Maternal and Child Health Services Title V Block Grant

Kansas

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Office of the Secretary
Curtis State Office Building
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

August 15, 2020

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 2021 Title V Maternal and Child Health Services Block Grant Application and FFY 2019 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,

TO BE SIGNED UPON SUBMISSION

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

Enclosures

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

TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT PROGRAM

www.kdheks.gov/bfh • www.kansasmch.org • facebook.com/kansasmch

Title V Overview

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 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." In addition to the MCH conceptual framework and public health essential services, the Title V program depends on many strengths—translated through core values and guiding principles—to promote a strong culture of continuous quality improvement, innovation and growth, and a sustained focus on what matters.

MCH Population

Kansas, spanning 82,278 sq. miles, is divided into 105 counties with 628 cities. The US Census Bureau estimates there were approximately 2,911,505 residents living in the state in 2018, a 0.1% decrease from 2017. Kansas has a unique geographic layout that ranges from urban to frontier counties based on population density. During 2014-2018, the population of the urban peer group increased by 2.4%, while the frontier, rural, densely-settled rural, and semi-urban peer groups decreased by 4.3%, 2.9%, 2.0%, and 2.1%, respectively. In 2018, there was an estimated 36,439 infants or 1.3% of the total population (2,911,505) and 837,605 children and adolescents (ages 1-21) representing 28.8%. The number of females in the reproductive/child-bearing age group (ages 15-44) was 560,121, representing 19.2%, down 2.5% from 574,617 in 1999 (the peak in the 1999-2018 period). In 2017-2018, 20.3% of children ages 0 to 17 (est. 144,559) were identified as having special health care needs. About 20.1% of males under 18 had special health care needs, compared with 20.6% of females.

Total Individuals Served by Title V* (2019 Annual Report)

Assessing State Needs

Kansas continuously assesses the needs of MCH populations through an ongoing Needs Assessment, and the State Action Plan is reviewed during interim years. With a goal to maximize the input of internal and external partners, the 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 2021)

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. All infants and families have support from strong community systems to optimize infant health and well-being.
3. Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.
4. Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.
5. Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.
6. Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.
7. Strengths-based supports and services are available to promote healthy families and relationships.

Title V National Performance Measures (NPMs) (FFY 2021)

Kansas selected five NPMs that most closely align with the state priorities.

- NPM1: Well-woman visit (women 18-44 years)
- NPM5: Safe sleep
- NPM6: Developmental screening
- NPM10: Adolescent preventive medical visit
- NPM12: Transition to adulthood

Title V State Performance Measures (SPMs) (FFY 2021)

Kansas identified four SPMs to monitor progress with priority needs not addressed by NPMs.

- SPM1: Postpartum depression
- SPM2: Breastfeeding exclusivity
- SPM3: Workforce development
- SPM4: Strengths-based family supports

Title V Activities & Program Highlights by Population Domain

The Title V plan reflects coordination of MCH activities across funding sources, 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 at www.kdheks.gov/c-f/mch.htm.

Women/Maternal & Perinatal/Infant Health

Maternal Mortality: Title V launched the Kansas Maternal Mortality Review Committee (KMMRC) in collaboration with key partners in 2018 in an effort to review pregnancy-related deaths, identify causes, and implement interventions to prevent future occurrences. The KMMRC meets regularly; information and data collected from cases will inform selection of an Alliance for Innovation on Maternal Health (AIM) patient safety bundle for statewide adoption in 2020. Learn more about the KMMRC and follow progress at https://kmmrc.org/.

Perinatal Quality & Systems of Care: Title V partnered with the Wichita State University Community Engagement Institute beginning in 2018 to convene the Kansas Perinatal Quality Collaborative (KPQC), a panel of experts to improve the safety and quality of care for mothers and infants. Since that time, Title V has been working with the KPQC and partners to implement a state-level response to address Neonatal Abstinence Syndrome (NAS) using the Vermont Oxford Network (VON) NAS Training Program. A total of 32 hospitals are enrolled in the effort, accounting for ~84% of births. Work has shifted from hospital setting assessment to safe discharge to support continuity of care. The KPQC is looking forward to the next initiative which will be focused on maternal health/safety (AIM initiative), driven by findings from the KMMRC.

Count the Kicks® (CTK): Title V has a partnership with Healthy Birth Day to implement Count the Kicks®, an evidence-based stillbirth prevention campaign that educates providers and patients about monitoring fetal movements during the 3rd trimester of pregnancy. The campaign launched in August 2018 and has been successful— with more than 67,000 pieces of materials distributed across the state.

One Key Question® (OKQ): Title V has a 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?” Training and collaborative learning have been provided and will continue through the next year.

Birth Outcomes/Perinatal Community Collaboratives: 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. Outcomes for mothers and infants participating in a KPCC are improving when compared to state outcomes.

Breastfeeding: Title V has a partnership with the Kansas Breastfeeding Coalition (KBC) to align and support breastfeeding across 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 partners to provide consistent messaging and leverage resources at the state and local levels.

Safe Sleep: Title V has a 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; develop and provide training for parents, physicians, home visitors, and child care providers; and promote consistent safe sleep messages across the lifespan. KIDS also provides technical assistance on the Community Baby Shower model and the Hospital Safe Sleep Certification and Outpatient Provider Safe Sleep Star programs.

Child & Adolescent Health

Early Childhood Systems Building: The Help Me Grow Kansas (HMG) framework promotes integrated, cross-sector collaboration to build efficient and effective systems. This was the foundation of the All in for Kansas Kids Strategic Plan, supported by Title V partnership and aligned with key MCH activities such as: expanding care coordination to primary care provider settings, implementing the Bridges program (support for families transitioning out of Part C/Infant Toddler Services), and expansion of peer supports through Supporting You.

Preventive Medical Visits (Annual Well Visits): Title V is actively engaged in 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. Last year Title V provided funding for a statewide license to access the online Bright Futures Tool and Resource Kit, 2nd Edition.

Oral Health: Title V has a formal partnership with Oral Health Kansas (OHK) to support activities such as: conducting an environmental scan to discover what educational materials are being used locally, working with the KPCC coordinator to develop oral health prenatal education, creating and disseminating an interactive oral health poster designed to engage parents and children while in a provider's office, and developing a free workshop for child care providers.

Behavioral Health: Kansas Title V 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 position that oversees two new federally funded projects focused on behavioral health—*Kansas Connecting Communities* (launched October 2018) and *KSKidsMAP to Mental Wellness* (launched July 2019).

Youth-Friendly Care: The *Youth Health Guide* was developed to support youth in living healthy – physically, mentally, and emotionally. Additionally, Title V used the Adolescent Health Institute's youth-friendly care tools to support quality improvement strategies and is devoted to providing technical assistance to local agencies to improve adolescent health measures and identify enhancements or improvements to policy. With this support, local MCH agencies will be prepared to clearly state their goals and identify MCH funding needs to meet milestones in future grant applications.

Children with Special Health Care Needs (CSHCN)

Holistic Care Coordination: The Kansas Special Health Care Needs program (KS-SHCN) provides holistic care coordination (HCC) and 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. Eligibility for HCC services are expanding to those with medically eligible conditions, regardless of financial status or resources, and families of children three to five years of age who received early intervention through Part C/Infant Toddler Services.

Family Engagement: KS-SHCN contracted with a Family Advisory Council (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 (1) participate in the Systems Navigation Training (formerly known as the Family Care Coordination Training) train the trainer program to expand program training capacity and offer additional opportunities and (2) serve as the KS-SHCN Peer Support Administrator to assist with connecting peers through the Supporting You Network.

Family & Consumer Partnerships

Peer-to-Peer Support Network: In partnership with the FAC, Title V launched a peer-to-peer support network, Supporting You, to connect parents and caregivers of CSHCN 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. There are three participating programs: KS-SHCN, School for the Deaf, and FAC. The network is expected to expand to at least two other programs in the coming year.

Family & Consumer Partnership (FCP) Program: Title V is building a formal partnership program with families through peer supports, family leadership, and advisory opportunities. This will serve as a framework for local and state Title V programs to assure families are engaged at the level they desire. Upon development of a robust resource toolkit, Title V can offer technical assistance and opportunity to support partners with engaging families in planning, implementation, and evaluation of services, programs, and policy.

Title V Block Grant Budget

The Federal-State Title V partnership budget totals $12,386,929 for FY2021 (federal funds $4,719,472; state funds $3,610,958; local funds $4,056,499). 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

Activities/services funded by the Block Grant are essential to overall systems development and filling identified gaps. 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 positioned Kansas to launch and sustain critical efforts aimed at addressing maternal mortality and behavioral health (substance use and mental illness) during critical periods such as pregnancy and postpartum, childhood, and adolescence.

Early childhood systems building efforts have relied on Title V to spread what we know has an impact and support systems alignment, infrastructure, and innovation at the local and state levels. Collaborations involving Title V set the stage for receipt of federal funds to advance important initiatives, thus leading to higher quality services, stronger family engagement across all systems, and supports for Title V services focused on children birth to 5 and their families.

Individuals with special health care needs rely on Title V for appropriate, coordinated services. Investments support expansion of services to serve more families locally, provide flexibility for the program to serve beyond state statutory limitations, and consider gap-filling services, such as funding for direct assistance programs, increased access to care, and services and supports for caregivers.

III.A.3. MCH Success Story

Title V partnered with Healthy Birth Day, Inc. to bring *Count the Kicks (CTK)* to Kansas in 2018. CTK, a proven stillbirth prevention campaign, teaches tracking fetal movement in the 3rd trimester of pregnancy. Expectant moms track their baby's movements once a day and learn how long it takes to get to 10 movements. If what is considered "normal" changes, it could be a sign of problems and indicates a call to the provider. The impact and value of this intervention is evident in the following story from Deanna Cummings, who saved her baby with CTK.

One night Deanna woke up feeling nauseous and dizzy. She had completed her kick counting earlier that evening and all was fine, but she decided to count again. After two hours, she only felt a slight flutter twice, which was not normal. She headed to the ER, where the doctor noted that there was hardly any amniotic fluid remaining, her daughter's heart rate was 73 (and declining), there was no movement, and the baby was still breech. During the emergency cesarean section, they discovered the cord was wrapped around the baby's neck four times, and the placenta was failing.

"The doctors said it was a miracle to see us both alive. They were thankful I knew of Count the Kicks and did them every day, and that they wish more moms did."

Deanna is now a CTK Ambassador and shares her story to help spread the word about the importance of kick counting.

Deanna's full story is available online at: www.kansasmch.org/countthekicks.asp.

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 Bureau of Family Health (BFH), one of six Bureaus in the Division of Public Health, administers the Title V MCH Services Block Grant program. The mission of the Bureau is to “provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.”

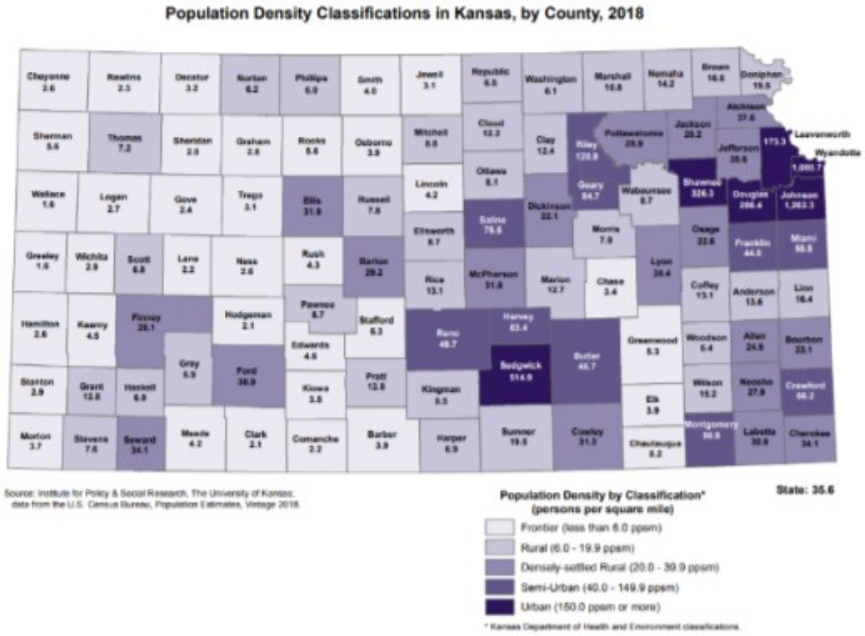
Kansas statutes do not mandate comprehensive services for MCH populations except for Children with Special Health Care Needs (CSHCN). Pursuant to K.S.A. 65-5a01, a "child with special health care needs” means “a person under 21 years of age who has a disease, defect or condition which may hinder normal physical growth and development." Statutes and regulations detail program requirements related to direct health services, in which services and supports are available to individuals birth to 21 with eligible medical conditions, and all ages with conditions diagnosed through the state's newborn screening program. Kansas provides direct services for state mandated eligibility criteria, care coordination for program defined eligibility criteria, and non-direct services through community partnerships to the broader CSHCN population, as defined by MCHB/HRSA.

KDHE convenes the Kansas Maternal and Child Health Council (KMCHC) and the Title V Family Advisory Council (FAC) to ensure ongoing stakeholder engagement, monitoring of Title V performance and outcomes, and provide opportunities to obtain input from subject matter experts to support innovation and early adoption of new strategies or initiatives on emerging needs, issues, or trends.

Kansas Demographics

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 2,911,505 residents living in the state in 2018. 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 389,255. Within that same region, also lies Pratt with a population of 6,630. 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]

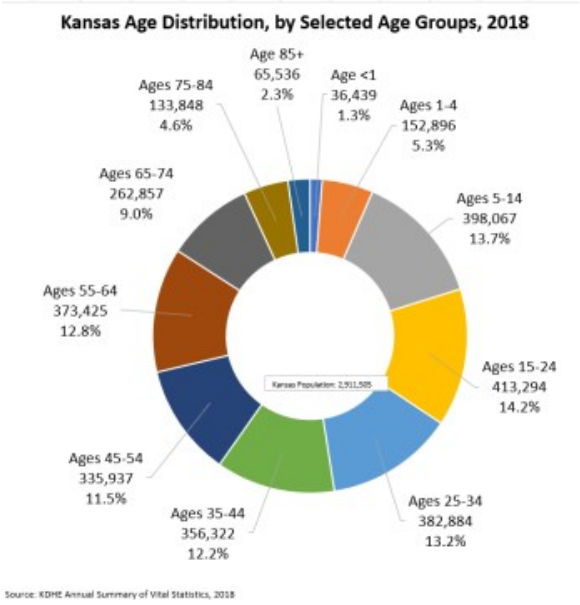
Population Density & Peer Groups (Urban, Semi-Urban, Densely-Settled Rural, Rural, and Frontier): The population density of Kansas was 35.6 inhabitants per square mile in 2018, a 9.9% increase from 32.4 persons per square mile in 1999. For comparison, the population density of the U.S. increased from 73.1 to 92.6 persons per square mile from 1999 to 2018, a 26.7% increase. In 2018, 36 of the state’s 105 counties had population densities of less than 6.0 persons per square mile. The most sparsely populated counties were Greeley and Wallace, each with a density of 1.6 persons per square mile. The most densely populated county was Johnson, with 1,262.3 persons per square mile. Kansas counties are assigned to peer groups based on population density. During the 2014-2018 period, the population of the urban peer group increased by 2.4%, while the frontier, rural, densely-settled rural, and semi-urban peer groups decreased by 4.3%, 2.9%, 2.0%, and 2.1%, respectively.[2]



Population Growth/Change: The percent increase in the Kansas total population from 1999-2018 was 9.7%, including an 11.1% increase for Kansas males and an 8.3% increase for Kansas females. Kansas decreased in population from 2,913,123 residents in 2017 to 2,911,505 residents in 2018, a 0.1% decrease. Pottawatomie, Douglas, and Johnson counties had the largest relative increases in population from 2014 to 2018 with changes of 6.0%, 4.2%, and 4.1%, respectively. Morton, Geary, and Comanche counties had the largest relative decreases in population, with changes of 14.2%, 11.2%, and 10.5%, respectively.[2] In 2018, there were an estimated 36,439 infants living in Kansas or about 1.3% of the total Kansas population (2,911,505). Women of reproductive age 15-44 accounted for 19.2% (560,121) of the Kansas population.[2] In 2018, there were 837,605 children and adolescents aged 1-21 years living in Kansas, which represents 28.8% of the Kansas population.[3] Among families with children under 18, 28.3% are single-parent families versus married-couple families (71.7%).[4] According to the 2017-2018 National Survey of Children's Health, 20.3% of Kansas children aged 0 to 17 (est. 144,559) were identified as having special health care needs (SHCN). The prevalence of children with special health care needs in boys and girls under 18 is about the same, 20.1% (est. 70,819) and 20.6% (est. 73,740), respectively.[5]

Age: The median age of Kansans in 2018 was 36.9 years, a 4.2% increase from the median age of 35.4 in 1999. The median ages of Kansas males and females in 2018 were 35.7 and 38.1, respectively. Shifts in the Kansas population distribution by age from 1999 to 2018 included a decrease in the 35-44 age group of 16.6% and 2.0% in residents 45-54 years of age. For the same period, Kansas experienced an increase among residents 55-64 years of age (69.5%) and

residents 65-74 years of age (49.7%) reflected the aging of the baby boomers. Furthermore, there were 2.7%, 2.6%, 3.8%, 12.6%, and 11.2% increases in the 0-4, 5-14, 15-24, 25-34, and 75 and over age groups, respectively.[2]



In 2017-2018, the prevalence of children with special health care needs within the child population increase with age, from 17.1% of 0-5, 17.0% of 6-11, and 27.1% 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 do not develop until later in childhood.

Race/Ethnicity: According to the 2018 Census Bureau estimates, 75.7% of Kansans were non-Hispanic white and 5.7% were non-Hispanic black. Hispanics made up 12.1% of Kansas' population.[2] The race and ethnicity composition of women aged 15-44 (i.e., of childbearing age) was estimated at 71.6% non-Hispanic white, 6.1% non-Hispanic black, 0.9% non-Hispanic Native American or Alaska Native, 4.3% non-Hispanic Asian and Pacific Islander, 2.9% non-Hispanic multiple race, and 14.1% Hispanic (any race).[2] The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. About one-third (30.9%) 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 (29.6%) young adults (20-21 years). About 16.6% of Kansans age 15-21 are Hispanic, compared to 18.5% of young children.[3] In 2017-2018, the prevalence of special health care needs varied only a small amount by child's race and ethnicity. Kansas Hispanic children (19.0%) had special health care needs, compared with 20.6% of non-Hispanic white children.[5]

Diversity/Languages: According to the 2018 American Community Survey, among people at least five years old living in Kansas, 11.8% spoke a language other than English at home. Of the same, Spanish was spoken by 7.9% and 4.6% 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. An estimated 92.8% of the people living in Kansas were U.S. natives. About 59.5% of these residents were living in the state in which they were born. Approximately 7.2% of Kansas residents were foreign-born. Of the foreign-born population, 40.1% are naturalized U.S. citizens, and an estimated 71.3% entered the country before the year 2010. Foreign-born residents of Kansas come from different parts of the world with the majority from Latin America (52.4%), followed by Asia (33.3%), Europe and Africa (5.6%), Northern America (1.2%) and Oceania (0.9%).[4]

Education: In 2018, Kansas compares favorably with the U.S. average in terms of educational attainment with 91.0% of people 25 years and over with a high school education or higher compared with 88.3% for the U.S. About thirty-three percent (33.8%) of Kansans had a bachelor's degree or higher compared with 32.6% for the U.S.[4] In Kansas, about 10.8% of children (1-17) received services under special education compared to 8.9% for the United States. For Kansas children with special health care needs 28.5% received special education or had an individualized education plan (IEP) compared to 31.0% for the United States.[5]

Income/Poverty: For 2018, the federal poverty level was $25,100 for a family of four.[7] Research suggests that, on average, families need an income of about twice the federal poverty threshold to meet their most basic needs.[8] In 2018, based on the Small Area Income and Poverty Estimates (SAIPE), a lower percentage of Kansans lived in households with incomes below the federal poverty level (11.9% vs. 13.1% for the U.S.) and a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (14.8% vs. 18.0% for the U.S.). During the past 5 years (2014-2018), Kansas experienced a decrease in the poverty rate for children under age 18 but in 2017 and 2018 there were slight bumps from the previous years. A decrease was seen in the United States without the bumps from 2016 to 2018.[9] In 2018, an estimated

102,616 Kansas children under 18 years of age were living in poverty. Five counties accounted for over half of all Kansas children (52,458 children; 51.1%) in poverty: Sedgwick (22,111), Wyandotte (11,949), Johnson (8,555), Shawnee (7,149), and Douglas (2,694). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty as well. In 2018, the percent of Kansas' families living below the federal poverty level (8.0%) was lower than the U.S. (9.3%).[10] Poverty was more common in Kansas families headed by single females with children in the household, regardless of race or ethnicity. In 2018, the Kansas percent of female headed households with related children under 18 years living below federal poverty level (33.6%) was slightly below the U.S. percent (35.1%).[10] According to the 2017-2018 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 (48.5%) of children with special health care needs lived in families with incomes less than 200% of the federal poverty level.[3]

The health of the economy plays a major role in the health status of the state's MCH population as well as the delivery of MCH services. The economy in Kansas has been recovering since the economic downturn suffered during the most recent nationwide recession. The statewide gross domestic product (GDP), which measure the total economic output of a given area, has been rising steadily since 2010 including a 1.9% increase from 2017 to 2018. In Kansas, the GDP increased in 10 out of the 11 major industries, with declines in the agricultural GDP causing the natural resources and mining GDP to decline as well. The median annual wage in Kansas currently stands at $35,950 which, 69% of the national average. There was a 3.2% increase in personal income from 2017 to 2018 in all components except farm income, which decreased by 36.7%. The three top occupation titles in Kansas include "Office and Administrative Support" with an annual mean wage of $35,580, followed closely by "Food Preparation and Serving" with an annual mean wage of $21,740, and "sales and related occupations" with an annual mean wage of $39,430. While the unemployment rate was the lowest in the state's history at 3.4%, prior to the COVID-19 pandemic, many of those jobs are low paying which makes it difficult for many individuals and families to meet their basic needs. Those households most disproportionately affected are female-headed households, blacks, Hispanics, people living with a disability, and unskilled recent immigrants. Moving the low-income population into the workforce is a protective factor for today's families.[12]

The state of Kansas (as with many other states in the nation) has seen a dramatic economic impact from the COVID-19 pandemic. The May 2020 unemployment rate in Kansas rose to 10%, a dramatic increase from 3.1% one year prior in May of 2019. While this was lower than the national rate of 13.3% and a decrease from the April 2020 rates (11.9%), it is clear the virus has negatively affected employment and the economy. Seasonally adjusted job estimates indicate that as of May 2020 Kansas has gained back 17% of the jobs lost in March and April due to efforts to contain the spread of COVID 19. Kansas enacted many executive orders during the pandemic, including: temporarily prohibiting evictions and foreclosures; expanding telemedicine and addressing licensing requirements; conditional and temporary relief from certain motor vehicle carrier rules and regulations; requiring continuation of waste removal and recycling services; temporarily suspending driver's license and vehicle registration expirations; allowing certain deferred tax deadlines and payments; and extending unemployment benefits to help ensure the protection of Kansas families.

Kansas Title V has worked closely with our local MCH agencies in order to use their funding in innovative ways to help support families in their communities during the pandemic, such as using MCH funds to purchase minutes for family cell phones so they could participate in telehealth activities and the purchase of "quarantine kits" for families in need (e.g., activities for families to enjoy together, coloring books, jump ropes, sidewalk chalk). Title V worked closely with the other KDHE bureaus and the Kansas Department of Emergency Management (KDEM) to make sure families have access to resources such as: the Emergency Food Assistance Program, the Supplemental Nutritional Assistance Program, Temporary Assistance for Needy Families, and Child Care Assistance. Additional resources for how to connect to crisis centers including mental health and substance use treatment facilities were developed.

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. Initially KDHE planned the summit directly with the Tribal Council (related to conducting

a community needs assessment and identifying priorities). Even though KDHE has not played a lead role in the recent past (Tribes are taking more of a leadership role in planning), the agency and staff have remained involved in planning as requested. The 2019 Summit (https://www.pbpindiantribe.com/event/kansas-tribal-health-summit/) was held August 19-20. On August 19th tribal employees, members, and partners were invited to learn from experts and discuss the 7 Circles of Indigenous Wellness. Representative Sharice Davids provided a special address during lunch. August 20th involved learning about opportunities to improve access to healthy, traditional foods. A partnership meeting was scheduled for November 5, 2019, with the Tribal Council and KDHE Bureau Directors, including the Title V/Bureau of Family Health Director; however, the meeting was canceled due to a conflict with agency leadership. It has not been rescheduled.

KDHE and Title V work to remain engaged with the Tribes through other work beyond the annual Summit. The Kansas Maternal Mortality Review Committee has tribal representation as well as the PRAMS Steering Committee and Early Childhood Recommendations Panel (similar to other states' Early Childhood Advisory Council [ECAC]). Kansas does not receive funding through the federal Office of Minority Health; however, KDHE recently created the new Health Equity Manager position within the agency to address the growing needs in the state and filled the position in July. The individual hired for this position had previously completed an internship with Kansas MCH/Title V focusing on health equity. In addition to addressing disparities that result in inequities across all populations, the efforts and initiatives will focus on the Native-American population as appropriate, considering the small population and lack of information available through Vital Statistics.

Kansas Medicaid & Health Insurance Coverage

Kansas Medicaid, known as KanCare, provides health coverage for traditional Medicaid and the Children's Health Insurance Program (CHIP). For most eligible groups, including children, pregnant women, low-income adults, people with disabilities and people with both Medicare and Medicaid dual eligibility, services are provided through a managed care model. Enrollees choose, or are assigned to, one of three managed care organizations (MCOs), who receive monthly payments from the state. MCOs are incentivized to ensure enrollees receive services that help reduce costs over time by improving their health and quality of life.[16]

Contracts with the MCOs require them to provide essential services through Medicaid, including prenatal care, well-child visits, preventive services, hospital care, medication, in home care, community-based services and nursing facility care. The MCOs also must ensure services are available statewide and at Medicaid-required levels. They may provide additional services not traditionally covered by Medicaid to help prevent hospital admissions or institutionalization. Additionally, Kansas has adopted seven Home and Community-Based Services (HCBS) waivers to provide flexibility around additional services not covered by Medicaid or CHIP.[16] See below table for list of those waiver programs.

Figure 11. Kansas Populations Eligible for Home and Community-Based Services (HCBS) Through Waivers and Their Institutional Equivalents

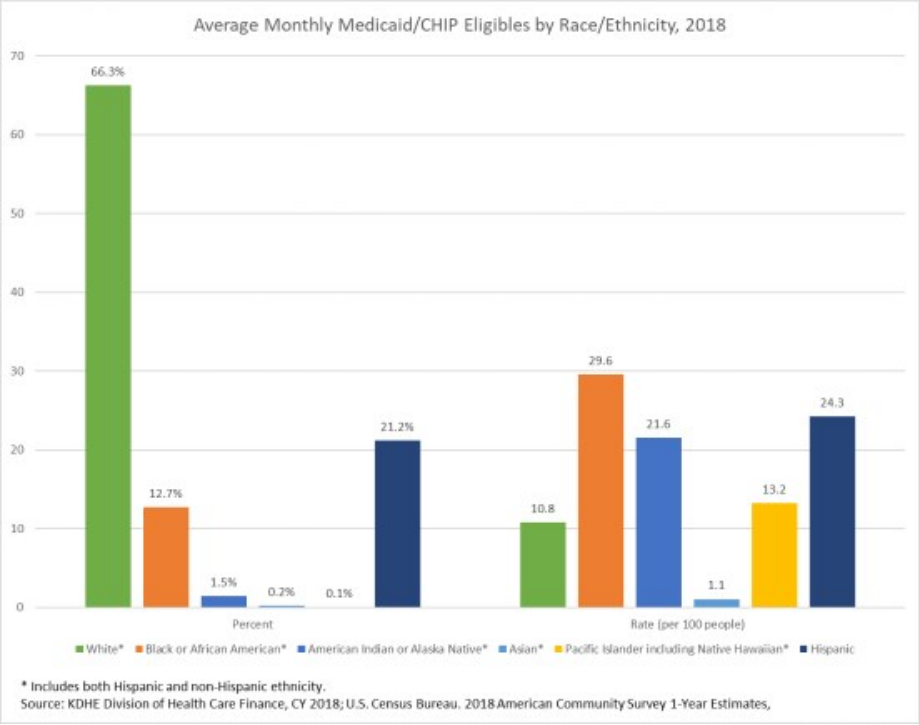
KANSAS HCBS WAIVER PROGRAMS	INSTITUTIONAL EQUIVALENTS
Autism (children; AU)	Inpatient Psychiatric Facility for Age 21 and Under
Frail Elderly (FE)	Nursing Facility
Intellectual/Developmental Disability (I/DD)	Intermediate Care Facility for Individuals with Intellectual Disabilities
Physical Disability (PD)	Nursing Facility
Serious Emotional Disturbance (children; SED)	Inpatient Psychiatric Facility for Age 21 and Under
Technology Assisted (children; TA)	Hospital
Traumatic Brain Injury (TBI)	TBI Rehabilitation Facility

Source: Kansas 1915(c) waivers

Medicaid Expansion: Medicaid expansion is a current topic of much discussion in Kansas. Kansas is only 1 of 14 states that has not expanded Medicaid coverage to all adults up to 138 percent of the FPL. Several legislative initiatives have

occured recent years, most recently in 2020, however these bills have continue to be unsuccessful during regular legislative sessions.

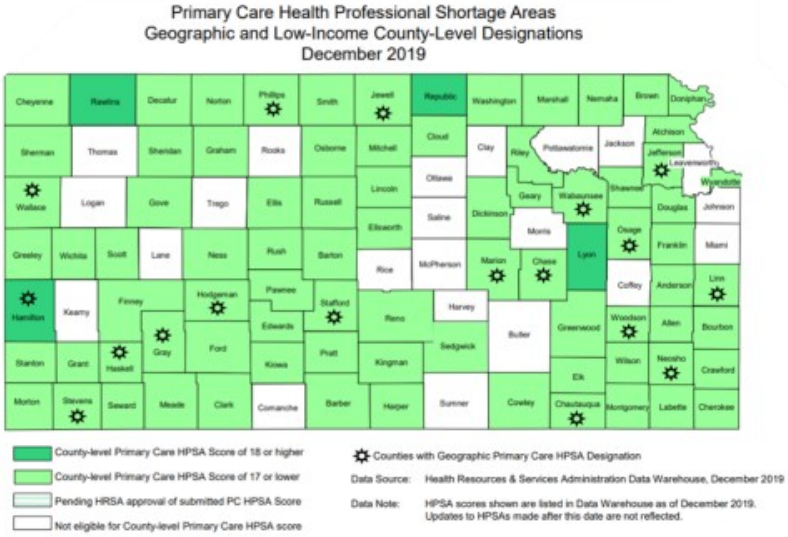
Health Insurance Coverage: Data from the Small Area Health Insurance Estimates (SAHIE) show that the percentage of Kansas children under 19 years old without health insurance decreased from 5.6% in 2014 to 5.0% in 2018, a 10.7% decrease. After a low of 4.5% in 2016, there was a slight increase in the uninsured population under age 19 in 2017 (5.2%), then a slight decrease in 2018 (5.0%).[11] The U.S. percentage also decreased from 6.3% in 2014 to 5.2% in 2018. In 2018, more than half (52.0%) 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 2017-2018 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: 49.4% had private coverage, 39.9% had public coverage, 8.4% had both, and 2.3% had no insurance.[5] Based on the 2018 average monthly eligibility for Medicaid and CHIP, Blacks made up 12.7% and 21.2% of eligible individuals but had rates of 39.6 per 100 people and 24.3 per 100 people, respectively. This puts the rate of Medicaid and CHIP enrollment for Blacks at 3.7 and 2.3 times higher than Whites (66.3% of enrollees) with a rate of 10.8 per 100 eligible people.[17,18]



Kansas Strengths and Challenges

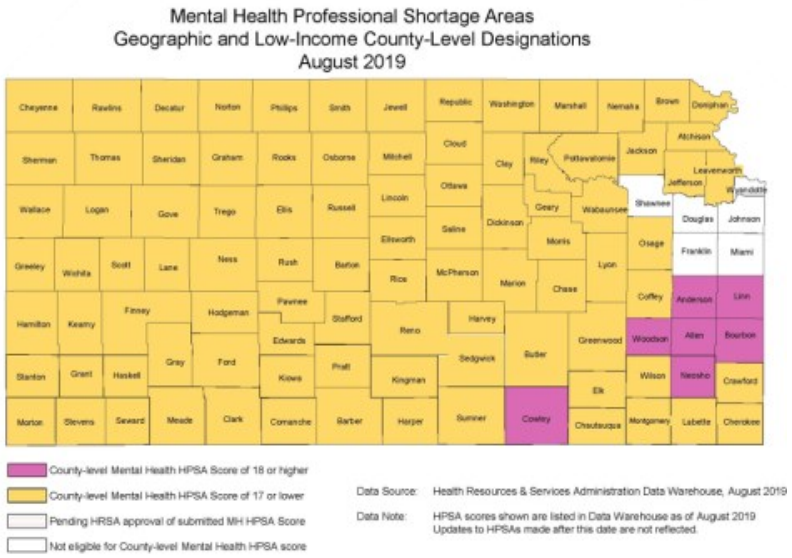
Primary Care Access & Workforce: In 2018, the supply of family and general practitioners per 100,000 population (15.1) was significantly lower in Kansas than the national average (34.9). The 2018 estimate for the supply of pediatricians and obstetricians/gynecologists in Kansas were not released/not 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 2017, the supply of obstetricians/gynecologists (1.7) was significantly lower in Kansas than the national average (5.8). 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] As of December 2019, there are eighteen (18) counties with a Geographic Primary Care Health Professional Shortage Area (HPSA) designation in Kansas.



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 urban and rural geographic areas, but 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, according to the 2016-2017 National Survey of Children's Health, in Kansas, 31.5% of CSHCN families reported that they had trouble getting specialist care versus 18.4% of non-CSHCN families.[5]

Estimates derived from national prevalence and 2017 US Census data suggest at least 157,151 or 21.9% of Kansas children have experienced a mental disorder, and around 34,888 or 4.9% of Kansas children meet the criteria for severe impairment. Over 65% of Kansas youth with major depression do not receive mental health treatment, and only 26.5% of Kansas youth with severe depression receive consistent treatment. Largely rural, Kansas faces severe shortages of medical providers across the state, particularly mental health professionals. Ninety-nine of the 105 counties in Kansas are designated as mental health professional shortage areas, or mental health HPSAs. This shortage leaves more than 70% of Kansas children with unmet mental health needs.[13]



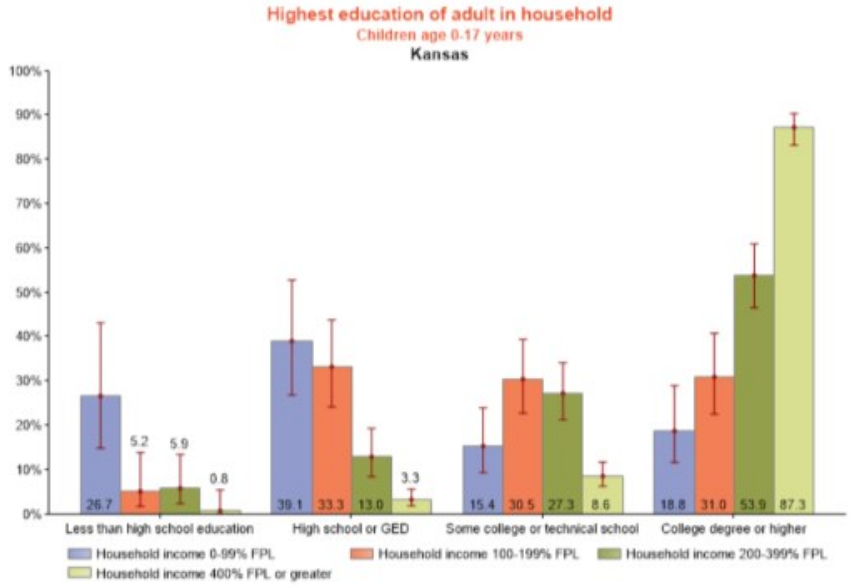
Due to the shortage of providers, ensuring adequate access to mental health services for Kansas youth will require an innovative approach that increases capacity across a range of medical settings and offers new avenues for care. Kansas is home to more than 700,000 children, all of whom should have access to integrated healthcare. Such integration would require primary care providers, including pediatricians, family practice physicians and non-physician primary care providers (PCPs), have the ability to screen, diagnose, and treat children and adolescents with uncomplicated mental illness, such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD). A reformed model of care would also require the establishment of an expert pediatric mental health care team to provide training, consultation, and support services to PCPs.

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.

Health Equity and Social Determinants of Health (SDoH)/Disparities: 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, such as:

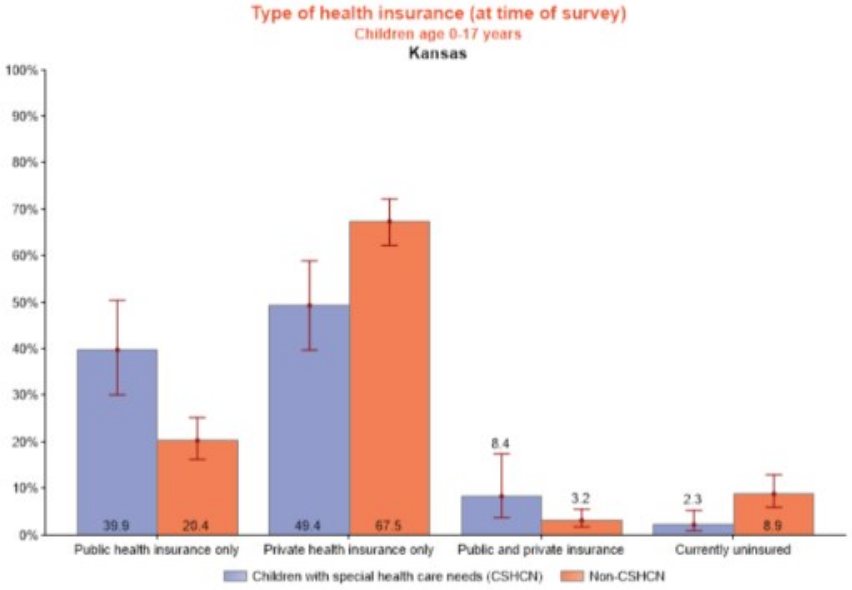
- Race/Ethnicity
- Insurance Type
- Education Level
- Federal Poverty Level
- Special Health Care Needs

It would not be prudent to look at these variables in isolation, as one often affects another. For example, people with lower education levels are more likely to live in poverty. According to the 2017-2018 National Survey of Children's Health (NSCH), households with lower income are more likely to adults in the household with a high school diploma, GED, or less. Whereas those with higher education levels also have higher household incomes.



Data Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.hrsa.gov/data/national-surveys

According to the 2017-2018 National Survey of Children's Health (NSCH), families of CSHCN utilize public insurance only at a much higher rate than those without special health care needs. The uninsured rate is lower among CSHCN families; however, they are more likely to utilize public and private insurance combined, than private insurance alone.



Data Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.hrsa.gov/data/national-surveys

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. According to the 2019 KIDS COUNT Data Book, Kansas ranked 15th for overall child well-being, 6th in economic well-being, 18th in education, 24th in health, and 23rd in the family and community.[14]

Kansas and Socioeconomic indicators[14,15]				
Education	% 4th graders not proficient in reading	2015 65%	2018 66%	**Increase**
	% 8th graders not proficient in math	2015 67%	2018 67%	No Change
	% 3-4 year olds not attending school	2012-2014 56%	2016-2018 53%	**Decrease**
Socioeconomic	% children under age 18 living in families where no parent has regular, full-time employment	2014 25%	2018 21% *Historic low (2016, 20%)*	**Decrease**
	% children living in high-poverty areas	2010-2014 9%	2014-2018 7%	**Decrease**

Health coverage is also a critical factor associated with differing health and birth outcomes. Mothers on Medicaid have a greater risk of worse health outcomes than mothers not on Medicaid.

Kansas Birth Statistics, by Insurance Status, and Year[19]

NOM#	National Outcome Measures	Medicaid Measures	2014	2015	2016	2017	2018	Trend	HP2020	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		80.0%	81.7%	80.8%	81.2%	81.0%		**84.8%**	
	Medicaid		70.5%	72.7%	70.2%	72.1%	71.7%			
	Non-Medicaid		84.8%	86.2%	85.8%	85.5%	85.3%			
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		7.1%	6.9%	7.0%	7.4%	7.4%		**7.8%**	
	Medicaid		8.5%	8.7%	8.8%	9.5%	9.9%	*		
	Non-Medicaid		6.3%	6.0%	6.1%	6.4%	6.4%			
5	Percent of preterm births (<37 weeks gestation)	P4P								1
	All		8.7%	8.8%	9.1%	9.6%	9.5%	*	**9.4%**	
	Medicaid		10.0%	10.3%	10.8%	11.3%	11.4%	*		
	Non-Medicaid		8.1%	8.0%	8.3%	8.8%	8.6%	*		

While the examples above focus largely on single issues, when SDoH factors overlap the risk of negative outcomes can grow. Kansas must work to address SDoH across multiple fronts to most effectively create change in the State.

Race and ethnicity are also a significant marker of mothers and children. Non-Hispanic Blacks, especially, show greater risk for worse health and pregnancy related outcomes. For example, Non-Hispanic Black Kansans have a lower prenatal care rates and higher rates of low birthweight babies, and infant mortality.[15]

Prenatal Care By Race (Percent)

Location	Race	Data Type	2016	2017
Kansas	White, Non-Hispanic	Percent	87.4%	87.5%
	Black/African American, non-Hispanic	Percent	73.3%	73.9%
	Hispanic	Percent	71.3%	71.3%
	American Indian/Alaskan Native	Percent	75.3%	73.4%
	Asian/Pacific Islander	Percent	83.6%	83.9%
	Unspecified	Percent	73.0%	61.3%

Low Birth-Weight Babies By Race Of Mother (Percent)

Location	Race	Data Type	2016	2017
Kansas	White, Non-Hispanic	Percent	6.5%	6.5%
	Black/African American, non-Hispanic	Percent	13.0%	13.3%
	Hispanic	Percent	6.3%	6.4%
	American Indian/Alaskan Native	Percent	5.6%	6.7%
	Asian/Pacific Islander	Percent	8.2%	7.6%

Infant Mortality By Race (Rate Per 1,000 - 5 Yr Average) (Rate)

Location	Race	Data Type	2017
Kansas	White, Non-Hispanic	Rate	5.0
	Black/African American, non-Hispanic	Rate	12.7
	Hispanic	Rate	6.7
	American Indian/Alaskan Native	Rate	8.5
	Asian/Pacific Islander	Rate	4.6

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 prenatal care and education, tobacco/smoking cessation (before, during, after pregnancy), and pre/early term birth. 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 231 infant deaths in 2018 in Kansas, an increase of 6.5% from 217 infant deaths in 2017. The infant mortality rate slightly increased from 6.0 infant deaths per 1,000 live births in 2017 to 6.4 in 2018. This does not meet the Healthy People 2020 target of 6.0 for infant deaths. The infant death rate for non-Hispanic white mothers in 2018 was 4.8, an increase of 2.1% from 4.7 in 2017. The rate for non-Hispanic black mothers in 2018 was 10.0, a decrease of 15.3% from 11.8 in 2017. The rate for Hispanic mothers in 2018 was 9.0, an increase of 25.0% from 7.0 in 2017. 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 (1999-2018). Rates for Hispanic mothers have sometime been higher and sometimes lower than those for non-Hispanic white mothers.[2]

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, as in there are clear patterns that can be identified within the data. The following Kansas women are at greater risk of maternal death and therefore remain 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.

Health Equity & Disparities: To address disparities, Title V has 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)
- Collecting quantitative and qualitative data through focus groups to determine impactful activities to address disparities in health outcomes within black communities.
- 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)
- Providing culturally appropriate breastfeeding support and resources in communities with demonstrated disparities (Chocolate Milk Cafes, Black Breastfeeding Coalition of Wyandotte County, increase breastfeeding educators and peer counselors of color)
- Assessing the need for health coverage, transportation, housing, food, education, etc. (holistic care coordination)
- 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
    - Assuring Medicaid reimbursement for perinatal mood and anxiety disorder screening in multiple settings, including the pediatric setting

- Screening for social determinants through local MCH programs
    - Development of a prescreening tool that aligns across MCH programs that includes screening for SDOH, mental health, substance use, IPV, Tobacco use, pregnancy intention
- Working with the agency-appointed staff person to coordinate/advance minority health and health equity strategies (utilizing the CollN SDoH network framework and resources)
- Development of a health equity learning collaborative that allows local communities to uncover root causes of a health equity issue in their community
- Raising awareness of health disparities with public education campaigns in partnership with the Kansas African American Affairs Commission
- 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
- Implementing a centralized, web-based data tracking system (Community Check Box) that allows monitoring of activities and initiatives focused on health equity and ethnic and racial minorities
- Supporting development among the MCH workforce through provision of health equity and SDoH trainings to the Family Advisory and Maternal and Child Health Councils
- Supporting development among the MCH workforce through the provision of health equity, SDoH, and unconscious bias training to state and local agency MCH staff

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.

Family and Consumer Partnership: The creation of Supporting You Kansas, a peer-to-peer support network, in 2018 greatly compliments the direction the new Strengths-based Family Supports priority under the 2021-2025 Title V State Action Plan. This provides opportunity to focus on family and consumer partnerships, leadership, peer supports, and the integration of the National Standards of Quality for Family Strengthening and Support. Additionally, Title V CSHCN has been working towards a shift in service delivery with maintaining state mandated program focus on direct health services and adding capacity through care coordination and other population health, systems of care, and policy initiatives.

Financial Assistance for CSHCN: Kansas Law mandates financial supports for health care services for CSHCN pursuant to K.S.A. 65-5a01, based on medical and financial eligibility, provided through the Kansas Special Health Care Need Program (KS-SHCN) and core Title V program. KS-SHCN provides this assistance through nine (9) direct assistance programs, referred to as DAPs. The chart below outlines the services available and eligibility for the DAP.
Each of the following DAPs have eligibility criteria and annual maximum assistance amounts. All families who meet medical and financial eligibility for the program can receive support through up to two DAPs each year. More information can be found in the CSHCN Section.

