/16/19	Rooks County Health Dept.		
01/28/19	Riley County Health Dept.		
02/04/19	Riley County Health Dept.		
02/27/19	Barton County Health Dept.		
03/28/19	Mitchell County Health Dept.		

MCH Local Agency Technical Assistance Webinars: KDHE MCH staff provide technical assistance and training webinars throughout the year to local MCH agencies. Topics are identified based on emerging issues identified by state or local staff; identified need for reporting changes in the health care/public health system; need for increased collaboration with other partners (EX: Safe Kids); and/or identified need for assistance with screening, intervention, education, referral or other service or support provided at the local MCH grantee level. Several webinars were provided about KGMS, the application and reporting system for local agencies. A wide variety of topics were presented during FY18 (see table below).

Date	Title/Topic	Attendees
3/18/2019	DAISEY Learning Collaborative Technical Assistance Webinar	2
2/21/2019	SFY19 MCH Technical Assistance Webinars	101
2/15/2019	DAISEY Learning Collaborative Technical Assistance Webinar	5
1/30/2019	Open-Mic - SFY20 KGMS Application & Budget	47
1/24/2019	Open-Mic - SFY20 KGMS Application & Budget	58
12/18/2018	DAISEY Advisory Group Meeting	6
12/17/2018	DAISEY Learning Collaborative Technical Assistance Webinar	5
10/18/2018	SFY19 MCH Technical Assistance Webinars	54
10/8/2018	Kearny County Hospital Introduction to MCH	1
9/26/2018	SFY19 MCH Progress Report in KGMS	18
9/20/2018	SFY19 MCH Progress Report in KGMS	25
9/17/2018	Kansas Medicaid Overview	9
9/12/2018	Kearny County Hospital - DAISEY Forms	1
8/29/2018	DAISEY Advisory Group Meeting	5
8/21/2018	Reno Co. Conversation Re: MOD Grant Proposal	1
7/24/2018	SFY19 MCH Technical Assistance Webinar - Count the Kicks	44
7/23/2018	BaM Monthly Webinar - July 2018 Program Updates	20
7/19/2018	SFY19 MCH Technical Assistance Webinars	45
6/19/2018	Kearny County Hospital Introduction to MCH	4
6/5/2018	SBHC Team Conference Call	8
5/17/2018	SFY18 MCH Technical Assistance Webinar - Local MCH Data Trends on Kansas Measures	69
5/8/2018	DAISEY Aggregate User Meeting	11
3/12/2018	Tobacco Free: Partnerships to Improve Birth Outcomes	8
2/26/2018	Tobacco Free: Partnerships to Improve Birth Outcomes	15
2/26/2018	Tobacco Free: Partnerships to Improve Birth Outcomes	13
2/20/2018	SFY19 MCH Application Open-Mic Q&A	45
1/29/2018	BaM Monthly Webinar	30
1/24/2018	SFY19 MCH Grant Application	45
1/16/2018	SFY19 MCH Grant Application	48
11/16/2017	SFY18 MCH Technical Assistance Webinar - Collaborations & Partnerships (SHCN, Safe Kids, WIC)	78
11/9/2017	BaM DAISEY Data TA with Riley Co.	1
9/28/2017	SFY18 MCH Progress Report	14
9/26/2017	BaM Reports in DAISEY - getting started as a new program site	1
9/25/2017	BaM Monthly Webinar - Safe Sleep Integration Update	18
9/20/2017	SFY18 MCH Progress Report	23
9/5/2017	MCH Technical Assistance Webinar - DAISEY Direct Entry Users	13

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

Supporting You: 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 Special Health Services (SHS) programs worked with the Special Health Services –Family Advisory Council (SHS-FAC) to develop "Supporting You". A support/connected peer data system, "Supporting You" was developed 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. "Supporting You" was designed as a global support network for a variety of peer support program options.

The mission of Supporting You is: Connecting parents who share experiences to support the health of their family through a system of support. The network strives to assure every family in Kansas has the opportunity to connect with a trained parent who can provide emotional support, referrals to relevant resources and a listening ear for those in need of help to support their family and caregiver health needs.

The Supporting You network is designed to be a:

- Connecting point for parents who share experiences to support the health of their family.
- Support system that uses personal or multi-disciplinary communication forums to allow parents to share experiences.

Referred parents can be connected to supporting parents, caregivers, or siblings who have similar experiences or needs. A web-based system supports matching parents based on a questionnaire about experiences and desired supports. The system can match on any criteria asked on the questionnaire.

Two SHS-FAC workgroups formed: Data System/Evaluation Measures and Policies/Training. The Data System and Evaluation Measures group has developed measures to identify the utilization of the system, but more importantly the quality of the experience. Evaluation of the network will revolve around favorable experiences, successful matches, relationship-building, and mutual benefit, among other quantitative data. This group has also focused on creating work flows and processes around evaluation and data collection and informing the development of the web-based matching system. The Policies and Training group has focused on the development of the Supporting You Handbook, the guiding document for those who sign up to provide support to a referred parent. This handbook will provide the outline and content of the supporting parent trainings, with the addition of special topics such as active listening, motivational interviewing, and compassion and empathy. Additional trainings on specific resources or population needs (such as the deaf/hard of hearing culture) will also be provided by some of the participating programs.

Currently, "Supporting You" consists of three pilot programs, School for the Deaf, SHS-FAC (behavioral health focused) and the KS-SHCN program. The program launched in December of 2018 for Supporting Peer enrollment and will open for Connected Peers in the coming months. Matches will occur once there is a large enough pool of trained Supporting Peers. Extensive work has been done to develop the data system, trainings, promotion, protocols, policies and onboarding criteria.

KS-SHCN Care Coordinators have continuously, over the past few years, reported that families frequently request this type of support and they are very excited to be sharing "Supporting You" with the families they work with. A part-time Parent Support Administrator was hired by the KS-SHCN program to support both the Supporting Peer and the Connected Peer, make the matches, monitor matches, provide training to Supporting Peers, if they are unable to attend one of the monthly webinar training (held the third Tuesday of each month at 12:00 and 7:00 pm), recruit Supporting Peers and to conduct program promotion. More information can be found in the

CSHCN Report.

Objective: Implement collaborative oral health initiatives to expand oral health screening, education, and referral by 2020.

Partnership with Oral Health Kansas: Title V and Oral Health Kansas (OHK) are working with other partners to create a state that values oral health as a part of overall health for Kansans of all ages, cultures and resources. A number of activities have been completed in an effort to improve awareness of the importance of good oral health to overall health and wellbeing. The following activities were completed in FY18.

- Launching biannual oral health awareness campaigns. These include hidden picture oral health posters and social media toolkits.
- Incorporating oral health information into the "Becoming a Mom" perinatal classes offered across the state.
- Creating on-line and in-person workshops for child care providers. Workshops include an opportunity for a site visit for technical assistance as well as oral health education and screening services for the site's children.
- Evaluating oral health materials MCH partners use to ensure they are up-to-date and accurate. Follow up will include creating a user-friendly tool to locate oral health handouts, books, and videos that offer consistent and evidence-based information.

In addition to advocacy efforts, OHK is working with the Geary County early childhood community to add oral health screenings to their developmental screening events. The dental community in Geary County has also been invited to participate in the Geary County IRIS community/referral network (http://connectwithiris.org/).

Care Coordination: KS-SHCN Care Coordinators will continue working with families to assure they have a dental health home and are receiving preventive oral health care services. For program participants with Cleft Lip/Cleft Palate, KS-SHCN will work with Medicaid, dentist, oral surgeons, and community partners invested in oral health care in Kansas to assure children receive the care they need to support optimal health.

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

SPM 5: Number of MCH grantees, families and partners that participated in a state sponsored workforce development event.

Local MCH Reach: During SFY2018, 47 of 70 grantees (67%) and during SFY2019, 37 of 71 grantees (52%) provided services to the Cross-Cutting/Systems Building population.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

The Title V program provides many opportunities on an annual basis for MCH professionals, partners, and grantees, including family members and consumers, to receive training, technical assistance, and consultation.

Local Public Health Program: Title V continues to have a strong partnership with KDHE's Local Public Health Program (LPHP). With direct support from Title V, LPHP staff led the following activities related to workforce development and capacity/systems building (not a comprehensive list).

- Developed and distributed the monthly newsletter, *Public Health Connections*, sent to all local health departments as well as other public health system partners. *Public Health Connections* provides Kansas public health professionals,

including the MCH workforce, with information on upcoming training opportunities, funding opportunities, recent public health research, and updates on changes in the state public health system. It often features information that allows the MCH workforce to increase their knowledge and skills to better address the needs of their communities.

- Facilitated and participated in monthly population health webinars for local health department staff and other public health system partners each month during the reporting period. The webinars include disease updates/outbreak information, training opportunities, STI updates, and other timely information.
- Continued to offer the course, Health in 3D: Diversity, Disparities and Social Determinants of Health, which focuses on specific cultures present in Kansas and includes the importance of cultural awareness and competence.
- Continued efforts to support local health departments in providing school sanitary inspections, which are required by statute to be conducted by local health departments but only 10% are currently meeting this requirement. LPHP staff presented at the 2018 Kansas Environmental Health Association conference about the statute and the expectations related to inspections at a day-long pre-conference session focused on school inspections. Approximately 50 people attended. An online training was developed using content from the conference.
- Convened and conducted 39 regional meetings for local public health agency administrators (and/or staff). These live regional public health meetings were held in the six KDHE public health regions of Kansas for the purpose of furthering statewide collaboration on public health topics and providing workforce development to the public health system. Each meeting provided, at a minimum, an update on state MCH activities and an opportunity for KDHE MCH staff to deliver relevant content in face-to-face settings details.
- Led the development and implementation of the 2017 Kansas Public Health Workforce Assessment based on the Council on Linkages Core Competencies. The assessment was distributed to state and local health department staff in the fall of 2017. Data collection and analysis began in early 2018. Reports were distributed to local health departments actively seeking accreditation. 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. The results of the assessment were used to identify training topics for the 2019 Governor's Public Health Conference and the Regional Public Health Meetings.
- Developed and delivered the 2018 and 2019 Governor's Public Health Conference.
- Coordinated training held April 26, 2018, with a national speaker, Jerry Moe from Hazelden Betty Ford Foundation who is the director of Children's Programs. The training focused on best practices for working with children who are impacted by parental substance abuse. Approximately 200 professionals attended.
- Leadership of and collaboration with the Kansas Public Health Workforce Development Coordinating Council. Developed and delivered content to further knowledge and understanding related to MCH best practices, Core Public Health Functions, Essential Services, and PHAB Standards and Measures to entry-level and advancing public health professionals and governing bodies.

Objective: Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.

Local MCH Agencies: Strengthening family resilience has been a common goal among all MCH related programs at the state level. Great effort has been made by KDHE to create an awareness among local grantees of the need for focused initiatives in this area. The 2018 Governor's Public Health Conference included breakout sessions supporting increased knowledge of Adverse Childhood Experiences (ACEs) and trauma-informed approaches. Many local grantees have been partnering with other community agencies as well as making referrals to early childhood and parenting support programs. Focus on kindergarten readiness, centering on the social emotional health of the child, is a part of collaborative efforts at the community level, as highlighted by partnerships in the KPCC collaborative models in Saline and Reno counties. Kansas Title V staff participated in ACEs 101 and Lemonade for Life trainings to gain insight into ways ACEs and resiliency tools can be provided to local MCH agencies.

NOTE: Refer to other domain narratives within the application to read more about workforce development opportunities specifically related to mental health targeted to women, pregnant women, children, and adolescents.

Other Cross-cutting Activities

Shared Measurement Systems in MCH: DAISEY: The Bureau of Family Health worked with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) (https://cppr.ku.edu/) to: 1) implement and support a secure, HIPAA compliant web-based shared measurement data system (DAISEY); 2) train and provide technical assistance to DAISEY users to capture MCH services at the individual level and use data to inform MCH practice and service delivery; and 3) provide analytics to improve accountability and continuous quality improvement at the state and local levels. KDHE's vision for integrated and coordinated community-level maternal and child health initiatives requires high quality, reliable data from all local MCH providers across the state. KDHE uses DAISEY to support Title V system transformation through a phased approach involving input and communication with local providers throughout the process.