Co-Payments, Deductibles and Co-Insurance	For those with private insurance who have a patient responsibility through co-pays, deductible limits or co-insurance.
	Up to 50% assistance towards deductible limits and/or limited support towards co-pays/co-insurance for specialty services
Medical Services	For those with no insurance, or those who are ineligible for KanCare (Medicaid) and/or private insurance through the health insurance marketplace.
	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 minimal co-pay.*
Orthodontic Treatment Services	Only for those with craniofacial anomalies.
	Assistance with orthodontic evaluations and comprehensive treatment plans.
Hemophilia	Only for those with hemophilia, or other bleeding disorders.
	Assistance with factor treatment and a comprehensive hemophilia treatment center visit.
Metabolic Products	Only for those with PKU, or other amino acid disorders.
	Assistance for metabolic formula and low protein food items.
Medication	For anyone who qualifies.
	Assistance with medication. *Client responsibility includes a $5 co-pay for every $100 per medication supported by KS-SHCN.*
Travel	This is for anyone who qualifies.
	Travel assistance to and from the client's home to medical specialty care appointments.
Medical Equipment and Supplies	This is for anyone who qualifies.
	Assistance for durable medical equipment and medical supplies. *Client responsibility includes co-pays for medical equipment, based on the cost of the equipment.*
Care Giver Relief	For families of children with complex medical conditions that require specialty medical care.
	Reimbursement for qualified care providers identified, trained, and approved by the primary caregivers. Allows opportunity for parents/caregivers to take care of their own physical, emotional, and social health.

Kansas' Systems of Care for Underserved and Vulnerable Populations

A primary focus of the Kansas Title V program is to provide ongoing leadership to advancing and improving systems of care for underserved and vulnerable MCH populations. To support this effort, KDHE 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.

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: https://www.kdheks.gov/c-f/downloads/SFY2021_MCH_Manual_&_Appendix.pdf. The manual provides background on the Title V MCH Block Grant legislation/authority, KS MCH program principles, and service guidance and offers a vast appendix of resources related to practice and national performance measures.

The process with local agencies begins with the development of Grant Application Guidance and Reporting Materials annually in December. Materials are available by mid-January to local agencies applying for Title V funding. The review process informs funding recommendations and 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. More information about the MCH Aid to Local Program is available online through the Kansas Grant Management System (KGMS) site: https://khap2.kdhe.state.ks.us/KGMS/Default.aspx.

Title V contracts with nearly 70 local agencies to provide MCH services across the population domains and the majority of local services 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. In May of 2020 an interactive map of MCH service delivery sites was created to allow community organizations, providers and the public to easily identify and connect to services in their area: The interactive map displaying reach can be found here: https://www.kdheks.gov/bfh/index.html. Aid to Local contract documents and the list of 2019 MCH grantees are attached as Supporting Documents.

Navigating Kansas Medicaid and the Insurance System: Local MCH agencies assist clients in navigating Kansas Medicaid and the public/private insurance system. Many local agencies facilitate on-site enrollment of MCH clients and screen for insurance status and coverage at each encounter. If the individual or family does not have insurance, Medicaid eligibility is reviewed, and a referral is made if appropriate. Staff assist in completing the application and submitting it to Medicaid when need. For those who do not qualify for Medicaid, private Marketplace health insurance information is provided along with contact information to a Navigation Specialist.

Systems of Care for CSHCN: The Kansas Title V and KS-SHCN vision spans far beyond the mandate for the supports listed above. Rather, Kansas aims to assess and address needs of all children and youth with special health care needs and their 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 CSHCN population. The completion of the Kansas State Plan for CSHCN in 2018 provides opportunity to further engage with partners in ways to improve the system of care and collaborate more effectively and efficiently.

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III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Goals & Framework

The Needs Assessment was implemented through the lens of the program's core values (prevention and wellness, social determinants of health, life course perspective, health equity) and embodies the four guiding principles of Kansas' work (collaboration, relationships, community norms, consumer engagement). These values and principles are described in the State Title V Program Purpose and Design section of this narrative.

Building from momentum created in the past five years, Title V leadership desired to focus on the MCH workforce and partnership engagement throughout this process. The alignment of the Title V Needs Assessment with other state assessments (e.g., Maternal and Infant Early Childhood Home Visiting, Part C/Infant-Toddler Services, Early Childhood Systems/Preschool Development Grant) provided opportunities to maximize resources and align efforts and allowed Title V to focus on needs of the MCH workforce and high-risk populations.

Stakeholder Involvement

Led by the state's Title V MCH and CSHCN Directors and supported by Bureau of Family Health (BFH) staff and MCH epidemiologists, Kansas led a robust Needs Assessment with strong engagement among partners and external subject matter experts in the MCH field.

University of Kansas Center for Public Partnerships and Research (KU-CPPR)

Facilitated the overall Needs Assessment data collection, analysis, review, and identification of state plan priorities.

Kansas Chapter of the American Academy of Pediatrics (KAAP)

Coordinated the Kansas MCH Council (KMCHC) meetings and input sessions.

EnVisage Consulting, Inc.

Planned and facilitated the KMCHC meetings and provided support for MCH social media messaging throughout the Needs Assessment.

DCCCA, Inc.

Conducted an adolescent health needs assessment, holding youth focus groups regarding their views on health and access to and navigation of health care systems.

Title V maintained an ongoing commitment to engage diverse voices through key partnerships with conveners and facilitators that played a direct role in conducting the needs assessment.
The following table outlines key stakeholder engagement activities.

Activity	Stakeholder Engagement
MCH Grantee Regional Meetings	108 staff, 59 programs
Regional Community Open Houses	135 attendees
Public Kiosks	14 kiosks, 4,703 responses
Family Strengthening and Support Participant Survey	362 surveys received
Adolescent Focus Groups	180 youth and young adults
Adolescent Photo Project	65 photos, 19 youth participants
Our Tomorrows Survey	144 stories
Community Norms Survey	532 responses
Key Informant Interviews	11 interviews
KMCHC Virtual Meeting	40 participants
FAC Meetings (Sept 2019, May 2020)	11 family leaders (combined)

Methodology

Quantitative and qualitative methods were used to assess strengths and needs of the MCH population, program capacity, and core partnerships/collaborations that support program efforts. Upon presentation to MCH stakeholders, the qualitative data provided support and meaning to the quantitative data being reviewed. The following public-facing, stakeholder activities were utilized to collect data for the Needs Assessment.

- *MCH Grantee Regional Meetings:* Semi-structured focus groups with MCH-funded programs were held, represented by 108 staff representing 59 MCH programs.
- *Regional Community Open Houses:* Regional open houses (n=6) were held. The events consisted of five "stations" where 135 participants were able to engage in activities to collect input on: the MCH workforce; home visiting programs; MCH performance (using Kansas data); perceived MCH priorities; and open-ended input regarding what is working well, challenges, and ideas.
- *Public Kiosks:* Kiosks placed in high foot traffic locations (e.g., health agency waiting rooms, libraries) collected responses (n=4,703) to questions about health needs and available services. Twelve touch-screen kiosk terminals across 10 different counties. Two additional kiosks traveled across the state to various events.
- *Family Strengthening and Support Participant Survey:* The Standards of Quality for Family Strengthening & Support were used to collected information from MCH grantee program participants on five key areas of practice: family-centeredness, family strengthening, embracing diversity, community building, and evaluation. Local clients and families were asked to respond to the Participant Survey, providing valuable data to determine how well local grantees are doing at meeting the Standards from the families' perspective (n=362 surveys returned).
- *Adolescent Focus Groups:* Focus groups (n=19) with 180 middle school, high school, and college students. Support from partners assured representation by youth from varying backgrounds and social groups (e.g., schools, tribal organizations, Boys and Girls Clubs, community organizations, and juvenile justice).
- *Adolescent Photo Project:* Youth groups participated in a photo documentation project to capture images of community factors that influence health, specifically of things that youth felt best represented how teens view influencers of health. Photographs and supporting narrative (n=65) information was received from 19 youth participants.
- *Our Tomorrows Survey:* The 2019 Kansas Early Childhood Systems Building Initiative resulted in the collection of over 2,600 stories through the Sensemaker® software. Utilizing analytical tools to make sense of complex, ambiguous narratives, the team analyzed 144 stories with relevance to the existing Title V priorities and measures.
- *Community Norms Survey:* An online stakeholder survey, including single-answer, open-ended, and community norm questions. Through this survey, Title V could identify themes of behaviors, among the 532 responses, on what communities expect/believe, based on the values, traditions, and policies.
- *Key Informant Interviews:* Stakeholders (n=11) participated in semi-structured interviews to fill gaps to assure adequate input was received from certain population groups. Informants represented foundations and associations relevant to MCH and provided experiences related to issues identified and gain insights on known gaps.
- *KS MCH Council (KMCHC) Virtual Meeting (April 2020):* Attended by key MCH stakeholders (n=40), this meeting focused solely on key aspects of the Needs Assessment process and review of draft priorities and objectives.
- *Family Advisory Council (FAC) Meetings (Sept 2019, May 2020):* Engaged at the onset and conclusion of the Needs Assessment process, FAC members provided input and feedback to ensure adequate representation from families, especially those with CSHCN. During planning, the families learned about data collection methods and offered insight on how to support family participation throughout the process. Upon completion of the draft plan, the FAC offered input on how Title V could assure adequate family engagement around the draft strategies.

Data Sources Used to Inform the Process

- *Population-level Data:* Data was collected at the state and regional levels (6 defined MCH regions), including demographic data downloaded from the Census.

- *Client-level Data:* The demographic profile for MCH clients was derived from DAISEY (Data Application and Integration Solutions for the Early Years), a public health shared measurement system used by MCH-funded agencies.
- *Information from Local MCH Programs*: Local agency applications provided information on public health priorities and reported capacity, allowing Title V to identify community-level disparities and gaps in MCH services.
- *Workforce Data:* Funded positions/staff demographics were reviewed and MCH personnel completed two activities to provide data around core MCH competencies.
    - Standards of Quality for Family Strengthening & Support: Staff Self-Reflection Checklist to assess how well they feel they meet these Standards
    - Online self-assessment of MCH competencies through the MCH Navigator.
- *Aggregate Data*: Specific to MCH populations, aggregate data was compiled and analyzed by MCH epidemiologists.

Top Data Sources Used*

- Health Resources and Services Administration (HRSA). National Survey of Children's Health (NSCH), 2016, 2016-2017 combined
- Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System (BRFSS), National Immunization Survey (NIS), EHDI Hearing Screening & Follow-up Survey, WONDER
- Centers for Medicare & Medicaid Services (CMS) Hospital Compare
- Feeding America. Map the Meal Gap
- Kids Count. Kids Count Data Center
- KDHE Bureau of Epidemiology and Public Health Informatics: Kansas resident data (e.g., birth, death, fetal death, linked birth and infant death, hospital discharge data)
- KDHE BFH, Nutrition and WIC Services
- Kansas Pregnancy Risk Assessment Monitoring System (PRAMS)
- Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Participation Report

**Complete list available upon request.*

Needs Assessment, Priority Needs, and State Action Plan

Development of MCH priority needs and the State Action Plan were informed through the Needs Assessment process. Title V convened several meetings to review the data collected, develop priority needs, create measurable objectives and actionable strategies to create the 2021-2025 MCH State Action Plan. Additional information about this process is included the Priority Needs and Links to Performance Measures section.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Strengths of MCH Populations

Given the association among economic well-being, disease, and premature death, lower levels of poverty and higher levels of education is a relative strength in Kansas (compared to the U.S.). A lower percentage of Kansans live in households with incomes below the federal poverty level (FPL) (11.9% vs. 13.4% for the U.S.) and a lower percentage of children under 18 live in households with incomes below the FPL (14.7% vs. 18%). More than 9 in 10 (90.5%) adults have a high school education or higher (compared to 87.3% for the U.S.) and 32.3% have a bachelor's degree or higher (compared to 30.9% for the U.S.). Other strengths noted below.

WOMEN/MATERNAL

87% of women aged 18-44 years say their general health is good, very good, or excellent

81% of pregnant women received prenatal care in the first trimester

Women who smoke during pregnancy decreased significantly from 12.5% in 2013 to 10.1% in 2017 and showed declines in most demographic groups

PERINATAL/INFANT

98% of Kansas infants had a well-baby checkup

1 in 3 Kansas infants were breastfed exclusively for 6 months - 11th highest in the U.S.

The percent of infants placed to sleep on their backs is 80.2% - higher than the Healthy People 2020 goal

CHILDREN

9 in 10 children are in excellent or very good health

7 in 10 children have completed the combined seven-vaccine series

More than 3 in 4 Kansas children had a preventive dental visit in the past year

ADOLESCENTS

78% of adolescents had a preventive visit in the last year

9 in 10 adolescents received at least one dose of the Tdap vaccine

The birth rate (per 1,000 teens) decreased significantly from 14.6 in 2013 to 9.5 in 2017

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

All Kansas children are screened for hearing loss, heart defects, and genetic/metabolic conditions at birth

93% of CSHCN have at least one preventive medical visit in a 12-month period

4 in 5 CSHCN have a personal doctor or nurse

Needs of MCH Populations

Despite recent improvements in health status for MCH populations in Kansas, needs remain. Kansas' performance is still not optimal, and disparities still exist among core outcome metrics. Some of the greatest areas of concern follow.

WOMEN/MATERNAL

Less than 2 in 3 women ages 18-44 have had a preventive medical visit in the last year (educational attainment and household income disparities exist)

12% of new mothers report symptoms of postpartum depression

Disparities persist in the percent of women in rural areas who smoke during pregnancy (e.g., income and educational attainment) compared to urban areas

PERINATAL/INFANT

Only 37.3% are placed to sleep on a separate, approved sleep surface and 44.3% are placed to sleep without soft objects or loose bedding

Diagnosis of neonatal abstinence syndrome (NAS) continues to increase (about 120 infants are diagnosed annually) and are more likely to be non-Hispanic white and insured by Medicaid

KS has the 17th highest infant mortality rate among non-Hispanic whites, the 14th highest among non-Hispanic blacks, and 7th highest among Hispanics in the U.S.

CHILDREN

37.8% of children 9 through 35 months received a developmental screening using a parent-completed tool in the past year

51.7% of children ages 3 through 17 years with a mental or behavioral health condition receive treatment or counseling

32% of children ages 10-17 years are overweight or obese, and 3 of 4 children are not physically active at least 60 minutes per day

ADOLESCENTS

The adolescent suicide rate is trending up, particularly among females

52.4% of adolescents have received at least one dose of HPV vaccine and 72.1% the meningococcal conjugate vaccine - well below national immunization rates

28% of adolescents in grades 9 through 12 are overweight or obese, and 8 in 10 adolescents are not physically active at least 60 per day

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Less than one in five adolescents ages 12 through 17 receive the services necessary to make transitions to adult health care (CSCHN: 16.1%; non-CSHCN: 19.6%)

40% of CSHCN had two or more adverse childhood experiences (far more than children without SHCN)

61% of CSHCN received effective care coordination, compared to 81% of non-CSHCN

Kansas' Successes, Challenges, and Gaps

Stakeholders noted positive changes or "bright spots," and also highlighted gaps that hinder better health for MCH populations. This section will focus on the issues most consistently noted during the Needs Assessment, broadly categorized into three themes: access and availability to care; behavioral health; social determinants of health (and the presence of health disparities).

Access and Availability to Care

Challenges and Gaps: Many women, infants, and children face barriers accessing health care services, either because of inadequate insurance coverage or availability of health professionals. Notable gaps include:

- Only 68% of KS children (2017) under 18 years are continuously/adequately insured
- Loss of Medicaid coverage for postpartum women (60 days after delivery); this coverage window is insufficient to adequately address issues such as postpartum depression
- Limited number of providers who do not accept Medicaid and concern about the gap between services needed and reimbursable services

Many comments were received on the shortage of health professionals (obstetrics and gynecology, general and specialty pediatrics, mental health and substance abuse treatment, and dental services) in their communities. The data supports these concerns.

- The number of family and general practitioners per 100,000 population (23.3) was significantly lower in Kansas than the national average (38.8).
- Of the 105 KS counties, a high number of counties are designated as Health Professional Shortage Areas (HPSAs) for primary medical care (80), dental care (78), and mental health care (101).
- Pediatricians are clustered in urban centers, a problem for 89 of 105 rural KS counties.
- The number of obstetricians/gynecologists per 100,000 people (1.7) is well below the national average (5.8).

Successes and MCH Efforts to Address Needs: While successful programs exist to support doctors working in rural settings, the shortage of providers remains a challenge. Title V has made significant investments to promote enhanced access to integrated, collaborative care.

- Kansas Perinatal Community Collaborative (KPCC): This model brings education, clinical care, and wraparound services together to improve outcomes for mothers. Infant mortality rates (deaths/1,000 live births) in counties with the longest-running KPCC programs (6 years) have decreased from 9.0 to 5.5 (Saline) and 11.9 to 5.7 (Geary).
- Help Me Grow (HMG): Leveraging community resources and connecting providers helps experience an organized system of resources. Through family/community outreach, provider outreach, centralized access, and evaluation, HMG promotes collaboration, mitigates the impact of adversity, and supports protective factors among families.

Behavioral Health

Challenges and Gaps: Mental health is cited as a priority issue in more Kansas Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) than any other issue. Mental health was cited in 34 CHNAs/CHIPs with the second highest being substance abuse (29). Mental health was also most frequently cited for service gaps (twice as often as substance abuse). Additional mental and behavioral health concerns noted:

- Increasing adolescent suicide rates (KS rates are higher than the national average)
- 51.7% of Kansas children received mental health treatment when they needed, well below the Healthy People 2020 target of 75%
- 18.9% of mothers were depressed, 25.2% experienced anxiety and 12.4% experienced postpartum depressive symptoms

Successes and MCH Efforts to Address Needs: Since 2018 Kansas has initiated two programs specifically focused on addressing the mental health needs of MCH populations.

- Kansas Connecting Communities (KCC): Increased screening, assessment, referrals, and access to treatment. KCC is building provider capacity to assist clients through telehealth, peer consultations, and training opportunities. Providers have access to a free Consultation Line staffed by a Social worker with training in perinatal mental health and substance abuse and a behavioral health team including a Clinical Psychiatrist.
- KSKidsMap to Mental Wellness: Promotes and supports integrating behavioral health into pediatric primary care and telehealth. An expert pediatric mental health team (social work care coordinator, child/adolescent psychologist and psychiatrist, pediatrician) provide training, technical assistance, and care coordination for primary care providers to help address the needs of children with behavioral health conditions.

Social Determinants of Health and Disparities

Challenges and Gaps: Despite ongoing recognition, concern, and "upstream" efforts, health disparities among MCH populations in Kansas persist. Affordability of housing, health insurance/access to health care, and food insecurity have been among the top issues cited in CHNAs. Kansans struggle economically, experience food insecurity, Inadequate transportation, and unhealthy/unsafe housing. Reduced child care opportunities often resulted in lost wages or employment, exacerbating economic hardship. Disparities are higher among minority populations (Black/African American, American Indian or Alaska Native, and Hispanic or Latino children live below the poverty level more often when compared to White and overall).

Suicide and alcohol/substance use are two top public health concerns by MCH programs. Additional determinants related to behavioral health/ substance use include:

- Kansas' suicide rate per 100,000 total population is 19.3, higher than the U.S. rate of 14.2, an increase each year from 2014 to 2018.
- Racial disparities exist among mental health hospital admissions rates—the rate for Black (106.1 per 100,000) is higher than the population by 31.0 (a 41.3% difference).
- Significant disparities exist between infants born exposed to harmful substances in utero for deliveries covered by Medicaid (8.8 per 1,000 birth hospitalizations) compared to private insurance (0.8 per 1,000 birth hospitalizations).

Successes and MCH Efforts to Address Needs: The Kansas Health Institute chartbook on racial and ethnic health disparities and the Kansas Health Foundation "Healthy Communities Initiative" created a network of advocates willing to learn and discover how to impact the health using a health equity lens. Building on this focus and readiness, Title V led the following efforts.

- MCH Opportunity Project: A learning collaborative to identify and address MCH health inequities. Support and technical assistance (TA) provided by KU Center for Community Health and Development (KU-CCHD) and guided by the Kansas Healthy Communities Action Toolkit, TA included capacity-building webinars and peer-to-peer learning.
- Adolescent Suicide Awareness and Prevention Efforts: Title V concentrates efforts on suicide risk factors and overall mental health. The KMCHC Adolescent Work Group developed a series of adolescent suicide action alerts based on the #BeThe1To campaign and the 5 Action Steps for Helping Someone in Crisis. Other Title V efforts include: a resource sheet (action steps for prevention); updates to the State Suicide Prevention Plan; participation in a Suicide Prevention Community of Practice; and engagement in creating "The Role of Public Health in Addressing Suicide Prevention.

III.C.2.b.ii. Title V Program Capacity

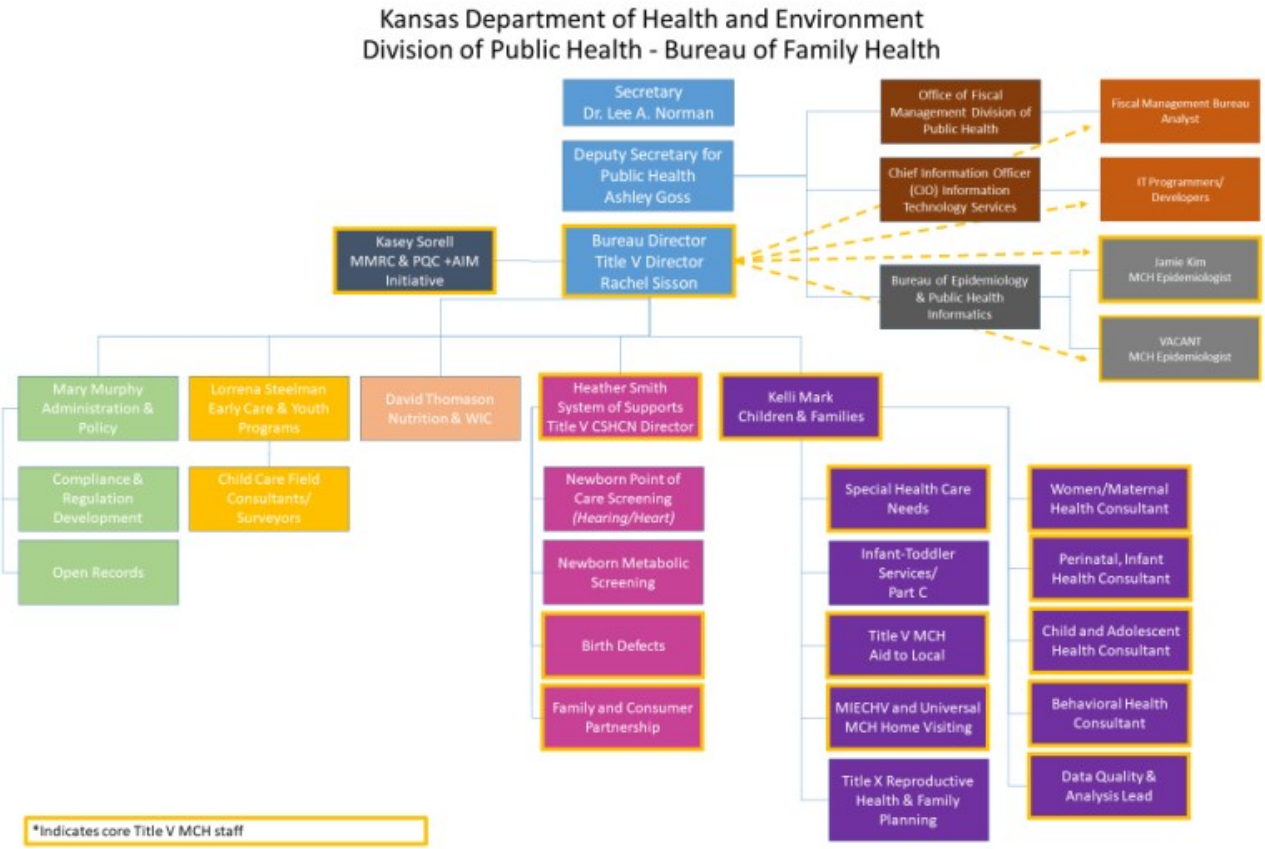
III.C.2.b.ii.a. Organizational Structure

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, Lee Norman, MD, is appointed by the Governor and serves as the State Health Officer. The agency is comprised of three divisions: Public Health, Health Care Finance, and Environment. The Title V Maternal and Child Health (MCH) Services Block Grant program is administered by the Bureau of Family Health (BFH), one of six bureaus in KDHE's 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 is led by an Administration team and organized into four sections: Children & Families; System of Supports; Nutrition & WIC Services; and Early Care & Youth Programs.

The BFH programs partially funded by the federal-state Title V Block Grant include MCH, CSHCN, and Child Care. The agency organizational chart with the programs/staff funded by Title V highlighted follows.



III.C.2.b.ii.b. Agency Capacity

Title V invests significantly in staff development and focuses on continuous improvement with alignment and coordination among the core team members. This is evidenced by the recent realignment/reorganization of the Bureau that: positioned staff and programs/teams to increase and improve communication and coordination; allowed for capacity to support the workforce through professional and leadership development, teambuilding, thoughtful decision-making, continuous quality improvement, and innovation; and ensure sustainability and clear the path for growth and advancement for Kansas children, families, and communities. Key changes within the BFH implemented beginning September 2019 include:

- The Cross-Cutting Section (MCH Population Domain Consultants) joined the Children & Families Section which houses core MCH programming/staffing.
- A new Children & Families (C&F) Section Unit was created to ensure consistency across community and direct service programs and facilitate development, implementation, and sustainability of strong, evidence-based services administered at the local level.
- Part C/Infant-Toddler Services and Special Health Care Needs joined the new C&F Section Unit (moved from the Special Health Services Section).
- The System of Supports Section (formerly Special Health Services) encompasses the following to build and maintain strong foundations of support for Kansas families.:
    - Screening & Surveillance (S&S) Unit: created to support public health screening and surveillance identifying congenital disorders and birth defects. Under this Unit, the Kansas Newborn Screening Program rebranded and merged hearing and heart screenings into the Point of Care Screening Program and aligned data and education efforts with the Blood Screening (genetic/metabolic) program.
    - Family and Consumer Partnership (FCP) Program: To be developed in 2020.
- The System of Supports Section Director also serves as the Title V CSHCN Director, MCH Block Grant Coordinator, and Family and Consumer Partnership Program Coordinator. Under this new alignment, capacity was added to allow stronger focus and intention on implementation of efforts to advance the Kansas State Plan for Systems of Care for CSHCN and family engagement activities. Initiatives that impact the broader Title V population (e.g., cross-cutting initiatives) will be housed in this Section.

Capacity to Provide Services by Population Health Domain

In the past five years Title V has seen significant shifts in staffing including middle management leadership changes, long-standing staff vacancies, and moderate turnover rates. While this presented challenges, it also created opportunities to expand capacity for each population domain. As such, the Bureau shifted investments to provide capacity for each MCH population domain by adding a MCH Data Analyst position and the positions outlined to the right, specific to each domain population.

Women/ Maternal	• W/M Consultant • Maternal Mortality Review Committee (MMRC) Consultant*
Perinatal/ Infant	• P/I Consultant • KS Perinatal Quality Collaborative (KPQC) Consultant*
Child/ Adolescent	• C/A Consultant
CSHCN	• Behavioral Health Consultant • Birth Defects Coordinator • Screening & Surveillance Unit Director • 2 Bilingual SHCN Care Coordinators

**The same Consultant oversees the MMRC/KPQC initiatives and provides staff support to those collaborative groups.*

In addition to staffing within the MCH program, two other KDHE Bureaus receive MCH support, including the Bureau of Community Health Systems (BCHS) for public health workforce development, capacity building, and systems development and the Bureau of Epidemiology and Public Health Informatics (BEPHI) for vital records data sharing, analysis, and reporting. MCH and SSDI funding supports two full-time MCH epidemiologists within BEPHI. Both coordinate data analyses for Title V and support MCH program evaluation and research efforts for many other activities and initiatives, particularly with regard to working with Medicaid data.

System of Care Capacity for CSHCN

The Title V program provides guidance for services for CSHCN; however, the program must meet certain expectations to provide medical treatment services to families with defined and limited diagnoses and disabilities (per state statute). Programmatic activities align with Title V requirements, recommendations, and guidance to engage as a catalyst for improving systems of care for all CSHCN. Title V funds several organizations to provide special supports for CSHCN ranging from specialty care clinics for medical complexities, cystic fibrosis, and cleft lip/cleft palate to wheelchair and posture seating supports to youth leadership development. Additionally, local health departments receive funding to operate CSHCN satellite offices, providing local support to families and assistance with navigating the system, including assistance with program applications and care coordination supports.

The vision in Kansas spans far beyond the state mandate for services and aims to assess and address needs of all CSHCN through quality improvement and evaluation to advance sustainable and systemic changes. The Title V CSHCN

Director serves as the CSHCN Domain Consultant and engages in high-level systemic and policy discussions related to the systems of care for the CSHCN population, such as access to care, insurance adequacy and coverage, cross-system collaboration, expansion of holistic care coordination beyond the Title V program.

State Support for Family Consumer Partnership

Family and Consumer Partnership (FCP) is a core focus of Title V. In the next reporting period, a formal FCP Program will be created to focus on empowerment, leadership and advisory opportunities, as well as peer supports. Title V continues to support the Family Advisory Council (FAC) to provide strategic input into planning and service delivery. The FAC has primarily focused on the CSHCN population, however these efforts will be expanded across MCH domain populations to assure the client/family voice is central to all programmatic activities.

State Support for Communities

Nearly half of the funds that make up the federal-state Title V budget ($8.4 million) is allocated to approximately 80 agencies at any given time, including: local health departments, FQHCs, medical centers, and others. Funds are allocated through contracts in compliance with Title V legislation and state agency protocols. Agencies apply through an Aid to Local (ATL) grant process and awards are based on several criteria (e.g., base formula, plans and collaborations, prior performance and compliance, and likelihood of achieving desired outcomes). Services across all MCH programs at the local level are depicted in the map below. Learn more about the ATL process: https://khap2.kdhe.state.ks.us/KGMS/Default.aspx (click on MCH).

Capacity Through Partnerships

Collaboration, relationships, community norms, and family/consumer engagement are the guiding principles of the Title V program. As such, partnership and community capacity for each population domain a core focus. Title V collaborates closely with several Bureaus within the state health department, many other state agencies, health services entities, private foundations and organizations, and other statewide partners to address MCH population needs and support health services delivery at the community level. These partnerships are described in detail in the Title V Program Partnerships, Collaboration, and Coordination section of this narrative.

III.C.2.b.ii.c. MCH Workforce Capacity

Recognizing the importance of investing in an adequately sized, skilled workforce, Kansas Title V has been building capacity to better monitor/track changing MCH needs, evaluate progress against program goals, and enhance state-local partnerships to advance MCH. As the Kansas vision for MCH has become more expansive and collaborative in nature, recruitment and retention of qualified staff has become an even higher priority. Great focus has been placed on recruitment and retention efforts to improve the MCH program, including updated position descriptions and interview processes better aligned with MCH competencies. For example, questions related to needs assessment, strategic planning, program development, lived experience, and understanding of health equity/disparities have been added in the interview process.

State MCH Workforce: Number, Location, and Full-time Equivalents

A workforce analysis was conducted as part of the Needs Assessment with a focus on:

- State program staff (MCH and CSHCN): provides oversight, guidance, and directives for MCH services, systems, and programs
- MCH local programs: provides core MCH services across domains
- CSHCN satellite offices and specialty service contracts: provides support for stronger systems of care for CSHCN
- Pregnancy Maintenance Initiative (PMI) local programs: provides care coordination services during pregnancy for women at high-risk for poor birth outcomes
- Teen Pregnancy Targeted Case Management (TPTCM): provides case management program for pregnant and

postpartum teen mothers

- Lifting Young Families Towards Excellence (LYFTE) local programs: provides an integrated approach to life-skills development for young teen parents – including fathers - utilizing case management with a focus on health, education and employment

Of the 160.2 estimated FTEs across state, local, and contracted entities, over 100 FTEs were employed in local MCH programs and 18.5 FTEs in the state program.

Total Numbers of Positions and FTEs by MCH Program Types

Program	Total positions	Total FTEs*
State Program Staff	12	12
State CSHCN Program Staff	7	6.5
Local MCH Programs	450	103.8
CSHCN Satellite Offices	15	2.3
CSCHN Specialty Care Contracts	34	5.8
PMI	67	13.6
TPTCM	55	10.6
LYFTE	18	5.5
TOTAL	**658**	**160.2**

**FTE and demographic information was collected for 550 of 658 positions, representing 84% of the MCH staff positions. Based on data for the 550 known positions, there are an estimated 192 FTEs in funded MCH programs serving the women, infants, children, and youth in the state.*

The following table shows the allocation of position types/roles among MCH staff statewide. Most resources are directed toward nursing, care coordination, home visiting, and administrative and leadership roles.

Number of Positions and FTEs by Position Type (all programs)

Position Type	No Hours/ Missing Data	Total Positions	Total FTEs
Administrative	29	124	15.2
Agency Administrator/Director	7	68	8.3
Agency Manager/Supervisor	5	33	4.5
Breastfeeding Peer Counselor/Educator	3	9	1.3
Case Manager/Care Coordinator/Navigator	2	45	25.2
Clinical Nurse	13	127	26.5
Dietitian/Nutritionist	6	11	1.3
Home Visitor	0	59	18.8
Interpreter/Translator	6	15	1.9
MCH Program Director/Coordinator/Supervisor	4	42	15.4
Physician/Medical Director	8	14	2.2
Social Work/Counselor	7	29	8.7
State MCH Program Staff	0	19	18.5
Other	18	63	12.4
Total	**108**	**658**	**160.2**

Qualification of MCH Leadership & Program Staff

Senior Leadership: Senior leadership include the BFH/Title V MCH Director, System of Supports (SOS)/Title V CSHCN Director, and the Children & Families (C&F) Section Director. Serving as the core MCH Leadership Team and providing guidance and support to program staff carrying out core MCH work, and assuring alignment across programs, bureaus, and agencies, specific qualifications are outlined below.

- *BFH/Title V MCH Director (Rachel Sisson, MS):* With a Master's in Early Childhood Education and Bachelor's in

Family Studies and Human Services, Rachel has been leading the Title V and BFH work since 2012 and has extensive experience in workforce development, program management, policy development, and alignment of statewide systems. Rachel drives policy advancement for the MCH populations through inter- and cross-agency initiatives.

- *SOS/Title V CSHCN Director (Heather Smith, MPH):* With a Master's in Public Health and a Bachelor's in Child and Family Development, Heather has been working with families of CSHCN since 2006. She has served as the Title V CSHCN Director since 2013 and has experience with program management, quality improvement, and family and consumer engagement. Heather oversees the System of Supports Section, including the Screening and Surveillance Unit (newborn hearing, heart, and blood screenings and birth defects surveillance), the Family and Consumer Partnership Program (including family leaders/advisory opportunities and peer supports), and serves as the Title V Block Grant Coordinator as of 2020.
- *C&F Director (Kelli Mark):* With a Bachelor's in Human Nutrition and pending Master's in Public Administration (May 2021), Kelli has experience with grant management and clinical experience in the hospital setting. She has expanded capacity within Title V through supervision, management, and alignment across Title V Domain Consultants through oversight of the C&F Section (direct services for the MCH population) and the team of Domain Consultants.

Consultants & Middle Management: In addition to the leadership team above, there are many staff that provide direct support in leading MCH-related activities. This team is comprised of staff dedicated to providing guidance and supports in Title V programming.

- *C&F Services Unit Director (Kayzy Bigler):* As a parent and the former KS-SHCN Program Manager, Kayzy shifted the program from direct service delivery to a holistic care coordination program for participants and as a result of the 2019 Bureau realignment, now oversees all direct service programs targeting the population, including MCH, Part C/Infant-Toddler Services, and SHCN Programs and affiliated state and local agency programs and contracts.
- *W/M Consultant (Jennifer Marsh):* With many years of experience in domestic and sexual violence, Jennifer has allowed Title V to expand its women's health capacity to include all women of childbearing age. She's activity engaged in developing content and interventions to support MCH state and local partners improving women/maternal health.
- *P/I Consultant (Stephanie Wolf, RN):* With many years of local public health service supervising one of the first local programs to implement a perinatal collaborative model, Stephanie serves as the resident perinatal expert. She oversees implementation and expansion of the proven MCH birth outcomes model and provides ongoing TA for MCH.
- *C/A Consultant (Elisa Nehrbass):* As a parent and former child care educator, Elisa advises on child and adolescent health, including early childhood systems.
- *BH Consultant (Kelsee Torrez, MPA):* With a Master's in Public Administration and experience in grants management and the behavioral health system in Kansas, Kelsee driven Title V's work into the behavioral health realm.
- *Health Planning Consultant (Kasey Sorell, BSN, RN, CPC):* Previous clinical and Medicaid program experience has positioned Kasey for progress on maternal and perinatal quality initiatives. She leads coordination for the MMRC and PQC. Kasey is currently working towards a Master's in Business Administration.
- *MCH Program Manager (Carrie Akin):* After nearly a decade working with local grantees, Carrie now supervises MCH staff and affiliated programming such as home visiting, teen pregnancy case management, pregnancy maintenance initiatives, and more.

Data Supports: Title V programs would not function without the support of a dedicated team of epidemiologists (Epi) and data analysts. In addition to staff listed, there are other BEPHI experts that partner with the Title V program to provide support for the Vital, MMRC, and PRAMS data collection and/or analysis. Additionally, the Screening & Surveillance Unit Data Manager was created to offer capacity in connecting data from the newborn screening and birth defects surveillance

programs with other critical MCH data sets.

- *Sr. Epi (Jamie Kim, MPH):* With a Master's in Public Health and Bachelor of Science in Chemistry, Jamie has extensive experience with MCH populations and data sets, serves as the State Systems Development Initiative (SSDI) project director, and focuses on pregnant women and infants (infant and maternal mortality and morbidity, teen pregnancy, family planning, substance use), CSHCN (birth defects surveillance and newborn screening), and WIC.
- *Sr. Epi (Lawrence Panas, PhD, MPH):* With a Doctorate in Population Health Sciences, Master's in Public Health and Sociology, and a Bachelor's in Sociology and Psychology, Lawrence conducts research and policy analysis for the MCH program.
- *Data Analyst (James Francis, MPH):* With a Master's in Public Health, James has expanded capacity within Title V for a data driven approach to decision making.

Parent and Family Leadership

Title V engages volunteer family leaders through the FAC, the AMCHP Family Delegate Program, and as Consultants. There are currently twelve active FAC members from both urban and rural communities. There are also an additional eight family leaders that have moved into the FAC Alumni and Mentorship Program, and one contracted FAC member serves as the FAC Peer Support Administrator. The AMCHP Family Delegate (Cassandra Sines) provides care coordination services for CSHCN, leads a systems navigation training, and serve as the program's Peer Support Administrator under Supporting You. She also serves alongside three other families on the KMCHC.

Additional MCH Workforce Information

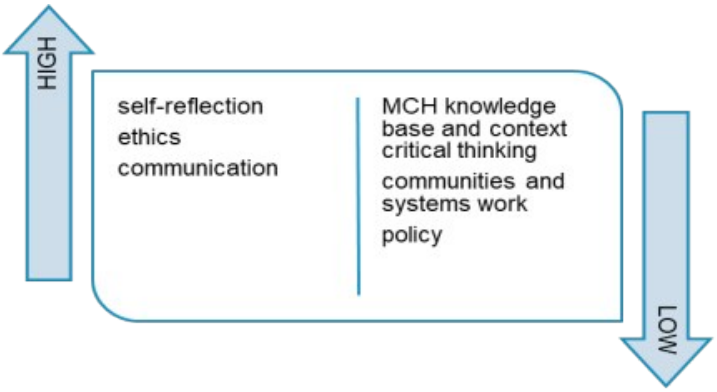
Demographics: Females make up nearly 95.8% of the KS MCH workforce. The median age of the MCH workforce in KS is higher than the overall state median age (45 years compared to 36 years statewide). The workforce over the age of 50 is almost one out of every four at 39.6%. As such, the MCH labor force, like the U.S. labor force, is likely to grow fastest in terms of older workers, and staff retention (particularly of older staff) will be an important priority.

Kansas MCH Workforce by Race

Population	Kansas	MCH Workforce
White	86.4%	86.7%
Black	6.1%	4.0%
Asian	3.1%	1.1%
Hispanic	12.1%	12.6%

The racial composition of the MCH workforce mirrors the KS population. Given the strong programmatic focus on health equity, continued growth of MCH workforce diversity should be a strategic goal of MCH statewide.

MCH Competencies: KS MCH received support from the national MCH Navigator project team at the Georgetown University National Center for Education in Maternal and Child Health (MCEMCH) to assess the knowledge and skills of the workforce using the Navigator online self-assessment. The KS MCH workforce had a relatively high knowledge score in cultural competency, but a lower score for skills around cultural competency.



MCEMCH developed a 2016-2018 “Kansas Workforce Snapshot” based on 296 responses. A copy of this snapshot can be provided upon request.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V is heavily focused on collaborative partnerships and demonstrate strong commitment to coordinating with others to address emerging and ongoing needs of MCH populations. Both formal and informal collaborative relationships exist that support the Title V work.

Title V Stakeholder Councils

Kansas Maternal and Child Health Council (KMCHC): The KMCHC is a multi-disciplinary team of professionals, family members, and other stakeholders that serves to: advise Title V; monitor progress; and develop recommendations. The Council is coordinated by the Kansas Chapter of the American Academy of Pediatrics (KAAP) in partnership with KDHE meets at least quarterly.

Title V Family Advisory Council (FAC): Currently, the FAC engages family and parent input around the CSHCN population. Future expansion efforts are planned to support the Title V vision that families should be involved in planning, design, implementation, and evaluation of program initiatives, across all domains. The FAC reviews program data, provides insight into strategies for data collection and the family perspective on existing and emerging issues.

Other MCHB Investments and HRSA/Federally Funded Programs

Title V works collaboratively with other MCHB investments, including but not limited to: State System Development Initiative (SSDI); Early Hearing Detection and Intervention (EHDI); Pediatric Mental Health Care Access; Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Early Childhood Comprehensive Systems (ECCS); Safeguarding Two Lives; and Emergency Medical Services for Children (EMSC). Strong linkages exist among MIECHV, ECCS, and Title V programs and alignment with the behavioral health investments is underway.

Title V works with the State Primary Care Association (Community Care Network of Kansas – CCN) and FQHCs to help meet the needs of women and children served by the state’s safety net. FQHCs are funded to provide MCH and CSHCN services and have served as lead agencies in HRSA-funded projects, such as efforts to improve the health and well-being of pregnant/postpartum women, and has collaborated to establish school-based health centers.

Title V works closely with WIC, Title X/Family Planning, Part C, Child Care (all overseen by the BFH/Title V MCH Director). Title V and Title X has strategically worked to set priorities, goals, objectives, and identify linkages between MCH and Reproductive Health/Family Planning. Significant progress has been made related to reproductive health and family planning with new activities, resources, and interventions in place. MCH works directly with WIC and Child Care on shared priorities (e.g., breastfeeding, oral health, smoking cessation) and both the State WIC and Child Care director are part of the MCH Coordination Team and KMCHC.

State Health Department Programs and Local MCH Programs

The BFH and MCH programs work closely with the Bureau of Health Promotion, specifically on chronic disease risk reduction, tobacco cessation, injury prevention (e.g., Safe Kids Kansas), and opioid use. MCH staff have been active in working to help develop/ implement the state's injury prevention plan, particularly around safe sleep, adolescent driving safety, preventing and addressing Adverse Childhood Experiences (ACEs), and substance abuse prevention.

Title V works with the Bureau of Epidemiology and Public Health Informatics and co-locates two MCH Epidemiologists with the BFH team. Collaboration has resulted in implementing PRAMS, launching maternal mortality review, and enhancing birth defects surveillance. Epidemiologists serve lead roles with the Perinatal Periods of Risk Analysis, Fetal and Infant Mortality

Review processes, local public health system assessments, and the state health needs assessment.

Partnership with the Bureau of Community Health Systems supports development, training, capacity building, and systems development among the MCH workforce. Including the annual Governor's Public Health Conference that focuses on public health resources and supports and includes a pre-conference and track specifically for those working in MCH.

Title V and Medicaid (housed in the KDHE Division of Health Care Finance) are dedicated to collaborating, particularly as it relates to addressing disparities among Medicaid beneficiaries. An area of focus has been the Medicaid-linked birth data set and areas where measures and programming align, such as disparities in prenatal care and birth outcomes. Title V also assists Medicaid to identify and address reporting and program requirements related to childhood immunization status, live birth weight, well child visits, and chlamydia screening.

Title V supports and works closely with local MCH programs, providing funding support to local MCH through the agency's aid to local grant process. Technical assistance is provided through a variety of means by state MCH consultants. It has been noted that local programs believe responsive and effective technical assistance are strengths of the Title V program.

Other Public, Private and Governmental Organizations Serving the MCH Population

Title V is a key partner in the Kansas Early Childhood Systems Building Needs Assessment and Strategic Plan, supported by the Preschool Development Grant Birth through Five (PDG B-5) funding. Coordinated by a State Directors Team consisting of key leaders from the Kansas Children's Cabinet and Trust Fund, Kansas State Department of Education, Kansas Department for Children and Families, and KDHE (Title V MCH Director), opportunities for statewide collaboration has focused on building coordinated systems to support early childhood.

Other key partners and organizations the private associations, foundations, and coalitions, such as: Kansas Hospital Association, Kansas Academy of Family Physicians, Kansas Health Foundation, Kansas United Methodist Health Ministry Fund, Kansas Breastfeeding Coalition, Oral Health Kansas, Child Care Aware, Kansas Child Care Training Opportunities, and Families Together (Family-to-Family Health Information Center), among others.