KDHE and KU-CPPR staff provided extensive training and technical assistance through webinars, individual phone instruction, on-site training and recorded navigational videos of forms in the DAISEY system. A DAISEY Helpdesk email is available to provide direct technical support for system users. To provide a central access point for all DAISEY-related information, a website was developed for use by local agency users (http://daiseysolution.com/kdhe/). Information available on the website includes user request templates, data security forms and policies, an implementation guide, user manual, instructional videos, printable versions of forms, report guides, Data Dictionaries and a calendar of upcoming scheduled trainings. In addition to the extensive TA and support that is provided, a DAISEY Advisory Group was developed in 2017 and met quarterly throughout FFY2018. The Advisory Group is made of local agency users representing multiple programs in both rural and urban areas. Their role is to provide input into local needs regarding data collection and measurement and also provide feedback regarding requested form and report changes and other technical elements of the DAISEY system.

Aid-to-Local Process: In addition to partnerships with state-level organizations working directly with communities, Title V contracted with more than 70 local agencies providing MCH services across the domains for FY18. Most local programs funded by the Block Grant are delivered by local health departments and safety net clinics (independent entities). These agencies are positioned to provide core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The services delivered by local agencies are designed to address ongoing needs and those identified by the most recent needs assessment. For a number of years, local agencies used the web-based Catalyst system for a single point of access, allowing local applicants/potential grantees to view and actively manage all Aid-To-Local (ATL) grants with KDHE. SFY18 was the last year ATL grantees used the Catalyst system. The Kansas Grant Management System (KGMS) was developed by KDHE IT staff for use effective July 2018. KGMS replaced Catalyst for all ATL grants, including MCH. Local MCH agencies utilized KGMS to submit the FY19 MCH grant applications and budgets. Grantees currently provide progress and financial reports through KGMS quarterly.

MCH Application Review & Award Process: In SFY18, we had 70 applicants apply for the MCH grant, 61 of the applicant agencies (87%) provided home visiting services, and 14 agencies served as a Special Health Care Needs Satellite Office. After the applications and budgets are submitted, proposals are reviewed by KDHE MCH staff, program staff in the Bureau of Family Health, other KDHE Division of Public Health Bureaus (Health Promotion and Community Health Systems/Local Public Health section), MCH council members, and family/consumer representatives (when available). Reviewers used a scoring rubric to assess each application and budget. Each application is reviewed by two reviewers. We have also developed a funding formula that considers a five-year average of: 1) children under 18 years of age in poverty; 2) the number of children 0-22 years of age; and 3) females 22-44 years of age in their county. We tried to align all applicants with their funding formula amount as well as their application average scores. If an applicant is over funded based on the formula, we considered previous performance, services provided, and the total population served to determine if a decrease needs to be made. We tried to not reduce applicants more than 10% of their previous award amount if possible. Applicants were given additional funds if they are providing home visiting services and/or serving as a special health care needs satellite office. KDHE MCH staff create progress reports in KGMS for local MCH agencies to report progress complete each

quarter. KDHE MCH staff review all progress reports to verify grantees are completing the work outlined in their applications as well as review Financial Status Reports (FSR) grant expenditures, including program revenue, related to their approved budget.

Local MCH Workforce Development: The MCH Navigator and online MCH Assessment are utilized and fully integrated into the professional development planning and performance reviews for all local MCH staff. All local MCH program staff and supervisors must complete MCH training via the online MCH Navigator. Two courses must be completed within three months of grant award or hire, whichever applies (MCH 101 and MCH Orientation). In addition to basic training and orientation, local program staff delivering certain messages or services, including education, are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination, etc.). Annual/ongoing training requirements for all local MCH staff include technical assistance calls/webinars throughout the year led by the state MCH team and the annual Governor's Public Health Conference. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing the online MCH Navigator Self-Assessment.

Local Public Health Listening Tour: KDHE held its first listening tour in 2018 to seek feedback from local health departments (LHDs) about KDHE's strengths as well as weaknesses/opportunities for improvement. The listening tour was conducted by Kendra Baldridge and Cristi Cain (Local Public Health Program director), Bureau of Community Health Systems, during the regional public health meetings held across the state. Regional meetings occurred in Chanute (July 12), Topeka (July 26), Hutchinson (August 1), Garden City (August 8), Oakley (August 9), and Beloit (August 22). Feedback was gathered from 90 attendees representing 69 counties across Kansas. A report summarizing the information gathered was developed. It was shared with KDHE leadership and the appropriate staff to review and create actionable steps to address needs and concerns. This information will also inform the agency's upcoming strategic plan. Program/employee specific concerns and compliments were shared with appropriate leadership immediately.

Public Health Accreditation – State: The Local Public Health (LPH) staff is responsible for leading the accreditation process. Efforts included organizing planning meetings, conducting a mock site visit, and hosting an actual PHAB site visit for the state healthy agency (KDHE). The agency was accredited in November 2017, and the Kansas Title V Director is a member of the State "A" Team. The accreditation process works towards strengthening health departments by advancing the quality and performance of the agency. Health literacy and cultural competency are key components of a high-performing health department that are recognized in the accreditation standards. Made possible with support from MCH, a number of advances were made to strengthen the agency's protocols and processes related to health literacy and cultural competency through KDHE's accreditation work. Health literacy was identified as an area for improvement; LPH staff have since worked closely with Communications and other KDHE staff to improve the readability of agency's communications and resources. LPH staff helped develop and submit an annual report to the PHAB Board on the improvements that have been made since KDHE achieved accreditation.

Cross-Cutting/Systems Building - Application Year

PRIORITY: Information is available to support informed health decisions and choices

SPM 4: Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them.

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

SHCN Care Coordination: The KS-SHCN Care Coordinators have continued to assist clients/families in making informed health decisions by assisting them in learning about their options, make informed decisions, and assisting in problem solving solutions. All information, written or oral, is presented to families with the health literacy of the family in mind. All KS-SHCN Care Coordinators are encouraged to participant in health literacy trainings. During care coordination training, health literacy is discussed, and all coordinators participate in role playing activities to help them identify the families/client's literacy abilities and modify their assistance, so the families/clients' needs are properly being addressed. The Care Coordinators will continue to provide training and support to clients/families to equip and empower them to be able to make health decisions independently.

Navigating Kansas Medicaid and the Insurance System: Local MCH agencies will continue to assist their clients in navigating the insurance system and/or Kansas Medicaid. Local agencies will continue to facilitate the on-site enrollment of MCH clients into insurance and Kansas Medicaid. All agencies will screen clients for insurance status at every visit encounter. If the client does not have insurance, clients are also screened for Medicaid income eligibility. If the client meets Medicaid income guidelines, applications will be given to clients and assistance offered in completing the application and submitting it to Medicaid. For clients who do not qualify for Medicaid, Marketplace health insurance information will be provided along with contact information to a Navigation Specialist.

Research shows that individuals with low health literacy are less likely to engage in health care (preventative and sick visits), often misread prescription labels, have increased visits to the Emergency Room and have Higher Mortality rates. Kansas MCH recognizes the importance of promoting health literacy, especially in our primary high-risk population. Many of the training resources listed above and in the other domain report sections, such as the integration tool kits (well woman visit, reproductive life plan, oral health, smoking, mental health) One Key Question®, Count the Kicks®, Safe Sleep training programs, Community Baby Showers, breastfeeding, *Cuddle* books, etc. are all a means to help local MCH agencies provide health education to clients to improve decision making about their health. This will remain a priority for Title V in the upcoming year as the primary responsibility for health literacy lies with public health professionals and the health care and public health systems.

Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI): All TPTCM & PMI awardees will continue to incorporate parenting education as a fundamental part of their service model. Educational material will be presented individually through one-on-one sessions and in group settings when appropriate to facilitate peer support networks. Fathers will be encouraged to participate in activities alongside the mother when appropriate to increase knowledge, skills and resources.

Local MCH Agencies: A key component of local MCH agency work is education. All local agencies are providing education as part of MCH visit for all MCH populations. The DAISEY shared measurement system captures what type(s) of education are provided during each visit at the local level through the "MCH Service Form" (see screenshot, types of education outlined in red). Data is reviewed regularly to ensure alignment with local proposals and budgets tied to advancing the state action plan priorities/measures.

Kansas DAISEY

Maternal Child Health Service Form

Do you drink alcohol or use other substances?
- Yes
- No

Has the parent completed a child development screening tool for a child ages 9 months through 35 months, within the past year?
- Yes
- No
- Client is unsure
- N/A - Services for child over 4 years, adolescent or adult

PROGRAM SERVICES

Program Services: (Select all that apply)
- Ages & Stages Questionnaire (ASQ)
- Adverse Childhood Experiences (ACE)
- Allergy Shot
- Blood/Lab Work
- BP/WT/Hgb
- Breastfeeding Assessment
- Breastfeeding Assistance/Counseling
- Car Seat Installation/Check
- Chlamydia Test
- Contraception
- Counseling
- Dental
- Developmental Screening
- Education
- Gonorrhea Test
- Hearing Screening
- High-risk Case Management
- HIV Test
- Immunization
- Kan Be Healthy
- Lead Screening
- Maternal Depression Counseling
- Maternal Depression Screening
- MCH Breast Exam
- MCH Home Visit Education
- MCH Pap Smear
- Other Nursing Assessment
- Other Service/Screening
- PHQ-9
- Pregnancy Test
- Prenatal/Post-partum Nursing Assessment
- Sick Visit
- Smoking Cessation 5As/2As & R
- Well Child Visit
- Well Infant Visit
- Well Woman Care/ Annual Visit

Specify other service/screening:

Education Provided: (Complete only if education was provided. Select all that apply)
- Alcohol/Substance Abuse
- Behavioral Health (Other than Post-partum depression)
- Breastfeeding
- Bullying
- Child Development/Developmental Screening
- Car Seat Safety/Installation
- Family Violence
- Father Involvement
- Health Care Coverage/Medicaid Eligibility
- Immunizations
- Infant Care
- Injury Prevention/Safety
- Labor/Childbirth
- Lifestyle risk factors/prenatal exposures
- Medical Home
- Nutrition
- Oral Health
- Parenting
- Post-partum care
- Post-partum depression
- Preconception/Interconception
- Prenatal Care
- Preterm Labor
- Reproductive Health/Family Planning
- Safe Sleep
- Smoking Cessation/Second-hand exposure
- State/local resources
- Suicide Prevention
- Teen Pregnancy Prevention
- Weight Management
- Well Child/Adolescent
- Well Woman
- Other

Specify Other Education:

Are any referrals needed? (Select one)
- Yes (If yes, fill out the referral form)

Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

Kansas Youth Empowerment Academy: The KS-SHCN program will continue to provide funding support for the Kansas Youth Empowerment Academy (KYEA) Faces of Change program for youth in Kansas. This program builds strong leadership skills for youth with disabilities. KS-SHCN has been providing Aid-to-Local grant funding for this program since 2016 and has seen tremendous value in the work the FACES staff are doing in increasing and improving youth's self-perception of themselves, ability to understand their disability, self-advocacy, becoming active community participants through their community projects and improving their overall leadership skills. Many of these youth return in subsequent sessions to help teach the new co-hort. This is a seven-month intensive program that for the first time in the program's history, will be opened for both youth with and without disabilities to participate in. The SHCN Program Manager will participate in at least one, FACES session to get to know the participants, learn about their community projects, become familiar with the work occurring, and answer question about the KS-SHCN program.

Care Coordination: The KS-SHCN program understand and values the importance of quality transition and has built it into the Care Coordination activities. Families will continue to be encouraged to start think about transition early in a child's life. Care Coordinators will continue to request that youth, 14 years or older, participate in the development of their Action Plan. Care Coordinators will continue to assist both the parents and youth with transition preparation and activities as appropriate to meet their individual needs. Over the next year, more KS-SHCN staff time will be devoted to reviewing and improving transition services by reviewing currently policies, protocols, materials and building a stronger collaborative partnership with the MCH Child & Adolescent Health Consultant and youth organizations such as the KYEA.

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

Special Health Care Needs: The KS-SHCN program will continue to build infrastructure and capacity to increase services for all children with SHCN in Kansas. KS-SHCN will continue to align program services and contractual supports with the "Standards for System of Care for Children and Youth with Special Health Care Needs." A state plan was developed as part of a D-70 grant opportunity that will be used for future program improvements and initiatives. The program understands that

these standards lay the ground work in improving the systems of care for the CYSHCN population and will continue to use them as the frame work as services and supports are changed, improved or added.

Local MCH Agencies: Title V staff will provide support for the 2020 Annual Governor's Public Health Conference which will include an MCH pre-conference that will focus on current and emerging MCH issues. State MCH staff will continue to provide technical assistance and training to all local MCH agencies by way of technical assistance calls and webinar and on-site visits. It is the role of the state health department to guide local agencies in moving MCH work ahead in their communities. When local agencies find a gap in services in their communities or come across a barrier that they need help navigating around state MCH staff is there to assist them with facilitation, coordination and innovative thinking.

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

Supporting You Kansas – Peer to Peer Support Network: The KS-SHCN program is one of three programs in the Supporting You peer to peer network system. This system is a peer to peer network that links a peer looking for emotional support and informal resources with another peer who has had a similar life experience. The network/platform was launched in December of 2018 and the search began for Supporting Peers (those providing support to others). Once there are enough trained Supporting Peers in the system, it will be opened for Connect Peers (those seeking support) to enroll. This is expected to occur in the summer of 2019.

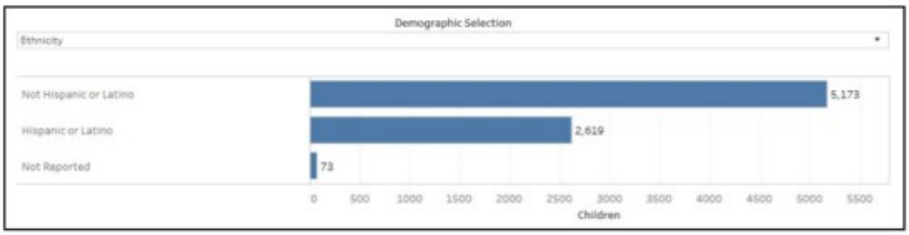
During FY 2020, all SHCN staff will assist with recruiting Supporting Peers and offering this program to those who would like to be matched. Promotional fliers will be distributed across the state at various conference, health fairs, and a variety of other events. Training webinars will be conducted the third Tuesday of every month at noon and 7:00 pm to provide training to those who sign up to be a Supporting Peers. The Peer Support Administrator (PSA) will match Connected Peers with Supporting Peers and monitor all peer matches for fidelity. The PSA will be there throughout the match to provide ongoing support for both Supporting and Connected Peers. Additional trainings will be developed as identified for Supporting Peers. It is hoped that these trainings will also be available within the data system sometime within 2020. It is expected that enhancements to the data system will also occur as the program expands.

Other Cross-Cutting Activities

Shared Measurement Systems in MCH – DAISEY ((https://kdhe.daiseysolutions.org/): Title V's vision for integrated and coordinated community-level maternal and child health initiatives requires high quality, reliable data from all local MCH providers across the state. We are intently focused on measuring what matters. Kansas MCH uses DAISEY to collect data from local agencies providing services for Title V MCH, Title X Family Planning, Healthy Start (through June 2019), MIECHV, and LYFTE. DAISEY is also the data collection and reporting system for the KPQC Neonatal Abstinence Syndrome initiative. Hospitals capture timely information for reporting related to the process measures. At the time of application, there were 1,126 total users representing 158 unique organizations. Title V and KU-CPPR Staff will continue to provide extensive training and technical assistance for DAISEY users via webinars, individual phone instruction, on-site training and recorded navigational videos.

In an effort to support MCH local agencies with utilizing data in meaningful ways, the **Priority Populations Report** was developed and released March 2019. The report aggregates and compares demographic data as captured on the KDHE Program Visit Form (Adult and Child). The purpose of the report is to allow DAISEY users (MCH local agencies/workforce) to assess information about the communities they serve, across all of the KDHE programs they administer. The report contains 4 dashboards – 2 for caregivers and 2 for children, one of which displays any one user-selected demographic dimension (for example, employment status), and the other which allows users to compare any two demographic dimensions they select (for example, employment status by race). On both Caregiver Dashboard 2 and Child Dashboard 2, users can select any *two* demographic data points collected on either the Profile form or Program Visit form to view a comparison across those dimensions – for example, Child ethnicity by Child race.

Child Dashboard 1:



Child Dashboard 2:

Demographic Selection: Ethnicity

Secondary Demographic Selection: Race

		Race							Grand Total
		White	Black or African American	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	Multi-racial	Unknown/Not Reported	
Ethnicity	Not Hispanic or Latino	4,331	343	160	52	15	262	10	5,173
	Hispanic or Latino	2,482	24	2	9	9	34	59	2,619
	Not Reported	41	3	2	1		6	20	73
Grand Total		6,854	370	164	62	24	302	89	7,865

DAISEY LEARNING COLLABORATIVE

Innovative Project Guide

1. Identify a project:

Use data, theory, and expertise to help identify a potential problem and determine the change that you would like to see as a result of your intervention(s).

What area of focus have you identified?

What is your vision in this area?

What is the current state of the problem?

In October of 2018 Title V partnered with KU-CPPR to host our first ever **DAISEY Learning Collaborative**. Plans are in place to bring the DAISEY Learning Collaborative back for FY20. For this innovative project, we worked with three local MCH agencies to collaborate and explore ways to impact their programs and practices with DAISEY data. Each of the three agencies was awarded a mini grant of $1,000 to support time on the project. With expert technical assistance and support from Title V as well as the KU DAISEY team, each agency used their local DAISEY data to identify an area of opportunity for improvement within their practice. They implemented a Plan-Do-Study-Act (PDSA) cycle/s to make small-scale changes and then used DAISEY data to measure the impact. This project kicked off with an in-person live event in which grantees worked together with Title V and DAISEY staff to identify their project. Three technical assistance webinars were held to help the teams along the way. The project ended with a wrap-up session in which teams summarized their project and impact. The teams presented what they learned and challenges they had to their peers at the 2018 Governor's Public Health Conference. Title V plans to host cohort two of the DAISEY Learning Collaborative in FY20. Requests for applications will be released in September 2019 for a project start date of October 2019. Cohort two project will run until April 2020 and wrap with the participating teams presenting summaries of their projects at the 2020 Governor's Public Health Conference. This encourages utilization and application of MCH data at the local level.

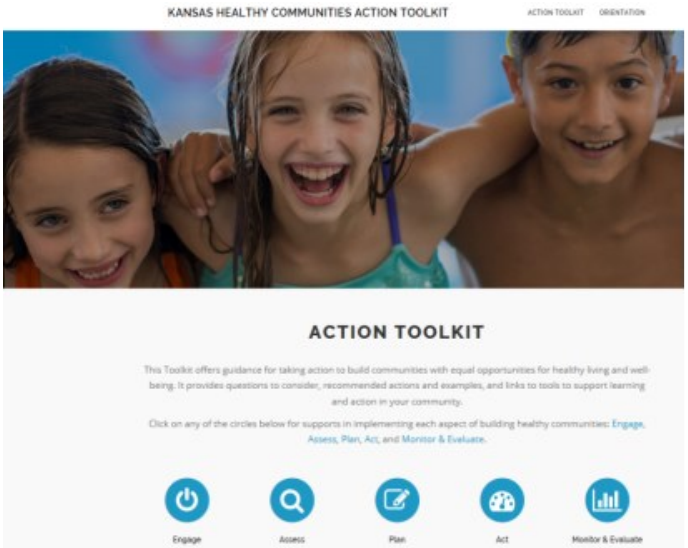
Continuous quality improvement is a top priority of Title V. We will continue to gain feedback from local MCH agencies through our DAISEY Advisory Board that will inform emerging issues that need to be address in DAISESY as well as what upgrades and changes to current forms is needed. A lot of work will continue to be done internally related to "deep dives" into the data, evaluating progress and needs of MCH partners based on DAISEY data, and determining the impact of services. For example, we will be assessing if individuals screened were referred for services educated on topics related to needs identified through screening. DAISEY houses more than 45,000 caregiver profiles and nearly 27,000 child profiles.

MCH Health (Equity) Opportunity Project: Health equity means that everyone has a fair and just opportunity to be healthy. Health equity work requires identifying and removing obstacles to health such as lack of access to good jobs, quality education, safe housing and environments, fresh food, health care and more. Creating health equity is a guiding priority and a core value of public health. In order to advance equity in MCH, Title V is innovating with the University of Kansas Center for Community Health & Development (KU-CCHD) to implement the first-ever *Maternal and Child Health Opportunity Project (MCHOP)*.

The MCHOP is intended to support local community efforts to assure equal opportunities to health for all Kansas mothers, children, and their families. A request for applications was released in May 2019 and several applications were received. The application provided guidance and an opportunity for agencies to describe how their organization and partners will work to advance local efforts to assure equal opportunities for maternal and child health populations regardless of income, education, age, race/ethnicity, or where people live. Title V plans to work with seven local MCH agencies with awards of up to $10,000 each. Review of applications began in June 2019 and implementation is scheduled through April 2020.

The Kansas Healthy Communities Action Toolkit was developed as a resource for participating agencies to offer guidance for taking action to build communities with equal opportunities for healthy living and well-being. The toolkit provides questions to consider, recommended actions, and examples (resources and links to tools) to support filling out the application as well as learning about action in community work. Kansas Title V and KU-CCHD will offer guidance and technical assistance throughout this project.

Screenshot of Healthy Communities Action Toolkit (https://ksactiontoolkit.org)

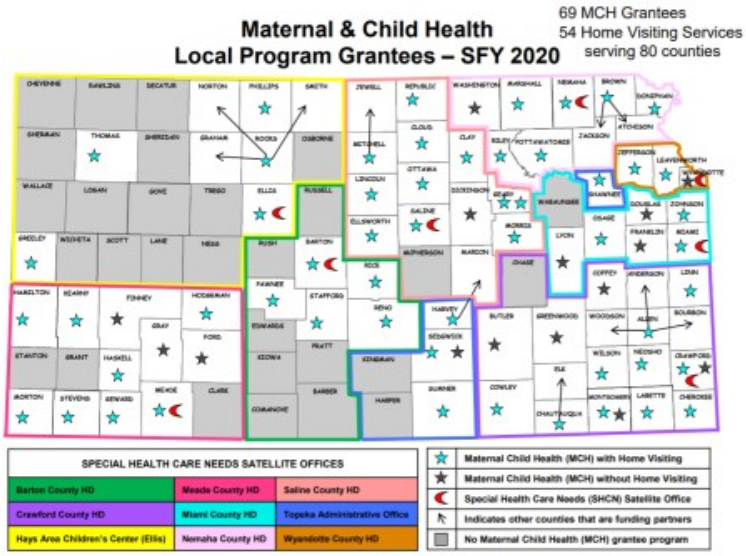


PRIORITY: Professionals have the knowledge and skills to address the needs of maternal and child health populations

SPM 5: Number of MCH grantees, families, and partners that participated in a state sponsored workforce development event.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

Local MCH Network of Agencies: Title V plans to contract with nearly 70 local agencies during FY20 to provide MCH services across the population domains. The majority of local programs funded by the Block Grant are delivered by local health departments and safety net clinics (independent entities). These agencies are positioned to provide core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The services delivered by local agencies are designed to address ongoing needs and those identified by the most recent needs assessment. A map displaying reach is included below, based on FY20 recommendations.



The MCH Navigator and online MCH Assessment are utilized and fully integrated into the professional development planning and performance reviews for all staff. All MCH program staff and supervisors must complete MCH training via the online MCH Navigator. Two courses must be completed within three months of grant award or hire, whichever applies (MCH 101 and MCH Orientation). In addition to basic training and orientation, local program staff delivering certain messages or services, including education, are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination, etc.). Annual/ongoing training requirements for all local MCH staff include Technical Assistance Calls/Webinars throughout the year led by the state MCH team and the annual Governor's Public Health Conference. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing the online MCH Navigator Self-Assessment.

During Fall 2019, for the first time MCH program staff will provide an opportunity for grantees across programs to connect and network. The agenda will include an opportunity to review regional and county data, share successes, and discuss challenges collaboratively with regional peers. Additionally, grantees will be able to schedule one-on-one meetings with their agency program contacts to discuss individual technical assistance needs.

Special Health Care Needs (SHCN) Care Coordination: The KS-SHCN Care Coordinators have continued to assist clients/families in making informed health decisions by assisting them in learning about their options, make informed decisions, and assist in problem solving solutions. All information, written or oral, was presented to families with the health literacy of the family in mind. All KS-SHCN Care Coordinators were encouraged to participant in health literacy trainings. During care coordination training, health literacy was discussed, and all coordinators participated in role playing activities to help them identify the families/client's literacy abilities and modify their assistance, so the families/clients' needs are properly being addressed. The Care Coordinators will continue to provide training and support to clients/families to equip and empower them to be able to make health decisions independently.