Other Key Partners (e.g., Tribes, Universities)

KDHE continues its work to build relationships with the four Kansas tribes (Iowa Tribe of Kansas and Nebraska, Prairie Band Potawatomi Nation, Sac & Fox Tribe, and Kickapoo Tribe). KDHE and the tribes collaborate on a Kansas Tribal Health Summit, the latest of which was in 2018 and focused on the status/future of each of the tribes' community health assessments. Tribal representatives are invited to participate in state and local level efforts, including the Maternal Mortality Review Committee includes a tribal representative. KDHE and Title V are interested in increasing collaboration with the tribes, but response has been inconsistent or lacking.

KDHE works closely in support of public health education, including undergraduate programs at state Regents Institutions and the MPH program at the Kansas University Medical Center. Multiple health professions educators play an active role in development and implementation of the MCH State Action Plan and MCH programs. Multiple faculty members with state universities play active roles on the KMCHC, including a pediatrician who serves as the Council Chair.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Methods Used to Rank Needs and Select Priorities

Data was compiled and reviewed with Title V prior to engaging an expanded stakeholder team (KDHE Bureaus and programs, Medicaid, KS African-American Affairs Commission, KS Hispanic & Latino American Affairs Commission, KS MCH Council, State Early Childhood Directors Team). Through interactive exercises, participants ranked their top five issues, supported with relevant data, to be included as potential priorities. MCH epidemiologists then compiled detailed

information around sixteen issues identified through stakeholder meetings. Key themes emerged and guided the selection of the 2021-2025 MCH Priorities.

1. *Well-functioning/Holistic Systems of Care*: Across all population domains and the state: need for access to high-quality, comprehensive, coordinated, and affordable services.
2. *Mental Health*: A priority in each community was access to screening, intervention, and referrals. There was discussion about focus or emphasis on "diseases of despair" (e.g., suicide, drug abuse/overdose, and excessive drinking).
3. *Healthy Relationships*: Interpersonal/domestic violence was identified as a contributor to stress, injury, death and other poor health outcomes.
4. *Disparities & Social Determinants of Health*: Focus on chronic stress as a contributor to chronic disease, including disparities associated with higher risk factors (e.g., tobacco use, physical inactivity, poor diet/food insecurity). Taking an "upstream" approach will require focus and intentionality with partners and stakeholders to address the needs of the MCH population linked to stressors associated with social determinants of health.
5. *Family Strengthening and Supports*: All agreed services and supports for families are most beneficial when families are engaged and actively working with program and policy leaders to assure a strengths-based approach to service delivery.

Seven priorities were developed, one for each population domain and two for Cross Cutting/Systems Building. Development of objectives and strategies, alignment with national performance measures (NPMs), adoption of new state performance measures (SPMs), and the creation of evidence-based strategy measures (ESMs) followed. During this process, five NPMs and four SPM's were selected to cover state needs. The final draft of the 2021-2025 State Action Plan was developed and presented to Title V advisory groups.

With similarities to priorities from the 2016-2020 plan, these new priorities expand on previous work or focus on new/emerging issues. Kansas adopted a stronger focus on holistic, well-functioning, strong systems of care and support for the MCH population and their families. Recent efforts with the early childhood systems (PDG B-5 planning and renewal grants) has set the foundation for more alignment across systems so families can experience seamless service delivery and transitions across systems. Kansas envisions fully-integrated systems of care and the development of policies, systems, and environments that reduce and/or eliminate persistent disparities. The table the follows compares 2021-2025 priorities to those from 2016-2020.

2021-2025	2016-2020
Women/Maternal Health Priorities	
Women have access to and utilize integrated, holistic, patient-centered care before, during and after pregnancy. *REVISED*	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
Key Changes: This was modified slightly to address the need to assure a seamless system of care and improve the quality and comprehensiveness of services provided.	

Perinatal/Infant Health Priorities	
All infants and families have support from strong community systems to optimize infant health and well-being. *NEW*	Families are empowered to make educated choices about infant health and well-being. *DISCONTINUED*
Key Changes: The new priority focuses on ensuring high-functioning community systems and supports and reflects the growing focus on social determinants and disparities, especially around maternal mortality and infant death. Compared to the previous focus on ensuring families have information and support to make educated choices.	

Child Health Priorities	
Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities. *REVISED*	Developmentally appropriate care and services are provided across the lifespan.
Key Changes: The revision seeks add emphasis to access while ensuring screening, referral, and treatment to support healthy physical, social, and emotional development of children.	

Adolescent Health Priorities	
Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health. *REVISED*	Communities and providers support physical, social and emotional health.
Key Changes: The priority remains on the adolescent well-visit and mental health, with stronger focus on integrated and holistic care. A stronger focus on youth self-empowerment and-determination, expanding on community supports, than in previous plans.	

Children with Special Health Care Needs Priorities	
Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities. *NEW*	Services are comprehensive and coordinated across systems and providers. *DISCONTINUED*
Key Changes: Focus on: empowering CSHCN as active participants in their own health and involved in transition planning; recognizing the important link between youth leadership, social connectedness, and positive health outcomes; expanding on the vision that effective transition planning is best done through coordinated care from a medical home.	

Cross-Cutting/Systems Building Priorities	
Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations. *REVISED*	Professionals have the knowledge and skills to address the needs of maternal and child health populations.
Strengths-based supports and services are available to promote healthy families and relationships. *NEW*	Information is available to support informed, healthy decisions and choices. *DISCONTINUED*
Key Changes: The revised priority captures the intent to expand knowledge and skills and address the comfort level associated with providing MCH services. The new priority focuses on changing the culture around family/consumer partnership, engagement across Title V populations, family leadership development (equip and empower), peer support, strengths-based services, and building systems focused on holistic needs.	

Emerging Issues/Frequently Cited Needs

One issue cited frequently that was not explicitly called out among the selected priorities is inadequate insurance coverage (NPM 15). There are strategies included in the plan to support efforts to improve in this area given ongoing efforts in the state to expand Medicaid coverage and Title V engagement in discussions about enhancing insurance coverage. Examples of this engagement are:

1. *State Directors Team for Early Childhood Care and Education (ECCE)*: The Title V MCH Director is heavily involved in the ECCE systems building work to advance the new "All in for Kansas Kids Strategic Plan." Several strategies in this plan support policies that contribute to economic security for families, including the adoption of policies to expand covered/billable services for Medicaid, the types of providers who qualify for reimbursement, and the settings where services can be provided.
2. *Early Intervention Strategic Plan:* The Title V CSHCN Director provided support and guidance for the program where focus was placed on billing structures and practices to find ways to enhance reimbursement for early intervention

services.

3. *Kansas PSP Workgroup*: Public health, Medicaid, child welfare, behavioral health, pediatrics, philanthropic organizations, and families identified gaps and opportunities to improve health outcomes – the proposed policy change was to allow maternal depression screenings to be covered under the child's Medicaid plan in pediatric care settings. When approved, MCH will support implementation, assist with necessary guidance to providers, and assist in training development.

Factors Contributing to Changes in Kansas' Priority Needs

Title V's focus remained on adapting to emerging needs, trends, and newly identified gaps. The following table outlines the factors that provide rationale for the shifts proposed across domains.

Priority Area	Contributing Factors to Priority Changes
Women/Maternal	Data showed decreases in the rate of women receiving annual visits; however, it also showed increased rates for unintended pregnancies and domestic violence. This was viewed as a possible factor that visits are occurring, but the comprehensiveness of the visit could be lacking. Therefore, the priority shifted to focus less on access and more on quality.
Perinatal/Infant	Established partnerships and sustainable programs around breastfeeding and safe sleep practices provides opportunity for focus to shift from family education on infant health/well-being to systemic needs and expansion of evidence-based models. Data indicate programs should focus on key disparities among the domain population, especially around breastfeeding.
Child	The "Connected Families, Connected Communities" framework and ECCE strategic plan focus on service/system integration, program/community transitions, equitable access, and resource navigation, allowing Title V to focus on community supports in context of the developmental screen.
Adolescent	Data indicate that adolescents generally engage with health professionals for school/sports physicals and immunizations, however the quality of the well-visit may be lacking transition planning and preventive screenings. The new priority provides opportunities to get "upstream" to address some of the broader social determinants and drivers of disparities and inequities.
CSHCN	Holistic care coordination has created an infrastructure for families served and acknowledge the role the medical home plays in transition planning. Shifting focus to health and social transitions as part of care coordination, supports CSHCN desires to be active partners in their health care.
Cross-Cutting: Workforce	The shift in workforce development towards comfort, beyond knowledge and skills, was supported by the results of the MCH Navigator Assessment report, indicating that people lacked the ability to translate knowledge to action. This also addresses the need and desire of professionals to be comfortable serving families of CSHCN.
Cross-Cutting: Family Strengths	Title V's ongoing investment and dedication to family and consumer engagement, providing strengths-based approaches, focus on peer support and holistic care coordination led to the creation of a new priority.

Relationship Between Priority Needs and Measures

The Kansas Title V Needs Assessment process focused on identifying and addressing issues at the state and local levels, and priorities were selected with Title V mission, purpose, and legislation in mind. The top state priority issues that most closely aligned with the national priorities and NPMs were selected.

Women have access to and utilize integrated, holistic, patient-centered care before, during and after pregnancy (Domain: W/M)

- NPM 1: Well-woman visit (Percent of women, ages 18-44, with a preventive medical visit in the past year).
- SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

All infants and families have support from strong community systems to optimize infant health and well-being (Domain: P/I)

- NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)
- SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities (Domain: C).

- 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)

Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health (Domain: A).

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

Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities. (Domain: CSHCN)

- NPM 12: Transition (Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care)

Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations (Domain: CC)

- SPM 3: Workforce (Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event)

Strengths-based services and supports are available to promote healthy families and relationships (Domain: CC)

- SPM 4: Family Strengths (Percent of families who know all of the time they have strengths to draw on when the family faces problems)

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,689,065	$4,729,794	$4,651,427	$4,777,544
State Funds	$3,557,713	$3,556,155	$3,531,773	$3,800,940
Local Funds	$3,981,689	$3,832,636	$3,906,504	$5,186,201
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$12,228,467	$12,118,585	$12,089,704	$13,764,685
Other Federal Funds	$58,007,639	$66,300,416	$71,105,934	$70,975,390
Total	$70,236,106	$78,419,001	$83,195,638	$84,740,075

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,756,879	$4,773,454	$4,780,598	
State Funds	$3,531,621	$3,642,252	$3,949,804	
Local Funds	$3,911,125	$5,853,388	$3,992,669	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$12,199,625	$14,269,094	$12,723,071	
Other Federal Funds	$69,627,621	$66,751,514	$70,031,333	
Total	$81,827,246	$81,020,608	$82,754,404	

	2021	
	Budgeted	Expended
Federal Allocation	$4,719,472	
State Funds	$3,610,958	
Local Funds	$4,056,499	
Other Funds	$0	
Program Funds	$0	
SubTotal	$12,386,929	
Other Federal Funds	$65,973,561	
Total	$78,360,490	

III.D.1. Expenditures

The state maintains budget documentation for all Title V 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) 2019 is reflected on Forms 3a and 3b.

2019 Expenditures: The FY 2019 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). MCH expenditures totaled $14,269,094: 4,773,454 federal; $3,642,252 state; and $5,853,388 local. Other federal funds overseen by the Title V Director totaled expenditures of $66,751,514 for a grand total FY 2019 amount of $81,020,608.

The total FY 2019, federal only spending to support MCH and CSHCN initiatives within the state health department included:

- $132,203 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics;
- $36,811 Local Public Health program;
- $18,800 Child Care Licensing;
- $41,000 Family Planning (One Key Question partnership);
- $1,156,698 Title V Administration/Staffing;
- $531,299 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;
- $1,819,180 MCH Aid to Local payments to local agencies for services totals.
- $579,845 Special Health Care Needs (SHCN) staff, operating costs, contracts and supplies;
- $46,805 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) $3,722; Hospital $15,886; Pharmacy $12,017; Physician/Office Charges $12,532; Audiology $610; Other (interpreters, travel, honorariums) $2,038.
- $1,445 Newborn Screening Follow Up
- $49,368 Fiscal Management
- $360,000 Administrative Costs

<u>Form 2 Expenditures Details</u>: Form 2 reveals the Title V expenditures for FY 2019 are in compliance with the 30% - 30% requirements for priority populations: preventive and primary care for children $1,469,985 (31.0%) and children with special health care needs $1,493,918 (31.0%), similar to previous reporting periods. Other requirements related to expenditures such as administrative costs at $360,000 (7.5%) (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 "other" federal funds expenditures for FY 2019 are $66,751,514 and include the following: Women, Infants, and Children (WIC) $51,207,354; Breastfeeding Peer Counselor Program $480,951; Early Childhood Comprehensive Systems $407,356; Newborn Hearing Screening $258,795; Newborn Hearing Screening Data Enhancement $150,407; Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula $4,622,374; MIECHV Innovation $409,924; Part C Infant-Toddler Services $4,416,629; Abstinence Education $418,188 (final year – did not reapply); Title X Family Planning $2,479,088; Toxic Substances (Lead Hazard) $368,215; Healthy Start $50,618 (ended 8/31/2019); Pregnancy Assistance Fund – LYFTE $1,003,096; Safeguarding Two Lives Maternal Behavioral Health $360,597; Newborn Screening $117,922 (state evaluation $88,992 and new condition implementation $28,930).

<u>Form 3a Expenditures by Types of Individuals Served</u>: All Block Grant partnership expenditures (federal, state, and local), not including administrative costs of $360,000, total $13,909,094 ($4,413,454 federal; $9,495,640 non-federal). Expenditures

by “Types of Individuals Served” (MCH population groups) includes: Pregnant Women and Infants <1 Year $1,449,551 federal, $3,875,756 non-federal; Children & Adolescents 1-22 Years $1,469,985 federal, $3,057,432 non-federal; and CSHCN $1,493,918 federal, $2,562,452 non-federal.

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 $14,269,094 (including administrative costs). Expenditures by “Types of Services” (MCH pyramid) include: Direct Services $61,126 ($46,805 federal/$14,321 non-federal) (<0.5%); Enabling Services $6,675,519 ($1,697,630 federal/$4,977,889 non-federal) (47%); and Public Health Services and Systems $7,532,449 ($3,029,019 federal/$4,503,430 non-federal) (53%). The Kansas Title V MCH and CSHCN programs vigilantly monitor allocation and use of funds in an effort to 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 2019 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.

2021 Budget: The total State budget submitted for Federal Fiscal Year (FFY) 2021 and detailed on Form 2 is $78,360,490. 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 $4,719,472 (based on the allocated amounts in the State budget and a final authorized federal MCH award amounts for FFY19 and FFY20); state MCH funds $3,610,958; local MCH funds $4,056,499; and estimated other federal funds $65,973,561. In accordance with the Title V Block Grant guidance, the “other” federal funds reported are only those under the direction of the Title V Director. Other federal funds includes the following: Women, Infants, and Children (WIC) $51,411,436; Breastfeeding Peer Counselor Program $432,341; Early Childhood Comprehensive Systems $410,740; Safeguarding Two Lives Maternal Behavioral Health (KS project: Kansas Connecting Communities) $647,824; Pediatric Mental Health Care Access (KS project: KSKidsMAP to Mental Wellness) $444,576; Universal Newborn Hearing Screening $247,767; Newborn Hearing Screening Data Enhancement $132,904; Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula $5,032,531; Part C Infant-Toddler Services $4,208,479; Title X Family Planning $2,494,996; Pregnancy Assistance Fund (Office of Adolescent Health; (KS project: Lifting Young Families Toward Excellence – LYFTE) $4,500; Newborn Screening Evaluation $56,904; Reducing Maternal Deaths: Maternal Mortality Review Committee $299,493; Newborn Screening New Condition Implementation $149,070.

NOTE: One grant included in the previous years’ “other federal funds” category that is not included this year is the EPA Toxic Substances (Lead Hazard). An agency reorganization resulted in the program moving to the Division of Environment’s Bureau of Air.

NOTE: Some "other" federal funds budgeted amounts reflect the amount budgeted by the state 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 the 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 $12,386,929 (federal MCH funds $4,719,473; state MCH funds $3,610,958; local MCH funds $4,056,499). 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: Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics $139,944; Local Public Health Program $48,876. Within the Bureau of Family Health, $20,000 is allocated to support Child Care Licensing activities and partnerships related to MCH and Child Care initiatives (such as breastfeeding and oral health); $657,653 for MCH section staffing, MCH aid to local programming/monitoring, and other operations; $417,942 for Bureau/Title V director, Deputy Director and staff, Bureau assistant, and fiscal support; $869,553 for SHCN staffing, programming, outreach, and direct services (federal portion of direct services totals $65,450; estimate is based on FY2020 expenditures and authorized plans); $1,006,457 for MCH consultants, local agency contracts, vendor contracts (MCH council, DAISEY, MCH Check Box), and interventions/programming related to the state action plan (safe sleep, breastfeeding, oral health, reproductive health, stillbirth prevention, adolescent health, equity); $1,110,843 for local MCH agencies providing community-based, family centered services including home visiting (local public health departments, community health centers, hospitals, health foundations); and $330,000 for administration costs.

The Kansas budget for FFY 2021 meets the maintenance of effort requirement of $2,352,511.The Title V match requirement is achieved through projected State matching funds budgeted at $3,610,958 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 and $237,914 for Universal Home Visiting (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; $278,155 for SHCN administration, case management, care coordination, and direct services ($41,563); $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 $4,056,499. NOTE: The amount of local match for State FY 2018 and 2019 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 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 2021 was estimated based on an average of actual State FY 2017, 2018, and 2019 match reported by local grantees/agencies. The local match for State FY 2020 is in line with the trend of rising/increasing local investment; however, it is not yet known how the COVID-19 pandemic may impact local agencies' investments the remainder of this FY and next FY.

The Title V budget and funding allocations are in compliance with the 30% - 30% requirements: preventive and primary care for children $1,501,567 (31.8%) and children with special health care needs $1,462,990 (31.0%), similar to previous reporting periods (see Form 2). Other requirements related to budget categories such as administrative costs ($330,000; 6.9%) are less than 10% as required and maintenance of effort is maintained. The indirect cost rate for KDHE is 15.0% effective July 1, 2020, a decrease compared to the previous rate of 20.3%.

Form 3a Budget by Types of Individuals Served. Considering the total budget of $12,386,929 ($12,056,929 excluding budgeted administration costs of $330,000), Form 3a details the (federal/nonfederal) budgeted amounts by types of individuals served including $1,424,916 federal and $3,229,646 nonfederal for pregnant women and infants under 1 year of age; $1,501,567 federal and $3,020,524 nonfederal for children and adolescents 1-22 years; $1,462,990 federal and $1,417,287 nonfederal for children with special health care needs (CSHCN).

Form 3b Budget by Types of Services. Considering the total budget of $12,386,929, Form 3b details the (federal/nonfederal) budgeted amounts by types of services including $65,450 federal and $49,413 nonfederal for direct services (1%); $1,467,308 federal and $4,371,274 nonfederal for enabling services (47.1%); and $3186714 federal and $3,246,770 nonfederal for public health services and systems (51.9%). 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

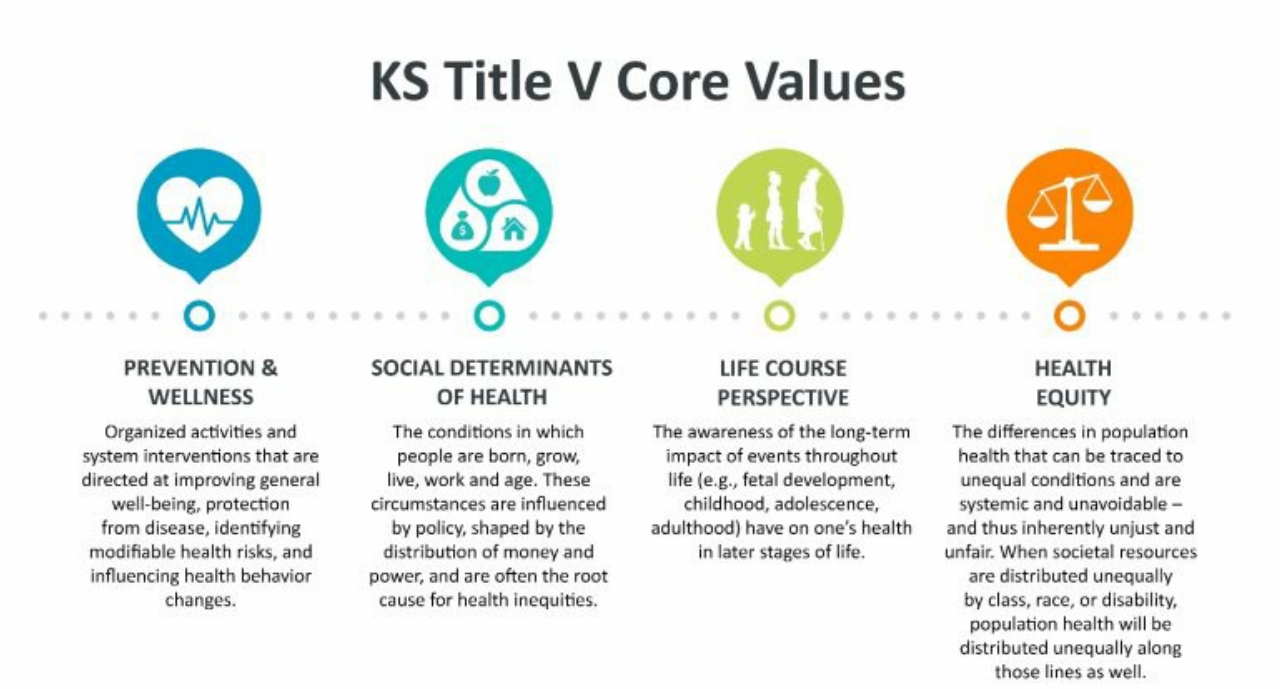
III.E.2.a. State Title V Program Purpose and Design

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, assessment for community level MCH initiatives, family and consumer engagement, and service coordination through innovative approaches to ensure families receive the right support and services they need to thrive. There is increased focus on behavioral health as part of whole-person health and addressing the needs of MCH populations 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 all phases of work: planning, design, implementation, and ongoing assessment/monitoring/evaluation.



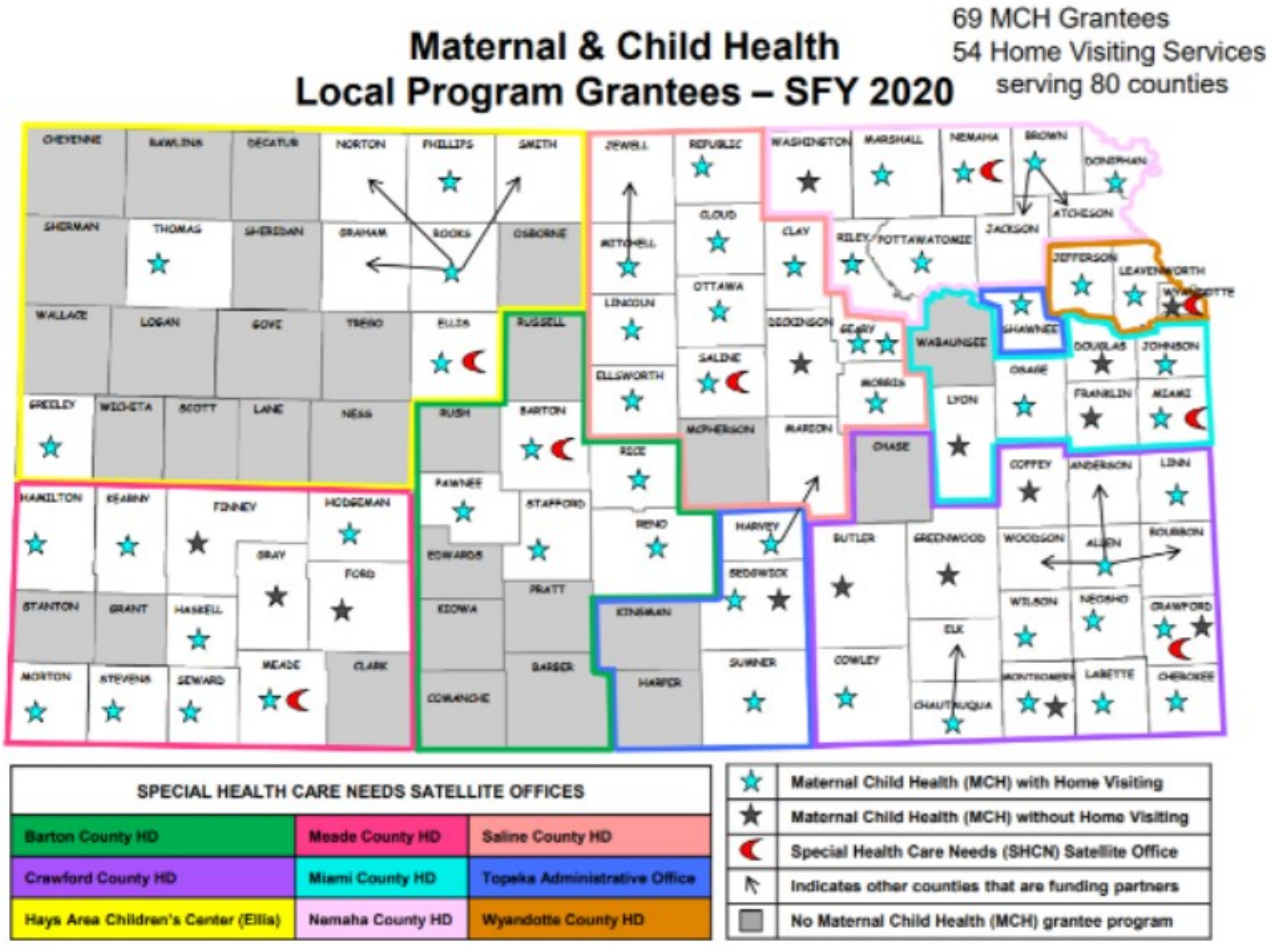
Title V recognizes and understands the connections between priorities across MCH population domains. In alignment with and including critical elements of the Collective Impact framework, Kansas' approach is supported by the tangible and intangible elements of collaboration, relationship building, and innovation. Four overarching themes have been identified as guiding principles that impact MCH work. 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 66 local agencies, 52 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 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 team is 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 support facilitation of conversations and activities necessary to address the needs of MCH populations. Effective July 2020, BFH has approximately 87 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.

CORE TITLE V STAFF

Senior Leadership (3)	Consultants & Middle Management (7)	Data Supports (3)	Special Health Care Needs (5)	Maternal and Child Health (4)
•Title V MCH Director •Title V CSHCN Director •Children & Families (C&F) Director	•C&F Unit Director •W/M Consultant •P/I Consultant •C/A Consultant •Behavioral Health Consultant •Maternal Mortality & Perinatal Quality Consultant •MCH Program Manager	•MCH Senior Epidemiologists (2) •MCH Data Analyst	•SHCN Program Manager •SHCN Lead Care Coordinator •SHCN Care Coordinators (3) •SHCN Administrative Specialist	•MCH ATL Consultant •MCH Home Visiting (2) •MCH Administrative Assistant

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.

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.

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).

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

To assure adequate capacity for ongoing needs assessment, monitoring of the state action plan, systemic approaches, and state-local partnerships necessary to advance the MCH state action plan, the BFH recently engaged in a realignment to increase and improve communication and coordination among staff and programs/teams, especially related to core programming and services for MCH and early childhood. This allowed for capacity to support staff through professional and leadership development, teambuilding, thoughtful decision-making, continuous quality improvement, and innovation. This realignment ensures sustainability and clears the path for growth and advancement for Kansas children, families, and communities.

Key changes within the Bureau of Family Health in 2019/2020 include:

- The Cross-Cutting Section, the new section formed in 2018, which houses the MCH Population Domain Consultants and MCH Data Analyst joined the former Children & Families Section which houses core MCH programming/staffing.
- A new Children & Families (C&F) Services Unit was created to ensure consistency across community and direct service programs and facilitate development, implementation, and sustainability of strong, evidence-based services administered at the local level. This Unit includes Title V MCH and SHCN services, Home Visiting (e.g., MIECHV and Universal MCH Home Visiting), Title X/Family Planning, teen pregnancy programs, and Part C/Infant-Toddler Services.
- The Part C/Infant-Toddler Services and Special Health Care Needs (moved from the Special Health Services Section) joined new C&F Services Unit.
- The System of Supports Section (formerly Special Health Services) encompasses the Screening & Surveillance (S&S) Unit and the Family and Consumer Partnership program (to be developed in 2020). This new Section works to build and maintain strong foundations of support for Kansas families.
- The Screening & Surveillance Unit was created to support critical public health screening and surveillance identifying congenital disorders and birth defects in Kansas. The Kansas Newborn Screening Program rebranded and merged hearing and heart screenings into the Point of Care Screening Program and aligned data and education efforts with the Blood Screening (genetic/metabolic) program. This Unit also houses the Birth Defects Surveillance Program.
- The System of Supports Section Director also serves as the Title V CSHCN Director, MCH Block Grant Coordinator, and Family and Consumer Partnership Program Coordinator. Under this new alignment, capacity was added to allow stronger focus and intention on implementation of efforts to advance the Kansas State Plan for Systems of Care for CSHCN and family engagement activities. Initiatives that impact the broader Title V population (e.g., cross-cutting initiatives) will be housed in this Section.

In addition to staffing within the MCH program, two other KDHE Bureaus receive MCH support, including the Bureau of Community Health Systems (BCHS) for public health workforce development, capacity building, and systems development; and the Bureau of Epidemiology and Public Health Informatics (BEPHI) for vital records data sharing, analysis, and reporting. MCH and SSDI funding supports two full-time MCH epidemiologists within BEPHI. Both epidemiologists coordinate data analyses for Title V needs assessment and support MCH program evaluation and research efforts. One epidemiologist is focused on working with Medicaid on data sharing, review/analysis, application and impact on programmatic efforts.

An updated organizational chart is included as part of this application.

State Title V Workforce Development & Training Needs

In addition to required agency training programs like Public Health Quality Improvement, the Bureau/Title V state staff participate in annual training events that apply 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.

Year	Topics
2015	Everyday Leadership Mindset in the Workplace The 12 Dimensions of Trust Developmental Relationships Framework
2016	Making Your Connection The BFH Rules of Engagement Mindset in the Workplace (continued)
2017	Strengths Finder Health Equity Hope is Contagious
2018	Important and Benefits of Mindfulness & Wellness in the Workplace
2019	Equip to Lead Using Collective Imagination to Create Social Innovation Understanding Individual and Team Strengths to Maximize Potential

Additionally, an annual BFH staff-development event began in 2015. At that first event, the BFH Rules of Engagement (image below) were developed and continue to be used today in new staff onboarding and ongoing leadership discussions.

This staff development event will continue annually to address ongoing and new staff training needs. Future considerations for training topics include: cultural competency and humility, 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, family and consumer partnership, 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 for FY21 will be tailored to specific grantee needs and emerging issues through the grant year. Regional meetings will be provided to grantees for FY21. BFH staff will travel to six regions in the state 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 identified gaps and needs. Facilitated conversations will allow regional grantees to share successes and lessons learned regarding data and program implementation as well as client engagement and recruitment. 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 program reports.

SFY2021 Maternal & Child Health Technical Assistance Webinars

MCH Technical Assistance Check-In *Attendance REQUIRED*		
Date	Topic	Calendly Link
MCH Grantees schedule TA check-in calls/virtual meetings with MCH Program Consultant		https://calendly.com/taylor-atwood

MCH Training Webinars *Attendance Highly Recommended*		
Date	Topic	Registration Link
12/10/2020	SFY2021 MCH Progress Report	https://attendee.gotowebinar.com/rt/2671149558133824268
12/16/2020	SFY2021 MCH Progress Report	
1/21/2021	SFY2022 MCH Application	https://attendee.gotowebinar.com/rt/4234360423715131916
1/27/2021	SFY2022 MCH Application	

KDHE BFH staff will continue to use the tool that launched in 2019 to increase opportunities for on-going support. The WorkStation for MCH grantees was built to offer shared access to resources, a calendar, videos, discussion boards, contact lists, and more. The platform has proven to be useful for grantees to troubleshoot challenges with one another.

In addition to engaging with the MCH TA efforts, KS-SHCN provides ongoing training, supports, and technical assistance to the eight Satellite Offices (SO). On-site visits are provided each year to support the partnership and learning/growth for SO staff. One visit is scheduled for existing/veteran SOs and two visits are scheduled for new SOs. Additional onsite visits will be scheduled upon request. Site visit agendas typically include:

- Program policy/process review, additional training is provided as needed (including a procedural notebook with

step-by-step processes and checklists for all SO activities).

- Intensive training on application processing, calculating of financial eligibility and navigation of the data system by the program's Financial Eligibility Specialist.
- Training for the local care coordinator on holistic care coordination services (e.g., role playing, documentation, building trust and rapport).

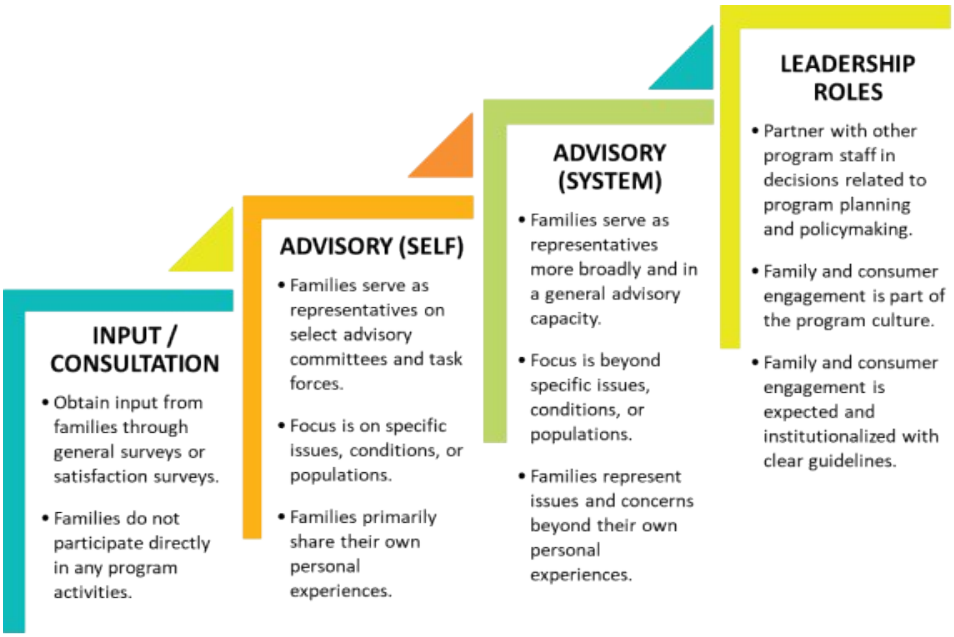
Each year KS-SHCN hosts an in-person training, centered around expanding knowledge of resources, system navigation, relationship and partnership building activities, and family engagement techniques. Guest speakers are often invited to provide additional trainings that may be beneficial to KS-SHCN program and SO staff. For example, the fall 2020 training agenda includes a presentation on Mental Health First Aid, which the KS-SHCN program feels is a critical component of care coordination services, now more than ever. Additionally, due to COVID-19, this training will be conducted virtually.

Ongoing TA efforts include a bi-monthly webinar/Brain trust calls where the Topeka staff, or guest speakers, present on a variety of subjects. In the past, these have included presentations on insurance, how to appeal insurance denials and how to develop an IEP or IHP with schools. For SFY2021, the trainings will include: home and community-based service waivers, supported decision making and guardianship, and advocacy. During these calls (Brain Trust portion), care coordinators are provided an opportunity to present challenging cases to gain input, recommendations, and feedback on ways to address the situation. This has been highly beneficial for serving the KS-SHCN clients, but for staff unity and team building.

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

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

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. 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. Title V strives to support family and consumer engagement at all levels, as outlined by the Levels of Family Engagement in Title V as outlined in the 2016 AMCHP brief, and below. This includes engaging families through programmatic and community input surveys, offering opportunities to represent their individual families and communities in advisory capacities, and engaging with families as staff, leaders, and key partners in the Title V work.



In addition to striving to engage families at these levels, Title V has also been heavily involved in the development and implementation of the Kansas Family Engagement and Partnership Standards for Early Childhood which guides early childhood programs, providers, communities, and educational system on the effective engagement of families. These standards are designed to help others view families as:

- Foundation: All families are recognized and promoted as their child's first and most influential teacher.
- Communicators: Early childhood provider and families have effective and ongoing communication.
- Advocates: Families actively engage as an advocate and decision-making for their child
- Partners: Successful partnerships exist between families and professionals based upon mutual trust and respect.
- Community Members: Families are active participants in their communities and connect to resources and services.

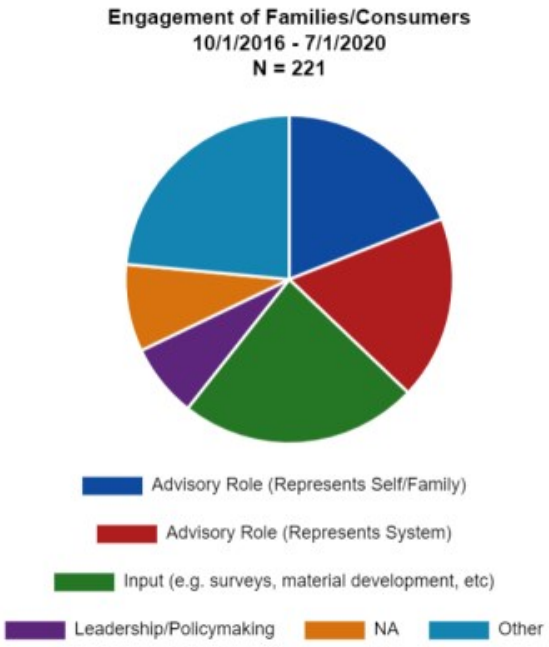
Recommended by the FAC, Title V is beginning to support the provision of services in alignment with the Standards of Quality for Family Strengthening and Support and adopting this as the foundation for the agreement among Supporting You Participating Programs. The Standards focus on building strong families, supporting families, and assuring family engagement in program practices by establishing "a common language to promote quality practice across many different kinds of programs that work with families." Integrating and operationalizing two key frameworks aligned with other service

systems in Kansas (Principles of Family Support Practice and Strengthening Families Protective Factors Framework), the Standards consist of 17 Standards and 29 Indicators organized by 5 Sections: Family Centeredness; Family Strengthening; Embracing Diversity; Community Building; and Evaluation.

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 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. Staff are asked to think critically around advancing and enhancing consumer and family engagement across programs. In past years, the BFH Family Liaison role held by the former KS-SHCN Program Manager. A valuable resource to the Bureau, this role was designed to provide technical assistance to any interested program around family and consumer engagement. The past couple of years, the KS-SHCN program has experienced many positive changes to how they provide services and have established a holistic care coordination model that is being replicated across Title V programs in the future. With these shifts, it became clear that there was not enough capacity in the existing position to maintain the level of desired expansion and focus in this arena. With the recent Bureau reorganization and the creation of the System of Supports Section, the Section Director will serve as the Family and Consumer Engagement Liaison with plans to develop a formal Family and Consumer Partnership (FCP) Program. In addition to the .25 FTE capacity added to this position, an administrative position at .50 FTE has also been assigned, with plans to expand this to 1 FTE in the coming year. Additionally, the MCH Domain Consultants also have family engagement activities within their job responsibilities to build in an *integration* component centered on consumer and family engagement.

Measuring Family Engagement: The levels of family engagement in MCH activities is tracked through 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 to the left depicts the level of family engagement for activities since we began monitoring through the Check Box in 2016. The “other” and “N/A” categories are often used to indicate no direct family involvement. The coming year will include enhanced guidance and supports for staff to collect the most meaningful data.



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

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. Formally, families can serve in two advisory council roles at this time. Across the board, Title V has adopted a Consumer Reimbursement policy, in which family participations in state meetings are eligible to receive a consultant fee (hourly or daily), travel reimbursements, and child care costs for in-person meetings attended. These are available for all meetings in which a family leader serves in a formal membership role.

Family Advisory Council (FAC): The primary way families have been engaged with Title V in the past has been through the FAC, and most specifically the CSHCN population. In recent years, the FAC expanded from only the KS-SHCN program and began providing family input and guidance for all the former Special Health Services programs (e.g., KS-SHCN, Part C/Infant-Toddler Services, Newborn Screening, Birth Defects). However, as noted above, it is an expectation of the Title V MCH Director 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. With the Bureau reorganization and the expanded focus across all MCH population, not only the CSHCN population, there is effort to expand the FAC. More about this can be found in the Cross-Cutting Plan Narrative in this Application/Report.

Organizationally, the System of Supports Section Director and Family Engagement Administrative Specialist serves as Council "staff" with continued support from the C&F Services Unit Director. Additionally, an Executive Committee, comprised of three FAC members, provides balance and specific family guidance in the development of agendas. The EC will also make recommendations for bylaw revisions, bring key issues to the table, and provide oversight of FAC operations. The EC 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.

In the past, Council leadership would strive to maintain a diverse membership roster (e.g., geographic regions, family experiences, varying racial/ethnic backgrounds, varying ages and medical needs of children). As the FAC expands beyond the CSHCN population focused-arena this will remain an important part of Council recruitment, to assure we are representative of Kansas' diverse population. To assist with recruiting members, six core membership benefits are promoted.

- *Advocacy Training:* FAC members are provided an overview of legislative policy processes to support individual interests in advocating for their families or communities at the local, state, or national level.
- *Leadership Skills*: FAC members are provided opportunities to serve in leadership roles in the FAC structure (e.g., Executive Committee, Work Group Leaders, New Member Orientation, Alumni & Mentorship Program). Additionally, they are provided training on the MCH core competencies and complete the StrengthsFinder Assessment.
- *Peer Supports:* Peer supports, serving alongside other families, is one of the greatest benefits noted by FAC members over the years. Opportunities to learn from and get to know one another are integrated into meeting agendas throughout the day.
- *Conference Opportunities*: Funding is dedicated each year to support FAC members in attending leadership conferences and at least one FAC member, in addition to the AMCHP Family Delegate, is provided an opportunity to attend the AMCHP conference.
- *Programs Planning/Policy*: FAC members provide input, feedback, guidance, and support to Title V program planning and policy development.
- *Making a Difference in the Community*: FAC members are encouraged to engage in other community initiatives to support their interests.

Individualized resources, guidance, or special training may be provided to support a FAC members' participation in other community initiatives. In the past, this has included 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. Several FAC Alumni now serve on the Kansas Council for Developmental Disabilities. 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.

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 and the goal is to have at least two family member representatives for each domain group (total of eight). Families are provided an 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. Prior to and immediately following meetings, family members are invited to join in a "debriefing session" to answer questions, clarify discussions, and provide additional information they may need. Support is available between council meetings for questions when needed. This support continues to be effective in keeping families engaged and confident in their role on the Council.

Alumni & Mentorship Program (AMP): Developed in 2016 for members who leave the Council due to term limits or personal reasons and would still like to be involved at some level. The Alumni group provides opportunities for these seasoned and motivated family leaders to remain engaged or and/or see the impact of their contributions. Additionally, Title V hopes to nurture their investment and expand the cross-cutting community of Title V family and consumer partners with these leaders. The Alumni program has been the most widely utilized part of this program. Any member who has served for at least one year is eligible to participate in the Alumni program. The Mentor program was designed to assist new members in learning about the 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.

Family Delegate Program: The 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. More about future changes to the Delegate program can be found in the Cross-Cutting Plan Narrative in this Application/Report.

Strengthening & Advancing Family Partnership

Title V is committed to family/consumer engagement, partners, leadership, and mentorship. This include both opportunities for family leaders and the consumers/families served by MCH programs. This supports the engagement of training activities and opportunities to support the MCH workforce in embracing and engaging in family engagement locally and at the state level. The alignment with the frameworks outlined previously, MCH staff and ATL grantee technical assistance trainings and webinars will be made available as implementation of the Standards of Quality for Family Strengthening and Support begins. There are three implementation tools available in utilizing these Standards, all of which will be implemented as part of the Family and Consumer Partnership Program, as well as with Supporting You participating programs. These tools were first introduced to MCH partners and stakeholders as part of the Title V 2021-2025 Needs Assessment.

1. *Program Self-Assessment Tool*: To be used by program teams to determine how well the program is engaging families. Initiated by management/leadership, direct and administrative staff, parent leaders, or other stakeholders.
2. *Staff Self-Reflection Checklist*: To be used by program staff, individually, to determine how well they embrace and adopt family engagement as a value added for their work.
3. *Standards Participant Survey*: A developed survey (available in English, Spanish, and Chinese) for program participants to provide input on how well the program is doing with providing family strengthening and support services.

Family Leader Contributions

While a key activity of the FAC is to advise the Title V program, it also identifies a project each year to assist in program and material development and promotional activities relevant to the needs of the program populations. Past FAC accomplishments include:

- Medical Home Resources
- White Paper Series
  - Communicate and Partner with Families of CSHCN
  - Raising Children with CSHCN and the Impact on Family Health
  - Financial Impact of Raising CSHCN
- The Future is Now, Think Big!!! Transition Planning Series
  - Taking the First Steps Towards Helping Your Child Be Independent (0-6 Years)
  - Taking Steps Towards Being Independent (7-13 Years)
  - Taking Steps Towards Independence (14-19 Years)
- Trauma-Informed Approaches Fact Sheet
- Supporting You Kansas

Impacts of Family Partnership

The primary impact of family partnership over the years is evident in the shift of the provision of Title V services. In addition, there is clear investment, commitment, and dedication of the Kansas Title V leadership and staff to assuring the family voice is central to services and activities of the programs. This is solidified in the adoption of a new priority, specifically focused on assuring families are supported, engaged, and provided opportunities for leadership development.

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:

- Refinement of the 5-year State Action Plan, ESMs and SPMs;
- Setting annual objectives (linear forecasts) for NPMs and SPMs;
- Writing trend analysis;
- Highlighting major statistical findings and providing interpretation as part of a broader monitoring/assessment/evaluation plan;
- Updating the funding formula for the MCH Block Grant allocation to local grantees; and
- Preparing the resources/tools to increase knowledge and understanding about the Title V MCH federal-state partnership, services, and the state's priority issues.

Published products and data analyses can be found at http://www.kdheks.gov/c-f/mch.htm.

Access to MCH-Related Data for Assessment & Monitoring

The SSDI Project Director, MCH Epidemiologist, and Data Analyst provide extensive support throughout the statewide MCH needs assessment process. Additionally, SSDI provides capacity and support in the following data initiatives to enhance the Title V access to other MCH health data that can inform programming, assessment, and monitoring during and between formal needs assessment periods.