Local Public Health Program (LPHP) Partnership: Kansas Title V will continue to partner with the LPHP to provide professional development events to the MCH network. In the coming year the LPHP will provide the following activities:

- Continue, launch, and/or expand efforts focused on health equity, adverse childhood experiences, and implementing trauma informed systems of care at KDHE as well as with local health departments
- Produce and disseminate MCH articles, news, resources and training opportunities through the Public Health Connections electronic newsletter
- Link MCH priorities to the Foundational Services
- Provide sessions related to cross cutting/life course issues at the Governor's Public Health Conference, Regional Public Health meetings and other venues
- Conduct monthly population health webinars for local health department staff and other public health system partners
- Plan and deliver of the 2020 Governor's Public Health Conference to meet the workforce needs of Kansas local health departments, including MCH workforce
- Plan with Title V to address workforce needs for well woman visits and reproductive life plans
- Facilitate regional public health meetings and other events for local public health administrators as an avenue for providing workforce development—future regional public health meetings will include a variety of topics including:
    - A presentation from MCH leadership
    - An update on the Immunization Program
    - A presentation from the Division of Health Care Finance on Medicaid billing and Medicaid updates
    - Sharing updates from KDHE as a result of what was learned from the listening tour

- Organize live KanBeHealthy (EPSDT) trainings for health department staff and explore options for an online opportunity
- Continue collaboration with Kansas Public Health Workforce Development Coordinating Council
- Develop and provide quality improvement training for KDHE staff and local health departments

One Key Question® (OKQ): As discussed in the Women/Maternal Report, Title V brought The Power to Decide to Kansas this year to train local MCH, Family Planning, and other community providers on the pregnancy intention screening initiative, OKQ. In 2020, Title V will bring The Power to Decide back to Kansas for training cohort two. The plan for training cohort two is to target staff from Federally Qualified Health Centers, Rural Health Clinics, and other safety net clinics to scale and spread OKQ.

Integration Toolkit Training Webinars: As discussed in the relevant domain reports, Title V has developed or is developing several integration toolkits that focus on MCH priority work such as breastfeeding, safe sleep, oral health, well-woman visits, reproductive life plans, smoking, substance use, and mental health. All of these toolkits will include a live recorded training webinar as one of the available resources. This allows staff to re-watch the training webinar for a refresher or train newly hired staff on the contents and purpose of the toolkits.

LARC Grand Rounds: As discussed in the Women/Maternal Report, MCH and Family Planning and other state partners are planning a full day training event all about Long Acting Reversible Contraceptives (LARC). This one-day event will include education on billing and coding for LARC, clinical indications and myths, expert panel discussions and hands on insertion training. Kansas MCH plans to keep the energy going around LARC throughout the next year by hosting lunch and learn events based on the top ten questions surrounding LARC as well as continuing to market the LARC tool kit and offer technical assistance to communities that want to offer LARC but have barriers to service.

Objective: Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

The Title V program will continue to work on strategies related to offering information and training to child care and early education providers to support inclusion within those settings and assure higher quality care for CYSHCN. Activities include hosting webinars and online trainings for health providers on caring for CYSHCN, adapted from the Caring for People with Disabilities course, and partnering with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients. See the CSHCN Plan Section for more information on training and education for providers related to providing services for the CSHCN population.

Special Health Services Family Advisory Council (SHS-FAC): The SHS-FAC will continue to be involved at all levels of the KS-SHCN program. Without their guidance, assistance and input, the program staff would have no way of determining if the program is truly meeting to needs of the CYSHCN population. This group of family members have lived experiences that they openly share, to help the program grow to best meet the needs of CYSHCN. Their vision and direction drove the KS-SHCN Action Plan and will continue to hold program staff accountable for the fidelity of the plan. They will continue to assist with projects, be consulted for guidance on program implementation/changes and be active participants the new five-year needs assessment. Read more about the SHS-FAC in the Family Partnership section.

Partnership with Midwives: Among KDHE's efforts to increase the knowledge and skills of professionals to address the needs of the maternal and child health populations, intentional workforce development activities are planned to target midwives. In an effort to engage this provider group, tremendous work has taken place since the later part of 2017 to develop the first annual Midwife Symposiums held July 10, 2019, in Wichita and August 7, 2019, in Overland Park. Through joint efforts between KDHE and the Kansas Midwife Association there is a full agenda for each day focused on educating midwives on Kansas MCH work and inform them what role midwives can play in Title V. MCH Consultant Stephanie Wolf will present on the Kansas Perinatal Community Collaboratives model, outcomes, and opportunities for partnership in their community. The symposium will also feature Juliet Swedlund, Doula and MCH Council member.

Objective: Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.

Trauma-Informed Care (TIC) & Adverse Childhood Experiences (ACEs): Kansas Title V generally works to frame activities and efforts in a comprehensive way vs. focusing on topics or singular issues. Therefore, many activities that relate to mental health, specifically TIC and ACEs, may not always be labeled as such. We are consistently focusing on positive, healthy relationships and environments for children and youth-positive experiences have a lasting impact on development, well-being and functioning. Infusing hope and resilience in all we do (optimism and strengths-based perspective) is an important part of our work, although we are aware of and understand the importance of considering well-documented impacts of toxic environments.

Lemonade for Life: Title V has been learning more about ACEs prevention and intervention in practice. A promising approach developed by the University of Kansas Center for Public Partnerships & Research that's been implemented in Kansas and other states is Lemonade for Life (LFL). According to the website, LFL trains professionals working with parents and caregivers on use of the ACEs Questionnaire. The goal of is to prevent future exposure to ACEs while promoting resiliency and hope. The program helps individuals understand how early life experiences may have long-lasting effects on how they interact in relationships. The LFL training conveys that individuals cannot rewrite the beginning of their story, *but they can change how it ends***.** It is not victim blaming, but rather instills hope and responsibility for change with the individual and is a key stepping stone for self-sufficiency. Title V recognizes the importance of educating public health professionals on ACEs as well as hope and resiliency. In FY20, Title V plans to host LFL training MCH Universal Home Visitors, and available space will be offered to partners in their communities. In addition, Title V plans to invest in a pilot community to participate in a LFL learning collaborative based on an Oklahoma model and positive outcomes when delivered through home visiting. This pilot will allow Title V to assess and measure the impact prior to integrating LFL into more MCH communities. The requirements for a community to participate include:

- Complete two online ACEs learning modules
- Attend a full day in-person training
- Attend at least one group coaching call approximately 45-60 days after training
- Participate in evaluation of Lemonade for Life Curriculum
- Commit to showing the Brain Builder video during the first three months, before the sixth visit to all prenatal clients and clients with children birth to 3 (scripted conversation provided)
- Commit to introducing ACEs Questionnaire after video has been watched
- Download video to Home Visitor cell phone or device and allow parents to hold the phone or device at the home visit

while watching the video

- Introduce a discussion about parenting and the parent's experience as a child, ACEs, stress/toxic stress, and how trauma can affect parenting (scripted conversation provided)
- Serve and return as a way to discuss the importance of interactions and building pathways in the brain especially reading and talking with baby
- Use YouTube videos of parents interacting with their babies as a closing for the visit
- Collect data on training, ACEs Questionnaire, referrals, parental motivation, and more

Family-Centered Care Focus: The Special Health Services Family Advisory Council (SHS-FAC) developed a one-page information sheet on trauma-informed care/approaches to help educate providers about this important topic (see image below). During the next year, this information sheet will continue to be shared with a wide variety of providers (medical, educational and community) at various conference across the state. Trauma informed care is an ongoing area of interest for the KS-SHCN program, including providing additional trainings and resources to the Satellite Offices and Aid to Local grantees over the next year.

Mental Health First Aid (MHFA): The MCH program will continue to be involved in ongoing discussions related to increasing access to mental health first aid and youth mental health first aid training through promotion and support. MHFA has already been provided to MCH home visitors across the state (and their partners—see what they said about the training below), but plans are underway to expand reach to school personnel, teachers, nurses, other MCH local agency staff (beyond home visitors), and any other community level partners interfacing with and/or providing services for adolescents.

Plans involve promoting mental health initiatives at the state and local levels, distribution of resources via counselors and MCH local agency listservs and updating websites and social media sites with relevant resources and information, including professional development/training opportunities. The Title V program has promoted MHFA on the Kansas MCH website and Facebook pages. The MCH website has a number of resources related to trauma-informed care and resilience available for use by local agencies and communities. http://www.kansasmch.org/aces.asp.

Mental Health First Aid (MHFA) Reviews from MCH Local Agency Attendees

- "I found the information presented to be very helpful. It is important knowledge to have. It was a long day but worth it!"
- "With mental health becoming more of a concern, I found this information helpful."
- "I think it was valuable information that I can use on a daily basis!"
- "Very informational and opened my eyes and will help me educate others and be more aware."
- "This was honestly the BEST training course that I have attended in a long time. I fully enjoyed all the information that was provided and the way that the team presented it to us. Thank you so much for inviting the supervisors to attend. I have encouraged others to attend this course as well."
- "I was able to take the steps from the Mental Health First Aid USA training the very next day during a home visit with a new mother, especially the listening skills!"

Objective: Implement collaborative oral health initiatives to expand oral health screening, education and referral by 2020.

Partnership with Oral Health Kansas: Title V will continue a formal agreement/partnership with Oral Health Kansas (read more in the Cross-cutting Report) in 2019 and 2020 to:

- Support work to expand oral health screenings in public health settings (WIC, SHCN, MCH)
    - Integrate oral health into the Kansas Help Me Grow initiative
    - Explore sustainability of oral health screenings
    - Develop a referral system between medical/dental/early childhood/social services
    - Create consistent messaging and promotional materials
    - Build demand for services (from parents and screening sites)
    - Build capacity for providing screenings across multiple settings including MCH/SHCN
- Develop/present professional development MCH staff and partners
    - Annual update to Oral Health 101 course
    - Oral Health and early childhood (home visitors)
    - Oral Health and Pregnancy (home visitors)
    - Oral health and CSHCN (staff as pilot then offer to families in regions)
- Develop/present oral health workshops for families with children with special needs
    - Cleft Lip/Cleft Palate (CLCP) and oral health needs information
    - Address barriers and issues with CLCP Medicaid claims
- Provide technical assistance to child care providers for oral screenings for children in their care
    - Evaluation plan to measure adoption of healthy habits as a result of taking online child care courses on oral health
    - Integrate goal setting into online oral health education for child care providers
- Integrate oral health messaging into school age programs
    - Create a toolkit for schools to reach children and adolescents about healthy habits and choices by integrating oral health and components of Thirsty for Health curriculum
    - Introduce Thirsty for Health into new elementary and middle schools
    - Create and oral health presentation toolkit that can be used by program staff or local dental professionals at child and youth programs
    - Create Thirsty for Health model for after-school programs
- Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referral
    - Assist MCOs with educating KanCare members on their current dental benefits
    - Educate navigators on dental insurance options in the marketplace to assist with enrollment
    - Prepare an educational campaign prior to open enrollment about dental options
- Increase access to primary and specialty care in underserved areas

- Conduct oral health needs assessment to determine barriers to access to oral healthcare for vulnerable populations such as CSHCN
- Use data from needs assessment to craft advocacy messages to legislators around CSHCN-specific policies, reimbursement rates, tele-dental, etc.

Oral Health Services for CSHCN: KS-SHCN Care Coordinators will continue working with families to assure they have a dental health home and are receiving preventive oral health care services. For program participants with Cleft Lip/Cleft Palate, KS-SHCN will work with Medicaid, dentist, oral surgeons, and community partners invested in oral health care in Kansas to assure children receive the care they need to support optimal health.

III.F. Public Input

FFY2020 Title V Block Grant Application/FFY2018 Annual Report Feedback

The Kansas Title V Team is committed to collecting input throughout the year and works in partnership with local agencies and the state MCH Council to assess and identify needs. Always looking for input, the staff work in additional opportunities to collect input and feedback through regular technical assistance calls/webinars as well as during local site visits, community meetings, and conferences/events.

In addition, a public input survey is developed and posted annually (via survey monkey) to collect information on the DRAFT Application and Annual Report from consumers and partners across the state that are informed of and concerned about the needs of MCH populations. Details related to this year's public input process and period follow.

Public Comment Period: June 5-June 24, 2019

Methods: A post card was developed and distributed to partners and MCH Council members via email and in-person meetings.

The following email was sent by the Title V Director to partners statewide (see partner list below).

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 Services Block Grant 2020 Application and 2018 Annual Report. The MCH Block Grant is administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health. The document is available for public review and comment on the Bureau of Family Health website.

Please take time to review this year's block grant application and provide comments and/or additional detail you might have to strengthen the application and ensure plans and reports represent our collective efforts statewide. This year's application

includes the newest State Action Plan for the period 2016-2020 (priorities, measures, strategies) which was developed in response to the most recent statewide, comprehensive needs assessment Kansas is required to conduct every five years. Each of you provided input through the process in some way and we thank you! We are asking you again for your time and input. After reviewing the draft document, we ask that you complete a short online survey. Please respond to the survey by ***June 24*** *in order to ensure that your comments are reviewed and considered for the application. Resources to increase your knowledge about the MCH block grant program and Kansas' priority issues for 2016-2020 can be found on the Bureau of Family Health's MCH Block Grant website.*

Your input is valuable and needed to assure the MCH Program is guided by the needs of Kansas families and 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, MCH 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.

Key Partner List (not comprehensive)

- American Congress of Obstetricians and Gynecologist (ACOG) Kansas Section
- Birth Centers
- Cerebral Palsy Research Foundation
- Child Care Providers and Facility Owners
- Children's Alliance
- Families Together
- Family Advisory Council
- Family Planning grantees
- High 5 for Mom and Baby Sites
- Kansas Academy of Family Physicians
- Kansas Action for Children
- Kansas Association for the Medically Underserved
- Kansas Breastfeeding Coalition
- Kansas Chapter of American Academy of Pediatrics
- Kansas Chapter of Family Physicians
- Kansas Children's Cabinet & Trust Fund
- Kansas Children's Service League
- Kansas Department of Aging and Disability Services
- Kansas Department for Children and Families
- Kansas Foundation for Medical Care
- Kansas Health Foundation
- Kansas Hospital Association and members (hospitals)
- Kansas Maternal & Child Health Council members
- Kansas Perinatal Quality Collaborative members
- Kansas Public Health Leadership Institute and Core Public Health Programs
- Kansas School Nurse Organization and members
- Kansas State Department of Education
- Kansas State University
- Kansas University Medical Center
- KDHE Department of Public Health Directors/staff

- Kansas Infant Death and SIDS (KIDS) Network
- Local Health Department Administrators
- Managed care organizations
- March of Dimes
- MCH grantees and partners
- Mother & Child Health Coalition of Greater Kansas City
- Newborn Hearing Advisory
- Newborn Screening Advisory
- Nutrition Physical Activity Collaborative
- School nurses
- Special Health Care Needs Specialty Clinics/Providers
- State Children's Institutions
- Sunflower Foundation
- Teen Pregnancy Targeted Case Management and Pregnancy Maintenance Initiative grantees
- United Methodist Health Ministry Fund and grantees/partners
- University of Kansas Center for Research
- University of Kansas Health System – Kansas City, Topeka, and Wichita
- WIC Advisory Committee
- WIC grantees and program representatives

Results

A total of 52 responses were received. Although we had a low number of responses, 60.0% responded that this was their first time providing feedback on a draft MCH application/annual report. 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 the five MCH population domains:

- Women/Maternal Health (96.8%)
- Perinatal/Infant Health (90.0%)
- Child Health (90.6%)
- Adolescent Health (87.5%)
- Children and Youth with Special Health Care Needs (87.5%).

The majority responded that the 2020 Application and 2018 Annual Report:

- clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities (90.3%);
- demonstrates strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas (83.9%); and
- accurately reflects the capacity/work/activities across Kansas as they relate to the state priorities (90.3%).

After reviewing "Five Year State Action Plan" and "Financial Narrative", the majority responded that:

- the State Title V Program Purpose and Design were adequately addressed 92.8%);
- the Supportive Administrative Systems and Processes: MCH Workforce Development, Family Partnership, State Systems Development Initiative and Other MCH Data Capacity Efforts, and Health Care Delivery System were adequately addressed (85.2%);
- the State Action Plan by MCH population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children with Special Health Care Needs was adequately addressed (96.2%); and
- the resource allocation/expenditures were adequately addressed 86.4%).

Approach to Utilizing & Applying Input on an Ongoing Basis

The Kansas Title V MCH Program utilizes input collected during the public comment period and throughout the year to inform state direction and MCH activities such as providing a foundation for the comprehensive statewide needs assessment and bringing together providers from multiple systems to support movement toward integrated services and comprehensive approach to care. Internally, regular MCH coordination/working meetings are held monthly to ensure all program and epidemiology staff have the forum to communicate updates, develop plans/activities, and monitor progress related to Title V, especially the Block Grant measures/indicators and needs assessment priorities. The Kansas Maternal & Child Health Council (KMCHC) meets quarterly and remains actively involved in reviewing on going input as well as continually reviewing progress related to the state action plan, assessing and monitoring the needs of MCH populations, and addressing emerging issues faced by families and communities. New activities, collaboratives, councils, coordination, and communication are the keys to success with reaching goals and creating movement toward collectively improving outcomes.

Discussion items within the program and across partners center on the following.

- Data/benchmarks (positive and negative trends)
- Opportunities for alignment and integration at the state and local levels
- Status of MCH investments (initiatives and activities)
- MCH Epidemiology requests, tasks, and projects
- Essential coordination with other bureaus in the Division of Public Health and the Division of Health Care Finance (Medicaid)
- Continuous improvement of public comment and input related to services and emerging issues
- Increasing and improving communication with local agencies and contracts as well as other MCH partners including those that serve on the KMCHC

III.G. Technical Assistance

Collecting Measurable Evidence for the CYSHCN Population: As the Kansas Special Health Care Needs (KS-SHCN) program has transformed and transitioned to a program focused on community-based services and supports, the model for service delivery is naturally changing. The establishment of Satellite Offices, the focus on expanding capacity through contracts and partnerships, and the shift from clinical and direct services support to care coordination services creates a need for more relevant, timely data around the children and youth with special health care needs (CYSHCN) population. The recent shift in capturing data for CYSHCN from the National Survey for Children with Special Health Care Needs (NS-CSHCN) to the National Survey on Children's Health (NSCH), has resulted in fewer data points specific to the CYSHCN population and needs. Additionally, the more frequent data set, while helpful and beneficial for many purposes, is not a large enough sample size for statistically significant data for the CYSHCN population in some cases. It is needed to consider a state-specific data set to best capture the impact and long-term outcomes of shifting to a care coordination model. Extensive evaluation planning is complete for the KS-SHCN Care Coordination model. However, it is unclear how to fully measure the impact of the non-KS-SHCN families served through Aid to Local and community partnerships. Technical assistance could help to better understand, in real-time, the needs of the CYSHCN population in Kansas. Additionally, as Kansas engages in efforts related to integrated data across early childhood systems it will be important to consider the availability of CYSHCN-related state-level data, the interoperability of data systems, and the potential opportunity and impact across programs, such as birth risk factors, newborn screening, birth defects surveillance, and other public health programs, in addition to education programs involved in early childhood systems initiatives.

Planning & Collaboration with Title X: Focus on Women's Health & Adolescent Health: The KDHE Children & Families Section includes the Title V MCH and Title X Family Planning programs. The programs have spent meaningful time together reviewing shared priorities, goals, and objectives in order to identify linkages between MCH and Title X/Family Planning. Over the last year, the programs have worked together to coordinate and plan site visits for greater impact/gains and committed to launching the evidence-based reproductive health intervention, One Key Question® (OKQ) in partnership with local agencies. Technical assistance may be requested to support additional, meaningful and impactful coordination and collaboration between the Kansas Title V and Title X programs. Shared messaging and data sharing can be improved and clearly articulating the alignment between the two programs should take place with the local agencies. The expected change resulting from this partnership is increased access to reproductive life planning/counseling, improved maternal and infant health, and a continuum of care and integrated community-based services, and stronger families.

Implementing AIM Patient Safety Bundles and Other Maternal Health Initiatives: Alliance for Innovation on Maternal Health (AIM) has created maternal safety bundles that represent best practice for maternity care and are endorsed by national multi-disciplinary organizations. Kanas re-energized the Perinatal Quality Collaborative (KPQC) in 2017 with the implementation of a quality improvement effort around neonatal abstinence syndrome; concurrently the Kanas Maternal Mortality Review Committee was launched. The timing is ripe for Kansas to utilize data from the maternal mortality reviews to launch maternal education quality improvement initiatives. With bot the KPQC and the maternal mortality committees working in close partnership we have both meaningful data and access to a substantial network of birthing centers and women's health providers to impact meaningful change. Technical assistance could help ensure alignment and offer successes and lessons learned from other states who have undertaken AIM bundle implementation through continuous quality improvement cycles.

Aid to Local Title V Grant Monitoring: Kansas has been conducting an in-depth program review of our grant processes for sub-contracting with local partners for implementation of Title V goals and objectives and considering alternative funding structures to achieve greater impact. As a next step, our state could benefit from technical assistance that would include review of other state grant processes and discussions of lessons learned and challenges transitioning these processes over time. This could include models focused on regional vs. county-level models.

Other Technical Assistance Areas for Consideration: collecting measurable evidence related to program impact,

program evaluation, school health, strategies and approaches for empowering youth (preventing bullying, reducing risky behaviors, improving self-image, building strong character/social-emotional development for children and youth, etc.), youth engagement/leadership, substance use and public health's role (screening, brief intervention, referral), mental/behavioral health and integrating services at the community level

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - Doc1_SAP Measures PQC MMRC.pdf

Supporting Document #02 - Doc1_MCH SHCN Supplement.pdf

Supporting Document #03 - Doc3_Supporting You Supplement.pdf

Supporting Document #04 - Doc4_KCC_KPCC_OKQ.pdf

Supporting Document #05 - Doc5_CTK KEY.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Organizational Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Kansas

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,780,598	
A. Preventive and Primary Care for Children	$ 1,527,371	(31.9%)
B. Children with Special Health Care Needs	$ 1,481,251	(30.9%)
C. Title V Administrative Costs	$ 300,000	(6.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,308,622	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,949,804	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,992,669	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,942,473	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,352,511		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,723,071	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 70,031,333	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 82,754,404	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 135,900
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 410,910
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,782,829
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 444,577
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health	$ 648,994
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 249,995
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 941,475
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,614,946
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 53,786,823
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,309,122
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	$ 318,599
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 583,299
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 803,864

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,651,427		$ 4,777,544	
A. Preventive and Primary Care for Children	$ 1,434,816	(30.8%)	$ 1,618,153	(33.8%)
B. Children with Special Health Care Needs	$ 1,476,175	(31.7%)	$ 1,435,328	(30%)
C. Title V Administrative Costs	$ 265,250	(5.7%)	$ 329,000	(6.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,176,241		$ 3,382,481	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,531,773		$ 3,800,940	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,906,504		$ 5,186,201	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,438,277		$ 8,987,141	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,352,511				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,089,704		$ 13,764,685	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 71,105,934		$ 70,975,390	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 83,195,638		$ 84,740,075	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 511,500	$ 659,466
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 2,607,083	$ 5,828,726
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 151,020	$ 401,075
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 680,250	$ 750,175
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 244,156	$ 91,261
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 218,660	$ 182,352
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,352,000	$ 2,601,750
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 59,534,594	$ 54,320,570
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 486,249	$ 480,393
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,032,960	$ 4,304,797
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	$ 287,462	$ 343,778
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs		$ 130,232
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants		$ 4,844

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens		$ 875,971

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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount is based on expected investments for FY2020 which were estimated at the time of submission. The total budgeted is approximately $90K less for this population due to increase in indirect rate, additional staffing for maternal and infant initiatives, and increase for CSHCN budget.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenditures at the time of submission	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: The local match reported for MCH grants awarded to communities was reported at a much higher level for SFY2018. The same trend is happening as of today for SFY2019. The high level of match is not expected to continue, so the budget for SFY2020 is based on averages from the last three years even though the trend for the last two years is more than $1M increase in local match.	