Suicide Among Service Members Project: The Kansas Department of Aging and Disability (KDADS) receives Substance Abuse and Mental Health Services Administration (SAMHSA) funding to build state infrastructure for service members, veterans, and their families suicide prevention efforts through the development of public-private partnerships and legislative or administrative policy change. SSDI and Title V staff provided suicide data and population statistics of reported active/non-active duty military personnel through vital statistics and the state violent death surveillance system. The compilation of MCH data regarding the age, gender, and geographic location of the deceased with data from the Veterans Affairs on method of suicide and last appointment contact, narrowed the focus of where services and initiatives are greatly needed. This support positioned the Kansas team to select priorities: consistent messaging, improved access and capacity of care, shared and collective ownership, and consistent statewide training.

School Nurse Survey: Title V/BFH collaborated with the Bureau of Health Promotion (BHP) in 2018 to conduct a survey of public school districts and accredited private schools to determine the school nurse workforce, management of students with chronic diseases, health screenings data, and immunization policies. School district health staffing and chronic disease data points and definitions were collected as part of the National Association of School Nurses' (NASN) National School Health Data Set: Every Student Counts! initiative. The SSDI Project Director assisted with questionnaire planning and development and data collection, cleaning, and analysis. The survey sheds light on the lack of referral follow-up or resolution following the school nurse screenings. The Child and Adolescent Health Consultant will continue to work with the KS School Nurse Organization on guidance to increase referral follow-up. Title V will partner in providing targeted technical assistance to communities that request help with building connections among schools and health professionals, including increasing communication around referrals by utilizing IRIS (more information about IRIS is available throughout this application).

Preterm Birth Project: Funded by the Robert Wood Johnson Foundation, the National Institute for Children's Health Quality (NICHQ) 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 the project is to identify strategies that both lead to better outcomes for mothers and babies and impact disparities in PTB rates. Kansas' 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. NICHQ visited Kansas in 2019 and is currently developing case studies intended to more closely examine factors in each of the four states that may have contributed to PTB results. Ultimately, the case studies will document and disseminate best practices, barriers, and strategies with the potential to decrease PTB rates. SSDI provided data analysis on trends (2007-2017) and disaggregated data by 17 alpha-hydroxyprogesterone caproate (17P), race and ethnicity, gestational age, mother's age group, prenatal care, smoking status, location (e.g., counties, 5 peer groups - urban/rural, 6 public health regions), socio-economic characteristics (e.g., maternal education level, Medicaid vs. non-Medicaid), among others. More in-depth analysis was conducted, including a hot spot map examining the association between the concentrated disadvantaged children areas and preterm. NICHQ plans to reveal findings during virtual meetings in 2020 (not yet scheduled).

Kansas Perinatal Community Collaborative (KPCC) Annual Reports: The 2018 Becoming a Mom® State Aggregate Report was completed in December 2019. The MCH Epidemiologist worked with Vital Statistics to conduct a pilot project linking the 2018 program data with birth record data for the 2019 evaluation report. The goals of this process were: (1) assess the feasibility and benefit of linkage process; and (2) identify how data quality changed in KPCC outcomes data when supplemented with available birth record data. Five measures were captured for the initial pilot linkage process: gestational age, low birth weight, induced deliveries, cesarean deliveries, and breastfeeding initiation. From the linkage process, there was nearly a 50% increase in the possible records available for analysis. The linked data showed a significantly lower preterm birth rate (4.9%) than for Kansas births overall (9.5%), a slightly lower rate of low birthweight, and a slightly higher rate of breastfeeding initiation. KPCC sites had a statistically higher percentage of induced births, but with the linkage there was also a significant decrease in the reported induction rate, which may indicate overreporting. This indicates an opportunity for further education about induction in the KPCC programs.

KPCC Preterm Birth Analysis: The MCH Epidemiologist analyzed participant reported outcome data from 2017 and 2018 to identify potential issues associated with the growing number of preterm births in Kansas. The sample sizes for preterm births in either year were small with 66 and 52 preterm births in each respective year. Analyses were conducted for several measures for both years and, overall, there were no consistent patterns across time that would be linked to a potential cause of preterm birth. One exception, however, was maternal health condition. In both years, 2/3 of mothers with a preterm birth had reported a health condition (e.g., diabetes, hypertension). Based on additional analysis of birth records, obesity is suspected to be the primary contributor. Future linkage between KPCC and birth records will include BMI to better evaluate preterm births in the KPCC data.

KPCC Dashboard: As part of work to streamline KPCC data reporting as more sites join the program, is currently working with the MCH Data Analyst and the University of Kansas' Data Application and Integration Solutions for the Early Years (DAISEY) team to create a Tableau dashboard that allows participant sites to have increased ownership over their data. This dashboard will be based on data provided for the site-specific reports but also included enhancements such as quarterly metrics to allow sites to better use their data for programmatic needs. This work is expected to continue into the year 2020 and once developed should allow for more efficient site onboarding and data tracking.

KPCC Infant Mortality Analysis: To help with program evaluation and planning, in the fall of 2019, SSDI began planning an analysis of the infant mortality rates for KPCC counties, non-KPCC counties and the state of Kansas using resident birth records for the state through time. This project will evaluate the aggregate group rates, individual KPCC county rates, and aggregate data for respective groups across various stratifiers to identify where KPCC and non-KPCC counties differ overall. The findings will be used to understand the underlying patterns associated with infant mortality through time which can be used to identify areas for improved education.

Edinburgh Screenings Data Analysis: As part of ongoing epidemiologic support, this analysis evaluated the number of total Edinburgh screenings and unique participants (including demographics for the unique high-risk participants). High-risk screenings were linked to subsequent referrals for behavioral health and counseling to identify what services were provided. This process allowed Title V and SSDI to identify limitations in the available data, including lack of information about the program screening and potential lack of referral documentation by grantee sites. Changes to DAISEY forms and improved

guidance for sites were recommended based on the findings.

Postpartum Coverage Extension: Throughout 2019, Title V explored the feasibility of extending postpartum care for mothers covered by Medicaid for an additional 10 months (12 months following delivery vs. 60 days) with support from the MCH Epidemiologist. Literature and other published materials from states that had expanded postpartum care with similar political structures to Kansas were reviewed. Potential components of care/services and programmatic elements were also considered.

Data Enhancement Activities

Aid to Local Funding: The MCH Epidemiologist and Teen Pregnancy Targeted Case Management/Pregnancy Maintenance Initiative (TPTCM/PMI) Program Manager worked to identify potential changes to the TPTCM/PMI funding formulas to better reflect the populations served within each grantee county, including several funding formula options for consideration. The TPTCM ATL formula is now utilizing more up-to-date Medicaid data for teen pregnancies to better account for the target population in respective service areas. The funding formula criteria for each are outlined below.

Program	Funding Formula Criteria
TPTCM	• females ages 12 to 21 years on Medicaid • overall population of females ages 12 to 21 years • county teen pregnancy rates in ages 10 to 19 years
PMI	• overall population of females ages 15 to 44 years • uninsured females ages 18 to 64 years • county infant mortality rates

Medicaid-Birth Record Linkage: Several efforts have taken place to link Medicaid and birth record data. Most recently an analysis of Medicaid data linked to the birth records for resident mothers for calendar year 2015 was conducted. To support continued linkage, a draft report provided statistics related to the initial linkage process and evaluation of differences in key demographic factors (age, race/ethnicity, geography) for the linked Medicaid/birth data. Known limitations of the 2015 linked data set were provided to help foster improved data acquisition and linkage in the future. Unfortunately, a change in the Medicaid data vendor limited compatibility of the 2015 linkage with any future linkages. SSDI began working with Medicaid and Vital Statistics partners in the fall of 2019 to develop a data request that addressed the limitations identified during the 2015 data analysis. This request, which included data for the years 2015 through 2018, expanded the requested age ranges for mothers to age 55 and added additional records such as dental to better provide relevant data for maternal and child health work. This work, while in the initial stages, is expected to be executed in 2020, and will be the basis for several analytical products moving forward.

Active Live User Totals		All Organization Totals	
Initiative	User Total	Grantee Total	Org Total
KDHE Title V/X	854	91	114
KDHE MIECHV	62	1	9
KPQC	38	1	30
KDHE LYFTE	28	1	5
KCC	12	1	1
Total	994	95	159

Shared Measurement System—Data Application & Integration Solutions for the Early Years (DAISEY): BFH has been working with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) (https://cppr.ku.edu/) over the past five years to: 1) implement and support a secure, HIPAA compliant web-based system (DAISEY); 2) train and provide technical assistance to 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. The 2015 launch of DAISEY supports Title V's vision for shared measurement and integrated community-level MCH initiatives. Increased data capacity allows the program to demonstrate the impact of coordinated, essential MCH services on improved outcomes. As of May 2020, there are 994 users representing 95 grantees and 159 organizations.

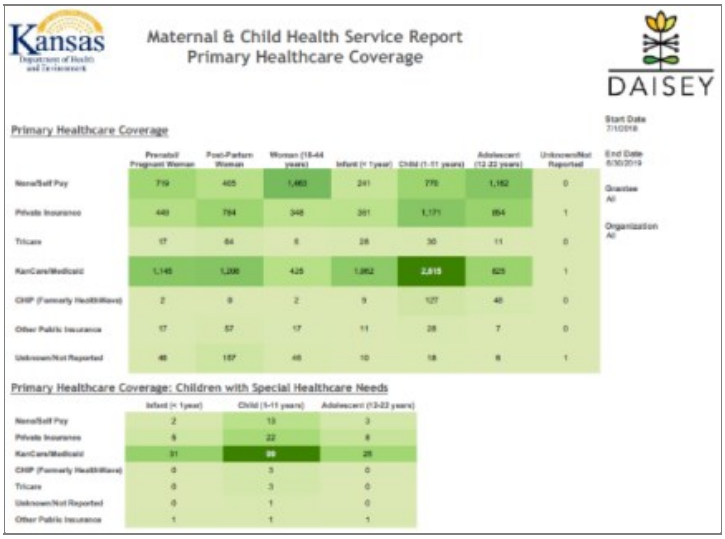
DAISEY is available free to all providers as the required centralized collection system for MCH services. DAISEY's data and analytics infrastructure continues to be enhanced, and focus has shifted over time from *data collection* to *using data* to drive

decisions and quality 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, education provided, and referrals made/completed. 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 levels.

A website (http://daiseysolution.com/kdhe/) was developed at the time of launch to provide a centralized access point for users to find information and resources such as training, printable forms, data dictionaries, user guides, and technical briefs. KDHE and KU staff provide extensive training and technical assistance through webinars, individual phone instruction, on-site training, and recorded navigational videos. A DAISEY Helpdesk email is available to provide direct technical support for system users.

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

Sample DAISEY Report



In addition to the extensive TA and support that is provided, a DAISEY Advisory Group was developed in 2017. The group is

comprised of users representing multiple programs in both rural and urban areas (currently 22 members representing 15 local agencies). Their role is to provide input into local needs regarding data collection/measurement and provide feedback regarding requested form and report changes as well as other technical elements of the DAISEY system. The group held a virtual webinar in fall 2019 focused on DAISEY reports. Prior to the meeting, all members completed a survey about reports. The responses were discussed to understand how members use reports, generate ideas about how to get the most out of the reports, and identify potential future enhancements to DAISEY forms and reports.

Input from the Advisory Group and staff is collected throughout the year, and a comprehensive review of DAISEY forms and reports is completed annually to assess for needed changes. Effective July 1, 2019, five new forms were made available to all users, including MCH local agencies.

- Ages & Stages Questionnaire (ASQ-3)
- Ages & Stages: Social Emotional (ASQ:SE-2)
- Client Contact
- One Key Question
- Parental Health Screener

In addition to adding new forms, several forms were revised. The Edinburgh Postnatal Depression Scale now includes a "Plan of Action", which can be used to record information on referrals, interventions, or other actions taken in response to the score. An additional annual income field was added to the Visit form to allow an income range to be selected. This addition is intended to ensure the quality of income data entered on all Visit forms (exact amounts were not being entered). The MCH Service form was updated to add several new response options to the Program Services question. The DAISEY Data Dictionary is available online at https://kdhe.daiseysolutions.org/find-answers/.

Staff participate in monthly DAISEY "Deep Dives" to review and discuss data. The team strategizes around topics/focus areas and how to show impact. Recent focus has been on Well Woman Visit data (NPM1). Data was pulled for all programs and shared with local program agencies during 2019 regional meetings. KDHE staff presented on the data from DAISEY to discuss where local agencies could make changes to improve their data to tell their story. Well Woman data included if the client has had a well visit in the past 12 months and whether education on the importance of well visits was provided during the encounter.

Integrated Referral & Intake System (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 and online at http://connectwithiris.org.

Growing a Connected Network Around a Family

IRIS

A simple, data-driven communication tool paired with community generated solutions.

6,148
KANSAS FAMILIES

Unduplicated number of individuals who were the subject of at least one referral in IRIS.

8,950
REFERRALS

Many families were involved in multiple referrals.

42.1%
ENROLLED IN SERVICES

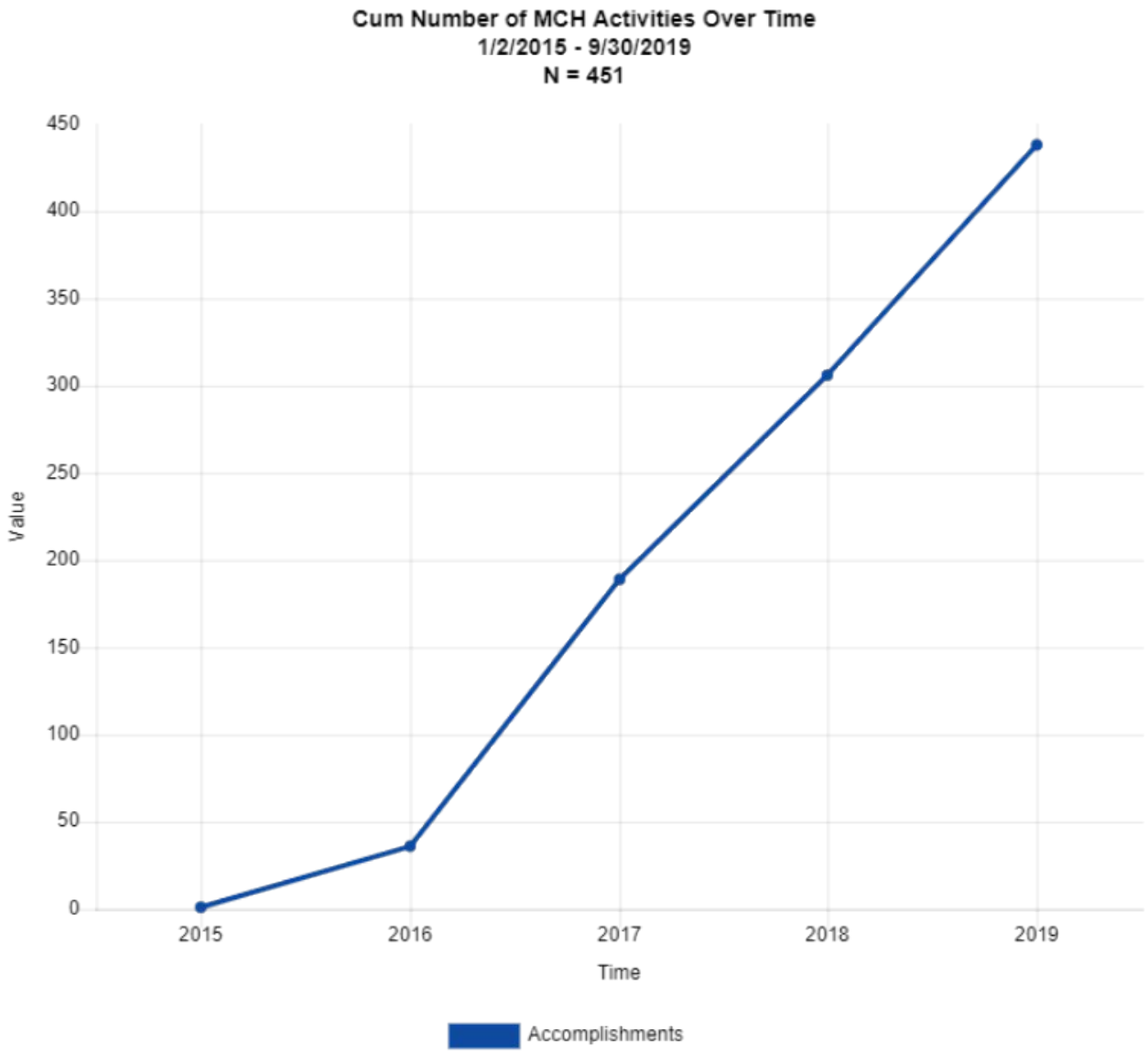
Families connected with needed services in IRIS communities.

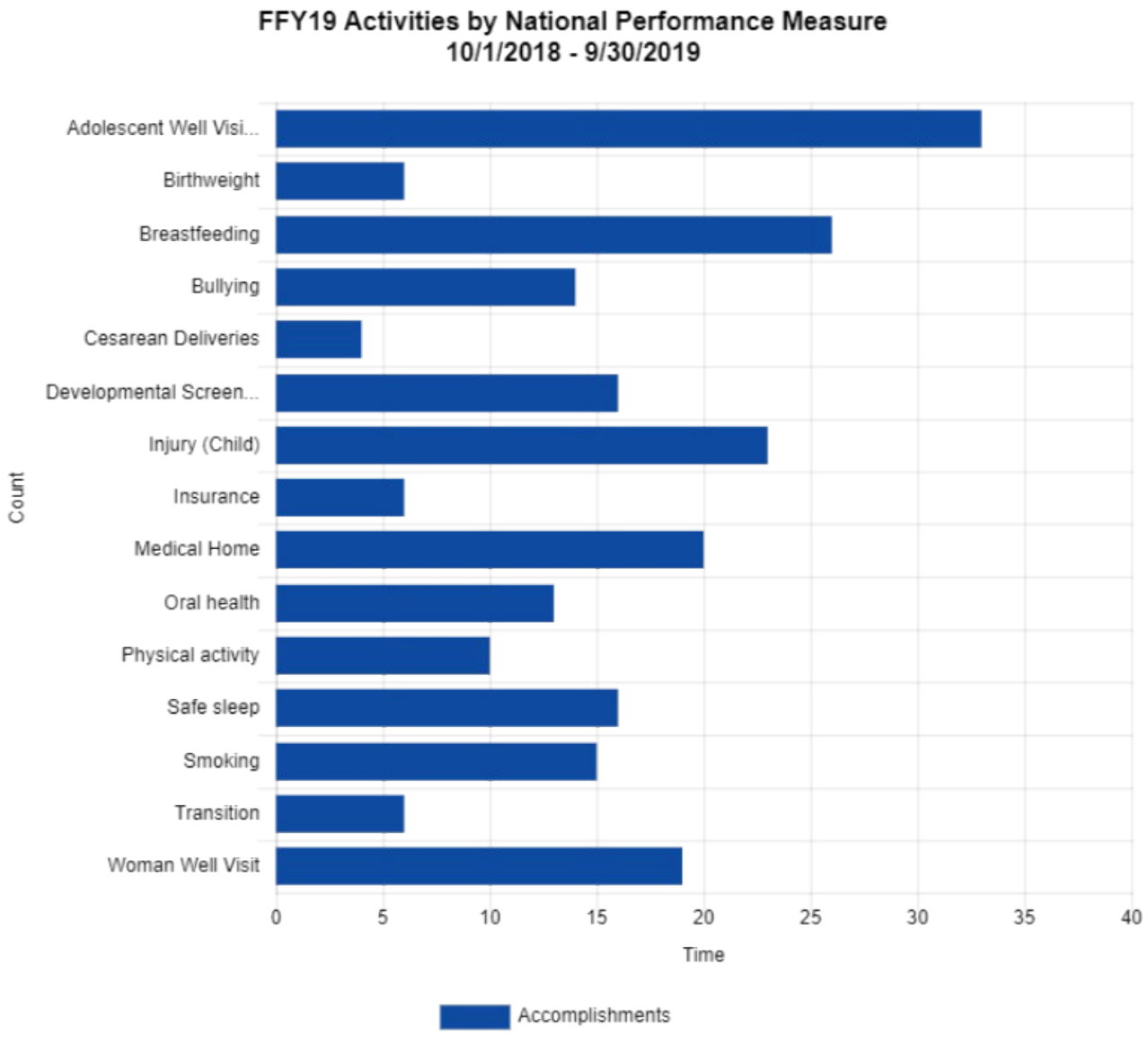
Updated May 31, 2020

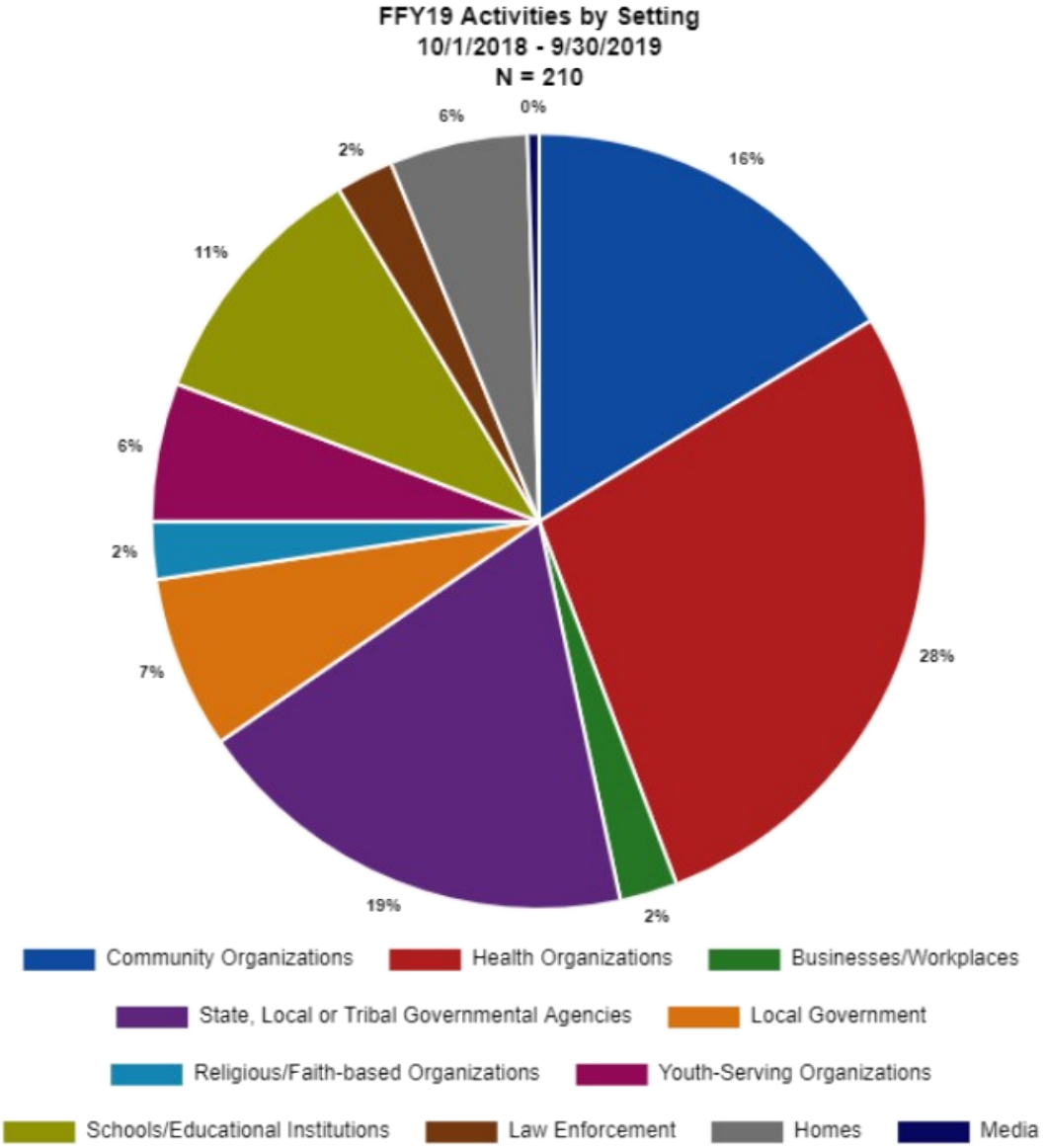
The IRIS approach fosters collaborative discussions that are fundamental to changing minds, practices, and perceptions of partners working together in a community.

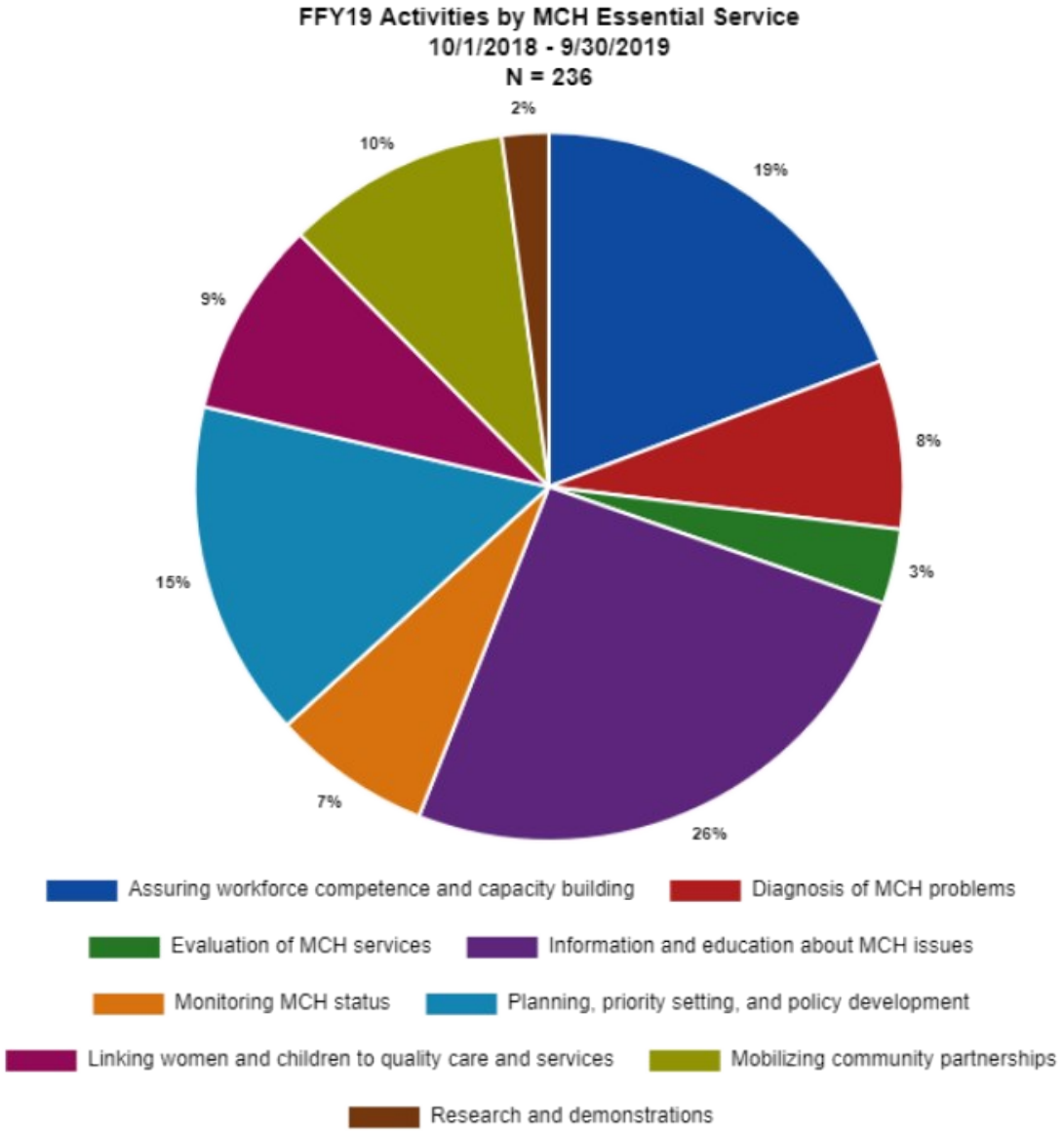
COMMUNITIES	LAUNCH	PARTNERS	FAMILIES	REFERRALS	% ENROLLED
Barton, Rice Counties	6/3/2019	23	12	12	25.0%
Ellis County	9/16/2019	10	21	25	28.0%
Franklin County	5/20/2019	22	47	48	18.8%
Geary County	2/28/2018	33	1,119	2,203	61.8%
Harvey County	7/22/2019	38	15	26	38.5%
Johnson County	7/1/2019	48	190	249	43.8%
Mitchell County	11/15/2019	38	1	1	0.0%
Reno County	10/1/2018	20	133	148	32.4%
Riley County	5/9/2018	39	1,066	1,422	23.0%
Saline County	9/30/2019	41	64	68	55.9%
Sedgwick County	3/4/2019	22	550	937	43.1%
Shawnee County	8/27/2018	7	191	197	21.3%
Southeast Kansas	12/11/2017	73	1,860	2,607	35.9%
Wyandotte County	4/2/2018	46	879	1,007	47.4%

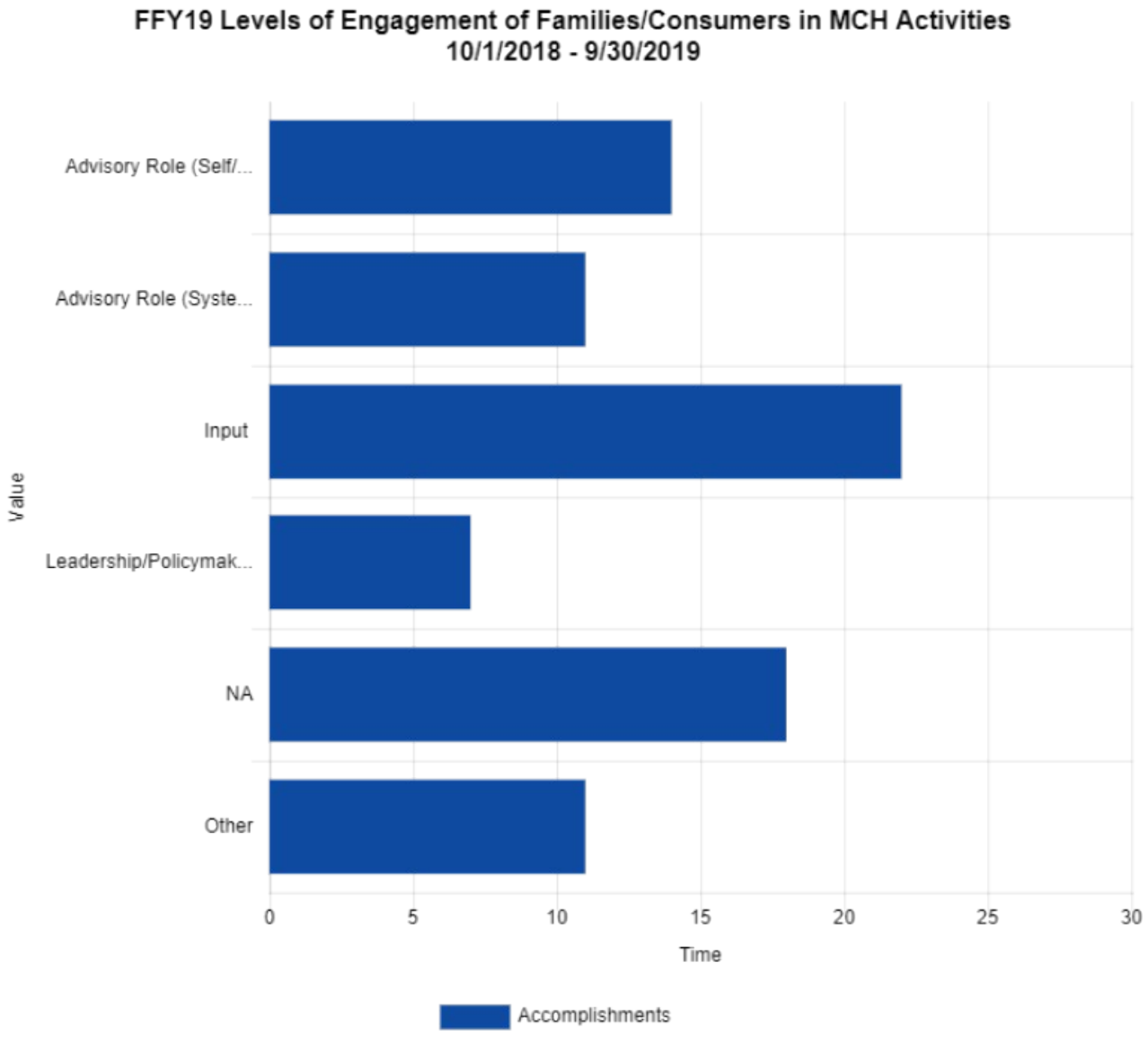
MCH Community Check Box: Monitoring the State Action Plan: Developed by the KU Center for Community Health and Development through the MCH Community Check Box (http://communityhealth.ku.edu) Title V captures, characterizes, and communicates what we are doing across the state. The information collected 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.

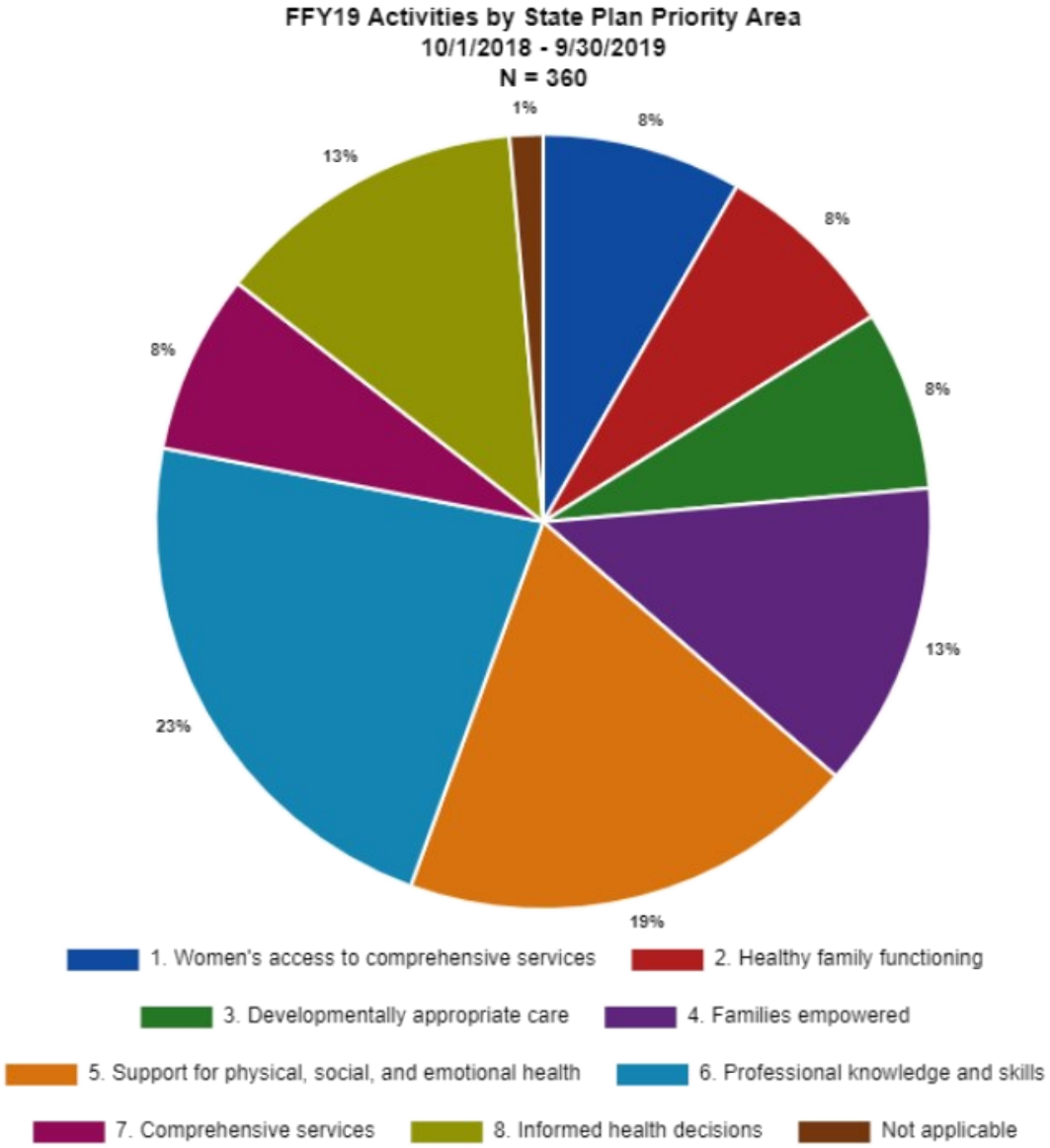

Cum Number of MCH Activities Over Time
1/2/2015 - 9/30/2019
N = 451
450
400
350
300
250
200
150
100
50
0
Value
2015
2016
2017
2018
2019
Time
Accomplishments


FFY19 Activities by National Performance Measure
10/1/2018 - 9/30/2019
Adolescent Well Visi...
Birthweight
Breastfeeding
Bullying
Cesarean Deliveries
Developmental Screen...
Injury (Child)
Insurance
Medical Home
Oral health
Physical activity
Safe sleep
Smoking
Transition
Woman Well Visit
Count
0
5
10
15
20
25
30
35
40
Time
Accomplishments


FFY19 Activities by Setting
10/1/2018 - 9/30/2019
N = 210
0%
16%
28%
2%
19%
7%
2%
6%
11%
2%
6%
Community Organizations
Health Organizations
Businesses/Workplaces
State, Local or Tribal Governmental Agencies
Local Government
Religious/Faith-based Organizations
Youth-Serving Organizations
Schools/Educational Institutions
Law Enforcement
Homes
Media


FFY19 Activities by MCH Essential Service
10/1/2018 - 9/30/2019
N = 236
2%
10%
19%
9%
8%
3%
15%
7%
26%
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
Research and demonstrations

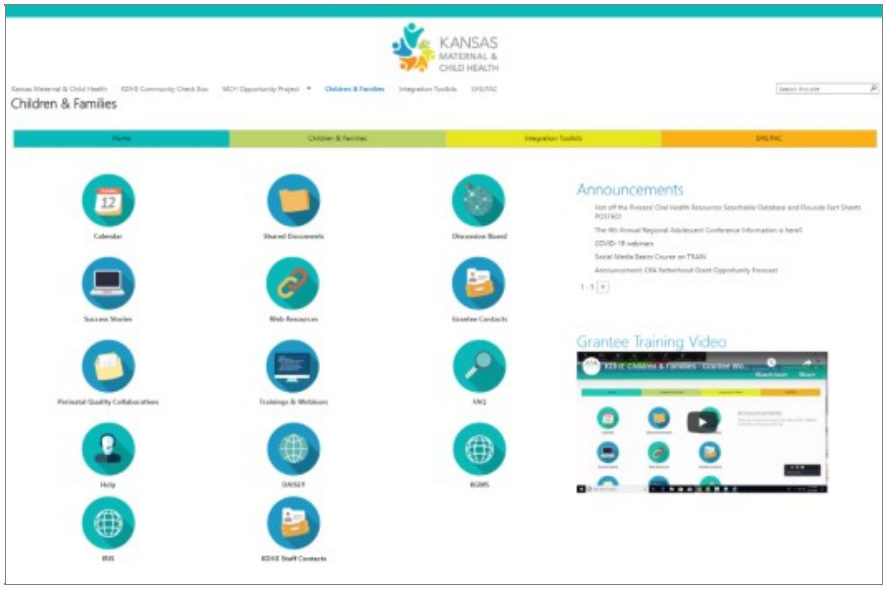

FFY19 Levels of Engagement of Families/Consumers in MCH Activities
10/1/2018 - 9/30/2019
Value
Advisory Role (Self/...
Advisory Role (Syste...
Input
Leadership/Policymak...
NA
Other
0
5
10
15
20
25
30
Time
Accomplishments


FFY19 Activities by State Plan Priority Area
10/1/2018 - 9/30/2019
N = 360
1%
8%
8%
8%
13%
19%
23%
8%
13%
1. Women's access to comprehensive services
2. Healthy family functioning
3. Developmentally appropriate care
4. Families empowered
5. Support for physical, social, and emotional health
6. Professional knowledge and skills
7. Comprehensive services
8. Informed health decisions
Not applicable

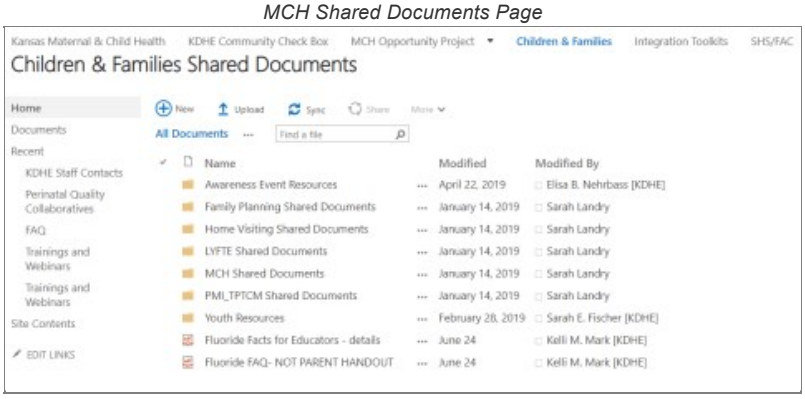
BFH invested in the development of a shared collaborative SharePoint application within the Community Check Box, commonly referred to as the WorkStation. This tool is being used to enhance training and technical assistance while also increasing statewide connections and collaboration amongst program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

Screenshots of the MCH WorkStation

Main Page https://www.myctb.org/wst/KansasMCH/cf



MCH Shared Documents Page



Discussion Board Page

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

Collaborative Work & Relationships

The BFH and Title V have partnerships at the state and local levels to ensure capacity meets the coordination of components within the MCH health care delivery system. As a leader and partner, the state MCH team provides expertise, gathers feedback, facilitates partnerships and conversations, and makes connections to assure access to services and maximize the effectiveness of the health system. Title V services are provided across the state through local agencies contracting to provide family centered, community based, and culturally competent services/care to MCH populations. Local awards are based on MCH population data (census as source), plans, performance, collaboration, and potential to impact.

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.

Other Federal Maternal & Child Health Bureau Investments

The Title V vision leads the way and provides the overall direction for all we do in Kansas across the life course, from birth through adulthood. Strong linkages have been identified across plans and needs assessment findings. BFH staff continue to better align and coordinate with other programs and initiatives such as Newborn Screening; Part C/tiny-k; Title X Family Planning; 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.

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 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 (e.g., Connected Families, Connected Communities as part of the Help Me Grow Kansas framework). We expect the newer behavioral health programming focused on pregnant women, mothers, and children to lead to something bigger for the state's behavioral health system.

Title XIX & XXI – Medicaid

Title V has an agreement in place with Medicaid and has been working to strengthen the relationship for several years. This original agreement was established in 2016 and outlines the formal partnership. The agreement was reviewed in 2019 and amended to further define and detail the relationship between Title V and Medicaid as it relates to Maternal Mortality Review.

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 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 were launched with Medicaid staff and MCOs because of the incumbent's efforts, but the position is vacant (as of December 2019) and timeline to recruit is unknown.

Although communication has improved and notable progress has been made, there have been delays with implementing and advancing aspects of the Medicaid alignment, integration, and data sharing. This is likely due 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. Now a year later, the Medicaid Director and Medicaid Medical Director have turned over again—both resigned in May 2020. An interim Medicaid Director has been named. Despite the past challenges and recent events (key vacancies, COVID-19 pandemic), agency leadership continues to embrace, understand, and support the need for increased collaboration and communication, including data sharing.

Medicaid staff have been more engaged than ever and a new team member was just appointed to the KS MCH Council. We will continue to build on past activities and progress that have provided a strong foundation for the partnership between Title V and Title XIX/XXI. Key activities and initiatives have broken down barriers and paved the way for a new precedence of partnership, data sharing, and collaboration. While the high turnover in Medicaid and agency leadership is not ideal, these foundational efforts provide opportunity for sustainable partnerships and forward progress that Title V may not have had in the past. Some notable efforts include:

- Vital Statistic/Medicaid data linkage
- Recurring opportunities to present to the MCOs regarding MCH measures targeting the Medicaid population disparities
- Leveraging Medicaid funding to support expanding access to prenatal education, maternal depression screening, LARC, and substance use screening, education, referral, and treatment
- Access to the KS Eligibility Enforcement System (KEES) to reduce burden for staff (KS-SHCN and maternal mortality) working to confirm Medicaid and other benefits and for families applying to the KS-SHCN program

In partnership with the Kansas Pediatrics Supporting Parents (PSP) team (including Medicaid reps) and national consultants. A new policy was drafted to cover maternal depression screenings in pediatric care settings under a child's Medicaid plan. The policy is moving through the state-level approval process, and workforce development is underway. The team has discussed revisiting this policy to include the home as a qualified setting, public health/MCH home visitors as qualified professionals, and other caregivers (fathers, grandparents, foster parents) as eligible to be screened along with the mother in both the home and pediatric setting. Preliminary discussions for phase 2 are focused on expanding Medicaid telehealth and care coordination services. The PSP team is discussing early childhood mental health and exploring ways to expand codes, so they are available to providers and settings that screen for/assess and treat young children with anxiety and mental illness.

KS-SHCN works collaboratively with Medicaid/MCO partners to assure dually enrolled clients receive appropriate services and quality case management/care coordination. MCOs share data monthly through an electronic report that provides information around authorized Medicaid services to the KS-SHCN Care Coordinator, allowing them to assist clients in getting appointments scheduled, fill prescriptions, communicate with providers, among other supports. KS-SHCN coordinates with MCO care coordinators around gaps or barriers in services they may not be aware of. KS-SHCN routinely presents to the MCO's and Medicaid partners to discuss varies challenges in meeting the needs of CSHCN.

There are several initiatives that will continue to be pursued to advance systems of care for the MCH population. The below slide outlines some of the key policy areas already in progress.

Medicaid and BFH/MCH Shared Work – Key Activities

- Goal: Expand Medicaid pregnancy coverage from 60 calendar days to a full 12 months postpartum.
  - Research of leading organizations and states and proposal for KS services
  - Fiscal note was provided by Medicaid, but work needs to be done related to agree upon criteria to assess a more realistic fiscal impact.
  - Discussion among Medicaid Director, KS PSP team, and national consultants
  - Project on hold due to recent legislative work to expand Medicaid (did not pass in 2020)
- Goal: Expand telehealth reimbursement policies for virtual early intervention (Part C/tiyn-k) services to
  - Focus has been on virtual services during public health emergencies, however the goal would be to ensure these policies extend beyond public health emergency declaration timeframes.
- Goal: Kansas Perinatal Community Collaborative Alternative Payment Model (APM) pilot
  - Medicaid clinical team interested in efforts focused in urban hospital settings to improve outcomes for the mother, infant, and family.
  - Discussion focused on incorporating maternal depression screening, prenatal and postpartum education, and home visiting into APM
- Goal: MCO participation in IRIS to seamlessly connected to services outside of the MCO
  - Meetings with United HealthCare (UHC) to exchange information about services, participant needs, and referrals.
  - UHC Care Coordinators are actively connecting beneficiaries to local MCH programs and using IRIS and Title V is working to get the UHC community to join the broader community-based IRIS network.

KANSAS MATERNAL & CHILD HEALTH

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

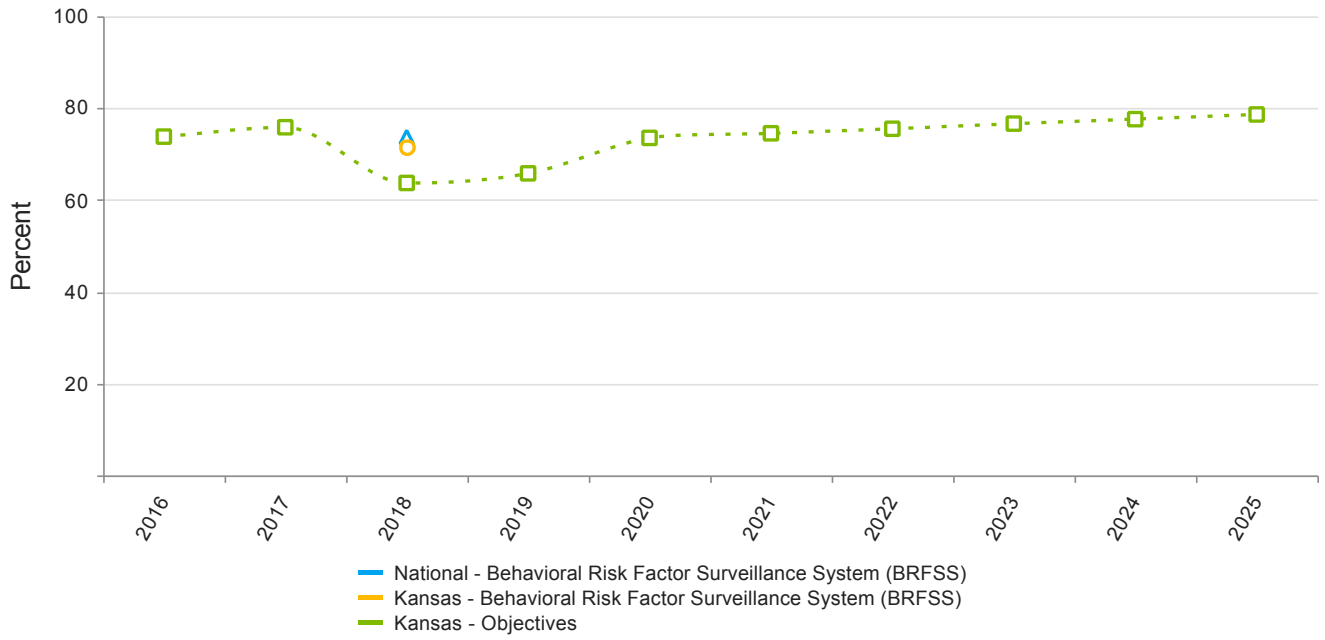
Women/Maternal Health

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-2017	55.9	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	14.8	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	7.4 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	9.5 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	26.3 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.0	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	6.0	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.3	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.8	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	210.8	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	104.1	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-2017	3.7	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.5 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.0	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2018	14.7 %	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**	**2019**
Annual Objective	73.7	75.7	63.6	65.7
Annual Indicator	65.1	61.0	64.8	71.4
Numerator	317,072	294,297	311,046	351,350
Denominator	486,998	482,804	480,042	492,351
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	73.4	74.4	75.4	76.5	77.5	78.5

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women program participants (18-44 years) with a preventive medical visit in the past year

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	78.5
Numerator	5,412
Denominator	6,896
Data Source	DAISEY
Data Source Year	2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	80.5	82.5	84.5	86.6	88.8

State Performance Measures

SPM 1 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	14.7
Numerator	4,930
Denominator	33,605
Data Source	PRAMS
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	14.0	13.3	12.6	12.0	11.4

State Action Plan Table

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

Priority Need

Women have access to and utilize integrated, holistic, patient-centered care 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

Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit by 5% by 2025.

Strategies

Provide resources and tools to support local health agencies on educating women about the importance of a high quality, comprehensive annual preventive medical/well visit, assessing for insurance coverage, and assisting women to obtain insurance if needed.

Provide on-site assistance for accessing health care coverage through certified application counselors or Medicaid eligibility workers to ensure coverage before, during, and after pregnancy.

Utilize peer and social networks for women, including peer group education models, to promote and support access to preventive care.

Provide technical assistance to support local health agencies in developing policies and protocols that incorporate women's goal-setting and health screenings to assess for basic needs and health status (e.g., substance use, tobacco use, mental health, social determinants of health, intimate partner violence [IPV]) into all preventive medical visits for women.

Promote and support Medicaid policy change to expand pregnancy coverage through 12 months postpartum and the inclusion of screening for PMADs as a covered service.

ESMs	Status
ESM 1.1 - Percent of women program participants (18-44 years) with a preventive medical 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 utilize integrated, holistic, patient-centered care 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

Increase the proportion of women receiving pregnancy intention screening as part of preconception and inter-conception services by 10% by 2025.

Strategies

Increase consumer/family and provider awareness about the importance of preconception and inter-conception care, counseling/planning, and pregnancy intention screening by utilizing social media, infographics, data briefs, and partner networks.

Provide resources and education specific to preconception and inter-conception care to providers in support of quality services and comprehensive visits during these critical periods.

Increase the number of local health agencies utilizing evidence-based pregnancy interventions including One Key Question® and support implementation into practice through in-person or virtual skills building sessions, increase provider capacity to implement pregnancy intention screening into their practice.

ESMs	Status
ESM 1.1 - Percent of women program participants (18-44 years) with a preventive medical 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 3

Priority Need

Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.

SPM

SPM 1 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Objectives

Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period by 5% annually through 2025.

Strategies

Integrate evidence-based mental health interventions into community-based services.

Increase consumer and provider awareness about the importance of screening pregnant/postpartum women and new fathers for PMADs.

Increase the number of local health agencies screening pregnant/postpartum women and fathers for postpartum/paternal PMADs.

Partner with Medicaid and pediatric providers to implement parental depression screening during the child well visit to assess the needs of the family to support child social-emotional development, healthy family functioning, and ensure referral and early intervention.

State Action Plan Table (Kansas) - Women/Maternal Health - Entry 4

Priority Need

Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.

SPM

SPM 1 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Objectives

Increase the proportion of high-risk pregnant and postpartum women receiving prenatal education and support services through perinatal community collaboratives by 10% annually by 2025.

Strategies

Strengthen existing perinatal community collaborations and programs, with a focus on expanding community-specific supports (e.g., doula services) and targeting disparities in birth outcomes.

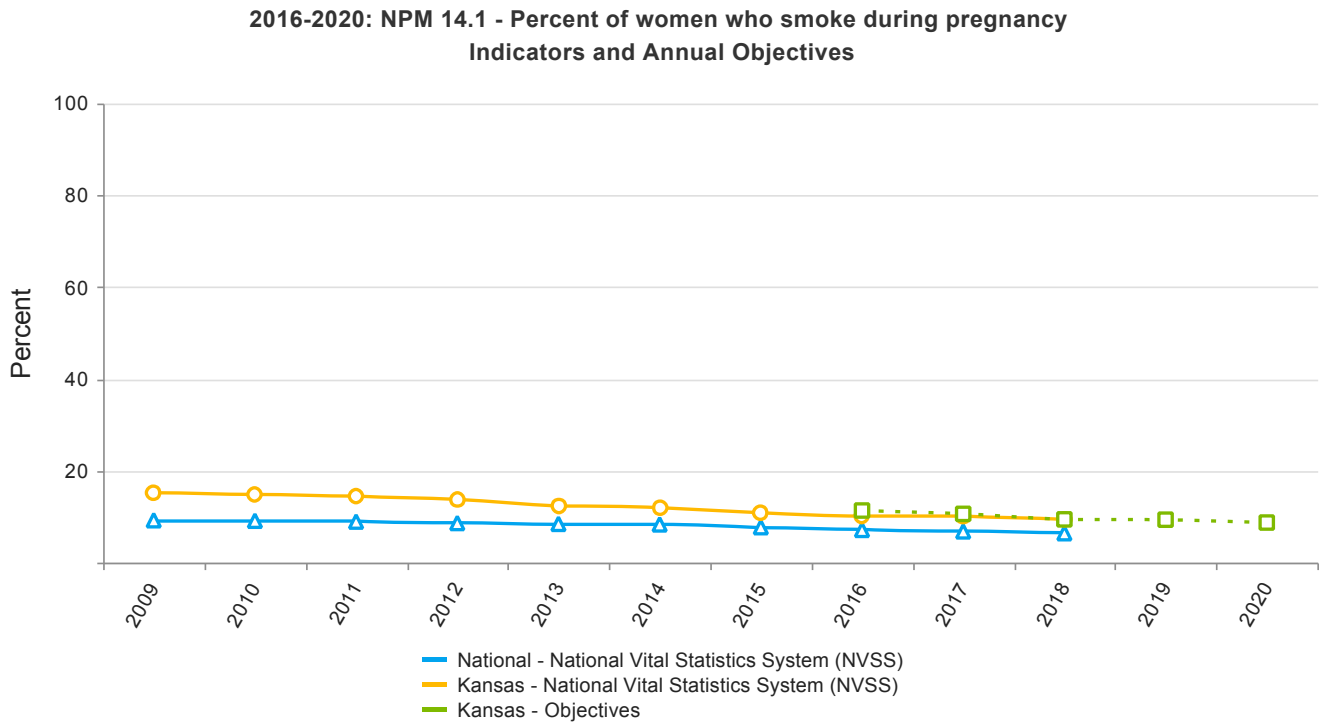
Engage FQHCs in more community collaboratives across the state to increase coordination and access to a variety of services for those at greatest risk.

Develop regional models and innovative approaches to increase reach and support rural expansion of perinatal community collaboratives.

Integrate web-based education and telehealth capabilities within the existing perinatal community collaborative models in targeted areas.

Increase the number of Kansas Perinatal Community Collaboratives implementing postpartum education sessions.

2016-2020: National Performance Measures



Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	11.4	10.7	9.5	9.4
Annual Indicator	11.0	10.2	10.1	9.5
Numerator	4,298	3,877	3,683	3,440
Denominator	39,083	37,965	36,434	36,155
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

State Provided Data				
	2016	2017	2018	2019
Annual Objective	11.4	10.7	9.5	9.4
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	

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**	**2019**
Annual Objective		15	30	50
Annual Indicator	31.1	38.9	43.5	32
Numerator	42	96	104	89
Denominator	135	247	239	278
Data Source	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 1 - Percent of preterm births (<37 weeks gestation)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		8.3	8.9	9.1
Annual Indicator	8.8	9.1	9.6	9.5
Numerator	3,426	3,457	3,492	3,440
Denominator	39,105	38,033	36,440	36,239
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

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 SFY2019, 61 of 71 grantees (86%) provided services to the Women & 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]

In 2018, an estimated 71.4% 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. Women living in households with an annual income $75,000 or higher (80.7%) are most likely to report having a routine checkup. This is significantly higher than women in households earning less than $25,000 (66.2%). There was no significant difference reporting a routine checkup within the last year for Non-Hispanic black (78.8%), Non-Hispanic white (72.2%) or Hispanic women (64.0%). Women with a college education (76.9%) compared to women with less than a high school education (52.6%) were significantly more likely to have received a routine checkup in the past year. Uninsured women (44.8%) were significantly less likely to have had a routine checkup within the past year than insured women (77.8%). Women ages 35-44 (76.9%) were significantly more likely to have a routine checkup than women ages 25-34 (67.6%) but not women ages 18-24 (69.3%). There was no significant difference in receiving a routine checkup between married women (72.7%) and unmarried women (69.8%). Place of residence was significantly associated with use of routine checkups (metro 73.9% vs. non-metro 65.3%).

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): 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, including but not limited to the importance of well visits. Activities include 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; and managing chronic health conditions. Program evaluation data shows improvements in knowledge and planned behavior related to education received. Read more about the program, impact, and evaluation findings in the 2018 BaM State Aggregate Report.

The data and trends cited at the beginning of this section reveal disparities we are working to address. The promising news is that according to the Report, mothers receiving education through the program were *more likely* than other mothers giving birth in the state to be racial/ethnic minorities; younger; lower education level; enrolled in WIC; and covered by non-private insurance. The education sessions and associated activities are aimed at improving rates of well-woman visits among disparity populations.

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 the Data Application and Integration Solutions for the Early Years (DAISEY) system, which is the shared data measurement system for all Kansas MCH lead agencies, at least annually, but most agencies verify at every visit if there are any changes from the last visit. All Aid-to-Local grantees (including home visiting), FP, Pregnancy Maintenance Initiative (PMI), and Teen Pregnancy Targeted Case Management (TPTCM) complete this form for all clients at every visit. Results of the screening question from every program for SFY19 show the majority (56.4%) reported "yes" to receiving a well visit in the last 12 months; however, 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 through individual and group technical assistance related to this measure.

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

One Key Question® State Initiative: Historically, a preventative well-woman visit addresses a woman's existing state of health, often missing a prime opportunity to discuss varying pregnancy intentions or likelihoods. The birth outcome and healthiest start for a child is impacted by a woman's health and wellbeing before conception.

The prevalence of unintended births in Kansas can be estimated using the Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) survey data. Nearly 1 in 4 mothers who had a live birth in 2018 (23.2%) reported that their pregnancies were unintended[2]. This means the timing of the pregnancy wasn't as intended, and the mother either wanted to be pregnant later or not at all. Title V recognizes that reproductive health is an integral part of whole person health, and the upstream approach of screening for pregnancy intention can reduce the number of unintended pregnancies. Kansas MCH implemented One Key Question® (OKQ) in 2018 through a partnership with the national team, Power to Decide. Kansas MCH invited representatives from Power to Decide to present three in-person trainings across the state. The trainings prepared practitioners to:

- Ask the One Key Question® and follow the 4-response protocol with fidelity
- Be conversant on contraception, inter-conception, and preconception practices and care
- Clearly articulate referral systems when direct care isn't an option
- Develop and implement a personal practice plan, based on best practices, to integrate One Key Question® into workflow
- Provide all counseling and services in a way that support women's intentions, regardless of the answer in a non-judgmental and unbiased way
- Observe practices consistent with One Key Question® Code of Ethics

Over 100 professionals were trained in February and March 2019, including local MCH, Family Planning, Home Visiting, and WIC staff. In addition, staff from other community organizations (e.g., faith based) attended. These trainings were followed by two open consultation calls (June and July 2019) facilitated by Power to Decide in which newly trained staff had an opportunity to get all their implementation questions answered and discuss best practices and challenges in asking the OKQ. A series of webinars were conducted for the first cohort. Webinar topics were chosen based on the open consultation calls and what technical assistance was needed among trainees. The first webinar "Contraception 101" was held on October 17, 2019, with two more planned for the future.

SFY2019 - Local MCH Agencies Entering Client Level Data in DAISEY				
OKQ	No	Yes	Unsure	Ok either way
Prenatal/Pregnant Woman	2,038	70	166	27
Post-Partum Woman	2,604	45	160	46
Woman	2,179	37	83	30

The one key question (Would you like to become pregnant in the next year?) and responses were built into the shared data system, DAISEY, at the time of launch in anticipation of implementing the intervention. All local MCH programs answer this question and use it to guide follow up and referrals. As part of the OKQ implementation, a new stand-alone form was added to DAISEY specifically for use by the MCH agencies trained on the intervention. Data collected during SFY19 is presented in the table below. Analysis of the data reveals education, services, and referrals that were made for each participant in response to their answer. Staff continuously review the data with local agencies to ensure appropriate follow up.

Long Acting Reversible Contraceptives (LARC): Kansas MCH recognizes that unintended pregnancy is a major public health issue and mistimed, unplanned, or unwanted pregnancies are associated with increased risk of poor health outcomes for mothers and babies. American College of Obstetricians and Gynecologists (ACOG) advocates for increasing access to LARCs as they are the most effective contraceptive method at preventing unintended pregnancies[3], as a part of a prevention solution. For that reason, Kansas MCH has chosen to recommend the use of LARC as a prevention effort to:

- Reduce unintended 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)

To help local Title V and Title X agencies overcome the barriers to providing LARCs, MCH partnered with Title X, Wichita State University Community Engagement Institute, and other local partners to develop a LARC toolkit. The toolkit is available on the KDHE Bureau of Family Health website and includes the following sections: Case for Change, Clinical Indications, Coding and Billing, Community Collaboration, LARC Myths, LARC Resources, and LARC Training Resources.

Online *Lunch and Learn* sessions were offered to provide an in-depth walk through for local agencies through each section of the toolkit, allowing time for a question and answers and group discussion around LARC issues. The first LARC *Lunch and Learn* webinar was held on September 27, 2019. The impact of this work is evident in the rise of LARC implants from 1,483 in calendar year 2018 to 1,666 in calendar year 2019, a 12.3% increase.

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, Kansas MCH has been committed to supporting expansion and sustainability of the KPCC initiative, providing training and technical assistance on community collaborative development and MCH program integration. Kansas MCH 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 in providing implementation technical assistance, educational resources for clients and providers and standardized screening, referral and outcome measurement systems. Integration toolkits, such as the Mental Health 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 (MOD) Becoming a Mom/Comenzando bien® (BaM/Cb) curriculum, has been standardized to ensure program fidelity across communities. An MOU is now required for all sites to gain access to training and programmatic resources. In partnership with the University of Kansas, MCH 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 slides/PowerPoints, lesson plans, activity plans and supplemental handouts; 3) promotional material templates; 4) a private website portal to provide direct access to these resources. All supplements to the MOD curriculum have been translated to Spanish (partnership with the University of Kansas School of Medicine-Wichita, Department of Pediatrics and a workgroup with representation from five Spanish dialects). All the extensive tools and resources have provided the mechanism for statewide expansion and support both growth and future sustainability.

Statewide expansion to include all interested 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 again in SFY19 to encourage statewide implementation utilizing Block Grant resources. KPCCs utilizing the MOD BaM curriculum had expanded to 15 sites by 2018, with an additional site launching in Northwest Kansas in October 2018 and in Southwest Kansas (SWK) in October 2019. Within this timeframe, Lincoln County had been piloting virtual implementation with Saline County and decided to provide sessions live on site despite small numbers. During 2019, focus was centered on strengthening infrastructure to support current and future sites and providing for greater long-term capacity for expansion and sustainability rather than focusing on recruitment or solicitation of other new sites. View a map of existing sites and implementation progress on the KPCC website.

The first regional perinatal community collaborative (launched in SWK) is now operational with four lead sites serving a total of 16 counties. The SWK collaborative has come to be the greatest cross-sector collaborative formed to date, with the region's four leading (and competing) birthing facilities, public health departments, FQHCs, large employers, and other community partners working collaboratively with each other. Partners within this collaborative have worked to develop regional marketing tools, press releases, shared class schedules, and numerous other resources, all 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. Seward County 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. 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. This is the regional collaborative prototype that will be replicated in additional communities in SFY21.

Since inception in 2010, KPCCs have been a driving force behind improved birth outcomes in Kansas. Overall, KPCCs have a lower preterm birth rate than the state (6.7% compared to 9.4%). Attention should also be directed to the reduced Infant Mortality Rate (IMR) per 1,000 live births (5-year average) from pre-implementation to post-implementation in two of

the longest running sites. The Geary County IMR decreased significantly from 11.9 in 2005-2009 to 5.7 in 2014-2018. The Saline County IMR decreased from 9.0 in 2005-2009 to 5.5 in 2014-2018.

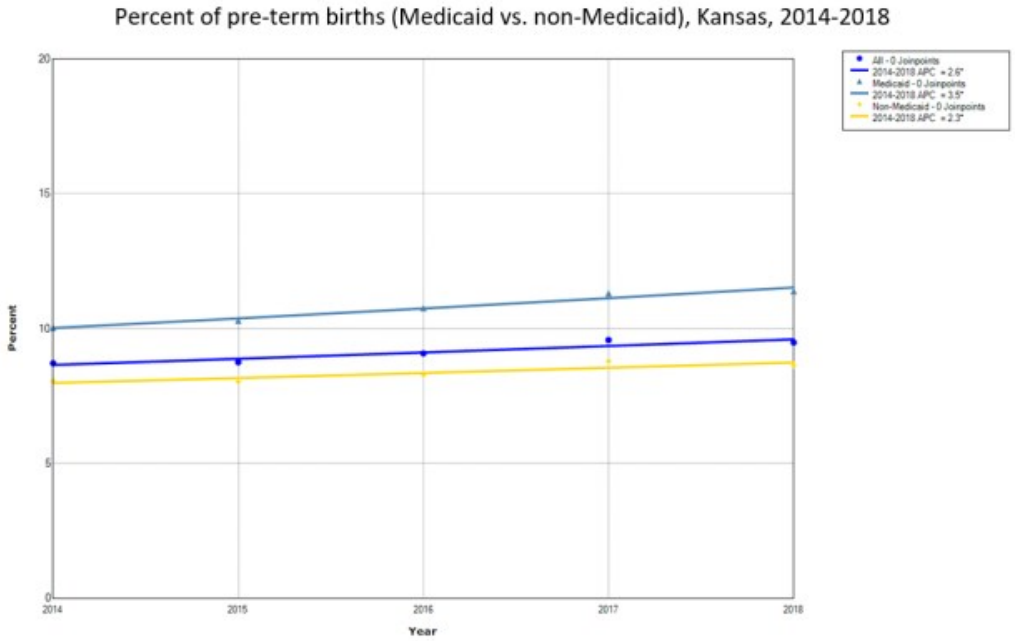
Preterm Birth Rate (<37 Weeks)	All Community Collaboratives[2]	Kansas/State[1]
2016-2018 3-year avg.	6.7%	9.4%

Infant Mortality Rate[1]	Geary Collaborative established July 2012	Saline Collaborative established Jan. 2010
2005-2009	11.9	9.0
2014-2018	5.7	5.5

Sources: [1] KDHE, Bureau of Epidemiology and Public Health Informatics;
[2] 2016-2018 KDHE, Bureau of Family Health

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

The preterm birth rate, those occurring before 37 weeks gestational age, has decreased slightly from 9.6% in 2017 to 9.5% in 2018, although this decrease was not statistically significant. Decreases were seen in preterm births among Hispanic (9.2% in 2018 from 9.3% in 2017) and non-Hispanic blacks (13.3% in 2018 from 14.3% in 2017), and increases were seen for non-Hispanic whites (9.2% in 2018 from 9.1% in 2017). In 2018, the rate for preterm births, was lower in Kansas (9.5%) than the U.S. (10.0%). The overall Kansas prematurity rate in 2018 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 (11.4%) than other non-Medicaid payers (8.6%). This pattern was consistent for 2014-2018. During 2014-2018, the overall preterm birth rate for Kansas showed a significant increase.



*Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Source: KDHE, Bureau of Epidemiology and Public Health Informatics

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 17P + Optum/Alere Health Partnership: Increased use of prophylactic progesterone has been a long-term priority to support reduction of 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. Tracking utilization of 17P among Medicaid-covered pregnant women is difficult due to lack of access to timely data.

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. Partner roles and responsibilities (screen, educate, refer, prescribe, administer, track) were clarified and tools were provided to facilitate activities which included screening and referral tools, a process flow chart, and prenatal education resources including a patient brochure.

There has been ongoing work with Medicaid over the past several years to identify and remedy barriers and policy issues

that impact providers and patients alike. The scope of work has included referrals, policy/reimbursement, and data sharing. 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 late 2018 (FY19), Optum OB Homecare expanded their service area to include Wichita in Sedgwick County and the surrounding communities. Optum is under contract with the KanCare Medicaid MCOs to provide 17P home administration under the guidance of clinical prescribers, but it's still only being offered in two areas of the state (Kansas City and Wichita).

MCH activity around promoting 17P as an intervention to reduce recurring preterm birth has been limited since 2019 considering the evidence appears unclear. A statement from the FDA Advisory Committee on October 29, 2019, informed the committee's recommendation to remove Makena (17P) from the market due to findings that weekly injections of the treatment were ineffective. Kansas MCH is discussing this with local partners as well as the Kansas Chapter of ACOG to see what affect this recommendation will have on the future of 17P administration.

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.). It has become apparent in this reporting period that the tool originally developed is underutilized. In response, state Title V staff worked with partners during this grant period to develop a more comprehensive "perinatal risk assessment" tool that will be aligned across programs to be utilized in BaM, home visitation, and other MCH programs. Please see more about the development progress in the Women/Maternal Plan.

Education targeting preterm labor risk reduction has been a major focus area for collaboratives utilizing the BaM/Cb 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.

Which of the following are signs of preterm labor / labor? (check all that apply)

- Contractions that make your belly tighten up like a fist every 10 minutes or more
- Change in color of your vaginal discharge or bleeding from your vagina
- The feeling that your baby is pushing down
- Low, dull backache
- Belly cramps with or without diarrhea
- Cramps that feel like your period

Table 2: Pre/Post-Intervention Answers to Knowledge Questions (percentage answering correctly)

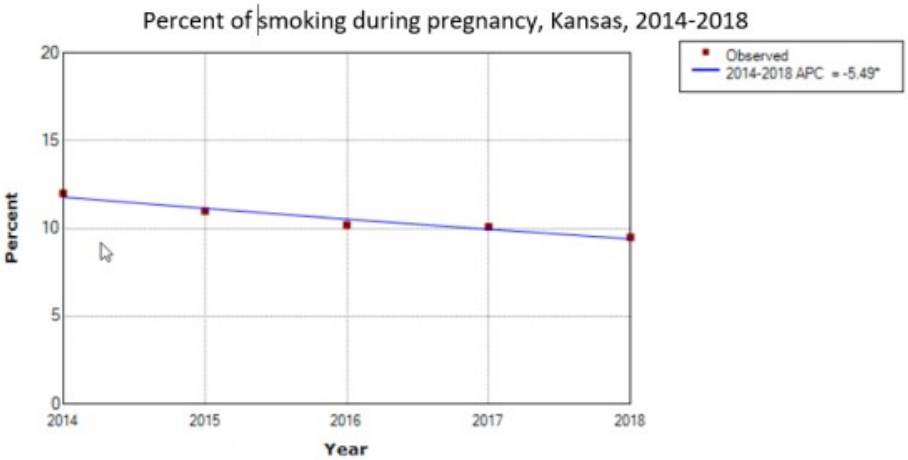
Question	Pre-Survey (%)	Post-Survey (%)
Signs of Preterm Labor		
Contractions	76.2	86.4*
Color of discharge or bleeding	56.8	78.9*
Feeling that baby is pushing down	49.7	78.1*
Backache	45.8	72.1*
Belly cramps	33.8	65.6*
Cramps that feel like your period	47.3	72.4*

While education of BaM/Cb mothers is a critical element of the program, it is also important to recognize the impact of the education on pregnancy outcomes through time. For the BaM/Cb report, several measures are tracked to understand birth outcomes as well as the general health of both the mother and baby at the time of delivery. For the 2018 report, the first linkage of BaM records and vital records was completed for key outcome measures including gestational age, low birth weight, and cesarean deliveries to improve data reporting for mothers giving birth after participation in the BaM/Cb program. The linkage was successful and led to nearly a 50% increase in the possible records available for analysis utilizing those measures. This demonstrates that BaM mothers had a:

- Significantly lower preterm birth rate (4.9%) than for Kansas births in general (9.5%);
- Similar, but slightly improved low birthweight rate (6.9%) compared to Kansas births in general (7.4%); and
- Lower likelihood of cesarean deliveries (27.4%) compared to Kansas births in general (29.7%).

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 2018, 9.5% (3,438) of women reported smoking during pregnancy, a non-significant decrease from 2017 (10.1%). During 2014-2018, there was a statistically significant decreasing trend observed. The smoking rate was highest for non-Hispanic Native American women, at 22.4%, followed by non-Hispanic white women, 11.0%, and non-Hispanic black women, 10.3%. Rates for Hispanic (3.6%) 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 (14.0% and 12.9%, respectively). Smoking rates for women in their thirties and older were sharply lower, around 7%. In 2018, Medicaid paid for the delivery of 11,283 (31.3%) Kansas live births. Among women who reported smoking during pregnancy, 73.0% were deliveries covered by Medicaid. This was a slight increase from 2017 (72.0%).



*Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Source: KDHE, Bureau of Epidemiology and Public Health Informatics

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 2017-2018 National Survey for Children's Health, parents were asked whether anyone in the household used cigarettes, cigars, or pipe tobacco. Overall, 17.9% of Kansas children were reported to live in households where someone smokes. About 19.1% of non-Hispanic white children and 15.4% of Hispanic children lived in households with a smoker. Rates of household smoking decline as income increases. Of children with household incomes below the poverty level 24.8% lived in a household with a smoker, of children with household incomes between 100 and 199 percent of the Federal poverty level (FPL), 20.6% lived with a smoker, of children with household incomes between 200 and 399 percent of FPL, 16.9% lived with a smoker, and of children with household incomes of 400 percent or more of FPL, only 17.1% 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 tobacco cessation. During this reporting period, MCH concentrated on a multi-faceted tobacco cessation campaign which included: multiple evidence-based cessation programs (SCRIPT, Baby & Me Tobacco Free, and the KS Quitline/KanQuit);

- 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): 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 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 the reporting period.

Smoking Cessation & 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. 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. The BFH continued to provide technical assistance as needed throughout the reporting period and will continue to monitor progress. 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 to monitor participation related to implementation and quality improvement.

SFY2019 - Local MCH Agencies Entering Client Level Data in DAISEY	
Smoking Cessation Services	
Counseling	314
BMTF	188
SCRIPT	7
5As/2As & R	48
Other	56

SFY2019 - Local MCH Agencies Entering Client Level Data in DAISEY			
Smoking Cessation	Referrals Made	Referrals Completed	% Completed
BMTF	74	47	64%
Kansas Tobacco Quitline	600	528	88%
SCRIPT	10	3	30%
Other	32	17	53%

E-Cigs & Vaping: As use of electronic cigarettes is on the rise, special efforts have been made to be inclusive of acknowledging such devices in both our screening and educational efforts around tobacco use and cessation. Very early on after brief use of the initial Tobacco Use Survey through MCH programming, the survey was revised to include the question, "Do you use electronic cigarettes or E-cigarettes?" Additionally, when the survey assesses how many cigarettes are smoked per day, clarification is provided by stating "(by cigarette, we would like you to include cigarettes, e-cigarettes, cigars, or cigarillos like black and tans)". The SCRIPT program also includes specific information about E-cigs/vaping. A resource developed by the California Department of Public Health titled "Protect Your Family from E-Cigarettes" has also been included as a patient education resource in the Tobacco Cessation Integration Toolkit. In early October 2019, the Secretary of the Kansas Department of Health and Environment announced KDHE's efforts to fight the E-Cig Vaping epidemic in Kansas. To streamline communication/messaging and ensure staff, partners, and the public have access to the most credible and current information about e-cigarettes/vaping, KDHE launched a website with resources for parents, teens, providers, local health departments, and educators.

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 being adapted for the entire MCH network and will be available via the KDHE website in early FY21. 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 BFH MCH and WIC programs along with the 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 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 (KIDS) Network and the Kansas Breastfeeding Coalition (KBC) 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. A warm referral process has been established whereby KPCC sites can directly enroll women into the Kansas Quitline 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. A Memorandum 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 ensures 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 FY 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 (VON).

The Title V program partnered with the Wichita State University Community Engagement Institute (WSU) throughout 2018-2019, 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. 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 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 October 2019, over 500 subscribers are 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 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 2019, there were a total of 33 birthing centers enrolled with VON; those 33 centers cover more than 85% of all births in the state (see map below). Efforts were expanded during the year to include social workers from the Department for Children and Families 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.

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 met 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 FY21.

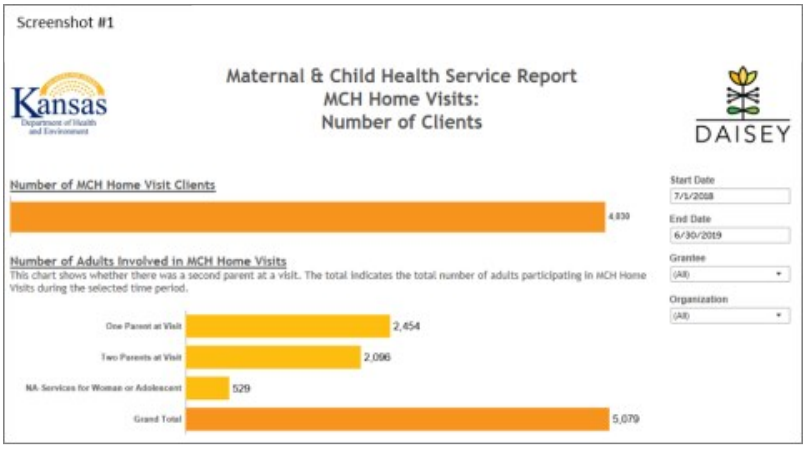
Other Activities Impacting Women & Maternal Health

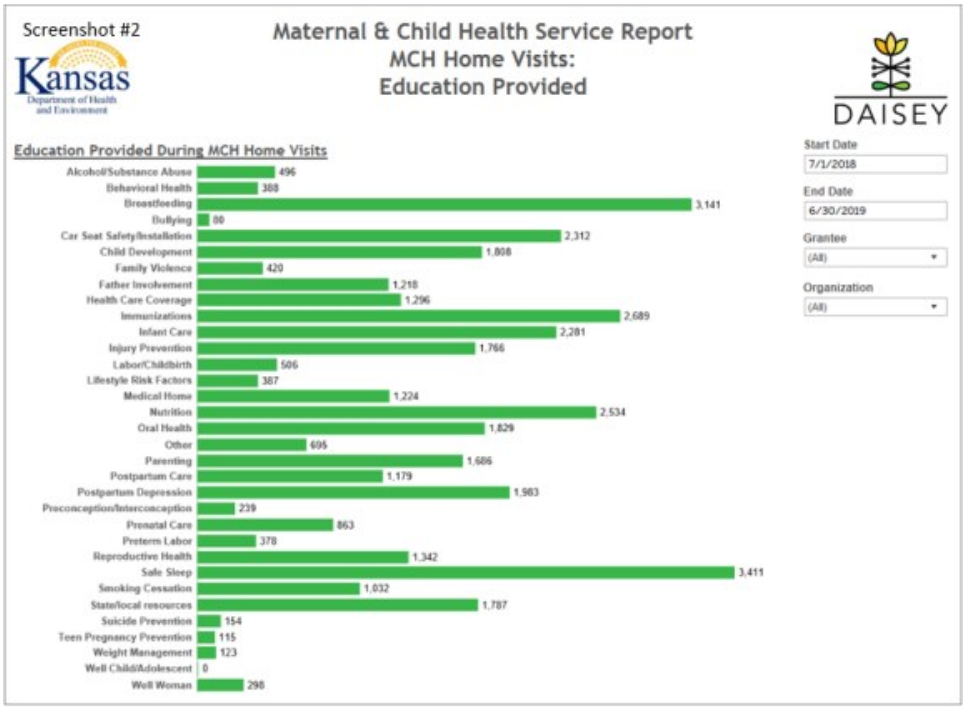
Universal Home Visiting: The MCH Universal Home Visiting program includes protocol and utilization of standard tools for smoking/tobacco, alcohol, substance abuse, and mental health, including perinatal depression. MCH Home Visitors make every effort to ensure that prenatal and postpartum mothers and 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 6,449 visits, reaching 4,030 women (14% inter-conception; 32% pregnant; 54% postpartum) during FY19. 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.

For SFY19, parents were educated on a variety of topics including breastfeeding, safe sleep, infant care, immunizations, etc. (see screenshot #2). There were 432 women who received a home visit that reported they smoked (11%) and 719 reported someone else in the household smokes (18%). A total of 69% of women reported they initiated prenatal care in the 1st trimester (see screenshot #3). Of the total women served in SFY19, 1,818 women-initiated breastfeeding (68%). NOTE: This data reflects information collected from local MCH agencies related to the individuals served and services provided. Results may not be comparable to state data or rates. We regularly monitor data for local MCH agencies in relation to state/local goals and data.

Screenshots from MCH Service Report





MIECHV & MCH Universal Home Visiting Partnership: The MIECHV local 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. 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 the performance measures.

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 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.

Local MCH Agencies: Local Kansas MCH agencies are working to screen mothers for postpartum depression and anxiety in office and during home visits. This recent success story from Jefferson County Health Department revealed the impact of this effort.

"Our home visitor saw a mother two weeks postpartum. This mother was normally a talkative, happy go lucky individual. At this first postpartum visit she was not at all talkative and not smiling. Her Edinburgh Depression screening result was 9. The home visitor discussed depression with the mother, but she denied depression and stated she was just plain tired. After the visit, the longtime boyfriend of the mother followed the home visitor out to her car. He told her that he believed his girlfriend was depressed and he did not know what to do about it. He indicated that she cried all the time and hardly spoke which was not like her at all. Our home visitor gave suggestions of how he could talk to her and encouraged seeking medical care for her immediately. A few weeks later the mother indicated she had gone back to the doctor to discuss depression. She was prescribed Zoloft and her Edinburgh score at this time was 8. One month later she was smiling and acting her cheerful chatty self. Her Edinburgh score was down to a 5. Her boyfriend thanked out home visitor to helping guide them in the right direction and said he had his girlfriend back and the kids had their mother back. The mother was very thankful and had not realized she was depressed and now feels so much better!"

Jefferson County Health Department

Analysis of MCH network DAISEY Edinburgh Data shows significant increases from FY18. Continuing education opportunities for the MCH network is needed to ensure all referrals for behavioral health services are captured, even referrals made directly to PCPs.

SOURCE: DAISEY, October 2018 – October 2019

	FY18	FY19
Total number of Edinburgh Screens entered in DAISEY	2,670	4,661
Total unduplicated count of caregivers who received an EPDS	1,632	2,929
Maternal Depression Screening provided during an MCH Visit	1,595	3,356
Maternal Depression Counseling provided during an MCH Visit	168	2,049

	FY19
Total count of screens indicating the client may be at risk	1,089 (23%)
Total unduplicated count of caregivers with a concerning screen	629 (21%)
Referrals for behavioral health services*	480
Clients accepted behavioral health services	286

**Many local agencies refer women to a primary care physician which may not be reflected in referrals for behavioral health services.*

An additional action plan form has been added to the Edinburgh screening tool in DAISEY, which includes fields for local staff to capture referral and follow-up notes. It is anticipated that these additional fields will assist KDHE staff with tracking referrals on positive screens to improve data quality and evaluation efforts. Additionally, a DAISEY report has been designed and implemented to assist staff with following up on positive Edinburgh screens.

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. In early 2019 this training previously provided in-person, was recorded and is now available online as part of the infrastructure that has been built to support program sustainability long term.

Behavioral Health Investment & Expanded Programming: The 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 investments and the State Action Plan. To elevate coordination and increase effectiveness, 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. Creating the Behavioral Health Consultant position improved coordination with MCH staff and resulted in a messaging or awareness campaign for National Depression Screening Day (10/10/19) on social media through the KS MCH Facebook page.

Title V Maternal Depression Screening (MDS) Workgroup: Title V and other state and local partners came together to form a *Maternal Depression Screening (MDS) Workgroup* in 2018 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, & 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: The Kansas Stillbirth rate increased from 4.4 per 1,000 live births and stillbirths in 2007 to 5.0 per 1,000 live births in 2017. Kansas Vital statics reports that 196 Kansas stillbirths occurred in 2018 which was up from 184 stillbirths in 2017. 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 a call campaign to all providers to verify they received the letter, determine if they had questions, and ask if 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 continues to promote CTK and increase awareness about stillbirth by recognizing October as Stillbirth Awareness Month. In October 2018 the month was recognized with a Proclamation by the Governor of Kansas and stillbirth infographics sent to partners. In October 2019, a stillbirth fact sheet was created and sent to partners which included action

steps providers could take to support stillbirth prevention.

A CTK webinar was launched in October 2019 to re-energize the campaign and recruit additional providers. A series of social media posts were also made to increase awareness and expand reach. Review the posts and find more information on the Kansas MCH website (www.kansasmch.org/countthekicks.asp) and Facebook page (facebook.com/kansasmch).

KS MCH CTK Social Media Posts (Oct. 2019)	
Total Posts	4
Total People Reached	1,853
Total Reactions, Comments, & Shares	59
KS CTK Page Views	18

The statewide initiative has been very successful. From the time of launch in August of 2018 to September 2019, over 190 total orders of free educational materials were made by providers from all corners of the state, equating to 67,030 pieces of educational materials being distributed. Nearly 3,000 Kansans have visited the CTK website seeking more information about kick counting and more than 930 expectant parents have downloaded the free app to track their baby's movements. The introduction of CTK in Kansas has the potential to save 60 babies every year if Kansas' stillbirth rate decreases by 26 percent, which is the result of the campaign in neighboring Iowa. In October 2019, Kansas MCH was introduced to a Kansas Mother who credits CTK for saving her baby's life. The success story was highlighted in the MCH Success Story portion of the narrative and the full story, with video, can be found on the CTK website.

Maternal Mortality Review: The Kansas maternal mortality work launched in 2018 with the passage of HB 2573. The bill amended existing public health law (K.S.A. 65-177) to strengthen efforts related to monitoring maternal morbidity and mortality and established the first Kansas Maternal Mortality Review Committee (KMMRC). The KMMRC held its first meeting in November 2018. As of June 2020, a total of six meetings have been held and cases for 2016, 2017, and 2018 have been completed. The first report will be released by September 2020. Kansas received the Preventing Maternal Deaths: Supporting Maternal Mortality Reviews CDC grant effective September 2019. The grant provides critical support for infrastructure and prevention efforts.

The KMMRC 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 40 members representing diverse backgrounds including obstetrics, anesthesiology, midwives, social service, local public health and law enforcement have committed to serving on the committee. Learn more about the KMMRC and follow progress at https://kmmrc.org/.

[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]2017 PRAMS Surveillance Report. Kansas Department of Health and Environment. April 2019. Available from: http://www.kdheks.gov/prams/downloads/Kansas_PRAMS_2017_Surveillance_Report.pdf

[3]Increasing access to contraceptive implants and intrauterine devices to reduce unintended pregnancy. Committee Opinion No. 642. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e44–8)

Women/Maternal Health - Application Year

PRIORITY 1: Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy

NPM 1: Well-woman visit (Percent of women, ages 18-44, with a past year preventive visit)
SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

Local MCH Reach: Based on SFY2021 MCH Aid-to-Local applications received:

- 58 of 67 grantees (87%) plan to provide services to the Woman & Maternal population
- 33 of 58 grantees serving Woman & Maternal population (57%) plan to provide well-woman services

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NPM 1: Well-woman visit (Percent of women, ages 18-44, with a past year preventive visit)

Objective: Increase the proportion of women receiving a high-quality, comprehensive preventive medical visit.

Title V staff will continue to support the promotion of women receiving a well-woman visit annually, by messaging the importance of local MCH agencies partnering with other community agencies to provide on-site assistance for accessing health care coverage in the preconception and interconception periods. Local grantees either offer direct well-woman preventive care or enabling services by providing resources and referrals for annual well-woman visits. The tag line "Every Woman, Every Time" will ensure that all women are assessed for a well-woman visit and educated on the importance of comprehensive annual preventative care at every visit. Primary strategies to increase the number of women receiving an annual well-woman visit include:

- Providing resources and tools to support local health agencies on educating women about the importance of a high quality, comprehensive annual preventive medical/well-woman visit, assessing for insurance coverage, and assisting women to obtain insurance if needed;
- Providing on-site assistance for accessing health care coverage through certified application counselors or Medicaid eligibility workers to ensure coverage before, during and after pregnancy;
- Utilizing peer and social networks for women, including peer or group education models, to promote and support access to preventive care;
- Providing technical assistance to support local health agencies in developing policies and protocols that incorporate women's goal setting and health screenings to assess for basic needs and health status; and
- Promoting and supporting Medicaid policy change to expand pregnancy coverage through 12 months postpartum and the inclusion of screening for Perinatal Mood and Anxiety Disorders (PMADs) screening as a covered service.

This work will be done in alignment and collaboration with the Title X Family Planning program and other state partners. The importance of women's health and the annual visit will be highlighted at trainings and other events, and associated resources will be distributed at the annual Governor's Public Health Conference, MCH Home Visiting Regional training, and other appropriate venues as well as online through the Kanas MCH website and social media.

Recent activities have focused on the development of a Well-Woman Visit Integrated Toolkit 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. These resources will be expanded in scope to include comprehensive screening guidance and tools as well as technical assistance related to implementation. This will continue to be the primary work for women of reproductive age throughout FY25.

Well-Woman Visit Integration Toolkit: Title V and Title X are collaborating to create a Well-Woman Visit Integration Toolkit. The release is planned for summer 2020. Patient, provider, and community resources will be cited from the American College of Obstetricians and Gynecologists (ACOG), CityMatCH's *Well-woman, Well Communities Initiative*, and Office of Women's Health (guidance from the Women's Preventive Services Initiative will be incorporated).