Data Alerts: None

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

State: Kansas

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 735,988	$ 697,531
2. Infants < 1 year	$ 735,988	$ 697,532
3. Children 1 through 21 Years	$ 1,527,371	$ 1,618,153
4. CSHCN	$ 1,481,251	$ 1,435,328
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 4,480,598	$ 4,448,544

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 1,887,717	$ 1,937,553
2. Infants < 1 year	$ 1,887,717	$ 1,937,553
3. Children 1 through 21 Years	$ 2,859,496	$ 2,957,453
4. CSHCN	$ 1,372,543	$ 2,154,582
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 8,007,473	$ 8,987,141
Federal State MCH Block Grant Partnership Total	$ 12,488,071	$ 13,435,685

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

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 104,367	$ 66,064
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	$ 104,367	$ 66,064
2. Enabling Services	$ 1,960,450	$ 1,703,905
3. Public Health Services and Systems	$ 2,715,781	$ 3,007,575
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		$ 16,952
Physician/Office Services		$ 19,403
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 12,018
Dental Care (Does Not Include Orthodontic Services)		$ 8,364
Durable Medical Equipment and Supplies		$ 9,094
Laboratory Services		$ 233
Direct Services Line 4 Expended Total		$ 66,064
Federal Total	$ 4,780,598	$ 4,777,544

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 49,413	$ 42,187
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	$ 49,413	$ 42,187
2. Enabling Services	$ 4,710,121	$ 4,860,722
3. Public Health Services and Systems	$ 3,182,939	$ 4,084,232
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 755
Physician/Office Services		$ 31,171
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 966
Dental Care (Does Not Include Orthodontic Services)		$ 7,530
Durable Medical Equipment and Supplies		$ 304
Laboratory Services		$ 302
Other		
Audiology		$ 1,159
Direct Services Line 4 Expended Total		$ 42,187
Non-Federal Total	$ 7,942,473	$ 8,987,141

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: 37,951 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	37,951 (100.0%)	1,804	145	145 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency				

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Infants are followed through the Newborn Screening (NBS) and Newborn Hearing Screening (NBHS) programs until the diagnosis is confirmed and the referral to the Special Health Care Needs (Title V CYSHCN) program is made. At the time the diagnosis confirmation is received, the NBS/NBHS programs will send a letter to the parent explaining the role of the SHCN program and supports that they can offer. A SHCN application for assistance is enclosed. If the family applies for assistance through the SHCN program and are financially eligible for assistance, they are assigned a SHCN Care Coordinator and provided an opportunity to select the relevant and desired direct assistance programs (DAPs) from with they will receive support. Families are asked annually to update their application and information to retain coverage.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2017 Data (January 1, 2017 through December 31, 2017) Data includes number of presumptive positive blood screens (1,101) and number of failed hearing screens (703). NOTE: Critical Congenital Heart Defect data is not included as the CCHD screening mandate was not effective until February 14, 2018.	
2.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2017 Data (January 1, 2017 through December 31, 2017) Data includes number of confirmed genetic/metabolic disorders (89) and number of confirmed cases of hearing loss (56). NOTE: Critical Congenital Heart Defect data is not included as the CCHD screening mandate was not effective until February 14, 2018.	
3.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2017 Data (January 1, 2017 through December 31, 2017) Data includes number of confirmed genetic/metabolic disorders (89) and number of confirmed cases of hearing loss (56). NOTE: Critical Congenital Heart Defect data is not included as the CCHD screening mandate was not effective until February 14, 2018.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Kansas

Annual Report Year 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		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	7,619	40.0	0.1	25.3	27.9	6.7
2. Infants < 1 Year of Age	3,554	52.7	0.3	16.9	14.9	15.2
3. Children 1 through 21 Years of Age	21,369	48.9	1.0	21.7	23.7	4.7
3a. Children with Special Health Care Needs	2,134	65.1	0.0	23.3	11.6	0.0
4. Others	6,180	33.0	0.1	30.1	27.5	9.3
Total	38,722					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	36,519	No	40,102	94	37,696	7,619
2. Infants < 1 Year of Age	38,013	No	37,951	100	37,951	3,554
3. Children 1 through 21 Years of Age	842,020	Yes	842,020	11	92,622	21,369
3a. Children with Special Health Care Needs	171,267	Yes	171,267	2	3,425	2,134
4. Others	2,033,044	No	420,424	14	58,859	6,180

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**

Field Note:
In July 2016, Kansas implemented a new data system called *DAISEY (Data Application and Integration Solution for the Early Years): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data. Because we have made intentional efforts to expand and improve the way we gather and process the data, new data cannot be accurately compared to previous years. As quality improvement continues, the data results will better reflect the MCH populations that we serve.

Direct entry grantees (MCH + Universal Home Visiting + Kansas Perinatal Community Collaborative/Becoming a Mom + Pregnancy Maintenance Initiative + Teen Pregnancy Targeted Case Management) and non-direct entry grantees' aggregate reports were combined.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**

Field Note:
In July 2016, Kansas implemented a new data system called *DAISEY (Data Application and Integration Solution for the Early Years): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data. Because we have made intentional efforts to expand and improve the way we gather and process the data, new data cannot be accurately compared to previous years. As quality improvement continues, the data results will better reflect the MCH populations that we serve.

Direct entry grantees (MCH + Universal Home Visiting) and non-direct entry grantees' aggregate reports were combined.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**

Field Note:
In July 2016, Kansas implemented a new data system called *DAISEY (Data Application and Integration Solution for the Early Years): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data. Because we have made intentional efforts to expand and improve the way we gather and process the data, new data cannot be accurately compared to previous years. As quality improvement continues, the data results will better reflect the MCH populations that we serve.

Direct entry grantees (MCH + Universal Home Visiting + Kansas Perinatal Community Collaborative/Becoming a Mom + Pregnancy Maintenance Initiative + Teen Pregnancy Targeted Case Management) and non-direct entry grantees' aggregate reports were combined.

4.	**Field Name:**	**Children with Special Health Care Needs**

	Fiscal Year:	**2018**

Field Note:
CYSHCN data reflects all numbers served through the Direct Assistance Programs, Care Coordination, Special Bequest, and Clinical services provided by grantees.

Note: The current data system for the program is unable to break this down by age, therefore this is reflective of both children and adults served by the Kansas Title V CYSHCN program. Due to the development of a new data system, program specific information will be able to be used beginning in 2020.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
In July 2016, Kansas implemented a new data system called *DAISEY (Data Application and Integration Solution for the Early Years): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data. Because we have made intentional efforts to expand and improve the way we gather and process the data, new data cannot be accurately compared to previous years. As quality improvement continues, the data results will better reflect the MCH populations that we serve.

Direct entry grantees (MCH + Universal Home Visiting + Kansas Perinatal Community Collaborative/Becoming a Mom + Pregnancy Maintenance Initiative + Teen Pregnancy Targeted Case Management) and non-direct entry grantees' aggregate reports were combined.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**

Field Note:
Numerator: Outreach by MCH grantees (pregnant women + postpartum 60 days) + Kansas Infant Death and SIDS Network + Kansas Breastfeeding Coalition + direct/enabling services (pregnant women + postpartum 60 days) = 22,000 + 852 + 7,075 + 7,619 = 37,546
Denominator: Pregnancy outcomes (live births + stillbirths + abortions) = 40,102

Total % Served = 37,546 / 40,102 = 94.0%

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**

Field Note:
Numerator = Infants served through newborn screening programs (37,951)
Denominator = Kansas vital statistics, occurrence live births (37,951)

Total % Served = 37,951 / 37,951 = 100%

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2018**

Field Note:
Numerator: Outreach by MCH grantees + Direct/enabling services = 73,112 + 21,369 = 94,481
Denominator: Reference Data = 842,020

Total % Served = 94,481 / 842,020 = 11.0%

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
Numerator = MCH service/SHCN outreach + SHCN Direct/enabling services = 269 + 2,134 = 2,403
Denominator = National Survey of Children's Health, CSHCN Prevalence estimates multiplied by US Census Bureau population estimates, 2017 (171,267)

Total % Served = 2,403 / 171,267 = 1.4%;
Note: TVIS allows only integer... thereby 1.4% was rounded to 2%. Otherwise it raises a flag error.

Kansas SHCN program 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. Therefore, the reference denominator may not reflect the definition/denominator of Kansas CSHCN.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
Numerator: Outreach by MCH Grantees + Direct service = 53,334 + 6,180 = 59,514
Denominator: Females 22-44 years old = 420,424

Total % Served = 59,514 / 420,424 = 14%

Data Alerts: None

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

State: Kansas

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	38,147	26,599	2,757	6,113	159	1,224	78	321	896
Title V Served	7,619	4,287	545	2,146	39	141	24	153	284
Eligible for Title XIX	11,701	6,941	1,633	2,199	157	5	13	0	753
2. Total Infants in State	37,951	26,461	2,735	6,088	158	1,222	76	320	891
Title V Served	3,554	1,705	221	1,012	16	57	5	118	420
Eligible for Title XIX	16,294	1,926	467	2,298	20	0	1	0	11,582

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: Kansas

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 244-5373	(800) 332-6262
2. State MCH Toll-Free "Hotline" Name	Parent Helpline	Kansas Resource Guide
3. Name of Contact Person for State MCH "Hotline"	Kelli Mark	Kayzy Bigler
4. Contact Person's Telephone Number	(785) 296-6136	(785) 296-1316
5. Number of Calls Received on the State MCH "Hotline"		550

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	Kansas Resource Guide (previous/in transition)	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	www.kdheks.gov/c-f/mch.htm; www.kansasmch.org	www.kdheks.gov/c-f/mch.htm; www.kansasmch.org
4. Number of Hits to the State Title V Program Website		2,500
5. State Title V Social Media Websites	www.facebook.com/kansasmch	www.facebook.com/kansasmch
6. Number of Hits to the State Title V Program Social Media Websites		350

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Kansas

1. Title V Maternal and Child Health (MCH) Director	
Name	Rachel Sisson
Title	Title V Director/Bureau of Family Health Director
Address 1	1000 SW Jackson, Ste 220
Address 2	
City/State/Zip	TOPEKA / KS / 66612
Telephone	(785) 296-1310
Extension	
Email	rachel.sisson@ks.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Heather Smith
Title	Title V CSHCN Director/Special Health Services Section Director
Address 1	1000 SW Jackson Street, Ste 220
Address 2	
City/State/Zip	Topeka / KS / 66612
Telephone	(785) 296-4747
Extension	
Email	heather.smith@ks.gov

3. State Family or Youth Leader (Optional)	
Name	Cassandra Sines
Title	Family Delegate
Address 1	P.O. Box 421
Address 2	
City/State/Zip	Maize / KS / 67101
Telephone	(316) 573-7097
Extension	
Email	cassandracc@cox.net

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Kansas

Application Year 2020

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

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:
Existing priority carried over--no change.

Field Name:

Priority Need 2

Field Note:
Existing priority need carried over--no change--addressing children and adolescent health needs such as developmental screening, social-emotional development/health, quality early care settings/environments, physical activity, and more.

Field Name:

Priority Need 3

Field Note:
Existing priority carried over--no change--focused primarily on breastfeeding and safe sleep as well as infant mental health.

Field Name:

Priority Need 4

Field Note:
Existing priority carried over--no change.

Field Name:

Priority Need 5

Field Note:
Existing priority--no change--focused on the workforce (capacity, skills, and competencies of professionals--are the prepared and "ready" to address unique issues MCH populations are facing in their community)

Field Name:

Priority Need 6

Field Note:
Existing priority carried over--no change--comprehensive in nature, with objectives and strategies focusing on more targeted issues/focus areas for CSHCN and children without SHCN.

Field Name:

Priority Need 7

Field Note:
Existing priority carried over--no change--focused on health literacy, navigating the health system, individuals being proactive when it comes to health care, services, coverage, transition, and more.

Form 10
National Outcome Measures (NOMs)

State: Kansas

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	83.2 %	0.2 %	30,311	36,416
2016	82.8 %	0.2 %	31,433	37,958
2015	83.6 %	0.2 %	32,685	39,081
2014	82.5 %	0.2 %	32,285	39,137
2013	79.6 %	0.2 %	30,846	38,743
2012	78.9 %	0.2 %	31,663	40,128
2011	77.4 %	0.2 %	29,663	38,337
2010	75.3 %	0.2 %	29,814	39,611
2009	74.8 %	0.2 %	29,610	39,605

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, 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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	96.5	6.1	257	26,635
2014	93.8	5.2	334	35,612
2013	75.8	4.7	268	35,360
2012	92.7	5.1	340	36,663
2011	76.4	4.6	278	36,411
2010	81.7	4.7	304	37,231
2009	82.1	4.6	317	38,634
2008	74.6	4.4	292	39,159

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	18.8
Numerator	36
Denominator	191,636
Data Source	Vital Statistics
Data Source Year	2013-2017

NOM 3 - Notes:

5 year rolling average (2013-2017)

Data Alerts: None

NOM 4 - 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
2017	7.4 %	0.1 %	2,685	36,497
2016	7.0 %	0.1 %	2,645	38,045
2015	6.8 %	0.1 %	2,672	39,142
2014	7.0 %	0.1 %	2,759	39,207
2013	7.0 %	0.1 %	2,721	38,824
2012	7.1 %	0.1 %	2,879	40,324
2011	7.2 %	0.1 %	2,854	39,620
2010	7.1 %	0.1 %	2,881	40,628
2009	7.3 %	0.1 %	3,011	41,381

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	9.6 %	0.2 %	3,495	36,504
2016	9.1 %	0.2 %	3,457	38,042
2015	8.8 %	0.1 %	3,426	39,134
2014	8.7 %	0.1 %	3,423	39,209
2013	8.9 %	0.1 %	3,447	38,824
2012	9.0 %	0.1 %	3,635	40,322
2011	9.1 %	0.1 %	3,596	39,601
2010	8.8 %	0.1 %	3,563	40,589
2009	9.2 %	0.1 %	3,808	41,325

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - 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
2017	25.7 %	0.2 %	9,364	36,504
2016	24.4 %	0.2 %	9,267	38,042
2015	24.1 %	0.2 %	9,432	39,134
2014	24.3 %	0.2 %	9,525	39,209
2013	23.0 %	0.2 %	8,936	38,824
2012	24.6 %	0.2 %	9,905	40,322
2011	25.4 %	0.2 %	10,043	39,601
2010	25.7 %	0.2 %	10,447	40,589
2009	26.8 %	0.2 %	11,067	41,325

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, 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
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	8.0 %			

Legends:

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

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.8	0.4	261	38,193
2015	6.0	0.4	236	39,256
2014	6.1	0.4	240	39,325
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
2016	6.0	0.4	228	38,053
2015	6.0	0.4	233	39,154
2014	6.2	0.4	243	39,223
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
2016	3.9	0.3	147	38,053
2015	4.1	0.3	162	39,154
2014	4.5	0.3	175	39,223
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
2016	2.1	0.2	81	38,053
2015	1.8	0.2	71	39,154
2014	1.7	0.2	68	39,223
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
2016	199.7	22.9	76	38,053
2015	204.3	22.9	80	39,154
2014	211.6	23.3	83	39,223
2013	213.7	23.5	83	38,839
2012	205.7	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
2016	128.8	18.4	49	38,053
2015	102.2	16.2	40	39,154
2014	89.2	15.1	35	39,223
2013	133.9	18.6	52	38,839
2012	111.5	16.6	45	40,341
2011	105.9	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

Federally available Data (FAD) for this measure is not available/reportable.

NOM 10 - Notes:

Currently, Kansas PRAMS does not ask about alcohol use in "the last 3 months of pregnancy", only ask about alcohol use in the 3 months before.

Data Alerts:

1.	Data has not been entered for NOM 10. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.5	0.3	118	34,154
2015	4.4	0.4	117	26,526
2014	3.0	0.3	107	35,669
2013	3.0	0.3	108	35,636
2012	2.5	0.3	94	36,863
2011	2.4	0.3	88	36,678
2010	1.6	0.2	59	37,909
2009	1.5	0.2	60	38,835
2008	0.9	0.2	36	38,298

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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

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 year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	10.8 %	1.2 %	72,165	669,869
2016	13.0 %	1.6 %	88,819	682,441

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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
2017	19.4	2.3	69	354,884
2016	18.2	2.3	65	357,728
2015	20.8	2.4	75	361,112
2014	15.7	2.1	57	363,940
2013	24.1	2.6	88	365,495
2012	19.6	2.3	72	366,922
2011	22.2	2.5	81	365,569
2010	27.0	2.7	99	367,153
2009	21.8	2.5	79	362,262

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	40.4	3.2	162	400,562
2016	34.3	2.9	137	399,639
2015	30.7	2.8	123	400,526
2014	35.7	3.0	143	400,763
2013	31.9	2.8	128	401,152
2012	32.9	2.9	132	400,793
2011	32.2	2.8	130	404,061
2010	38.2	3.1	154	402,705
2009	39.0	3.1	157	402,855

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	14.3	1.5	86	601,906
2014_2016	14.0	1.5	84	602,099
2013_2015	14.0	1.5	84	602,119
2012_2014	15.1	1.6	91	601,943
2011_2013	14.4	1.5	87	605,975
2010_2012	18.2	1.7	111	609,260
2009_2011	20.2	1.8	124	613,565
2008_2010	23.4	2.0	144	615,409
2007_2009	24.1	2.0	149	619,073

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	14.5	1.6	87	601,906
2014_2016	11.6	1.4	70	602,099
2013_2015	11.0	1.4	66	602,119
2012_2014	12.6	1.5	76	601,943
2011_2013	13.0	1.5	79	605,975
2010_2012	13.6	1.5	83	609,260
2009_2011	10.3	1.3	63	613,565
2008_2010	9.6	1.3	59	615,409
2007_2009	8.7	1.2	54	619,073

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	20.7 %	1.7 %	147,776	714,798
2016	20.5 %	1.7 %	147,272	718,578

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	15.9 %	3.2 %	23,510	147,776
2016	13.3 %	2.8 %	19,646	147,272

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, 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
2016_2017	2.8 %	0.9 %	16,907	598,389
2016	2.3 %	0.9 %	14,481	617,142

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, 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
2016_2017	10.4 %	1.4 %	61,744	594,985
2016	11.3 %	1.6 %	69,703	614,626

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, 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
2016_2017	51.7 %	6.2 %	45,713	88,354
2016	56.5 %	6.2 %	47,432	83,942

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, 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
2016_2017	91.0 %	1.3 %	649,518	714,049
2016	90.6 %	1.4 %	650,386	718,030

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.8 %	0.2 %	3,276	25,532
2012	13.1 %	0.2 %	3,913	29,939
2010	13.7 %	0.2 %	4,184	30,458
2008	13.5 %	0.2 %	3,553	26,342

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
2017	13.1 %	0.9 %	18,148	138,921
2013	12.6 %	1.0 %	17,861	141,756
2011	10.2 %	0.7 %	13,946	136,627
2009	12.2 %	1.0 %	16,101	131,837
2007	11.0 %	0.9 %	13,933	127,196
2005	11.7 %	1.0 %	16,530	141,316

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	13.0 %	2.2 %	39,650	305,450
2016	11.6 %	2.4 %	35,627	306,590

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	5.2 %	0.6 %	36,882	708,139
2016	4.7 %	0.5 %	33,437	714,300
2015	5.2 %	0.6 %	37,068	718,517
2014	6.2 %	0.6 %	44,705	723,985
2013	6.7 %	0.6 %	48,325	718,520
2012	6.9 %	0.5 %	49,694	719,066
2011	6.1 %	0.5 %	44,263	721,601
2010	7.7 %	0.6 %	55,698	725,339
2009	8.2 %	0.6 %	57,156	700,793

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	69.5 %	4.2 %	39,904	57,394
2016	76.4 %	3.3 %	43,771	57,280
2015	75.2 %	3.2 %	43,886	58,367
2014	76.5 %	3.6 %	44,149	57,728
2013	68.7 %	3.6 %	39,644	57,726
2012	65.0 %	3.4 %	37,798	58,137
2011	73.5 %	3.6 %	43,953	59,803
2010	54.9 %	3.8 %	32,378	58,955
2009	46.0 %	4.4 %	28,749	62,455

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	53.2 %	2.2 %	356,599	670,298
2016_2017	54.7 %	2.4 %	371,248	678,451
2015_2016	55.6 %	2.1 %	373,913	672,869
2014_2015	55.5 %	2.4 %	380,682	685,790
2013_2014	57.5 %	2.0 %	391,033	680,154
2012_2013	45.9 %	1.9 %	310,168	676,228
2011_2012	47.8 %	2.4 %	313,530	656,064
2010_2011	47.0 %	3.2 %	308,085	655,501
2009_2010	39.0 %	1.6 %	271,928	697,252

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	52.4 %	3.3 %	104,199	198,707
2016	51.8 %	3.3 %	102,507	197,992
2015	43.2 %	3.1 %	85,622	198,172

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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	89.7 %	2.1 %	178,326	198,707
2016	87.3 %	2.3 %	172,903	197,992
2015	87.3 %	2.2 %	173,003	198,172
2014	79.8 %	2.9 %	158,243	198,370
2013	84.6 %	2.5 %	169,347	200,122
2012	92.2 %	1.7 %	183,268	198,735
2011	79.1 %	2.8 %	158,210	199,999
2010	76.8 %	2.4 %	151,261	196,881
2009	63.6 %	3.5 %	122,436	192,607

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	72.1 %	3.0 %	143,230	198,707
2016	69.7 %	3.0 %	137,983	197,992
2015	63.7 %	3.0 %	126,260	198,172
2014	65.1 %	3.3 %	129,129	198,370
2013	55.9 %	3.5 %	111,787	200,122
2012	55.9 %	3.7 %	111,176	198,735
2011	47.7 %	3.4 %	95,410	199,999
2010	50.2 %	2.9 %	98,866	196,881
2009	38.3 %	3.5 %	73,838	192,607

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	21.3	0.5	2,057	96,711
2016	21.9	0.5	2,125	97,021
2015	25.5	0.5	2,479	97,115
2014	27.6	0.5	2,674	96,883
2013	29.5	0.6	2,869	97,183
2012	34.0	0.6	3,306	97,263
2011	35.6	0.6	3,493	98,232
2010	39.2	0.6	3,865	98,605
2009	42.7	0.7	4,233	99,129

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	12.4 %	1.4 %	4,195	33,879

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	2.1 %	0.5 %	14,729	712,436
2016	1.8 % ϟ	0.5 % ϟ	13,044 ϟ	713,854 ϟ

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Kansas

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	73.7	75.7	63.6
Annual Indicator	65.1	61.0	64.8
Numerator	317,072	294,297	311,046
Denominator	486,998	482,804	480,042
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	65.7	66.6	67.6	68.5	69.5	70.4

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	2017	2018
Annual Objective	87.2	88.6	90
Annual Indicator	83.8	77.1	83.6
Numerator	32,783	29,183	30,314
Denominator	39,126	37,866	36,276
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

State Provided Data			
	2016	2017	2018
Annual Objective	87.2	88.6	90
Annual Indicator	87.4	88.1	88.5
Numerator	34,078	33,429	32,162
Denominator	38,998	37,937	36,331
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	89.7	90.9	92.1	93.2	94.3	95.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	27.7	29.4	26
Annual Indicator	23.4	24.5	26.1
Numerator	9,025	9,095	9,159
Denominator	38,643	37,166	35,100
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	26.8	27.4	28.1	28.8	29.5	30.3

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			43.7
Annual Indicator		41.6	37.8
Numerator		33,290	30,554
Denominator		79,958	80,931
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	39.7	41.7	43.8	45.9	48.2	50.7

Field Level Notes for Form 10 NPMs:

None

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data			
Data Source: HCUP - State Inpatient Databases (SID) - CHILD			
	2016	**2017**	**2018**
Annual Objective	80.9	75.1	114.5
Annual Indicator	80.8	135.5	116.4
Numerator	325	406	461
Denominator	402,420	299,709	395,930
Data Source	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	113.4	110.4	107.6	104.8	102.0	99.4

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			80.8
Annual Indicator		79.8	77.5
Numerator		185,414	184,888
Denominator		232,249	238,418
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.5	79.4	80.4	81.4	82.5	83.5

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			39.6
Annual Indicator		38.6	46.1
Numerator		56,808	68,059
Denominator		147,272	147,776
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	48.4	50.8	53.4	56.0	58.8	61.8

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2016	2017	2018
Annual Objective	11.4	10.7	9.5
Annual Indicator	11.0	10.2	10.1
Numerator	4,298	3,877	3,683
Denominator	39,083	37,965	36,434
Data Source	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017

State Provided Data			
	2016	2017	2018
Annual Objective	11.4	10.7	9.5
Annual Indicator	11	10.2	10.1
Numerator	4,294	3,878	3,680
Denominator	39,052	37,961	36,374
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.4	8.8	8.2	7.7	7.2	6.7

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Kansas

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		8.3	8.9
Annual Indicator	8.8	9.1	9.6
Numerator	3,426	3,457	3,492
Denominator	39,105	38,033	36,440
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.1	8.7	8.2	7.8	7.4	7.1

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of children ages 6 through 11 who are physically active at least 60 minutes per day

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		29.6	35.4
Annual Indicator	28.2	32	26.7
Numerator	133,276	77,678	60,041
Denominator	473,426	242,379	224,657
Data Source	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2016	2016-2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	28.0	29.4	30.9	32.5	34.1	35.8

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   NSCH 2016 data cannot be compared with previous years.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   NSCH 2016 and 2016-2017 data cannot be compared with previous years.