In addition to these components, there will be supplemental modules added to the toolkit in 2021 that provide in-depth guidance related to:

1. *Comprehensive screening*: A streamlined prescreening tool is being developed by MCH Title V staff, with a launch date of July 2021. Technical assistance (e.g., 1-on-1 support, webinars, group trainings) will be provided to local partners on how to: administer the screening tool; respond appropriately to affirmative responses; conduct interventions; and identify and adequately complete appropriate referrals. This tool will prescreen for several evidence-based full-length screening tools, including:
    - Substance use – Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
    - Tobacco use – ASSIST, Tobacco Use Survey
    - Mental health – Patient Health Questionnaire-9 (PHQ-9) for depression
    - Pregnancy intention – One Key Question (OKQ)
    - Social determinants of health – KDHE Parental Health Screener
    - Intimate partner violence – CUES: Evidence-Based Intervention and Lethality Assessment Program
2. *Violence prevention*: The Centers for Disease Control and Prevention's *Connecting the Dots* violence prevention training will be promoted to local partners and shared via social media and KDHE's online resource library. In addition, one-on-one technical assistance and training will be provided to partners expressing interest in learning more about how they can incorporate violence intervention strategies into their agency, including the CUES: Evidence-based Intervention and the intimate partner Lethality Assessment Program.
3. *Partnerships*: A key component of the toolkit's success will rely on partnerships with allied professionals and community agencies. An additional chapter of the toolkit will focus on educating partner programs about the importance of the well-woman visit, what is included in the visit, resources, etc. Tailored templates for partner programs to distribute to clients will provide an overview of the visit and underscore its importance. Title V staff will conduct a webinar with key programs interested in learning more. Targeted programs include Title X, WIC, PMI, MIECHV and TPTCM.

MCH-led promotional efforts around awareness months and weeks will incorporate messaging related to the importance of the well-woman visit. These awareness events include National Women's Health Week, Minority Health Month, Black Maternal Health Week, and Sexual Assault and Domestic Violence Awareness Month. In 2021, during National Women's Health Week, the statewide media campaign *"Past the Pap…Why an annual preventative visit is more than a pap smear!"* will be introduced. 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 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.

Peer & Social Networks: Title V staff will continue to support pregnant and new mothers through the Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom (BaM). This program allows mothers to connect with one another during this important time and share lived experiences in an authentic and supportive environment. Plans to extend the program past birth are underway, which will provide an opportunity for mothers to share birth stories as well as postpartum struggles – reinforcing a network that can reduce isolation and promote healing and resilience. For women not participating in BaM, Title V staff will vet and promote secure and safe peer support options through social media, training and marketing including those offered through Postpartum Support International (PSI). Title V will also pursue the possibility of adding this as a target population for Supporting You.

Medicaid Policy Improvements: In 2019, KDHE and partners convened to engaged in the Center for the Study of Social

Policy's (CSSP) Pediatrics Supporting Parents (PSP) project. The goal of PSP is to explore transformation possibilities in pediatric primary care to promote the social and emotional well-being of young children, the parent-child relationship, and parent mental health. CSSP and Manatt Health developed a set of actionable strategies that can be used to leverage Medicaid to foster social and emotional development through pediatric primary care, *Blueprint for Using Medicaid to Finance Changes in Pediatric Care*.

The Kansas PSP Workgroup, including public health, Medicaid, child welfare, behavioral health, pediatrics, family members, and philanthropic organizations, convened to identify gaps and discuss opportunities to improve health outcomes. The Workgroup's first priority was a policy change allowing for maternal depression screenings (MDS) to be a covered service under the child's Medicaid plan and allowable in pediatric care settings. The Workgroup drafted an impact paper highlighting the prevalence of maternal depression, impact on child development, financial impact of untreated maternal depression, national recommendations for standard of care and practice, the role of Medicaid in screening and treatment, and made eight recommendations for Kansas Medicaid's consideration. They also drafted an MDS policy to establish a payment policy for health care professionals who are Medicaid providers conducting MDS and treatment for the benefit of the Medicaid beneficiaries in Kansas. Approval of this policy further supports the BFH's guidance to local health agencies to follow American Academy of Pediatrics (AAP)/Bright Futures Guidelines, which includes MDS during well-child visits.

The recommendations and proposed policy are pending Kansas Medicaid leaders' review. If approved, MCH will support implementation by assisting with any necessary guidance to providers, as well as in the development of training materials. The Mental Health Integration Toolkit and Well-woman Integration Toolkit will be updated to reflect this work. The Workgroup will then transition to other identified priorities, including but not limited to: expansion of Medicaid provider requirements to include Home Visitors (and allow for HV to bill Medicaid for MDS they are already doing), expansion of Medicaid pregnancy coverage from 60-days to 12-months postpartum, and enhancing the MDS policy to include all caregivers (e.g., fathers, grandparents, foster parents).

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 BaM® 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 (RLP) completed by each woman participating in BaM, and greater familiarity with the OKQ initiative. More information on the RLP can be found in a later section.

Once development of the RLP workbook 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 RLP to their provider for discussion during the remainder of their prenatal care and their postpartum check-up. Additionally, during session six of the BaM 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.

Local MCH Agencies: In addition to the Title V proposed strategies outlined previously, local MCH grantee agencies have proposed community-specific approaches to promoting well-woman visits. Some examples include:

- Community Health Center of Southeast Kansas staff plan to work closely with all Kansas Managed Care Organizations (MCOs) incentive programs to maximize the services available, while also working with local foundations to offer incentives for women to access preventative care. The well-woman exam will be incorporated into each participant's individual goals, be available at no "out of pocket" cost and include transportation to the appointment.

- Crawford County plans to increase the number of new patients and clients receiving preventative care by creating an informational flyer/brochure on the importance of annual well-woman visits. Flyers will be mailed to clients one month prior to their visit date and the MCH Navigator will assist with calling patients before their scheduled exam to remind them of their appointment. The flyer will be given to women visiting the health department for services and will be available in the waiting room.
- Wyandotte County will provide comprehensive care during annual well-woman exams. All staff (nurse practitioner, registered nurse, licensed social worker, public health educator) will be provided detailed training on all the components American College of Obstetricians and Gynecologists (ACOG) annual well-woman examination guidelines. Staff will be trained on implementing the evidence-based Smoking Cessation and Reduction in Pregnancy Treatment Program (SCRIPT). The Screening, Brief Intervention and Referral to Treatment (SBIRT) process has been implemented into the Sexually Transmitted Infection Clinic and will be implemented into all prenatal care and well-woman exams.

Objective: Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period.

KDHE BFH was awarded the HRSA *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement* funding in October 2018. 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. Read more about this project in the Cross-Cutting Report narrative.

KCC will continue to work to increase statewide access, using a regional phased approach, to screening, assessment, and treatment for maternal depression, anxiety, and substance use disorders. While grant activities will be focused in the SE KS region for the first 3 years of the award (10/2018 – 09/2021), all resources and capacity building opportunities have and will continue to be made available to the statewide MCH network.

Perinatal Provider Consultation Line: A dually-licensed mental health and substance use clinician, with training in perinatal behavioral health, is available weekdays from 8 a.m. to 5 p.m. to assist providers with their perinatal behavioral health questions. Consultation Line staff can help with diagnosis, medication, treatment, patient resources, identifying local referral options, and connecting the calling provider with a clinical psychiatrist for case consultations.

Provider Consultation Line Postcard

Telehealth Assessment & Treatment Services: In partnership with CKF Addiction Treatment, telepsychiatry assessments,

substance use addiction and treatment services are made available to perinatal women. CKF uses technology to complete substance use assessments, provide therapeutic individual services, and facilitate treatment groups to perinatal women regardless of her geographic location in the state or ability to pay.

Peer Support Groups: In partnership with Wichita State University's Community Engagement Institute (CEI), health care practitioners/organizations and interested groups can receive support in the development of peer support groups within their community. CEI manages the Kansas Support Groups website. Individuals can search for support groups by type of group and/or location of group meetings. Support groups can register on the site, so individuals can find and participate in their groups. CEI recently joined the Southeast Kansas IRIS Community; providers can refer patients to CEI who can help identify support groups in their area, as well as help establish groups, if that is the request.

Screening App Feasibility Study: KCC will be conducting a perinatal behavioral health screening app feasibility study. Identifying needs is a critical first step to connecting individuals and families with appropriate services. Common perceived barriers include limited time during the patient visit, lack of knowledge and training, fearing negative patient reactions, and feeling uncomfortable discussing substance use. A screening app makes reliable, validated screening tools available to the general public, overcoming some of these barriers and empowering individuals and families to engage in the process of identifying and understanding their own needs. A questionnaire will be sent out to gain consumer input.

Integration Toolkits: KCC and Title V will continue to promote the Perinatal Mental Health Integration and SBIRT Toolkits. These valuable resources are still underutilized and MCH, KCC, KPQC, and other interest groups will focus on promotion during this grant year. Promotional flyers were developed to aid in this effort. These can be found in Supporting Documents.

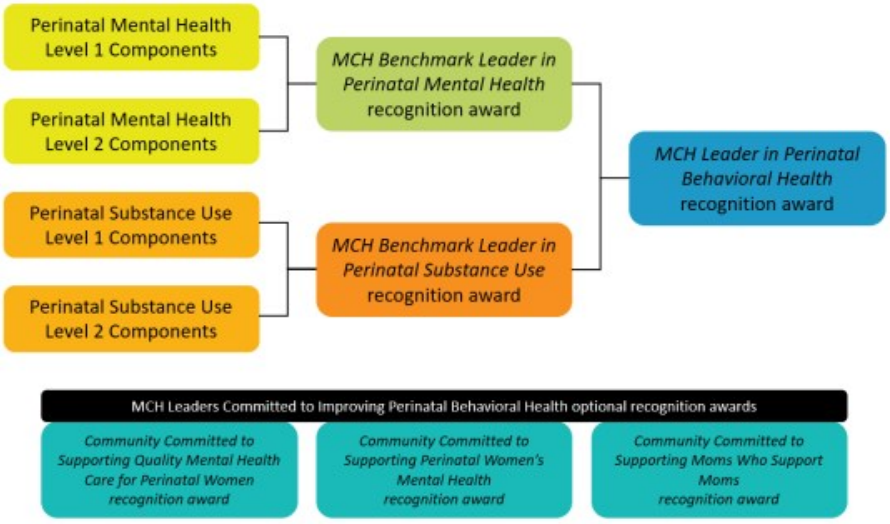
KCC Trainings: Several training opportunities will be made available in the coming year.

- *Postpartum Support International's (PSI) Frontline Provider Training*. This webinar-style training is designed to equip frontline healthcare providers with the skills necessary to assess patients for perinatal mental health complications and provide treatment with medication or connect individuals with additional resources and care. The training will be made available to 80 participants (e.g., nurses, family practice physicians, physician assistants) in September 2020. Following completion of the PSI webinar trainings, participants can engage in a peer-to-peer learning opportunity facilitated by PSI Kansas staff.
- *Every Mom Thrives! Regional Training Event*. This free training focuses on building skills to implement mental health and substance use screening, referral, and treatment support into participants' organizations. Designed for everyone who works with perinatal women including medical providers, public health, administrative staff, and social workers and is facilitated by Melissa Hoffman, DNP, APRN, PMHNP-BC, and Christina Boyd, LSCSW, LCAC. There have been two trainings to date, with a third being planned for FFY2021.
- *KCC Project ECHO Series*. Through partnership with the KU Medical Center, KCC offered training and case-based learning using the Project Extension for Community Healthcare Outcomes (ECHO). Utilizing video-conferencing technology for collaborative education, participants can hear form experts as mentors and share their expertise across a virtual network, linking interdisciplinary specialty team with multiple primary care clinicians. The model has proven to help provide better access for patients in rural and underserved communities, reduce treatment disparities, and promote consistency in care and practice. The KCC Project ECHO Series includes four one-hour sessions on various topics related to perinatal behavioral health. The third KCC Project ECHO Series will be held in Spring 2021.

- *Screening, Brief Intervention, and Referral to Treatment (SBIRT) Online Learning Collaborative*. As a process that can effectively identify risk and intervention of substance use, the BFH is promoting SBIRT and encouraging other to apply this same model to any behavior risk, including perinatal mood and anxiety disorders. The first "Implementing SBIRT into Practice in Communities across Kansas" training series will be held June 2020. The online learning series will provide instruction over six weeks and will include content related to utilization and implementation of SBIRT services. This will be an interactive learning environment with opportunity for questions, interaction, and networking with others in the state. Participants will be exposed to strategies to reduce stigma related to substance use; introduced to the components of SBIRT and creative ways to leverage technology in the administration of these services; and provided strategies for implementing SBIRT with patients. Future online learning collaboratives will be planned based on participant's feedback from this first training series.

Communities Supporting Perinatal Behavioral Health Community Collaborative: There is great interest in the expansion of KCC, and BFH is seeing a demand for additional perinatal behavioral health trainings from local MCH programs. To meet this need, BFH will facilitate a Community Collaborative from July 2020-June 2021, to provide an opportunity for five local MCH agencies to partner with the BFH to receive targeted technical assistance and 1:1 guidance to obtain recognition as a Community Supporting Perinatal Behavioral Health. The goal is for MCH agencies to implement perinatal behavioral health screenings, brief interventions, and referrals to treatment into clinical practice that meets both benchmark standards. Once a participant completes both benchmarks, they will be recognized as an "MCH Leader in Perinatal Behavioral Health" for communities supporting perinatal behavioral health.

Framework for the Community Collaborative & Recognition Awards



Addressing perinatal behavioral health and improving health outcomes is much grander than screening. BFH developed a list of components to serve as guidance for local agencies to enhance their programs. Becoming an "MCH Benchmark Leader in Perinatal Mental Health," includes screenings, brief interventions, and referrals to treatment for perinatal mood and anxiety disorders. Similarly, becoming an *MCH Benchmark Leader in Perinatal Substance Use* requires implementation of perinatal substance use screenings, brief interventions, and referrals to treatment, as well as level 1 and level 2 components.

Paternal Postpartum Depression (PPD): Perinatal depression affects about 1:7 women (14.7% according to the 2018 Kansas PRAMS Surveillance Report); however, many are surprised to learn that 10% of dads experience PPD, and prevalence can increase up to 50% when the mother is also experiencing perinatal depression. A 2005 study found that depression in fathers during the postnatal period was associated with adverse emotional and behavioral outcomes in children aged 3.5 years, and an increased risk of conduct problems in boys; these effects remained even after controlling

for maternal and paternal depression (Ramchandani, et al.). While more research is needed to determine the full impact of paternal depression on child development, it is reasonable to conclude there would be an adverse impact.

It is important for providers to understand the symptom and onset differences between paternal and maternal depression to increase identification and early interventions. For example, women endorse 4 symptoms at significantly greater rates than men: stress, crying, sleep problems, and loss of interest or pleasure in things they usually enjoy; men endorse anger attacks/aggression, substance abuse, and risk-taking behavior due to depressive symptoms at significantly higher rates than woman. Preliminary research suggests that the onset of paternal depression occurs much later in the postpartum period than maternal depression. In fact, findings suggest the rate decreases from birth to 6-weeks post-delivery, but then steadily increases throughout the postpartum period. As with maternal depression, paternal depression is a treatable condition and men do recover. Therefore, clinicians are encouraged to screen for depression in fathers, particularly during the first year postpartum, as early identification, intervention, and treatment can improve the quality of life for the father and family, as well as decrease the risk for emotional and behavioral problems in his children (Scarff, May 2019).

BFH developed a Paternal PPD Package that will be used in conjunction with the Perinatal Mental Health Integration Toolkit. BFH promoted this in recognition of International Father's Mental Health Awareness Day (June 22, 2020). Contents will be used to increase provider awareness about the prevalence of paternal PPD, educate about the symptoms and how they differ from perinatal depression, serve as guidance for implementing paternal screenings into their clinic workflow, and offer programming considerations. The toolkit includes resources for fathers who might be experiencing PPD. An infographic was created for fathers to help increase awareness and offer guidance on how and where to access treatment services and supports. The infographic is currently being reviewed by Geared Up Dads, a fatherhood initiative in Geary County. Consumer feedback will be used to make necessary changes before making the resource available to all local MCH agencies.

Local MCH Agencies: Many MCH agencies provide PMAD screenings during visits with pregnant and/or postpartum women using the Edinburgh Postnatal Depression Scale (EPDS). Case managers from the Pregnancy Maintenance Initiative (PMI) and the Teen Pregnancy Targeted Case Management (TPTCM) will screen clients using the EPDS to help identify woman experiencing or at-risk of experiencing PMADs. Several MCH agencies are taking advantage of technical assistance to create innovative ways to screen more women by implementing screenings during infant immunization appointments.

- Coffey County will provide the EPDS on all 2, 4, 6, & 12-month immunization appointments and make referrals as needed. They continue meeting with the Mental Health Collaborative Resource Team to improve access to care. MCH staff will meet with local primary care providers to discuss postnatal depression and the screening tool, in hopes that they will implement them at their agencies.
- Delivering Change will screen all clients, at a minimum, twice during the antepartum period and twice during the postpartum period for utilizing the EPDS.
- Dickinson County prenatal education clients will be screened for PMAD using the EPDS during sessions 3 and 6 as well as postpartum. All clients with positive screens are referred to a community mental health center (CMHC) and/or their primary care physician for further evaluation and care.
- Hamilton County utilizes the MCH Home Visitor who uses the EPDS at every home/clinic visit for both prenatal and postpartum women. The home visitor provides educational materials that address substance use during pregnancy and within the household. MCH staff provide clients with educational materials that address nutrition, good health hygiene, dental care, sleep practices, and having a medical home.
- Nemaha County Community Health Services has a PMAD Screening Policy that assures the MCH nurse universally screens every pregnant and postpartum woman (through one-year post-delivery) served using the EPDS. Repeat screening is administered according to the policy, as the client remains engaged in MCH Services, WIC, and/or the Breastfeeding Clinic. The EPDS is recorded in DAISEY and documents referrals on all positive screens. A referral is made to the client's primary health care provider or CMHC. The MCH nurse follows up by phone call to the client and if needed, the health care provider. MCH staff work with providers and agencies across the community to ensure an adequate system of care is in place. Staff also provide educational resources on PMAD and information on available

mental health services to every pregnant and postpartum woman served by the agency.

- Wichita Children's Home, who provides residential maternity care to pregnant and parenting teens to give them and their babies a healthy start and will screen PMI/TPTCM clients for mental health and substance use. Program staff are trained in trauma informed care to provide trauma sensitive direct care services. A biopsychosocial assessment is completed for each client and referrals are made according to identified needs.

Objective: Increase the proportion of high-risk pregnant women and mothers receiving prenatal education and support services through perinatal community collaboratives.

KPCC/BaM: As mentioned in the Women/Maternal report narrative, resources for regional and statewide implementation of KPCCs utilizing the MODs BaM curriculum have been under development over the past several years to ensure both growth and sustainability of the initiative. Phase 2 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. This will allow interested communities to explore the initiative and engage in conversations with community partners on their own timeline, utilizing TA resources provided online. This approach is hoped to better meet the needs of local communities who are interested in enhancing perinatal services, while reducing burden on Title V staff, which will improve expansion and sustainability efforts long term.

Revisions to the private BaM website are ongoing, intended to provide additional training and implementation resources for communities once they are ready to begin implementation. Enhancements to the resources include online training webinars for program coordinators and group facilitators. These resources will continue to be expanded upon as additional technical assistance needs are identified. Additional training webinars will also be developed as new integration toolkits are made available. Promotional material templates will also be expanded to include materials for provider outreach, as well as additional "getting started" resources and 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.

Conversations continue with clinical service providers in rural southwest Kansas to identify local issues and needs for the region around the KPCC model and BaM implementation. 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. Continued conversations with local stakeholders are planned for early FFY21.

A KPCC infographic was developed to aid communication and recruitment, planned for the coming years, for new communities among existing MCH local grantees to showcase the impact of the KPCC model and BaM programming in existing communities.

KDHE's Title V commitment to this model is greater than just increasing the number of KPCC who implement the BaM program, as our updated objective hopefully demonstrates. Rather than a primary focus on expansion of the model indicated by the number of sites, it is our desire to strengthen the model, targeting and reaching a greater disparity population, and integrating additional services and support mechanisms for populations at greatest risk. Plans for this work are in early stages but will focus on targeted outreach and potential funding opportunities for sites who develop disparity specific marketing and implementation plans that will engage these high-risk populations to a greater degree than have historically been reached. Additionally, work is already in progress to develop a postpartum session as an add-on to the already existing BaM prenatal education series, creating an additional touch-point opportunity following the birth of the baby. This will provide an environment of support for these new families, while giving a booster dose of education on several postpartum and infant care topics as well as infant development, creating an opportunity for very real conversations with parents that hopefully will begin to identify and address the real barriers to healthy maternal and infant care behaviors (e.g., safe sleep practices, breastfeeding, postpartum/inter-conception self-care activities).

Objective: Increase the proportion of women receiving pregnancy intention screening as part of preconception and inter-conception services.

According to the 2020 Title V MCH Needs Assessment community survey, approximately 44% of women said that reproductive health and family planning access was a concern. Title V will continue, and expand, work related to pregnancy intention through the following strategies:

- Increase consumer/family and provider awareness about the importance of preconception and inter-conception care, counseling/planning, and pregnancy intention screening by utilizing social media, infographics, data briefs, and partner networks.
- Provide resources and education specific to preconception and inter-conception care to providers in support of quality services and comprehensive visits during these critical periods.
- Increase the number of local health agencies utilizing evidence-based pregnancy interventions including One Key Question, support implementation into practice through virtual skills building sessions and increase provider capacity to implement pregnancy intention screening into their practice.

Local MCH Agencies: PMI/TPTCM Case managers will assure clients have access to holistic services and supports through coordinated and comprehensive care, include preconception and inter-conception care. They will utilize external partnerships and internal agency programs to help clients access any service that promotes healthy, full-term pregnancies. In addition, one of the common goals among all SFY21 grantees is to help clients increase self-sufficiency and reduce negative outcomes. Participants will receive assistance to set personal and professional goals according to the eight life domains: empowerment, key relationships, health, daily living, financial, parenting, education/training and employment. All PMI/TPTCM participants will receive RLP education, to support family stability through completion of basic education, vocational, and health goals prior to subsequent pregnancies.

- Unified Government of Wyandotte County plans to utilize OKQ to track pregnancy intent of all TPTCM enrolled clients. Each client will complete a birth plan. Medically accurate education will be used by providing and counseling each client with a contraception handout from Reproductive Access. A contraception kit will be used as a hands-on tool to demonstrate each method to clients.
- Barton County Health Department will provide annual training on OKQ to their staff and refer TPTCM clients to contraceptive services provided by family planning programs, OB-GYNs, or other health care providers. One of the goals is to discuss and implement OKQ with each intake and review semi-annually for each TPTCM participant.

Reproductive Life Plan (RLP) Workbook: The development of an RLP Workbook is ongoing. 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 RLP workbook for use across agencies and sectors of the health care system in our state. The workbook consists of the following sections:

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

The workbook is being designed with the intention of using the tool in a variety of settings where providers have varying degrees of opportunity to work through the workbook with a woman. For example, a case management or home visitation service provider 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 medical or Title X clinic. Use of the workbook can be customized by each type of service provider but does provide 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 workbook has been tested in a variety of settings including physician offices, safety net clinics, home visiting with parent educators, health department clinics, peer to peer conversations, and a barber shop. The responses were overwhelmingly positive, with an appreciation of the contraceptive devices and effective rates, space to plan/think/take notes, and the reflections on health. Some constructive feedback included: the length of the booklet, the number of notes pages, pictures do not reflect all populations intended or served, and there is nothing about the men/fathers in the woman's life. Work will continue in the upcoming year to finalize the workbook and create training and technical assistance for local MCH agencies wishing to incorporate the workbook into their practice.

Preconception Guide: In collaboration with the Bureau of Disease Control & Prevention, Title V staff created a *Prenatal Syphilis Screening, Staging, Treatment, and Monitoring for Congenital Syphilis* guide for women's health providers. This resource provides clinical guidance related to screening before and during pregnancy along with information about what questions should be asked of the patient related to their pregnancy intention. The guide will be shared and promoted to all local partners throughout the plan period and included as part of the Well-Woman Toolkit.

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, including continued implementation of the LARC Integration Toolkit (described in more detail in the Women/Maternal Report narrative). There are 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.

Title V plans to host LARC "lunch and learn" online events where organizations can call in for a short didactic session about a specific LARC topic (e.g., LARC myths, educating about LARCs) followed by a Q&A session where participants can discuss LARC cases and get expert and peer advice. Title V and Title X have offered three such programs to date and 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.

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 Power to Decide**,** in partnership with Title V and Title X clinics. Title V is currently working with Power to Decide to be the first state to pilot their online training module which will enable ongoing learning and growth of the program despite current restrictions on meetings and conferences. In addition, the online format will increase the number of potential attendees significantly, allowing for the inclusion of additional community partners and service providers. The goal is to pilot the online curriculum in the summer of 2020 and rollout full cohort implementation by fall 2020.

Other Women/Maternal Activities

Count the Kicks® (CTK) Stillbirth Prevention Initiative: Title V will continue the formal partnership with Healthy Birth Day to continue the CTK campaign to prevent stillbirth through provider and patient education around monitoring fetal movements during the 3rd trimester of pregnancy. This will continue to be provided across the state 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 build on the momentum of the CTK campaign through social media and sharing data and information with the MCH network. A new mailing will go out to all providers in counties with high still birth rates to promote CTKs and sharing the impactful story of a Kansas mom, Deanna Cummings, who saved her baby with CTK. In the upcoming year, a CTKs webinar targeted at midwives and doulas in Kansas will be offered and a new CTKs magnet will be added to the list of educational materials that Kansas providers can order for free. Stillbirth Awareness Month (October 2020) will provide opportunity to encourage local MCH agencies to spread awareness in their communities and encourage

moms to count kicks. Learn more about CTK, view materials, and access Deanna's story online at: http://www.kansasmch.org/countthekicks.asp.

Perinatal/Infant Health

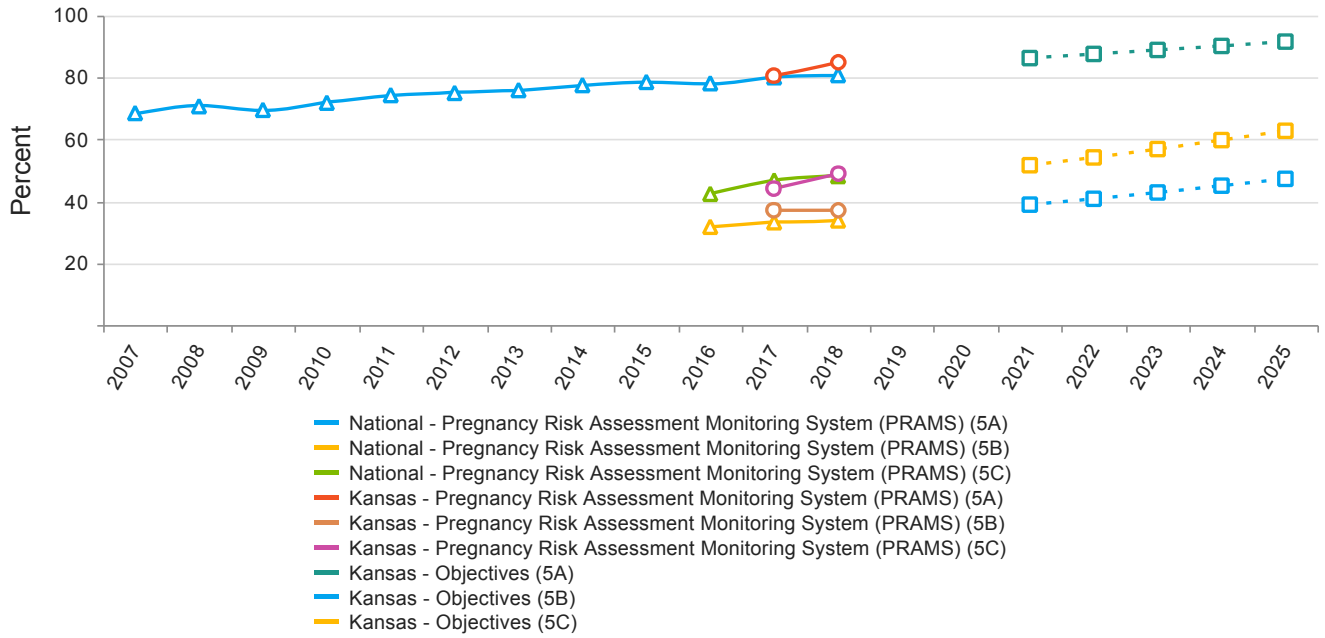
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	6.0	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.8	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	104.1	NPM 4 NPM 5

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	84.8
Numerator	28,021
Denominator	33,030
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	86.1	87.4	88.7	90.0	91.4

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	37.0
Numerator	11,666
Denominator	31,547
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	38.9	40.8	42.8	45.0	47.2

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	49.1
Numerator	15,627
Denominator	31,810
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	51.6	54.1	56.8	59.7	62.7

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	93.3
Numerator	223
Denominator	239
Data Source	DAISEY
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	94.2	95.2	96.1	97.1	98.1

ESM 5.2 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (B) in a crib/bassinet or portable crib

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	89.5
Numerator	214
Denominator	239
Data Source	DAISEY
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	91.3	93.1	95.0	96.9	98.8

State Performance Measures

SPM 2 - Percent of infants breastfed exclusively through 6 months

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	31.4
Numerator	10,404
Denominator	33,125
Data Source	NIS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	32.2	33.0	33.8	34.7	35.5

State Action Plan Table

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

Priority Need

All infants and families have support from strong community systems to optimize infant health and well-being.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Promote and support safe sleep practices and cross-sector initiatives to reduce the SUID rate by 10% by 2025.

Strategies

Provide technical assistance to Safe Sleep Instructors to ensure consistent messaging across the state and continuity of supports in partnership with the Kansas Infant Death and SIDS (KIDS) Network of Kansas.

Align and strengthen safe sleep education in partnership with the KIDS Network of Kansas through professional trainings and resources offered to local MCH agencies, Home Visiting programs, hospitals, and provider offices to support safe sleep practices and accurate, consistent safe sleep messages.

Partner with local coalitions and community organizations leading efforts to support safe sleep, breastfeeding, and tobacco use prevention to provide direct education and referrals to families at high risk for adverse outcomes through Community Baby Showers.

Assist local MCH service providers in creating opportunities for real conversations with parents and caregivers identifying true barriers to implementing safe sleep practices.

ESMs	Status
ESM 5.1 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs	Active
ESM 5.2 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (B) in a crib/bassinet or portable crib	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

All infants and families have support from strong community systems to optimize infant health and well-being.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Implement at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC) by 2025.

Strategies

Promote consumer awareness of maternal morbidity and mortality risk factors and the importance of perinatal risk screenings (e.g., chronic disease, substance use, mental health, IPV, prior high-risk pregnancy, pregnancy intention) and health interventions through social media campaigns, public awareness events, and dedicated community engagement efforts in partnership with local MCH programs.

Increase provider knowledge of the importance of perinatal risk screening, brief interventions, and referrals for treatment through integration toolkits, action alerts, webinars, in-person grand rounds, lunch and learns, and other approaches.

Identify and/or develop resources for cross-sector implementation aimed at reduction of preventable causes of maternal mortality based on Kansas Maternal Mortality Review Committee findings and recommendations.

Enroll as a participating state in the national Alliance for Innovation on Maternal Health (AIM) initiative and adopt one or more patient safety bundles for statewide implementation in appropriate setting(s).

Include Neonatal Abstinence Syndrome (NAS) as a reportable birth defect and build surveillance protocols to supplement community prevention and referral activities.

ESMs	Status
ESM 5.1 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs	Active
ESM 5.2 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (B) in a crib/bassinet or portable crib	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 3

Priority Need

All infants and families have support from strong community systems to optimize infant health and well-being.

SPM

SPM 2 - Percent of infants breastfed exclusively through 6 months

Objectives

Promote and support cross-sector breastfeeding policies, practices, and environments to increase exclusive breastfeeding rates at 6 months by 1.5% annually through 2025.

Strategies

Increase access to lactation support by African American providers such as breastfeeding peer counselors, doulas, International Board-Certified Lactation Consultants, and Certified Lactation Counselors that represent high-risk populations.

Support the implementation of community-centered, culturally relevant mother-to-mother, father, and grandparent breastfeeding support clubs for African Americans (e.g., Black Breastfeeding Clubs, Brown Baby Brigade, BSTARS, Reach our Brothers Everywhere (ROBE), Fathers Uplift, Grandmothers Tea Project).

Broaden the establishment of breastfeeding coalitions for African Americans that connect health care providers and the community to local information and resources, in partnership with the Kansas Breastfeeding Coalition (KBC) (e.g., African-American Breastfeeding Coalition of Wyandotte County).

Increase access for families to strong community breastfeeding education, supports and practices in cross-sector settings through collaboration with key community and state partners (e.g., Becoming a Mom, referrals to WIC and breastfeeding support and education, including the expansion of WIC Breastfeeding Peer Counseling, shared messaging through WIC and Home Visiting programs, hospitals, and provider offices, “Breastfeeding Welcome Here” initiatives, education about behavioral health and breastfeeding).

State Action Plan Table (Kansas) - Perinatal/Infant Health - Entry 4

Priority Need

All infants and families have support from strong community systems to optimize infant health and well-being.

SPM

SPM 2 - Percent of infants breastfed exclusively through 6 months

Objectives

Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services by 15% by 2025.

Strategies

Conduct a complete review of the MCH Universal Home Visiting program model as part of Kansas home visiting network and implement enhancements as necessary to assure all families across the state have access to crucial assessment, screening, and referral services.

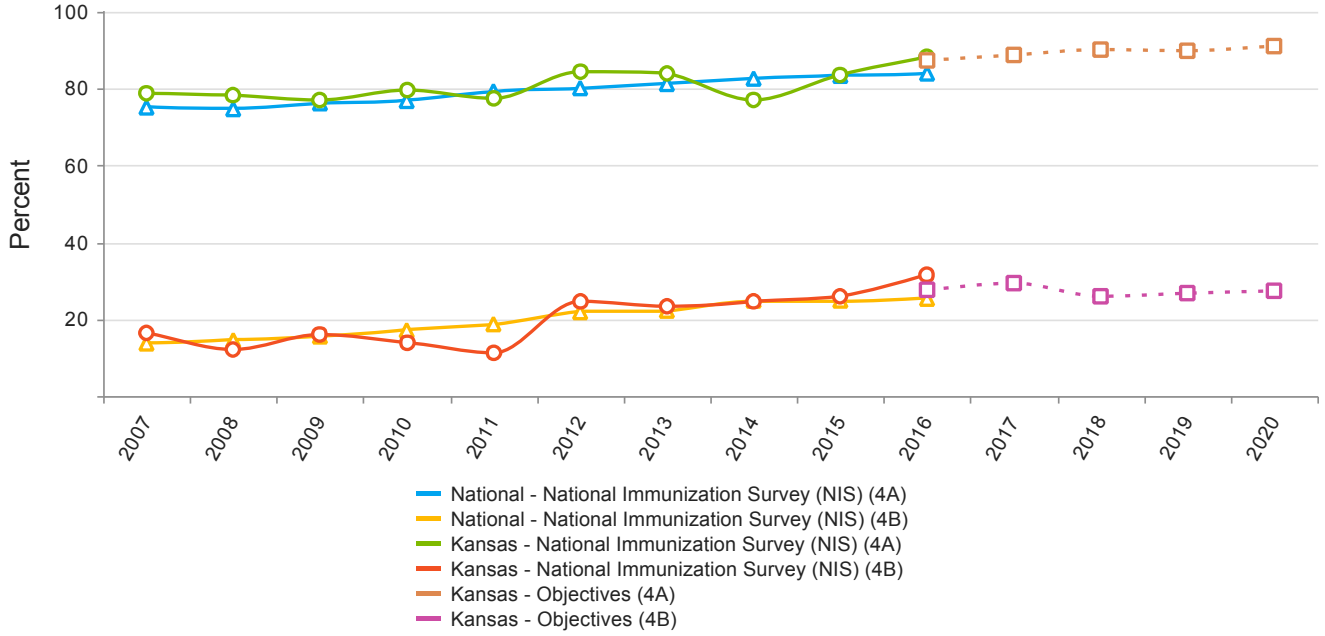
Establish and increase consumer/family and provider awareness about the importance of home visitation supports and impact on family and infant outcomes to increase referrals and number of families receiving support through MCH Universal Home Visiting programs.

Assure that MCH Universal Home Visiting programs can serve as an information source and connection point in communities to support safe, stable, nurturing relationships/environments and positive outcomes for infants and families, in alignment with All in for Kansas Kids initiative.

Incorporate family strengthening and parent training/support skills building sessions into MCH Universal Home Visiting standardized curriculum.

2016-2020: National Performance Measures

2016-2020: NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	87.2	88.6	90	89.7
Annual Indicator	83.8	77.1	83.6	88.0
Numerator	32,783	29,183	30,314	29,928
Denominator	39,126	37,866	36,276	34,017
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

State Provided Data				
	2016	2017	2018	2019
Annual Objective	87.2	88.6	90	89.7
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	

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	27.7	29.4	26	26.8
Annual Indicator	23.4	24.5	26.1	31.4
Numerator	9,025	9,095	9,159	10,404
Denominator	38,643	37,166	35,100	33,125
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**	**2019**
Annual Objective		22.5	15	17.5
Annual Indicator	14.1	13.9	13.7	13.1
Numerator	943	990	966	1,319
Denominator	6,671	7,121	7,075	10,035
Data Source	KWIC	KWIC	KWIC	KWIC
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			55	100
Annual Indicator	36	50	93	76
Numerator				
Denominator				
Data Source	KIDS Network	KIDS Network	KIDS Network	KIDS Network
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

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

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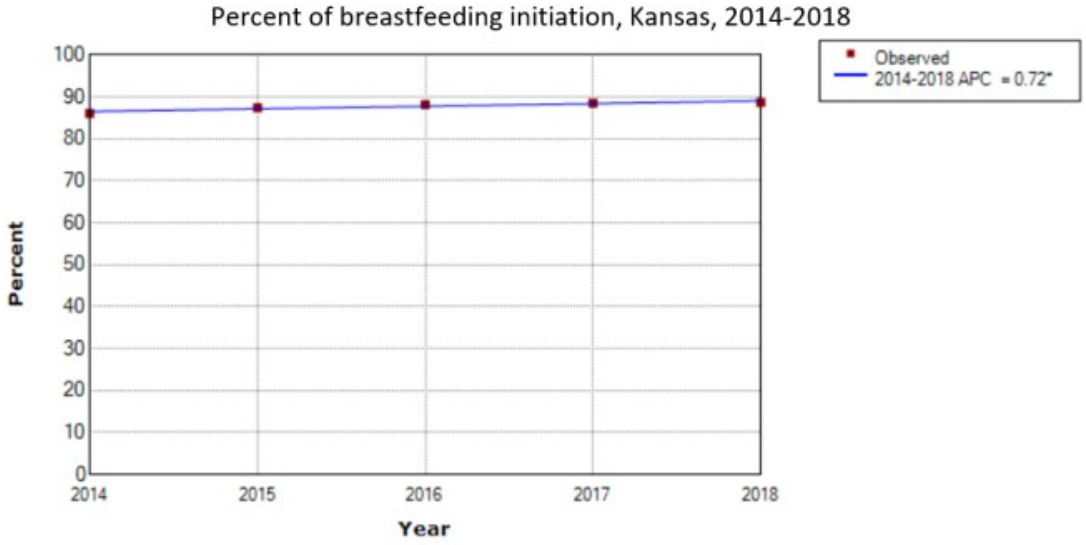
Local MCH Reach: During SFY2019, 62 of 71 grantees (87%) provided services to the Perinatal/Infant population.

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

In 2018, Kansas birth certificate data showed that mothers initiated breastfeeding in 88.7% of resident live births. This was a small increase from the 88.5% reported in 2017 and exceeded the Healthy People 2020 target of an 81.9% breastfeeding initiation rate. Non-Hispanic Asian mothers had the highest breastfeeding initiation rate (95.1%), followed by non-Hispanic white (89.7%) and Hispanic (87.8%) mothers. Non-Hispanic black mothers had the lowest breastfeeding initiation rate (79.5%). The overall breastfeeding initiation rate has been significantly increasing by .072% per year (95% Confidence Interval: 0.2%, - 1.2%) for the past five-year period (2014-2018).



**Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.*
Source: KDHE, Bureau of Epidemiology and Public Health Informatics

According to the most recent National Immunization Survey (NIS), for infants born in 2016, 88.0% of mothers reported ever breastfeeding, 53.0% reported breastfeeding at 6 months, and 31.4% reported exclusive breastfeeding at 6 months. 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]

Based on the most recent 2015 Maternity Practices in Infant Nutrition and Care Survey, known as the mPINC, 64 hospitals (93%) that deliver babies participated in the survey. Kansas scored 76 and ranked 36th out of 53 in the nation.[3] Hospitals are doing well in teaching prenatally about breastfeeding and teaching breastfeeding techniques which results in early initiation.

However, only 21% of Kansas hospitals report having comprehensive written policies to support breastfeeding. This may be reflected in the flattening rates of exclusive breastfeeding at six months.

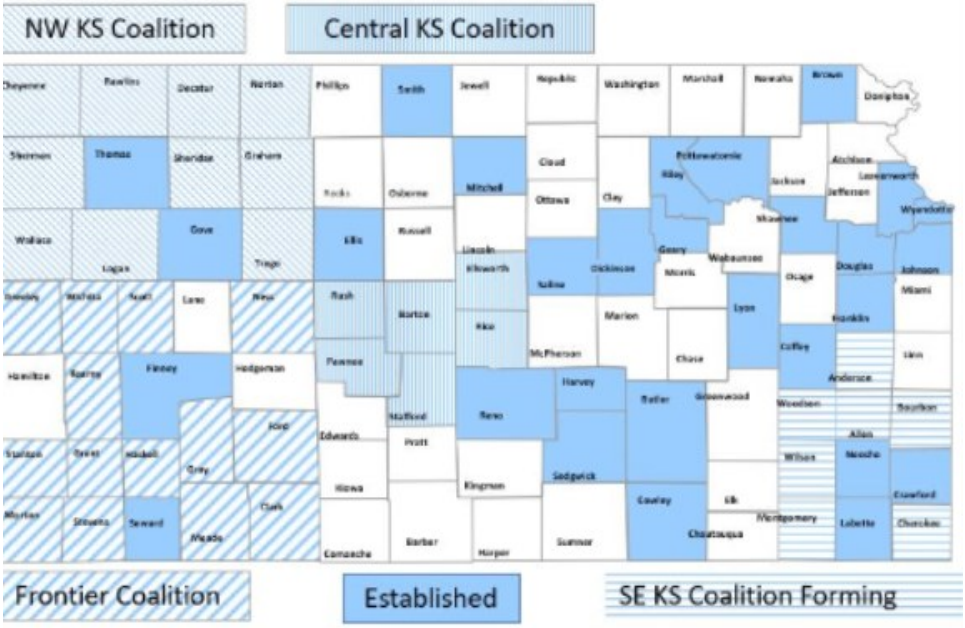
Objective: Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020.

Communities Supporting Breastfeeding (CSB): Title V has a strong partnership with the state breastfeeding coalition. The Kansas Breastfeeding Coalition (KBC), with support from MCH for the past several years, continued launch and sustain/develop CSB communities. CSB is a designation from the KBC that recognizes communities that are building 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 2019, 28 communities had achieved the CSB designation with support from the KDHE Bureau of Family Health MCH program, KBC, Kansas Health Foundation, United Methodist Health Ministry Fund, and Prime Health Foundation.

MCH and KBC continue to focus on disparities in breastfeeding. The KBC adapted the CSB criteria to define "community" as a *cultural community* rather than a geographical community which allowed "ready" African American (AA) and tribal communities to achieve the CSB designation. An AA window cling/table tent logo was developed in March of 2018, and the Wyandotte County AA community achieved CSB designation in March 2019. This project resulted in tools and a model for use to replicate in other Black/African American communities. The KBC promoted the CSB model at the 2018 Tribal Summit and has engaged three Kansas Tribes in conversation about working towards the CSB designation. The Prairie Band Potawatomi Tribe achieved the designation on June 6, 2019.

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 27 single counties and 5 regional coalitions, covering 71 counties or 68% of the state. A list of local breastfeeding coalitions and their contacts can be found at: http://ksbreastfeeding.org/coalitions/.

Map of Local Breastfeeding 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.

- Developed and deployed a needs assessment survey of Local Breastfeeding Coalitions to uncover technical assistance and supports needed
- Developed a tool kit for Local Breastfeeding Coalitions available online: http://ksbreastfeeding.org/wp-content/uploads/2019/09/ToolKit-for-BF-Coalitions-1.pdf
- Hosting of bi-monthly breastfeeding coalition meetings where local coalitions can share resources, strategies and project ideas
- Connecting the KBC and 53 local MCH agencies who selected breastfeeding as a priority in FY20, to facilitate the implementation of breastfeeding strategies
- Held quarterly conference calls with local coalition leaders
- Held annual "Kansas Breastfeeding Coalitions Conference" (The October 2019 conference drew over 195 attendees from 65 communities where they learned new skills for engaging their communities and improving breastfeeding support at the local level)
- Provided 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.

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. During the reporting period, 529 child care providers were trained and 36 were provided technical assistance. KBC also partnered with Oral Health Kansas to present three 2-hour trainings "How to Support the Breastfeeding Family" to Kansas Child Care providers. The first of these trainings was delivered in October 2019.

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 was featured in AMCHP's NPM 4 toolkit that was developed in Spring 2019. Resources from KBC contained in the toolkit include:

- Database of Breastfeeding Support and Rates
- Community Supporting Breastfeeding
- Business Case for Breastfeeding Website

The CSB is also included in the Kansas Health Matters database of promising practices. Read more about CSB here: http://ksbreastfeeding.org/.

Other CSB Related Efforts – Businesses & Employers: Other CSB breastfeeding initiatives are supported by MCH partner, The United Methodist Health Ministry Fund (UMHMF). The number of public establishments enrolled in KBC's "Breastfeeding Welcome Here" (BWH) program which recognizes establishments who support public breastfeeding in their facilities increased from 870 establishments (FY18) to 1,0008 establishments in FY19. These establishments make a commitment to support breastfeeding by taking a Business Pledge and displaying the BWH window decal and table tents as well as educating staff on the Kansas law protecting breastfeeding in public.

All BWH materials are available in English and Spanish including a BWH Toolkit that was created for advocates to promote the BWH program. BWH materials have also been translated to Potawatomi and Kickapoo Tribes 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 October 2019, 350 (up from 339 in FY18) 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.