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			55
Annual Indicator	36	50	93
Numerator			
Denominator			
Data Source	KIDS Network	KIDS Network	KIDS Network
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	105.0	110.0	115.0	120.0	125.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		44.7	7
Annual Indicator	47	7.2	7.2
Numerator	987,775		
Denominator	2,101,649		
Data Source	Kaiser Family Foundation	BRFSS	BRFSS
Data Source Year	2008	2016	2016
Provisional or Final ?	Provisional	Final	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	6.8	6.6	6.4	6.2	6.0	5.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Kansas BRFSS 2016 data cannot be compared with the 2008 Kaiser Family Foundation data.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Kansas BRFSS 2018 data will be available in fall of 2019.	

SPM 6 - Number of MCH grantees, families and partners that participated in a state sponsored workforce development event

Measure Status:						Active
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,000.0	1,500.0	2,000.0	2,500.0	3,000.0	3,500.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Kansas

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		20	30
Annual Indicator	24.7	28	25.9
Numerator	1,604	1,773	1,702
Denominator	6,496	6,335	6,578
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	35.0	40.0	45.0	50.0	55.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
CY2016: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom data

Evidence-based programs are Kansas Tobacco Quitline, Baby & Me Tobacco Free, Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT), and other smoking cessation program.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
CY2017: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom data

Evidence-based programs are Kansas Tobacco Quitline, Baby & Me Tobacco Free, Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT), and other smoking cessation program.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
CY2018: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom data

Evidence-based programs are Kansas Tobacco Quitline, Baby & Me Tobacco Free, Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT), and other smoking cessation program.

ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		22.5	15
Annual Indicator	14.1	13.9	13.7
Numerator	943	990	966
Denominator	6,671	7,121	7,075
Data Source	KWIC	KWIC	KWIC
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.5	20.0	22.5	25.0	27.5	30.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2018**

Column Name: **State Provided Data**

Field Note:
Numerator: Exclusive - Number of WIC infants breastfed exclusively through six months in communities that have reached the designation of a “Community Supporting Breastfeeding” (i.e., 7 month cohort)

Denominator: All - Number of WIC infants in communities that have reached the designation of a Community Supporting Breastfeeding (i.e., All babies enrolled in WIC)

ESM 6.1 - Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program (9-35 months)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		90	72.7
Annual Indicator	12.7	21.4	22.3
Numerator	243	347	340
Denominator	1,907	1,621	1,524
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	27.5	30.0	32.5	35.0	37.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: CY2016: MCH service data	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: CY2017: MCH service data	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: CY2018: MCH service data	

ESM 7.1.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		1,050	1,100
Annual Indicator	969	1,094	961
Numerator			
Denominator			
Data Source	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,000.0	1,050.0	1,100.0	1,200.0	1,250.0	1,300.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		30	40.3
Annual Indicator	24.4	32.6	30.3
Numerator	1,098	1,318	1,118
Denominator	4,492	4,042	3,690
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	32.5	35.0	37.5	40.0	42.5	45.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   CY2016: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data

2. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   CY2017: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data

3. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   CY2018: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data

ESM 11.1 - Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		5	5
Annual Indicator	0	0	66.7
Numerator			18
Denominator			27
Data Source	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	70.0	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   It is currently being piloted. The data will be available in January of 2018.

2. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   It is currently being piloted. The data will be available in January of 2018.

3. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Data are from the last three quarters of CY2018: Q2, Q3, and Q4.

ESM 14.1.1 - Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		15	30
Annual Indicator	31.1	38.9	43.5
Numerator	42	96	104
Denominator	135	247	239
Data Source	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: CY2016: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: CY2017: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: CY2018: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Kansas

SPM 1 - Percent of preterm births (<37 weeks gestation)
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the proportion of all preterm, early term, and early elective deliveries.
Definition:	**Numerator:** Number of live births before 37 weeks of complete gestation **Denominator:** Number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 9.1: Reduce total preterm births (PTB). (Baseline: 12.7% in 2007, Target 11.4%)
Data Sources and Data Issues:	Kansas birth certificate, Bureau of Epidemiology and Public Health and Informatics, Kansas Department of Health and Environment
Significance:	Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality. Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth. Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

SPM 3 - Percent of children ages 6 through 11 who are physically active at least 60 minutes per day
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of children and adolescents who are physically active.
Definition:	

Numerator:	Number of children ages 6 through 11 (NSCH) who report being physically active at least 60 minutes per day in the past week
Denominator:	Number of children ages 6 through 11 (NSCH)
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	Related to Physical Activity (PA) Objective 4.1: Increase the proportion of the Nation's public and private elementary schools that require daily physical education for all students. (Baseline: 3.8%, Target: 4.2%) Related to Physical Activity (PA) Objective 3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. (Baseline: 18.4%, Target: 20.2% for adolescents to meet current physical activity guidelines for aerobic physical activity)
Data Sources and Data Issues:	National Survey of Children's Health (NSCH) and Youth Risk Behavior Surveillance System (YRBSS). The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day.
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the number of professionals who have received Safe Sleep trainings.
Definition:	**Numerator:** Number of professionals who have received Safe Sleep training **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 1.3 Reduce the rate of all infant deaths (within 1 year); MICH Objective 1.8 Reduce the rate of infant deaths from sudden infant death syndrome (SIDS); MICH Objective 1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed); MICH Objective 20: Increase the proportion of infants placed to sleep on their backs
Data Sources and Data Issues:	Kansas Infant Death and SIDS (KIDS) Network
Significance:	Sleep-related infant deaths, called Sudden Unexpected Infant deaths (SUIDS), are the leading cause of infant death after the first month of life. Risk of SUIDS increases when babies are placed on their side or stomach to sleep. Placing babies on their back,on a firm surface,and without loose bedding are the recommended practices to follow according to AAP.

SPM 5 - Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To decrease the proportion of adults that report difficulty in understanding the information doctors, nurses and other health professionals tell them.
Definition:	**Numerator:** Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them **Denominator:** Number of adults aged 18 or older **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Health Communication and Health Information Technology (HC/HIT) Objective 1.1: Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition. Objective 1.2: Increase the proportion of persons who report their health care provider always asked them to describe how they will follow the instructions. Objective 1.3: Increase the proportion of persons who report their health care providers' office always offered help in filling out a form.
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS)
Significance:	Communication barriers often go undetected in health care settings and can have serious effects on the health and safety of patients. Limited literacy skills are one of the strongest predictors of poor health outcomes for patients. Health literacy can affect health status, health outcomes, health care use and health care costs. The entire health care systems relies on the assumption that patients can understand complex written and spoken information. If patients cannot understand health information, they cannot take necessary actions for their health or make appropriate health decisions. Reference: Graham S, Brookey J. Do Patients Understand? Perm J. 2008 Summer; 12(3): 67–69.

SPM 6 - Number of MCH grantees, families and partners that participated in a state sponsored workforce development event
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the number of professionals who have received the knowledge and skills to address the needs of maternal and child health populations.
Definition:	**Numerator:** Number of MCH grantees, families and partners that participated in a state sponsored workforce development event **Denominator:** NA **Unit Type:** Count **Unit Number:** 20,000
Healthy People 2020 Objective:	NA
Data Sources and Data Issues:	Kansas Maternal & Child Health - Community Check Box
Significance:	Developing Title V workforce skills is necessary to effectively implement strategies designed to move the needle on the 15 National Performance Measures (NPMs). Currently, in Kansas, technical workforce skills and evidence-based strategies are not necessarily sufficient to move the needle on outcomes; contextual factors such as challenging political environments, lack of leadership support, funding insufficiency, lack of focus, and historically inequitable programs and outcomes also influence Kansas Title V's ability to have an impact. However, many of these contextual factors can be at least partially addressed with robust workforce capacity. Utilizing the National MCH Workforce Development Center's workforce competency lists by measure, we simultaneously identified foundational skills that complement the more technical and specific knowledge and skills required to effectively implement strategies for each measure. These foundational skills, in addition to the key knowledge and skills by measure, can serve as a guidepost for Title V directors seeking to align resources to effectively implement selected strategies for achieving the NPMs. Source: https://mchwdc.unc.edu/knowledge-tools/skills-to-support-the-national-performance-measures/

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Kansas

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Kansas

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To ensure supportive programming for well woman visits/preventive health care.
Definition:	

Numerator:	Number of MCH women (including pregnant and postpartum, 18-44 years) program participants who have received education on on the importance of a well woman/ preventative visit in the reporting year
Denominator:	Number of MCH women (including pregnant and postpartum, ages 18-44) program participants
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data
Significance:	A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, shots, screenings, education, and counseling.

ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of WIC infants breastfed exclusively through six months of age, in communities defined as either a city or county, that have been designated as a "Community Supporting Breastfeeding" by the Kansas Breastfeeding Coalition, Inc.
Definition:	

Numerator:	Number of WIC infants breastfed exclusively through six months in communities that have reached the designation of a "Community Supporting Breastfeeding"
Denominator:	Number of WIC infants in communities that have reached the designation of a Community Supporting Breastfeeding
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Kansas WIC Data System (KWIC)
Significance:	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal grown and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. If mothers get the support they need in the first 4 weeks of a new baby's life, they are more likely to keep breastfeeding. Mothers may need help finding people who are trained to assist with breastfeeding after they leave the hospital. Without help, some mothers may stop breastfeeding. Communities often provide a number of resources and programs to help breastfeeding mothers. The Surgeon General recommends programs which provide mother-to-mother support and peer counseling, use a variety of media venues to reach young women and their families, and the expansion of the use of programs in the workplace that allow lactating mothers to have direct access to their babies.

ESM 6.1 - Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program (9-35 months)
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To ensure supportive programming for developmental screenings.
Definition:	

Numerator:	Number of children (ages 9 through 35 months) that received a parent-completed developmental screening tool as part of an infant or child well visit in the reporting year
Denominator:	Number of MCH children (age 9 through 35 months) program participants in the reporting year
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data
Significance:	The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows: Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

ESM 7.1.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To increase the number of free car seat safety inspections completed by certified child passenger safety technicians
Definition:	**Numerator:** Number of free car seat safety inspections completed by certified child passenger safety technicians **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 5,000
Data Sources and Data Issues:	Kansas Traffic Safety Resource Office
Significance:	Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings. Motor vehicle injuries are a leading cause of death among children in the United States. A correctly used car seat or seatbelt can keep a child from being ejected during a car crash. Many times, child restraint systems are used incorrectly. An estimated 46% of car and booster seats (59% of car seats and 20% of booster seats) are misused in a way that can reduce their effectiveness. The Community Preventive Service Task Force recommends car seat laws and car seat distribution plus education programs to increase restraint use and decrease injuries and death to child passengers.

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To ensure supportive programming for well adolescent visits/preventive health care.
Definition:	

Numerator:	Number of adolescent program participants (12-21 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year
Denominator:	Number of adolescent program participants (12-21 years)
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data
Significance:	Adolescence is an important period of development physically,psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors,manage chronic conditions, and prevent disease.

ESM 11.1 - Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the proportion of families who experience an improved independent ability to navigate the systems of care within a year.
Definition:	

Numerator:	Number of families who show an improved ability to navigate the systems of care as demonstrated by their care level status. A care level is determined by the identified needs based on the KS-SHCN Care Coordination Assessment.
Denominator:	Number of families who receive support for care coordination and have completed a follow-up KS-SHCN Care Coordination Assessment in the past year. This information is based on data from the KS-SHCN Care Coordination Assessment.
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	KS-SHCN Care Coordination Measurement Tool The lead care coordinator has a conversation with the family to identify their needs and assigned a level 1,2,3 to them to indicate the amount of assistance they will need from the care coordinator assigned to their case. Improved ability means that they will not show as many needs based upon the re-evaluation in 1 year. They are classified level 3 with five or more needs, level two with 2-4 needs and level one with no 0-1 need.
Significance:	Care coordination involves the “deliberate organization of patient care activities between two or more participants (including the patient) involved in the patient’s care to facilitate the appropriate delivery of health services.” Care coordination is a key function of the medical home. The Family Advisory Council for Kansas defines care coordination as a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and financial needs to achieve optimal health. Key activities of care coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family. The care coordination curriculum was adapted from the Boston Children’s Hospital, which is an evidence-informed program designed to help individuals, including patients and families, articulate the principles and activities necessary to serve as a care coordinator.

ESM 14.1.1 - Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation, referral and follow up.
Definition:	

Numerator:	Number of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services
Denominator:	Number of pregnant women program participants who smoke referred/enrolled to an evidence-based program
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data
Significance:	Secondhand smoke is a mixture of mainstream smoke and the more toxic side stream smoke which is classified as a“known human carcinogen” by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. In addition,women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby.

Form 11
Other State Data

State: Kansas

The Form 11 data are available for review via the link below.

Form 11 Data