Local MCH Agencies: Fifty-one local MCH agencies selected breastfeeding as a priority in FY19. Many communities have active local breastfeeding coalitions, have achieved CSB status, have staff trained as breastfeeding educators, and work closely with WIC to provide breastfeeding peer support specialists. Some local examples that illustrate the work include:

- Barton County hosted a breastfeeding booth at their community Farmer's Market to promote and help normalize breastfeeding.
- Dickinson County utilized an evidence-based technique, Laid Back Nursing approach to infant positioning, in their office by providing a recliner chair for breastfeeding consultation and weight checks. They also hosted their annual Dickinson County Community Baby Shower where fifteen service vendors from the area presented information to 54 new moms, moms-to-be, and their support persons about how to keep their families healthy and thriving. The goal of this event was to provide information and in-person contacts to promote breastfeeding and infant/family health, development and safety, and early intervention. Help in these areas have been shown to significantly reduce health care costs and benefit the community.

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

Kansas Breastfeeding Coalition (KBC) Partnership Activities: Title V collaborated with the KBC, UMHMF, and WIC to expand the High 5 for Mom and Baby program (funded and administered by the UMHMF) by increasing the number of hospitals trained and number implementing the program. As of the end of the reporting period, 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 High 5 program recognition.

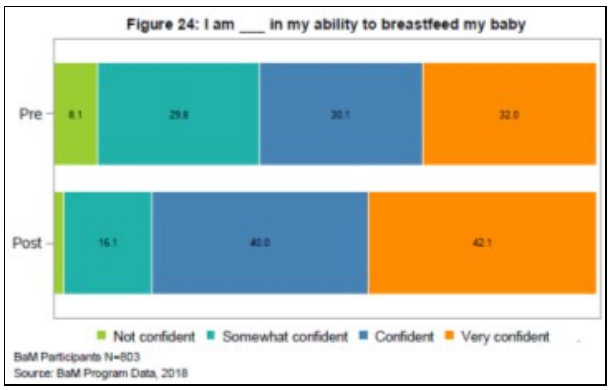
Objective: Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020.

MCH-WIC-KBC-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, and support from KBC, 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. The 2018 Kansas PRAMS report shows that 77.1% of mothers learned about breastfeeding from a breastfeeding of lactation specialist. 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.

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. Work was completed in early 2019 to produce a recorded training webinar for the Breastfeeding Integration Toolkit that is provided as part of the online resources on the BaM private website, to reduce the need for continued in-person training, promoting greater long-term sustainability of efforts.

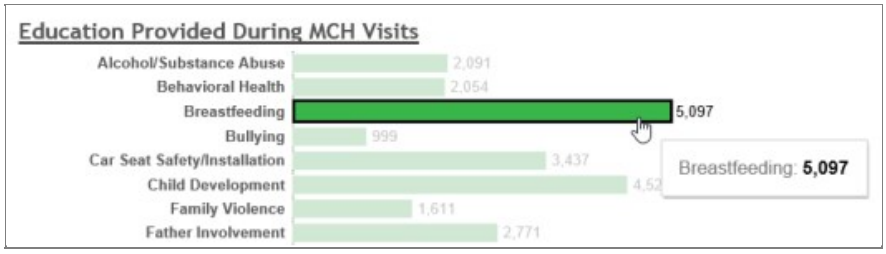
According to the 2018 BaM Aggregate Report for KPCC, initiation rates were 90.9% (slightly higher than the 88.7% state rate, according to Kansas Birth Certificate data, 2018), which we feel is reflective of efforts by KPCC to provide extensive education and support around this priority. See data to the right 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.



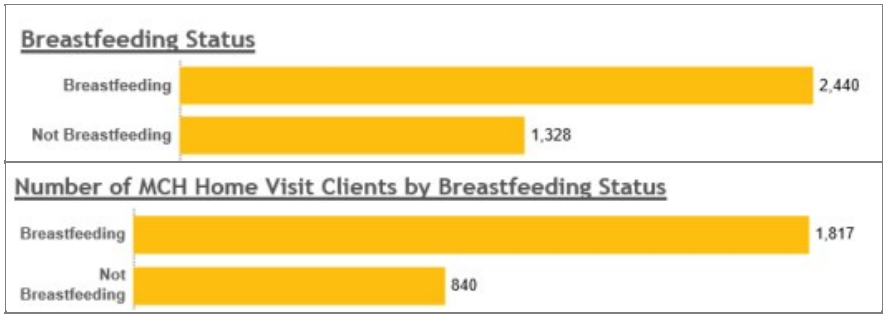
Additionally, data consistently show the BaM session focused on infant feeding as the highest ranking related to "helpfulness of the session", with 93% rating it between very (35.5%) and extremely (57.5%) helpful. Although breastfeeding initiation rates across the state have improved steadily in recent 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 five BaM sessions) were fully translated and piloted in the Sedgwick Co. community (with input being reflective of five 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.

Local MCH Agencies: Local MCH agencies provided education to 5,099 prenatal and postpartum clients. A total of 3,142 received the education as part of a MCH Home Visit.



During SFY19, 65% of all clients who gave birth in the past year reported breastfeeding. In addition, 68% of all home visit clients giving birth during the report period reported 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 SFY19, of the 1,112 referrals made for breastfeeding, 945 clients (over 90%) 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).

Many local agency staff 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. Some specific examples of Local MCH activities for breastfeeding include:

- Southeast Kansas Multi-County Health Department recruited nine new Breastfeeding Welcome Here sites. New sites were recognized on the agency's Facebook page.
- Barton County Health Department MCH Home Visitor is also the WIC Breastfeeding Peer Counselor. This allowed her to receive expanded breastfeeding training which in turn allowed more clients to receive Coffective materials to promote and support breastfeeding duration goals.
- Pawnee County Health Department hosted a breastfeeding reception in conjunction with World Breastfeeding week in August. Education and community resources were provided to participants.

The MCH Universal Home Visiting program provides education and support related to breastfeeding initiation, exclusivity, 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 (centralized 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.

MCH Workforce Initiatives with KBC: The KBC provides ongoing education to communities, including the MCH workforce. The following presentations were offered throughout the reporting period.

Presentation	Audience
How to Start Breastfeeding Support Groups	Public Health students in Wichita, KS
Insurance Billing for breastfeeding	Various
Adapting the Community Supporting Breastfeeding Designation	Tribal and African American Communities in Kansas
Breastfeeding: Racial Disparities and New Research	KU Public Health Grant Rounds
Intersection of Breastfeeding & Safe Infant Sleep	42nd Annual Governor's Conference for the Prevention of Child Abuse and Neglect
Breastfeeding's Impact on Mental Health	Early Head Start Home Visitors Conference
Supporting Breastfeeding Families during Times of Emergencies	Various
Making Breastfeeding "Cool Beans" with Coffective	Kansas WIC Conference

The KBC's Breastfeeding Education Workgroup conducted a needs assessment via an online survey to determine what individuals want from in-person breastfeeding education. The survey informed the design of in-person breastfeeding education courses, Breastfeeding Basics and Beyond the Basics. The two 1-day in-person courses will meet the need of anyone serving families, from the new home visitor to the breastfeeding peer counselor. The following are other activities supported through expanded capacity funded by MCH.

- Participated in the USBC Learning Community, Lactation Support for Incarcerated Women
- Facilitated the Johnson County Breastfeeding Coalition Startup-up Meeting
- Provided the 2-hour infant feeding prenatal curriculum was provided to Scott County Health Department
- Authored a guest blog post "Guidelines to Support the Breastfeeding Infant during Emergencies while in Child Care"
- Provided mini-grants to Ford County Breastfeeding Coalition and Lyon County Breastfeeding Coalition to increase usage of the Coffective system
- Contributed an article on breastfeeding resources and programs in Kansas to the Child Care Aware of Kansas Magazine "Kansas Child" Summer MCH Issue
- Completed an "Inventory of Public Health Programs" across Kansas that support pregnant women, mothers, and their children and how they integrate breastfeeding.
- Completed the "2019 State of Breastfeeding in Kansas" Report with new breastfeeding data from CDC and KDHE
- Provided input to KDHE MCH to align breastfeeding measures and improve consistent vocabulary within the breastfeeding questions within the DAISEY data collection and PRAMS survey tools
- 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

KBC also maintained a 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.

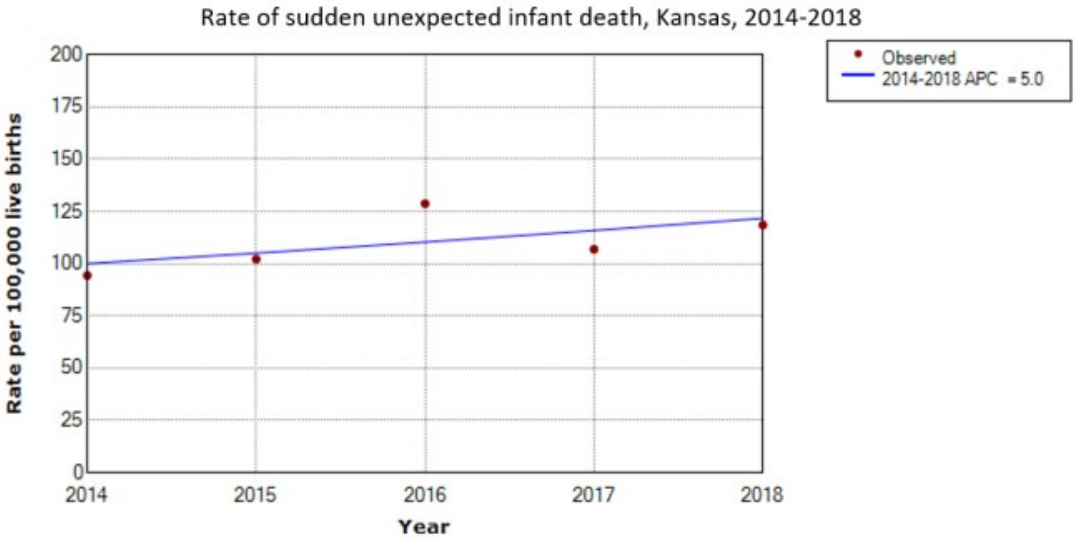
Local MCH Agencies: Breastfeeding and safe sleep trainings are important for all home visitors no matter the stage of professional development. It is important to build and enhance the statewide infrastructure to share consistent breastfeeding and safe sleep messages with providers, parents and caregivers to increase breastfeeding rates and reduce sleep-related deaths across Kansas. There were 161 MIECHV and Universal (MCH) Home Visitors who participated in a full day training on breastfeeding and safe sleep. These trainings were held regionally throughout the state (six locations), so each home visitor had a chance to participate. The half day breastfeeding training was presented by the KBC. The training included evidence-based knowledge related to basic breastfeeding practices, answering common questions and addressing concerns surrounding breastfeeding, and gaining a better understanding of breastfeeding resources in their communities.

KBC included a portion of their presentation time to incorporate information on building or expanding breastfeeding coalitions in their respective communities or regions. The second half of the event consisted of a safe sleep training provided by the Kansas Infant Death and SIDS (KIDS) Network. More information is provided in this report.

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 (2014-2018) 208 infants died due to SUID; overall SUID rates in Kansas increased by 5.0 per year (95% CI: -6.5, 18.0), from 94.4 deaths per 100,000 live births in 2014 to 118.6 deaths per 100,000 live births in 2018. This increase was not statistically significant. SUIDs are the second leading cause of infant death in Kansas (18.1%). SUID was the leading cause of death in infants who had reached at least 28 days of age (51.3%). Non-Hispanic black infants (31 cases, 244.7 deaths per 100,000 live births, 95% CI: 166.2, 347.3) died at a significantly greater rate than non-Hispanic white (119 cases, 89.4 deaths per 100,000 live births, 95% CI: 73.3 - 105.4), and Hispanic infants (38 cases, 124.0 deaths per 100,000 live births, 95%CI: 87.8 - 170.2) where the cause of death was SUID.



*Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Source: KDHE, Bureau of Epidemiology and Public Health Inforamatics

According to the 2019 Kansas State Child Death Review Board Annual Report (2017 Data), there were 41 sleep-related deaths. Of those, 19 were classified in a sudden infant death syndrome (SIDS) category, 12 as undetermined manner, or USID sleep-related deaths, and 10 as an unintentional suffocation or strangulation. Of the 19 SIDS cases, 17 (89%) were classified as SIDS II, indicating the presence of one or more elements of unsafe sleep; 7 (37%) were documented as not being placed supine (on the back) to sleep (recommended position).
Based on the 41 sleep-related deaths reviewed, 31 deaths (76%) occurred in the child's home followed by 5 deaths (12%) in a relative's home. The remaining 5 deaths (12%) occurred in other locations such as unlicensed child care centers, licensed foster care homes, hotels, or in unknown locations. Of the 27 deaths that occurred while sleeping on an adult bed

or couch, 21 infants (78%) were sharing the sleeping surface with another person(s) at the time of the incident. While 33 of 41 families (80%) were known to have a crib or bassinet in the home, only 7 (17%) occurred when the infant was in a crib or bassinet as recommended. In other words, 83% were not sleeping in a crib or bassinet. In 8 deaths (20%), the mother/caregiver reportedly fell asleep while breast (7) or bottle (1) feeding the infant. In those eight deaths, one was classified as a SIDS, two were classified as SUID, and five were classified as an unintentional injury. Mothers should be encouraged and supported to breastfeed. However, education about how to safely breastfeed in bed and counseling about risk factors and prevention is critical. Mothers should be reminded that if infants are brought to an adult bed for nursing, they should be returned to a separate safe surface (e.g., crib or bassinet) when the mother is ready to return to sleep. In 16 deaths (39%), nearly 40%, the caregiver had consumed alcohol or drugs at the time of the incident (including 5 whom had consumed drugs or alcohol and were breastfeeding at the time of the incident) or had previous concerns regarding substance use. In 20 deaths (49%), nearly half, there was current or history with child welfare agencies (Kansas Department for Children and Families). In 6 deaths (15%), those either the decedent or sibling(s) had been removed from parental custody at some time prior to the incident leading to the child's death.

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

The KIDS Network impacts the entire state in their efforts to reduce the number of infant deaths. Safe sleep promotion is the focus of most of the Network's outreach activities including community baby showers, Cribs for Kids, dissemination of safe sleep education, health care provider education, child care provider education, and parent/caregiver/public education. In FY19, 93 Kansas counties were directly touched by the KIDS Network through outreach and education. A total of 76 health care professionals were trained as Safe Sleep Instructors (SSIs). SSIs provided safe sleep training to 1,172 participants statewide. A total of 1,197 pregnant women were educated about safe sleep through demonstrations at community baby showers. The KIDS Network provided community outreach to an additional 12,220 people: 7,350 professionals and child care providers were trained on safe sleep and bereavement through presentations at hospitals, universities, KS Train online, and public health conferences. A total of 33,459 community members were connected through professional meetings, community events, social media, and live events (Susan E. Bredehoft Candle Lighting, Haley's SIDS Scramble, and Step Up for KIDS).

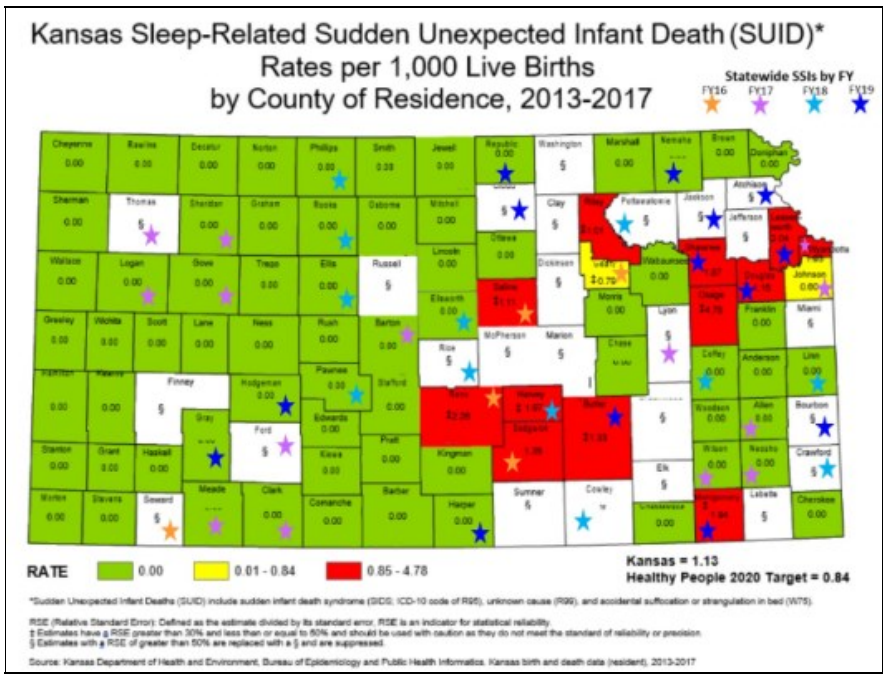
Kansas Infant Death & SIDS (KIDS) Network – Safe Sleep Expansion Initiative: Kansas Title V continued a formal (contractual) partnership with the KIDS Network of Kansas during the reporting period to reduce infant mortality. The primary work of this partnership focuses on continued implementation of 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).

Annual Safe Sleep Instructor (SSI) 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 76 SSIs (leads) were trained during the reporting period. 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; and
- Implement the National Safe Sleep Hospital Certification and/or the Safe Sleep Outpatient Toolkit in at least one pediatric, OB, and family medicine clinic.

The SSI network provided training to 1,172 professionals statewide during the reporting period. Annual SSI training was held September 19, 2019, in Wichita. Topics discussed included: sleep-related deaths, safe sleep locations, environment, position, and messaging strategies; risks of smoking and protective quality of breastfeeding. This map indicates SUID rates by county of residence with SSI instructor locations. It appears this initiative is making a difference—SUID rates for locations with SSI instructors are not increasing and rates are improving over time (2013-2017 compared to 2008-2012). Further analysis is being conducted by the MCH Epidemiologist and KIDS Network to determine targeted interventions for counties with the highest rates.



Community Baby Showers: The Community Baby Shower (CBS) 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 Bureau of Family Health/MCH, KIDS Network, KBC, and Bureau of Health Promotion/KS Quitline signed a memorandum of understanding to collaboratively support the CBS model statewide through staffing, education, and the provision of resources and referrals. The three-pronged approach includes safe sleep, breastfeeding, and tobacco cessation. This is a significant step forward as it brings together these key lead agencies to provide consistent safe sleep messaging and comprehensive services reaching a greater number of women during the perinatal period. The CBS 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

During the reporting period, 46 showers took place across the state with 1,197 women educated about safe sleep through interactive demonstrations. It's important to note that although the reporting period focuses on FY19, Kansas PRAMS report shows improvement of infants being placed to sleep "mostly on the back" from 80.2% in 2017 to 84.8% in 2018. The years of safe sleep collaboration/work is resulting in positive change.

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 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 Bronze activities listed above 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 Bronze and Silver activities listed above 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 local or national Cribs for Kids programs.

As of October 2019, five hospitals have reached gold level in the National Safe Sleep Hospital Certification Program and two are in the process of reaching gold. One hospital is working on achieving silver level and two hospitals are working towards achieving bronze.

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:

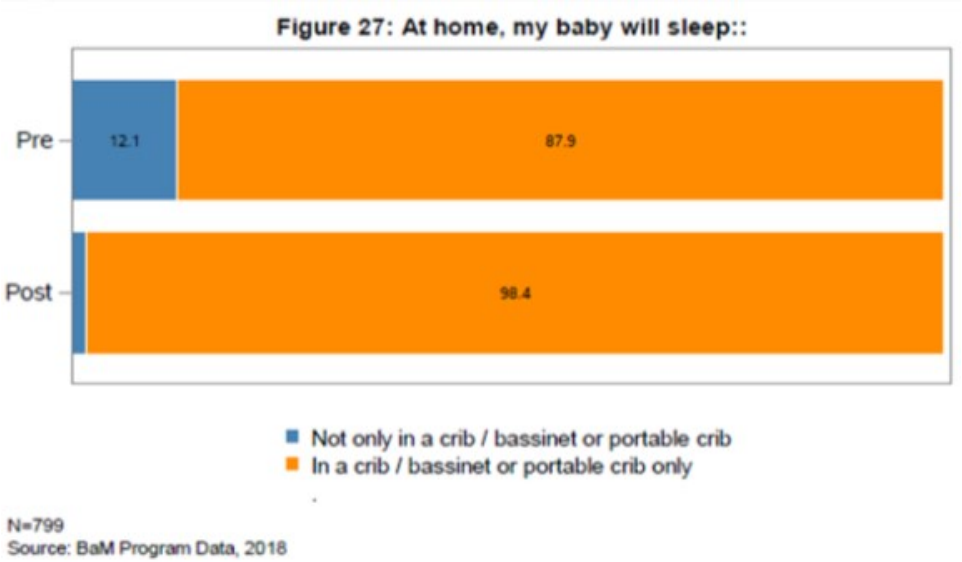
Bronze	Provides annual safe sleep training to employees Has a safe sleep policy regarding educating all appropriate patients/parents on safe sleep and includes information on referral for patients/parents to further safe sleep education, cribs or safe sleep resources and bereavement services Utilize 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 Bronze activities listed above Provides patients/parents with take-home materials on safe sleep, such as brochures, door handers, “this side up” onesies or wearable blankets
Gold	All Bronze and Silver activities listed above Engages in safe sleep education at the community level through health fairs, community baby showers, or other community outreach at least twice a year

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 October 2019, five outpatient clinics have reached gold level, with two more working to achieve gold level; two clinics have also achieved bronze level with four more working towards bronze level.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Integration efforts have included standardization of the SIDS/Safe Sleep component of the curriculum, led by state staff and the KIDS Network. Shared use of educational materials has been in place since February 2016 which supports consistency in messaging and trainings across all KPCC program sites. Staff have received training 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 May 2019 and were reviewed in a monthly TA webinar for all KPCC sites.

Figure 26: I will put my baby to sleep on his/her:

N=795
Source: BaM Program Data, 2018



In preparation for launch of the SW KS KPCC 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 2018 BaM outcome data (figures to right) show significant improvement in knowledge and intentions for safe sleep position and location, following provided education (based on pre and post-tests).

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 will be provided via recorded TA webinar to be housed on the private BaM website, as are current TA webinars on tobacco cessation, mental health, breastfeeding and oral health integration components. The training webinar for the safe sleep component will be recorded in partnership with the KIDS Network. This will allow new BaM facilitators to receive comprehensive training on all integration components in a timely manner that fits the local timeline rather than waiting on the schedules of 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 SFY19, safe sleep education was provided more than 4,500 times during clinic visits and more than 3,400 times during home visits provided to pregnant and postpartum women. Local staff educated and encouraged women to discuss safe sleep with all their infant's care providers (family, friends, child care).

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. As mentioned in the breastfeeding section above, home visitors were provided with a half-day safe sleep training provided by the KIDS Network. Each regional safe sleep training was done by a certified safe sleep instructor in that region, which gave each participant a resource for their specific region. This safe sleep training provided home visitors information on safe sleep practices and community outreach strategies to promote consistent messaging with parents, health care provides, hospitals, public health settings, etc.

The Saline County Health Department is the lead agency for the Safe Sleep Community Baby Shower community collaborative. Partnering agencies and local prenatal/postpartum providers offered the event, as safe sleep is one of the three main education components of the shower agenda. Participants complete a pre-test and post-test for data collection purposes specifically to measure knowledge/behavioral changes. The participants who indicated they do not have or cannot financially provide for a safety approved crib are presented with a Pack and Play crib and Halo sleep sack at the end of the event. Community professionals are welcomed to the event either as a vendor or to attend for safe sleep education purposes. The MCH Coordinator and MCH Home Visitor offer trainings to local providers through this event or through private training requests.

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, 2018 through September 30, 2019 was 408 (406 English and two Spanish).

The CCL program participated in three Baby Jubilee events held by Stormont Vail Hospital between October 1, 2018, and September 30, 2019. These events are attended by expectant parents. CCL distributed an average of 50 Safe Slumber DVDs (English and Spanish) at each event. Other information provided was related to select child care and oral health. CCL also participated in the 2019 Safe Kids Kansas Day at the Zoo in Shawnee County to distribute magnets and frisbees that celebrated the 100-year anniversary of the Child Care Act (first laws governing facilities serving children in out of home care) as well as information regarding finding quality licensed child care.

Safe Sleep Infrastructure & Support for Families: Title V (with support from the Kansas Children's Cabinet and Trust Fund) contracted with the KIDS Network during FY19 to provide a statewide support system to assist families, relatives, friends, caregivers, and all others 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.

The 2019 KIDS Network Impact Report can be found online at
https://kschildrenscabinet.org/wp-content/uploads/2019/10/2019_aiir_online.pdf.

Special Health Care Needs: The Kansas Special Health Care Needs (KS-SHCN) program 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 aid in navigating these complicated systems, so that over time, the family will be able to do so independently as they advocate for the needs of their child.

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 11,812 English books and 1,415 Spanish books. 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 3% increase in caregivers reporting that they would lay their baby down to sleep on its back from pretest to posttest.

Safe Sleep Literacy Impact Survey – Pretest and Posttest

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

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

Other Perinatal/Infant Health Activities

Pregnancy Risk Assessment Monitoring System (PRAMS): Since October 2018, Kansas PRAMS has continued to collect information on the health and experiences of Kansas mothers. PRAMS finished its second year of data collection, achieving a 60.8% response rate (minimum threshold set by CDC is 55%). PRAMS staff have networked with a variety of partners to raise awareness about PRAMS in the community, and to share results. PRAMS data on mental health informed efforts by the Bureau of Family Health to increase screening and treatment coordination of postpartum depression. Additional reporting revealed social disparities related to breastfeeding continuation. This information has been shared with the Kansas Breastfeeding Coalition to help reinforce the importance of their efforts to promote breastfeeding. Kansas PRAMS has also worked closely with local partners, such as WIC clinics and midwives, to spread the word about PRAMS in the community to help bolster response rates and create interest in using the data.

Timeline of Kansas PRAMS Activities (during reporting period)

- October 2018
  - Continued 2nd year of data collection
  - Received 2017 data from CDC (achieved 62.9% weighted response rate)
  - Exhibited at KS Public Health Association (KPHA) conference
- January 2019
  - Added disability supplemental questions to PRAMS questionnaire
  - Submitted continuation application for PRAMS grant, including supplemental funds for opioid and disability questions
  - Increased survey reward from $15 to $25
  - Started including baby board books from MCH in the second mailing of the PRAMS questionnaire to sampled mothers
- March 2019
  - Published the *2017 Kansas PRAMS Surveillance Report* (NOTE: The 2018 report is also available, published November 2019)
  - PRAMS epidemiologist attended 2019 AMCHP conference
- April 2019
  - Launched 2019 data collection
  - Added opioid supplemental questions (use and perceptions) to the PRAMS questionnaire
  - Presented 2017 report data to the KS MCH Council
- May 2019
  - Attended KS WIC Conference to network with local WIC agencies
- June 2019
  - Presented results on breastfeeding continuation during KBC monthly meeting
  - PRAMS epidemiologist attended 2019 CSTE conference to network with epidemiologists from across the country and to participate in MCH-related sessions and committees specifically
- July 2019
  - Submitted 2018 data to CDC for weighting
  - Attended first Midwife Symposium to network with Kansas midwives
- August 2019
  - Incorporated PRAMS data into a Workplace Indicator Dashboard created by the Kansas Power of the Positive (related to the KS Essentials for Childhood initiative funded by CDC), to track whether improvements in workplace benefits and improve indicators associated with family well-being
  - Attended the repeat session of the first Midwife Symposium
- September 2019
  - Presented a poster on disparities in access to prenatal care at KPHA
  - Presented PRAMS findings to Sedgwick Co. Maternal & Infant Health Coalition
  - Submitted an abstract for the 2020 AMCHP conference, related to screening and access to treatment for perinatal depression
  - PRAMS epidemiologist attended the 2019 CityMatCH conference, to network with other MCH professionals
- October 2019
  - Received 2018 data from CDC (achieved 60.8% weighted response rate)
  - Shared an infographic on breastfeeding continuation disparities at the KBC conference, and networked with conference attendees
  - Started presenting PRAMS findings to local health departments, at the 3rd Quarter Public Health Regional Meetings

Early Childhood Literacy: Research shows a direct connection between early reading and high school graduation rates. Grade-level reading, especially in the 3rd grade, is a key indicator of children's lifelong success. The window for early learning is short and kids must begin building reading skills before they enter school. The Title V program purchased copies of the book "Cuddle" (Happy Heathy Baby series by Spirit Publishing). These books serve to promote early childhood literacy and strengthen the parent-child bond. A total of 6,131 books have been shipped to home visitors and perinatal collaboratives to share with parents to encourage reading, talking, and playing as early as possible. The books were also provided to attendees of the 2019 Parent Leadership Conference. They are also sent to moms who complete the PRAMS survey.

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

Data notes: Starting with 2016 births, the National Immunization Survey (NIS) switched from landline and cell phone sampling to cell phone sampling only. Therefore, previous estimates may not be comparable to subsequent estimates.

Perinatal/Infant Health - Application Year

PRIORITY 2: All infants and families have support from strong community systems to optimize infant health and well-being

NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)
SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

Local MCH Reach: Based on SFY2021 MCH Aid-to-Local applications received:

- 61 of 67 grantees (91%) plan to provide services to the Perinatal & Infant population
- 53 of 61 grantees (87%) plan to provide breastfeeding services
- 52 of 61 grantees (85%) plan to provide safe sleep services

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NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)

Objective: Promote and support safe sleep practices and cross-sector initiatives to reduce the Sudden Unexplained Infant Death (SUID) rate.

Title V continues to focus on reducing SUID rates through safe sleep education and professional trainings/resources offered to local MCH agencies, home visiting programs, hospitals, child care facilities, and other providers to support safe sleep practices and accurate, consistent safe sleep messages. Title V will partner with local coalitions and community organizations leading efforts to support safe sleep, breastfeeding, and tobacco use prevention to provide direct education and referrals to families at high risk for adverse outcomes through Community Baby Showers (CBS).

Consistent and current safe sleep education and messaging is critical as we strive to eradicate unsafe sleep practices. Plans are underway to assist local MCH service providers in creating opportunities for real conversations with parents and caregivers to help identify root causes of unsafe practices and address barriers to implementing safe sleep practices.

KIDS Network Infrastructure & Family Support: Title V will continue the strong partnership with the Kansas Infant Death and SIDS (KIDS) Network. Title V continues to provide organizational infrastructure support for the Executive Director and support staff as necessary to execute the partnership agreement. The KIDS Network Safe Sleep Instructor (SSI) program is instrumental in providing shared safe sleep messaging and education across the state. KIDS will continue to provide technical assistance to SSIs to ensure consistent messaging and continuity of existing supports. More about the partnership can be found in the Perinatal/Infant Report.

The KIDS Network will provide a statewide support ystem to assist child care providers, families, relatives, friends, caregivers, and all others who are affected by the sudden death of an infant. Their plans include disseminating information statewide; revising existing evaluation efforts to include findings by parents and/or professionals; and developing assessment tools for caregivers, SSIs, and professionals. Objectives of the partnership/agreement include:

- Enhance referral network protocols to enable 75% of families affected by the unexpected or sudden death of an infant to receive initial contact and/or support services;
- Finalize a statewide network to assure parents and extended family members have access to follow-up and support services based on individual/family needs;
- Provide support for professional and parent/family representation on the KIDS Network, Inc. Board of Directors; and
- Implement a public information initiative to inform professionals, families, and others of network services, the resource center, and infant safe sleep education.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Training on the SIDS/Safe Sleep integration component will be provided to new KPCCs preparing to implement the BaM curriculum. This training is being provided via recorded webinar on the private website, along with the other integration components. This allows new facilitators to receive comprehensive training on all integration components in a manner that fits their local timeline. It also supports long-term expansion and sustainability efforts. KDHE will also work to adapt the current BaM Toolkit for utilization across the broader MCH network, providing easy access to all the tools and resources related to safe sleep integration across all health sectors in a community.

As described in the Women/Maternal Plan, the BaM curriculum is being enhanced ith a 7th session, which will include a safe sleep component to provide education after delivery. This provides an opportunity to engage with caregivers who are struggling with the reality of life with a newborn and help address the many temptations to do things in a manner different than what they may know is best. Incorporated activities will stimulate real conversations about the struggle's caregivers are facing and insight into how they can be approached and overcome.

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 (e.g., family members, friends, child care 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. A sampling of local efforts include:

- Jefferson County provides safe sleep educational materials to all mothers at each visit. Extra safe sleep materials are available to the family to share with additional caregivers including grandparent brochures. MCH staff also provide safe sleep materials to local providers to distribute to the community.
- Wyandotte County program staff will be educated on recommended safe sleep practices and MCH staff will train providers and direct service staff to screen, educate, and counsel parents and their family members on safe sleep practices for babies up to one year. MCH staff will make it a priority to integrate infant sleep environment assessment into training. Community distribution and education of the Safe Sleep videos developed by the local Fetal and Infant Mortality Review (FIMR) Board will assist in achieving these goals. The health department has a Certified Safe Sleep Instructor (SSI) who received training through the KIDS Network. The SSI in collaboration with Child Care Licensing (CCL) will train professional and community agencies regarding safe sleep practices and participate in a community baby shower. The SSI will present safe sleep education to all participants in the Perinatal Community Collaborative (BaM) prenatal education sessions.
- Hays Area Children's Center MCH home visitors provide information to all clients about safe sleep environments. Pregnant women and new parents will receive *Cuddle* and *Sleep Baby Safe and Snug* board books during the visit. The home visitor will assess the sleeping environment and offer suggestions to make it as safe as possible when the infant arrives.
- Sumner County SSI will host "Now I lay me down to sleep" educational sessions. Participants will receive a pretest of their knowledge and intentions regarding safe sleep. After the sessions, they will complete a post-test to assess their knowledge and intentions. Participants will also be provided with a *Sleep Baby Safe and Snug* board book.
- The University of Kansas School of Medicine-Wichita team has certified SSI staff who will provide education on safe sleep recommendations and share information on how to overcome barriers to all their MCH and affiliated program participants. The staff also make referrals to the Community Baby Showers in Sedgwick County and can schedule participants for an individual crib clinic where they can participate in a crib demonstration and receive free materials to prepare a safe sleep environment for their infant. They will provide safe sleep education during BaM Session 5 (Infant and Newborn Care). The curriculum includes standardized education on safe sleep, addresses risk factors for sleep related death, including SIDS, and risk reduction strategies for parents. Environmental factors are covered and addressed through an activity demonstration, where participants work with the instructor to identify why materials such as blankets, pillows, stuffed animals, and other unsafe items should not be included in the displayed

safe sleep space for the baby. Communicating safe sleep practices with child care providers and family members caring for baby is supported and encouraged. Participants also view a video promoting best practices. Safe sleep handouts and the board book *Sleep Baby Safe and Snug*, are provided during this session, which also reinforce the safe sleep guidelines.

Safe Sleep Education: As noted in the Perinatal/Infant Report, Title V provided board books, *Sleep Baby Safe and Snug*, to birthing hospitals and home visitors as a tool to educate new parents/caregivers 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 post-test until the current inventory is depleted. 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 directly from the manufacturer for a low cost or innovative funding streams, such as writing the expense into their KDHE funding proposals.

In partnership with Title V, CCL will continue to attend Baby Jubilee events to distribute safe sleep DVDs and educational literature for expecting parents. Additionally, the online "Safe Slumber" online training will be made available in English and Spanish at no cost to providers.

SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

Objective: Promote and support cross-sector breastfeeding policies, practices, and environments to increase exclusive breastfeeding rates at 6 months.

Kansas has high breastfeeding initiation rates, but there is more work to do related to increasing the duration and exclusive breastfeeding rates at 6 months. This will require continued multi-sector collaborative efforts. Title V will increase access for families to strong community breastfeeding education, supports, and practices across settings through collaboration with key community and state partners, such as KPCC sites. In addition to the group prenatal education models, other strategies include increasing referrals to WIC for breastfeeding support and education, including expanding WIC Breastfeeding Peer Counseling; shared messaging through WIC and Home Visiting programs, hospitals, and provider offices – building on the "Breastfeeding Welcome Here" initiatives; and education about behavioral health and breastfeeding.

Kansas Breastfeeding Infrastructure: Title V will continue the strong partnership with the Kansas Breastfeeding Coalition (KBC) to continue existing effective strategies, as well as to support Title V's goal to focus on disparities in breastfeeding and increasing breastfeeding rates among Black mothers. Several strategies are in place to help us achieve this goal.

- Increasing access to lactation support by African American providers such as breastfeeding peer counselors, doulas, International Board-Certified Lactation Consultants, and Certified Lactation Counselors (CLC) that represent high-risk populations will help increase the culturally relevant support women of color need to initiate and continue breastfeeding.
- Supporting the implementation of community-centered, culturally relevant mother-to-mother, father, and grandparent breastfeeding support clubs for African Americans (e.g., Black Breastfeeding Clubs, Brown Baby Brigade, BSTARS, Reach our Brothers Everywhere (ROBE), Fathers Uplift, Grandmothers Tea Project) will build capacity in the community to support mothers of color in breastfeeding.
- Broadening the establishment of breastfeeding coalitions for African Americans that connect health care providers and the community to local information and resources (e.g., African-American Breastfeeding Coalition of Wyandotte County) will help foster a culture of change within communities.

Title V continues to work with a variety of partners, referred to collectively as the Kansas Breastfeeding Support Network, to advance the work and partnership of the KBC. More about the ongoing work with the KBC can be found in the Perinatal/Infant Report.

Breastfeeding and Child Care: The CCL program will continue collaborating with KBC to provide *How to Support the Breastfeeding Mother & Family* online training available to early care professionals and to offer technical assistance as needed.

Breastfeeding and Marijuana Use: Title V will continue collaboration with KBC to increase education about risks associated with marijuana use while breastfeeding. KBC updated their website to include a *Marijuana and Other Illegal Drugs and Breastfeeding* section in their online resource center. MCH Aid-To-Local (ATL) grantees are requesting this information on a more frequent basis, as some surrounding states have legalized marijuana.

Breastfeeding and Behavioral Health: Research completed by Dr. Kathleen Kendall-Tackett, an international expert in this field, suggests that breastfeeding can be a protective health measure. When breastfeeding is going well, it lowers the risk of heart disease, diabetes, and depression. When breastfeeding is not going well, moms are at increased risk of experiencing depression. This demonstrates the importance of increasing education and awareness of breastfeeding and behavioral health. Title V will partner with KBC to offer a *Breastfeeding and Behavioral Health* webinar to Kansas and will leverage opportunities made available through the Kansas Connecting Communities (KCC) grant to provide training. KCC will offer a four-session ECHO series in FY21; one of the sessions will focus on the impact of breastfeeding on mental health. More information about KCC and Project ECHO can be found in the Woman/Maternal Plan.

Breastfeeding Education & MCH Workforce: Title V encourages and supports staff participation in a variety of breastfeeding education courses. It is important to meet MCH staff where they are and provide information on all the options for breastfeeding education including 1, 3, or 5-day courses. Tools such as the "Landscape of Breastfeeding Support" which provides staff with the various breastfeeding certification programs and the "Lactation Support Provider Training Directory" from The US Breastfeeding Committee will be included in a comprehensive Breastfeeding Integration toolkit.

MCH-WIC-KBC-Becoming a Mom® (BaM) Program Collaboration: Partnership among several programs and partners will continue in FY21 with annual updates to the BaM Infant Feeding curriculum component. KBC will provide 10 additional toolkits for new sites implementing in FY21 that include all the supplies needed for activities and visual aids as part of the Infant Feeding session. Additionally, the training webinar for the Breastfeeding Integration Toolkit will be added as an online resource on the BaM private website.

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.

- Additional tools and resources will be added to the existing Breastfeeding Integration Toolkit (e.g., follow-up flow chart/algorithm, home visitation, support/educational resources).

- Focused strategies will target when mothers are most likely to stop breastfeeding (e.g., in the first week following birth, upon return to work). These tools will be co-developed by a workgroup consisting of the KPCC state coordinator, state MCH Consultants, KBC, and BaM/MCH/WIC consumers in late 2020/early 2021.
- As capacity is available to build additional data collection fields and reports within the state data collection system (DAISEY), both will be built to support local Title V program staff in tracking breastfeeding status and follow-up efforts.

Technical assistance will continue to be provided to KPCC/BaM sites to develop plans for targeted outreach to disparate populations. The BaM DAISEY Dashboard allows sites to compare participant demographic data to identified high-need/risk groups in their individual counties to assess if the targeted population (e.g., teen, non-Hispanic black populations) is being reached and whether breastfeeding rates are improving. The current dashboard is being transitioned from a manual data reporting format to a live automated report supported by Tableau. The dashboard is expected to be live/real time by late 2020 or early 2021. This will assist BaM program sites and their collaborative partners to more easily identify trends in data and engage in 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 KPCCs, encouraging each to achieve designation as a *Community Supporting Breastfeeding*.

Local MCH Agencies: The majority of MCH grantees that chose the Perinatal/Infant Health domain in their FY21 MCH 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 child care 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 and engage in activities to achieve goals.

- Labette County plans to offer prenatal education to participants that will include information on breastfeeding and how breastfeeding exclusively for the first 6 months can help achieve optimal growth, development, and health for the infant. Prenatal women will be encouraged to enroll in BaM classes and the SCRIPT smoking cessation program (if applicable). MCH staff will continue to make visits to the local OB department to provide postpartum women and families with education on the benefits of breastfeeding. Breastfeeding information is provided to women in response to a positive pregnancy test with at least one follow-up visit by MCH staff to provide prenatal/postpartum education and resources. Breastfeeding education will be provided to the community at health fairs/baby showers, displayed in the health department lobby, through social media and the county website. Health department staff will continue to participate in the monthly Breastfeeding Coalition meetings.
- Pawnee County plans to educate and empower women with knowledge of normal expectations of breastfeeding. All pregnant women will be referred for one-on-one breastfeeding education sessions with the Breastfeeding Peer Counselor (BPC) or Certified Breastfeeding Educator (CBE) during the last trimester of pregnancy. They will be encouraged to start attending Breastfeeding Support Group meetings during the last trimester of pregnancy and after delivery. The breastfeeding support staff will collaborate with Central Kansas Breastfeeding Coalition with members from five surrounding counties. The coalition members include local delivering hospitals, nurses, dieticians, social workers, local health departments, La Leche, Parents as Teachers, and local business professionals. Breastfeeding information for Pawnee County and the surrounding four counties will be dispersed throughout various avenues both prenatally and postpartum. Support is offered through a monthly support group. Health department staff will complete a breastfeeding self-assessment tool and make improvements as indicated by the results. All breastfeeding mothers will also be screened for lead poisoning.
- Community Health Center of Southeast Kansas provides Centering Pregnancy, a group prenatal education program that integrates medical care throughout the pregnancy. Breastfeeding counselors engage with all pregnant participants to educate, support positive aspects of breastfeeding, and encourage participation in monthly breastfeeding support groups.

- Kearny County Hospital nurses will be educated through the Empowering Breastfeeding program with CDC. The goal is to have at least 88% of nursing staff complete 10 hours of breastfeeding education. MCH staff plan to educate pregnant women about breastfeeding during the 3rd trimester. Women will receive breastfeeding education and assistance from a CLC or nurse in the hospital after delivery. This will ensure the mother has community resources she can turn to with questions.
- Catholic Charities of Northeast Kansas will help clients better understand the benefits of breastfeeding through tools provided by the National Institute for Children's Health Quality, the Surgeon General (Call to Acton to Support Breastfeeding), and the CDC (guidelines on breastmilk storage). Case managers will educate clients about establishing good breastmilk supply, safely storing breastmilk, and overcoming common challenges.

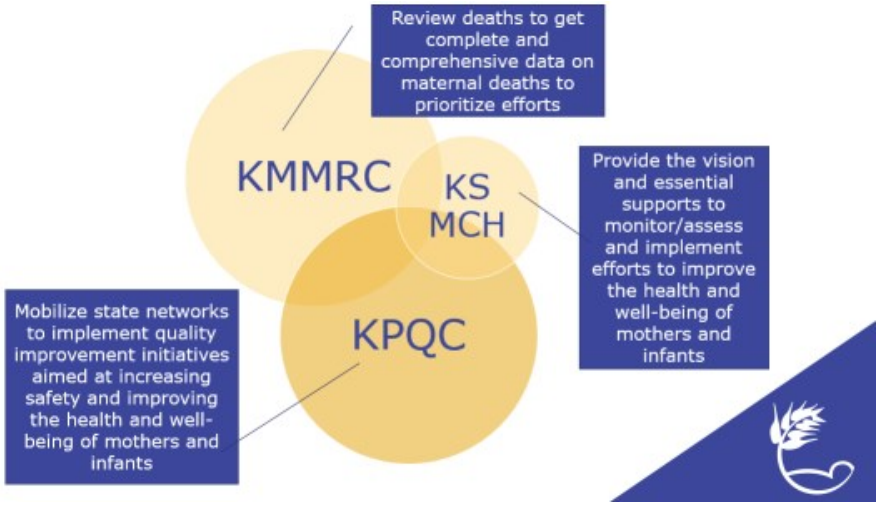
Other Perinatal/Infant Objectives

Objective: Implement at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC).

State Perinatal Quality Collaboratives (PQCs) and Maternal Mortality Review Committees (MMRCs) function to improve maternal and perinatal health and believe that investing in the mother's health leads to healthier birth/pregnancy outcomes. Roles are different 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

Diagram Showing the Roles of the KMMRC and KPQC



As convener of the Kansas PQC and MMRC, Title V brings together work of both entities to translate findings and recommendations to action, in partnership with other state organizations, such as American College of Obstetricians and Gynecologists (ACOG) and the Kansas Hospital Association (KHA). As the KMMRC focuses on identifying gaps in health services and making actionable recommendations to prevent future deaths, the KPQC focuses on acting on these recommendations by using data-driven, evidence-based practice and quality improvement processes (e.g., Patient Safety Bundles). This is intended to improve birth outcomes and strengthen perinatal systems of care for mothers and infants.

Kansas Perinatal Quality Collaborative (KPQC): In FY21 the KPQC will continue supporting substance exposed infants 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 providers to enhance supports.

Kansas Maternal Mortality Review Committee (KMMRC): The KMMRC will continue reviewing maternal death cases, with the goal of reviewing all maternal deaths that occur in the state within two years from the date of death. Data will be stored in the CDC's Maternal Mortality Review Information Application (MMRIA); sharing data in this way connects Kansas to other MMRCs and allows a deeper understanding of maternal deaths and opportunities for prevention.

KPQC/MMRC Collaborative Efforts: The KPQC will work more collaboratively with the KMMRC in FY21 to disseminate committee findings and identify the next quality initiative related to maternal and perinatal health. Kansas will enroll as an Alliance for Innovation on Maternal Health (AIM) AIM is a national data-driven maternal safety initiative based on proven implementation approaches to improving maternal safety and outcomes in the country. AIM works through state teams and health systems to align national, state, and hospital level 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; and
- Access to the AIM Community of States.

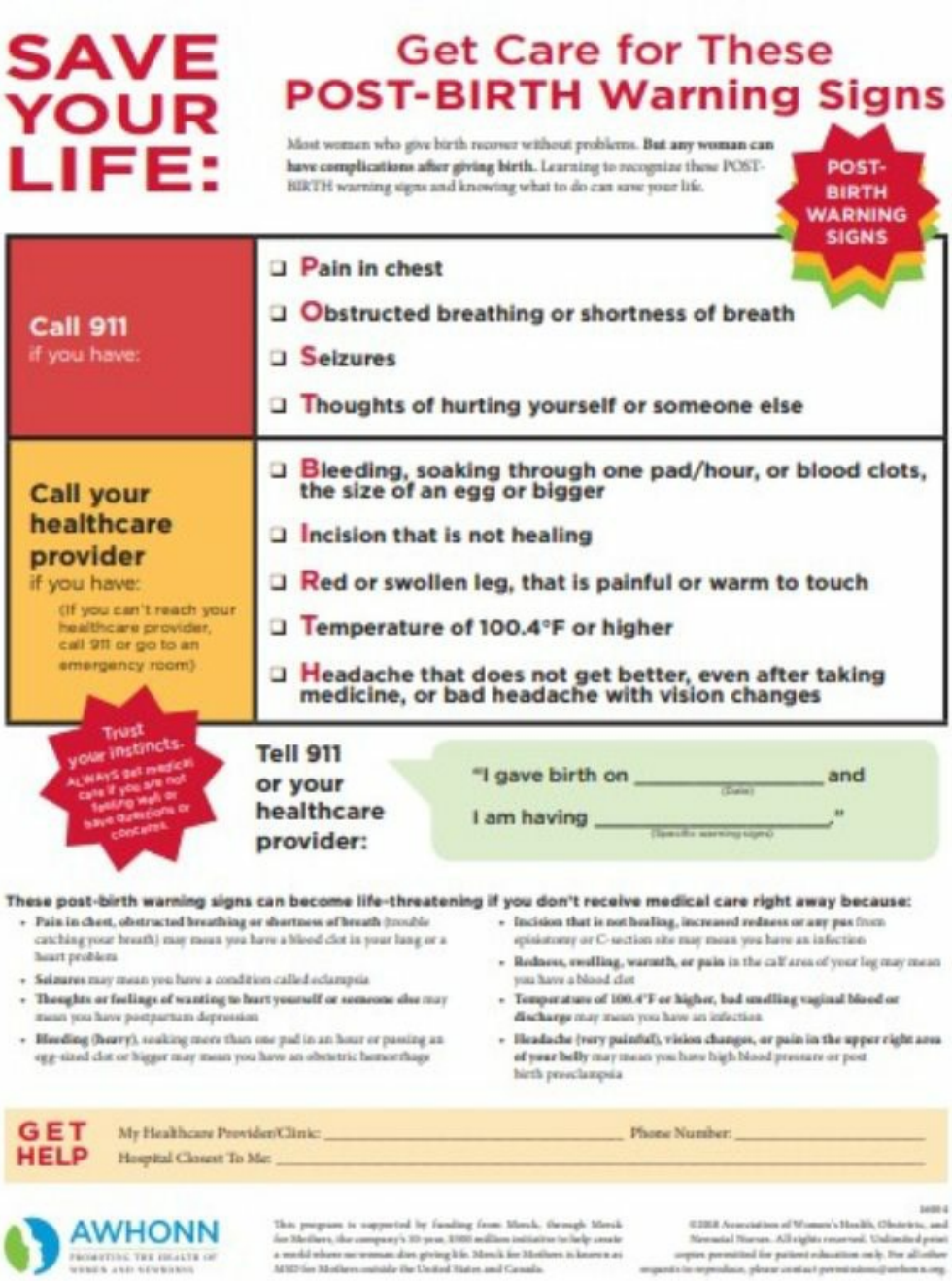
AIM-SUPPORTED PATIENT SAFETY BUNDLES

- 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

Kansas will identify an AIM bundle, identified by data gleaned from completed maternal mortality reviews as well as other MCH priority data for implementation.

Title V will continue to advocate for policy changes, develop action alerts and bulletins, and identify and develop public and patient education initiatives for statewide implementation in response to KPQC and MMRC data/findings. One example: 2016/2017 findings indicate the majority of "pregnancy-related deaths" are related to chronic pre-existing conditions that are exacerbated by the pregnancy, or conditions of pregnancy that worsen in the postpartum period (e.g., cardiovascular, auto-immune, psychiatric), where symptoms are not recognized as emergency/life threatening and appropriate treatment is not sought quickly enough. In response, plans are being developed to work with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) to implement their Post-Birth Warning Signs Education Program statewide, with adaptations to resources that support a public health approach.

This initiative will allow MCH grantees access to online education on maternal morbidity and mortality and the nurse/home visitor's role in reversing this trend by delivering consistent messaging about warning signs that can signal serious complications.



SAVE YOUR LIFE:

Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. **But any woman can have complications after giving birth.** Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

POST-BIRTH WARNING SIGNS

Call 911 if you have:

- ❑ Pain in chest
- ❑ Obstructed breathing or shortness of breath
- ❑ Seizures
- ❑ Thoughts of hurting yourself or someone else

Call your healthcare provider if you have:

(If you can't reach your healthcare provider, call 911 or go to an emergency room)

- ❑ Bleeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- ❑ Incision that is not healing
- ❑ Red or swollen leg, that is painful or warm to touch
- ❑ Temperature of 100.4°F or higher
- ❑ Headache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. ALWAYS get medical care if you are not feeling well or have questions or concerns.

Tell 911 or your healthcare provider:

"I gave birth on _____ (Date) and I am having _____ (Specific warning signs)."

These post-birth warning signs can become life-threatening if you don't receive medical care right away because:

- **Pain in chest, obstructed breathing or shortness of breath** (trouble catching your breath) may mean you have a blood clot in your lung or a heart problem
- **Seizures** may mean you have a condition called eclampsia
- **Thoughts or feelings of wanting to hurt yourself or someone else** may mean you have postpartum depression
- **Bleeding (heavy)**, soaking more than one pad in an hour or passing an egg-sized clot or bigger may mean you have an obstetric hemorrhage
- **Incision that is not healing, increased redness or any pus** from episiotomy or C-section site may mean you have an infection
- **Redness, swelling, warmth, or pain** in the calf area of your leg may mean you have a blood clot
- **Temperature of 100.4°F or higher, bad smelling vaginal blood or discharge** may mean you have an infection
- **Headache (very painful), vision changes, or pain in the upper right area of your belly** may mean you have high blood pressure or post birth preeclampsia

GET HELP

My Healthcare Provider/Clinic: _____ Phone Number: _____

Hospital Closest To Me: _____

AWHONN PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

This program is supported by funding from Merck, through Merck for Mothers, the company's 10-year, $100 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

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Additional public health campaigns will be implemented targeting causes of deaths found to be "pregnancy-associated, but not related." Most pregnancy-associated Kansas deaths have been the result of motor vehicle accidents and situations with other underlying factors, like substance use and intimate partner violence (IPV). During 2016-2018, there were 57 pregnancy-associated deaths, which translated to a pregnancy-associated mortality ratio (PAMR) of 50 deaths per every 100,000 live births occurred in Kansas. Of these deaths:

- 27 (47.4%) occurred 43 days to one year after the end of pregnancy
- 17 (29.8%) occurred during pregnancy, and
- 13 (22.8%) of deaths occurred within 42 days of the end of pregnancy.

Primary underlying causes of death were: 11 (19.3%) motor vehicle, 8 (14.0%) homicide, 6 (10.5%) poisoning/overdose, 5 (8.8%) infection, 4 (7.0%) cardiovascular and coronary conditions, 4 (7.0%) embolism, 4 (7.0%) suicide, 3 (5.3%) preeclampsia and eclampsia, 2 (3.5%) fire or burns, 2 (3.5%) hematoma, 2 (3.5%) malignancies, 1 (1.8%) autoimmune diseases, 1 (1.8%) blood disorders, 1 (1.8%) cardiomyopathy, 1 (1.8%) cerebrovascular accidents, 1 (1.8%) mental health conditions, 1 (1.8%) seizure disorders.

KPQC/KMMRC will promote and incorporate substance use screening, brief intervention, and referral to treatment (SBIRT) across MCH programming and perinatal service providers. The SBIRT process will be used as the a comprehensive, integrated, public health approach for the early identification and intervention of MCH patients exhibiting health risk behaviors, such as substance use. Promotional efforts will also include integration of screening and education on IPV, utilizing resources from the *Futures Without Violence* Initiative. Read more about this initiative in the Woman/Maternal Plan.

Objective: Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services.

Title V will enhance MCH Universal Home Visiting (UHV) services across the state to increase prenatal and postpartum care for women, infants, children, and their families. The upcoming year will be dedicated to evaluating, aligning, and refining the MCH UHV curriculum to assure that services reach families that need them, and local grantees provide consistent messaging and guidance when providing services. Title V will partner with the state Home Visiting Workgroup to carry out this work. Revised requirements, materials, and training will be based on updates or changes made to the UHV curriculum. Updated information will be disseminated to UHVs upon completion.

Title V will ensure that the MCH UHV program is aligned with the state early childhood systems building initiative, All in for Kansas Kids, to position UHV as an information source and connection point in communities to support safe, stable, nurturing relationships/environments and positive outcomes for infants and families. As part of this alignment, Title V MCH home visitors along with the Maternal, Infant, Early Childhood Home Visiting (MIECHV) home visitors will be provided with the Basic Home Visitor Training (BHVT), presented by the Kansas Head Start Association. The BHVT will consist of five online trainings and two days of in-person trainings, intended to cover a multitude of topics related to home visiting. Some of the topic to be covered include best practices and beliefs; confidentiality; self-care; dealing with stress; role of the home visitor; trust and respect; power of words; negative consequence of rescuer; boundaries; and home visitor safety. Other trainings that MCH Home Visitors will be participating in for this grant year include:

- Mental Health Frist Aid training;
- Cultural Humility (provided by MIECHV and open MCH UHV); and
- Motivational Interviewing (provided by MIECHV and UHV).

Another important aspect of the work will include establishing and increasing consumer/family and provider awareness about the importance of home visitation supports and the impact on family and infant outcomes to increase referrals and numbers of families receiving support thought the MCH UHV program. This will be done through social media blasts as well as infographics and fact sheets. Incorporating family strengthening and parent training/support skills building sessions in the MCH UHV standardized curriculum will help ensure families are strong and thriving.

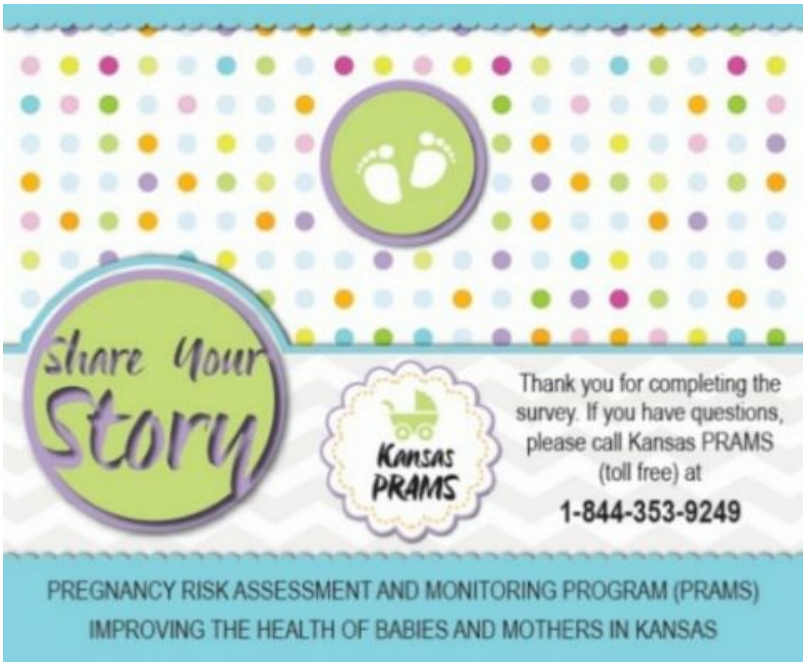
MCH Intensive Home Visiting Pilot Project: Title V partnered with the Bureau of Health Promotion to develop an innovative substance use prevention project for the Data Driven Prevention Opioid CDC grant (plan submitted in May 2019). The grant was awarded; a portion of the funds will be used to support a UHV pilot engaging mothers with infants diagnosed with Neonatal Abstinence Syndrome (NAS) in intensive home visiting up to 12 months postpartum. The BFH partnered with the University of Kansas Medical Center (KUMC) in Wichita to launch this pilot in two different locations for this pilot in the first year; however, due to the COVID-19 pandemic, the project will start with one site and expand locations in year two of the grant (tentatively September 2020, location TBD). Virtual training for KUMC home visiting staff will be provided by the Wyandotte County MIECHV Teams for Infants Exposed to Substance Use staff on motivational interviewing and relationship building for moms (August 2020). The project will continue to grow and evolve over the coming grant year.

Other Perinatal/Infant Health Activities

Infant Mental Health/Social-Emotional Development/Early Childhood Literacy: Title V will continue to provide the *Cuddle* board book for home visitors to encourage parents to read and hold/interact with their infants. Additionally, the books are provided to the PRAMS team for dissemination. These efforts will continue until the current inventory is depleted. Title V will encourage these partners to create a sustainability plan if they would like to continue providing the books o rother appropriate books. These partners will need to identify funding (they could write these expenses into their MCH budget requests), or work with early childhood partners in their communities to promote healthy development and literacy.

Pregnancy Risk Assessment Monitoring System (PRAMS): Moving forward in 2020 and 2021, KS PRAMS 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 regularly to review and discuss data, assist with media questions and interviews related to the PRAMS reports 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.



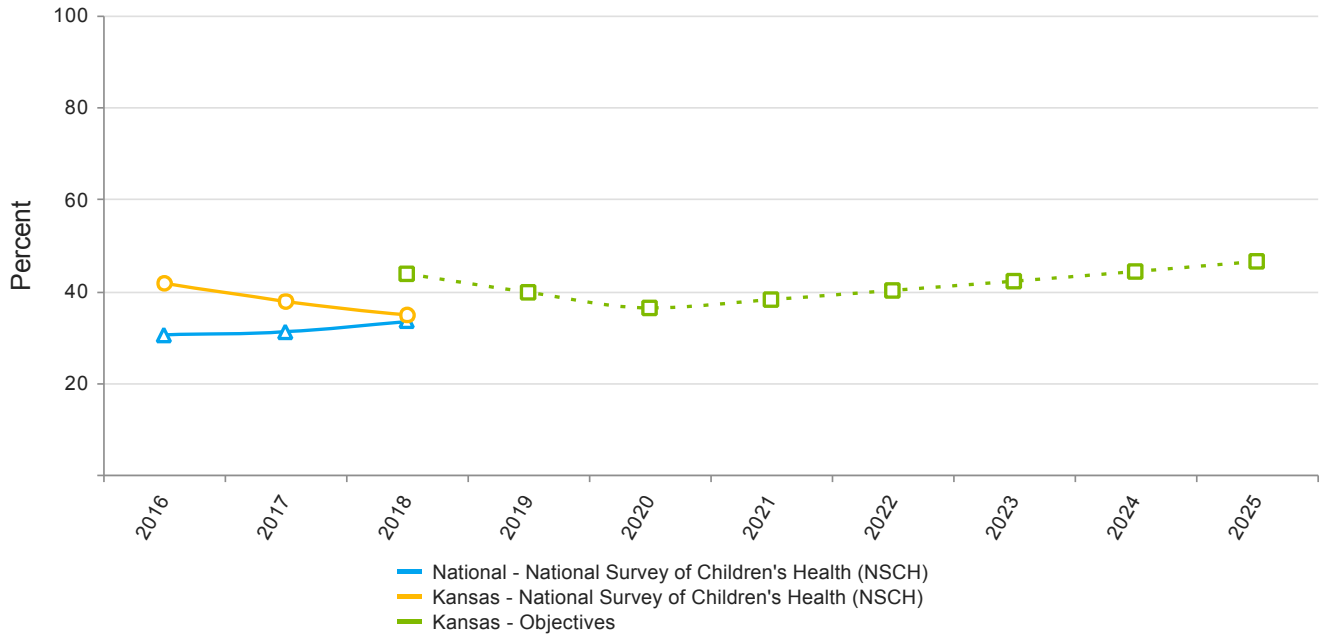
Child Health

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-2018	16.3	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	39.9	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	14.3	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	17.8	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.5 %	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**	**2019**
Annual Objective			43.7	39.7
Annual Indicator		41.6	37.8	34.6
Numerator		33,290	30,554	27,890
Denominator		79,958	80,931	80,611
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	36.3	38.1	40.1	42.1	44.2	46.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		90	72.7	25
Annual Indicator	12.7	21.4	22.3	15
Numerator	243	347	340	256
Denominator	1,907	1,621	1,524	1,707
Data Source	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	27.5	30.0	32.5	35.0	37.5	40.0

State Action Plan Table

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

Priority Need

Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

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

Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening by 5% annually through 2025.

Strategies

Build MCH capacity to support coordination and two-way referrals with other providers offering community-based services through utilization of the statewide 1-800-CHILDREN helpline, including referrals to providers and services through local health agencies participating in an Integrated Referral and Intake System (IRIS) communities.

Provide guidance, training, and technical assistance to MCH local agencies and marketing and education to families on the importance of early/ongoing developmental screening, use of evidence-based screening tools (e.g., ASQ-3, ASQ SE-2, MCHAT), and follow up.

Partner in the development of an integrated, statewide developmental screening data-sharing platform to drive the implementation of an early childhood integrated data system (ECIDS).

Promote evidence-based programs and initiatives for community and health care providers regarding healthy child development and early learning (e.g., social-emotional development; developmental milestones/Learn the Signs, Act Early; early literacy/Turn a Page, Touch a Mind/Brush Book Bed/Imagination Library).

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

Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

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

Increase the proportion of children, 6 through 11 years, with access to activities and programs that support their interests, healthy development, and learning by 10% by 2025.

Strategies

Partner with school-aged programs, local school districts and the Bureau of Health Promotion to align core messaging around child health initiatives (e.g., physical activity [Move Your Way and Let's Move], nutrition, literacy, screen-time, self-determination).

Provide resources and supports to partner with local officials to support safe, inclusive school and community playgrounds, including adapted play equipment for children with mobility and sensory needs.

Partner with community organizations leading efforts on social-emotional health and provide programs that support the encouragement and empowerment to build healthy relationships with parents/caregivers, teachers, mentors, health care providers, and peers.

ESMs	Status
ESM 6.1 - Percent of children, ages 9 through 35 months, who received a parent-completed developmental screen during an infant or child visit provided by a participating program	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 3

Priority Need

Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

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

Increase the proportion MCH program participants, 1 through 11 years, receiving quality, comprehensive annual preventive services by 10% annually through 2025.

Strategies

Engage partners to promote the importance of comprehensive preventive child well visits utilizing all elements of the Bright FuturesTM guidelines.

Assess need and capacity to increase access to care coordination services and supports in all settings where children receive preventive well-visits and support activities.

Provide technical assistance to MCH local agencies in existing IRIS communities using developed implementation toolkits to actively engage around the Help Me Grow core health care provider outreach components to provide coordinated services, supports, and connections.

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

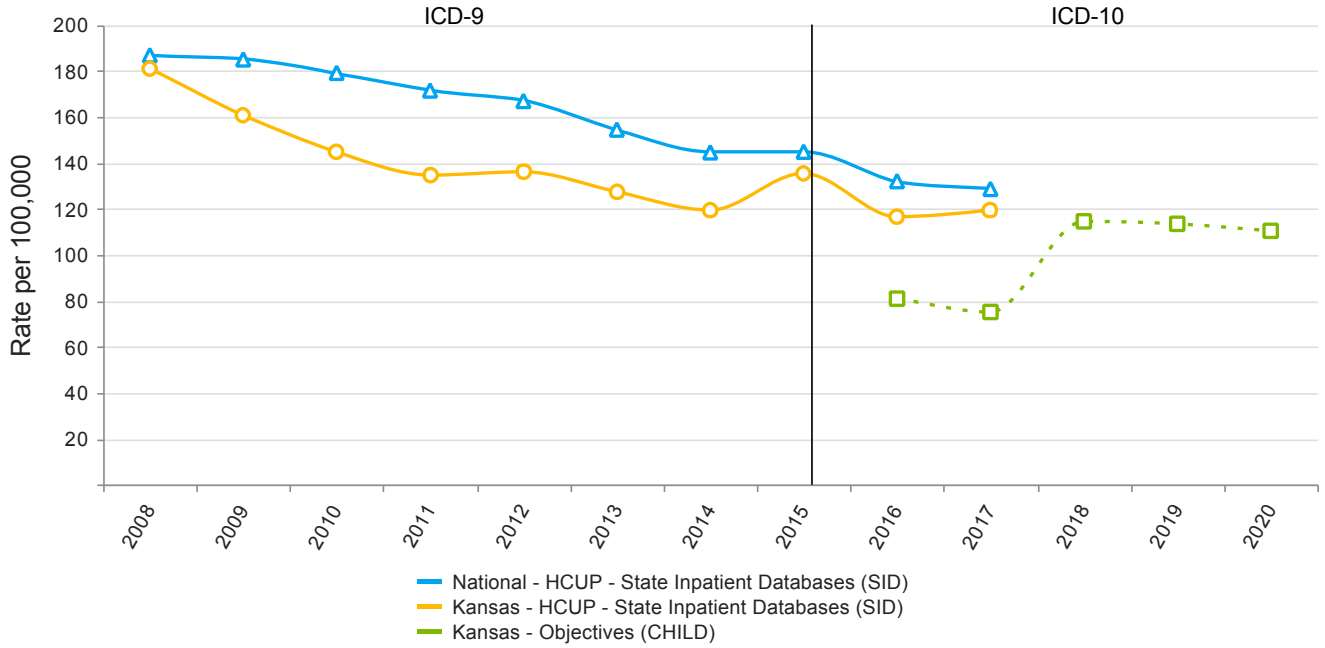
NOMs

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

2016-2020: National Performance Measures

2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Indicators and Annual Objectives



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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	80.9	75.1	114.5	113.4
Annual Indicator	80.8	135.5	116.4	119.1
Numerator	325	406	461	468
Denominator	402,420	299,709	395,930	392,943
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**	**2019**
Annual Objective		1,050	1,100	1,000
Annual Indicator	969	1,094	961	1,019
Numerator				
Denominator				
Data Source	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

2016-2020: State Performance Measures

2016-2020: 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**	**2019**
Annual Objective		29.6	35.4	28
Annual Indicator	28.2	32	26.7	26.8
Numerator	133,276	77,678	60,041	63,077
Denominator	473,426	242,379	224,657	234,934
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2016	2016-2017	2017-2018
Provisional or Final ?	Final	Final	Final	Final

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 2: Physical Activity (Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day)

Local MCH Reach: 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 2017-2018 National Survey of Children's Health (2 years combined), 34.6% (95% confidence interval [CI], 23.3% - 48.0%) of Kansas parents reported they completed a standardized screening tool during a health care visit, compared to 33.5% (95% CI, 31.1% - 36.0%) nationally. However, the difference was not significant. In fiscal year 2019 (10/01/2018-09/30/2019), according to the Kansas Medical Assistance Program Annual EPSDT Report, 45,101 (91.3%) of the 49,417 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 (e.g., activities are focused on all children birth to 5 years, rather than only on 9 through 35 months).

Help Me Grow Kansas: Kansans recognize the need for early identification of children at risk for developmental and/or behavioral challenges and for improved linkages between families and the services and supports they need. Help Me Grow (HMG) is a national framework that promotes integrated, cross-sector collaboration to build efficient and effective early childhood systems that mitigate the impact of adversity and support protective factors among families. 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, as shown in the image to the right.

Title V initiated HMG efforts in February 2017 by convening 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 2018, Kansas became a HMG national affiliate state. The Kansas HMG mission states, "Kansas families have informed and equitable access to seamless, comprehensive supports and services that ensure the well-being and lifelong success of all children." The HMG vision is "Connected Families Connected Communities: Every Child Thrives." This has been the foundational framework for much of the early childhood systems building work (described later in this report). The 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. 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 Screen Early Start Strong website, originally developed through the KIDOS 1.0 project, was redesigned and integrated into Kansas Help Me Grow website (screenshot below) updated to reflect the interests and needs of these three groups. This site also contains information about the HMG Framework and pilot communities, information on how to contact the statewide centralized access point, the Parent Helpline (1-800-CHILDREN), and family and provider resources.

MCH/Early Childhood Comprehensive Systems Partnership: Kansas is one of 12 states that received an Early Childhood Comprehensive Systems (ECCS) Impact grant and is in Year 4 of a 5-year grant cycle. The Title V priority and measures for child health are 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. 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 (HMG framework, integrated referral and intake system, state early childhood systems building, and more).

The ECCS Impact project, also known as the Kansas Initiative to Develop and Optimize Systems for early childhood (KIDOS 2.0), expands upon existing efforts and infrastructure to effectively coordinate, improve, and promote developmental health for infants and toddlers across a variety of health and early childhood support systems. 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 children who received a parent-completed developmental screening tool during an infant or child visit provided by a participating program (9-35 months).

The ECCS/KIDOS 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 (CoIIN) work that is central to ECCS Impact. As part of this CoIIN work and continuous quality improvement effort, 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. The number of developmental screenings reported in 2019 increased from 2018 in the areas where ECCS work takes place (576 in 2018 to 1,075 in 2019). Highlights of the reporting period activities 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.

These resources are used as appointment reminders for upcoming screenings/well child visits and for parent engagement opportunities (e.g., community health fairs, baby shower events). Geary County Hospital provided approximately 200 - 2-month developmental milestone postcards in the “new mom” packets. Early childhood programs, also in Geary County, gave out up to 40 passports each month during developmental screening events. As part of the 2019 KS Parent Leadership Conference held on November 15-16, Title V and other KDHE programs hosted breakout sessions about family self-care. During the session, families walked away with a bundle of developmental milestone postcards and a passport for each child. Approximately 200 passports and 100 bundles of postcards were given out. Feedback from the attendees were positive, indicating they would use the passports and loved the activities listed on the postcards and what to look for in their child’s development. The Developmental Screening Passports and Developmental Milestone Activity Cards were translated into Spanish to increase outreach to our Spanish-speaking population.

Title V is building from ECCS to impact the broader MCH work around developmental screening. The below table describes the distribution of ECCS materials with more than 1,527 pieces of developmental screening materials distributed through local and state level activity. Title V staff continue to receive requests from MCH Home Visitors and grantees for more materials, therefore the materials have been made available for free download on the HMG website.

Event	Agency Lead / Partner	Materials Distributed	Number of Materials
PRAMS Incentives Statewide randomly selected mailings	KDHE PRAMS Team	Milestone Activity Cards	427 Cards
2019 Parent Leadership Conference Topeka	Kansas Head Start Association	Milestone Activity Cards, Passports	100 Card bundles 200 Passports
Needs Assessment Meetings Statewide	KU-CPPR	Passports	200 Passports
“New Mom” Packets	Geary Community Hospital	Milestone Activity Cards	200 Cards
Developmental Screening Events Geary County (monthly)	Early Childhood Programs in Geary County	Passports	48 Passports

ASQ Trainings & ASQ Screening Data: ASQ Screening data shows that through the KIDOS 2.0 project 1,075 screening assessments were completed during this project year. Of these screenings, 41 were conducted on infants (< 1 year) and 1,034 were children between the ages of 1 year through 5 years old. A total of 57.5% were Caucasian, 9.3% were Black or African American, 1.3% were Asian, and 15.5% reported more than one race.

Building on past work of KIDOS 1.0, to increase the number of health and early childhood practitioners trained on administering ASQ screenings, KIDOS 2.0, with support from the United Methodist Health Ministry Fund and partnership with the University of Kansas, provided ongoing ASQ trainings 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.

During this program year, ECCS made great strides in building relationships with local medical professionals. With patience and the efforts of the local health provider champions, more medical facilities are being trained on the ASQ-3 and ASQ:SE tools. ECCS staff have also provided on-site technical assistance on how to incorporate development screening into policies and practices in these facilities. Between August 1, 2018 and July 31, 2019, 103 professionals attended an ASQ training. The following table outlines the impact of the trainings during the reporting period.

Date	Location	Sectors attending	#	Impact
Oct. 2018	Hutchinson	Home Visiting and Child care providers	20	A course was requested for an in-person training to train new staff.
Nov. 2018	Hays	Home Visiting and Child care providers	17	Ellis Co. HMG indicated a few childcare centers started to use developmental screening
Nov. 2018	Wichita	Home Visiting and Child care providers	21	A course was requested for an in-person training to train new staff.
Jan. 2019	Olathe	Medical Providers	10	Olathe Health/Olathe Medical started to use the ASQ-3 for their developmental screening during well child checks
April 2019	Junction City	Home Visiting and Child care providers	21	A new child care center had been established, ECCS project coordinator provided director with ASQ-3 and ASQ SE:2. Child care center started to use the developmental screens during parent-teacher conferences
June 2019	Eudora	Medical Providers	5	Lawrence Medical Centers: Rural Clinic in Eudora started to use the ASQ-3 for their developmental screening during well child checks
July 2019	Tonganoxie	Medical Providers	9	Lawrence Medical Centers: Rural Clinic in Tonganoxie started to use the ASQ-3 for their developmental screening during well child checks

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 the ASQ Enterprise, a secure online database for tracking ASQ screenings. Building from KIDOS 2.0 and HMG initiatives, Title V has been engaged in conversations among key state partners and backbone support from KU-CPPR, with Brooke's Publishing regarding using the ASQ Enterprise to expand data entry into the existing system by bringing data together into a data warehouse, or "hub." This would allow Kansas ASQ data to be available across all online/pro/enterprise accounts and moves the state forward in the development of an Early Childhood Integrated Data System (ECIDS), rather than increase the number of accounts across the state. While this is not a new goal for KS early childhood partners, current programming and leadership have brought about a renewed focus (specifically the alignment work and collaboration brought about with the work around HMG and the Preschool Development Grant activities). The broader vision is to inform services, connect parents to resources, and move the needle towards wide spread screening for all kids and earlier interventions. More information about the State wide ASQ Enterprise can be found in the Child Plan.

Developmental Screening Environmental Scan: Title V partnered with the Early Childhood Comprehensive Systems (ECCS) project to complete an environmental scan of developmental screening in the state in order to identify what entities offer screenings, the tools being used, and barriers preventing regular screening practices. Between November 2018 to April 2019, data from the developmental screening environmental scan was collected using the Qualtrics survey tool. A total of 550 unduplicated surveys were analyzed by early childhood partners representing all six regions of the state. A total of 491 respondents identified what provider settings across the state were utilized to complete developmental screenings.

Provider Setting	Number using tool/ Total Reponses from Setting	Percent of Total (n=491)
Child Care	50/72	69.4%
Child Services Nonprofit	38/41	92.7%
Community Developmental Disability Organization	16/19	84.2%
Head Start/Early Head Start	20/20	100%
Health Department	58/67	86.6%
Medical Clinic	62/75	82.7%
School/Education Setting	227/231	98.3%
Other	20/25	80.0%

The table below shows the developmental screening tools used by respondents. Results show most respondents utilize validated developmental screening tools. Title V staff are working on locating partners that are not using evidence-based tools to provide technical assistance and resources related to obtaining validated screening products for practice implementation.

Developmental Screening Tool	Number of Responses	Percent of Total (n=550)
Ages and Stages Questionnaire 3 (ASQ-3™)	441	80.2%
Ages and Stages Questionnaire Social-Emotional, Second Edition (ASQ:SE-2™)	368	66.9%
Parents' Evaluation of Developmental Status (PEDS)	31	5.6%
Modified Checklist for Autism in Toddlers (M-CHAT)	107	19.5%
Denver Developmental Screening Test-II (DDST-II)	4	0.7%
Developmental Indicators for the Assessment of Learning (DIAL-4)	39	7.1%
Individual Growth and Development Indicators (IGDIs)	9	1.6%
Developed or modified screening tool	6	1.1%
Other	97	17.6%
None	63	11.5%

The Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT), also referred to as KanBehealthy (KBH), guidelines recommend developmental screening at regular intervals including at 9, 18, and 30 months. The table below shows when respondents administer developmental screenings.

Frequency	Number of Responses	Percent of Total (n=399)
Every well child visit	81	20.3%
9 months	105	26.3%
18 months	118	29.6%
24 months	120	30.1%
30 months	113	28.3%
3 years	157	39.3%
4 years	151	37.8%
5 years	159	39.8%
Other*	174	43.6%

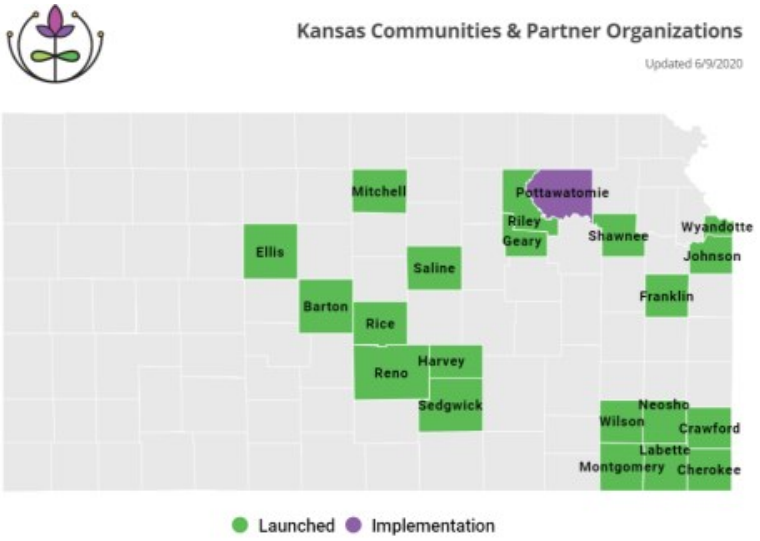
Aligning Developmental Screening Efforts: KIDOS 2.0 continued to align with Delivering Change and Lifting Young Families Towards Excellence (LYFTE) project (administered by the Bureau of Family Health) in Geary County. and with the MIECHV, LYFTE and Kansas Connecting Community (KCC) work in Montgomery County. As part of the efforts to strengthen early childhood systems, both communities are piloting the Help Me Grow (HMG) framework. The Montgomery County IRIS community expanded to include Crawford County which has resulted in 50 programs and 21 organizations. 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. LYFTE in SEK aims to improve the lives of young families, parents and children, through an integrated approach to life-skills development, focusing on health, education, and employment. KIDOS 2.0 staff work with LYFTE navigators to ensure that information about children's development is provided to parents in this program. Recently the state was awarded a maternal screening grant called Kansas Connecting Communities (KCC). KCC is being implemented initially in SEK (Montgomery, Labette, and Crawford Co.). KCC aims to improve the mental health and well-being of pregnant and postpartum women through increased screening, referral, treatment and recovery support services. KCC increases statewide access (with a regional approach) to screening, assessment, and treatment for maternal depression and substance abuse disorders. KIDOS 2.0 staff worked with KCC staff to integrate depression and substance abuse screening into the care coordination of SEK families.

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 Title V. IRIS enables service providers in a community to make,

receive, and track referral, essentially helping organizations connect families to providers, services, and supports in their community. IRIS empowers communities to build a family-centered network supported by common expectations. In addition to closing 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.

IRIS implementation in Kansas began with a MIECHV pilot and then spread to the Healthy Start project, with the two ECCS Impact and MCH communities, to support best practices in social service referral and coordination. Community conversations 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 provided to organizations to ensure that IRIS is successfully incorporated into staff workflow. Data available for two IRIS communities follows.

- Southeast Kansas includes 75 programs offered by 30 organizations. There were 1,848 referrals between February 2017 (launch) and September 2019.
- Geary County includes 32 programs offered by 14 organizations. There were 1,403 referrals between February 2018 (launch) and September 2019. 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.



IRIS has helped align systems and increase coordination between public health and social services. Fourteen multi-sector IRIS networks currently span 20 rural and urban counties, and local public health programs have been early and enthusiastic adopters in nearly all of them. Public health organizations have initiated implementation n in half of all IRIS networks, identifying and engaging multi-sector referral partners and providing ongoing leadership to sustain and expand their local network. Referrals involving a public health program or partner have increased from 48% in 2018 to 62% in 2019. Key connections include WIC program referrals to dental providers, MCH referrals to early childhood programs, and health care providers to WIC. These referrals reflect network partners' view of public health programs as critical access points to a holistic range of programs and supports. Local health departments also use IRIS to coordinate internal referrals, streamlining and easing patients' experience accessing programs located under the same roof. The impact of IRIS across all community-based networks continues to grow. Total referrals doubled from 2018 to 2019 and, to date, 6,148 families have received 8,950 referrals, 42% of which resulted in the family engaging in services and supports.

Learn more about IRIS at: http://connectwithiris.org/what-is-iris/. 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.

Local MCH Agencies: Local agencies provided developmental screenings to children served, birth to age 6 years. 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 KanBeHealthy (KBH)/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 materials are provided to parents regarding developmental milestones during the visit.

A review of local MCH agencies revealed that six health departments were found to be conducting developmental screenings using tools not recommended by Kansas MCH (e.g., Denver products). MCH staff contacted these health departments to advise on utilizing the ASQ starter kit, training, and Enterprise. A few MCH local agencies using the ASQ are highlighted.

- Hays Area Children's Center MCH home visitors completed 20 ASQ questionnaires with families with children less than one year of age. Information about the importance of annual developmental screenings was covered with 27 clients, resulting in one referral to the local Part C program.
- Pawnee County Health Department uses Ages and Stages parent completed questionnaires for developmental screening and Pediatric Symptom checklists for older children. Parents and youth are given safety information based on Ages and Stages guidelines, physical activity, and decreased screen time.
- Saline County Health Department provides ASQ-3 and KIPS (Keys to Interactive Parenting Skills) developmental screens to program participants. KIPS is a structured observation tool to assess parent-child interaction during play.
- Wabaunsee County Health Department staff have parents of infants complete the ASQ-3 developmental screening and counsel on the growth and development expectations for the next six months. Parent are provided with written and verbal health information and education.

Local agencies use an outline and multiple screening assessment tools to determine the needs of the child through direct services and indirectly through making referrals. Data is captured in DAISEY 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. Child development education and referrals are also provided to clients receiving MCH home visiting services.

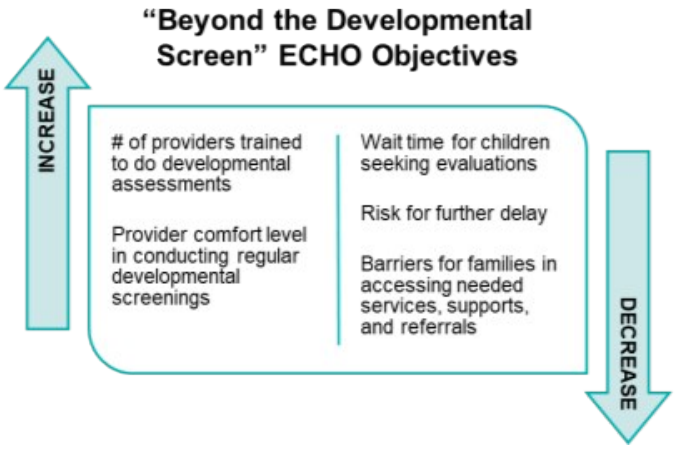
SFY2019 - Local MCH Agencies (client level & aggregate data in DAISEY)	
Child Development	MCH Visits (including Home Visits)
Services	1,830
Education	5,272
Referrals Made/ Completion Rate	172/255 67%

Feedback from local agencies emphasized their need to receive additional training on KBH visits and the Bright Futures 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, see more about this training in the Adolescent Report.

MCH home visitors provide child development and child social-emotional development screenings for families they serve. Universal MCH home visitors 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 the intent, purpose, and use of Bright Futures and the ASQ 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 Project ECHO: Title V partnered with the University of Kansas Medical Center Project ECHO (Extension for Community Healthcare Outcomes) team to conduct a four-part ECHO series entitled, "Beyond the

Developmental Screen." The series was designed to assist providers (medical, educational and community) to understand what to do after a developmental screening indicates a potential delay or 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 more timely or that may not even necessitate an appointment with a specialist. The goal was to increase the system's capacity to provide additional developmental evaluations and meet the needs of children with developmental delays, including providing access to services or diagnostic evaluations.



The ECHO team consisted 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 had experience with CSHCN and provided a valuable resource to all EHCO participants. This ECHO series occurred weekly throughout June 2019. Designed and led by Title V CSHCN, the objectives of the four sessions were: to raise awareness of the benefits of early screening, assessment and referral; provide an overview of screening implementation and the importance of working across systems to reduce duplication and assure screenings occur; help providers gain culturally competent communication strategies to help families better understand screening results; and share resources, referral points (specialty care, medical services, or community supports), and next steps when a developmental delay or concern is noted. Each session included didactic education, a case study, and allowed time for participants to ask questions and discuss.

The flyer for this event is located in the Supporting Documents included as part of this application.

Early Childhood Systems Building: Kansas received the Preschool Development Birth to Five Planning Grant (PDG B-5) in early 2019 to support the development of a comprehensive Needs Assessment and Strategic Plan for early childhood in Kansas. The Kansas Children's Cabinet and Trust Fund, Kansas Department for Children and Families, Kansas Department of Health and Environment, Kansas State Department of Education, and other early childhood stakeholders partnered with Kansas communities to carry out this important work. Throughout the process, young children ages birth through five and their families were at the core of the work. The collective vision of Kansas being "the best place to raise a child" served as the foundation of the efforts, echoed in the aspirations of thousands of Kansans who contributed to our shared understanding of early childhood in our state. Yet the reality for many Kansas families does not match this vision.

To this end, the Needs Assessment for the Preschool Development Grant Birth to Five (PDG) began in January 2019, consisting of five core components:

- Review and analysis of existing needs assessments
- Collection and analysis of additional data
- Story collection (SenseMaker®) and community sensemaking
- Community Engagement Sessions
- Synthesis

A large focus of the Needs Assessment was widespread community engagement and creating a mixed-delivery system that is coordinated, collaborative, and supportive to family needs. While these efforts provided extensive data around the struggles families face throughout the state, it also included many stories of resilience and community commitment to supporting families. This launched Kansas onto a journey in which children and families thrive in caring and connected communities, high-quality early childhood care and education services are equitably accessible and available, the early childhood workforce is valued and respected, and our resources and investments align with our vision.

Over 6,000 Kansans contributed to the data collection process, ranging from personal stories and online insights, to over 100 in-person community conversations with parents and caregivers, business leaders and elected officials, educators and health care providers, and a wide variety of early childhood care and education professionals and champions. In addition to the voices of Kansans, the Needs Assessment also includes an analysis of 45 existing needs assessment reports, and data collected from three new surveys on the early childhood care and education workforce, facilities, and pre-k services.

Building on the Children's Cabinet Blueprint for Early Childhood, promoting Healthy Development, Strong Families, and Early Learning, the new early childhood strategic plan was built from the analysis of thousands of data points, which resulted in two central messages:

- The experiences of families with young children in Kansas are shaped by where they live, both across the regions of the state and within their communities.
- Young children are growing up in families where basic needs are not being met.

Kansas Family Engagement and Partnership Standards for Early Childhood: Title V continues to be heavily invested and drive to streamline services and supports, improve early screening and identification, and assure needed services begin early in a child's life. As part of early childhood systems alignment work, Kansas Family Engagement and Partnership Standards for Early Childhood was reviewed and updated to better align with all early childhood systems across the state. The KS-SHCN Program Manager participated in both the original development team and the revision team.

The standards focus on families as: Foundation, Communicators, Advocates, Partners, and Community Members. The goal of this project was 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 Standards are:

designed to	are NOT designed to
Recognize the importance of the families in the early learning years.	Serve as a curriculum creating additional responsibilities for families.
Serve as a guide for appropriate family engagement and practices.	Exclude families from a service program, school or activity.
Serve as a guide for creating quality interactions and partnerships with families.	Place all responsibility on an individual family, early childhood educator or service programs.

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

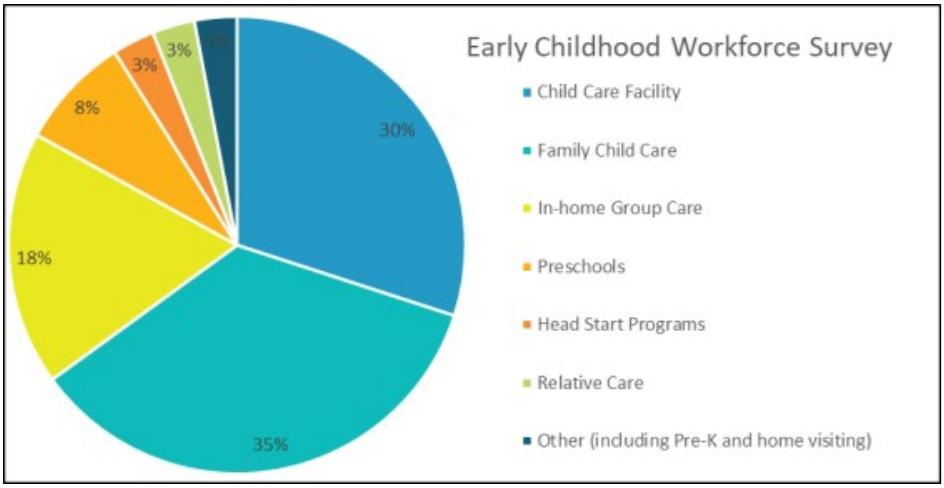
Child Care Licensing Partnership: In partnership with the Child Care Licensing program, the MCH Child and Adolescent Health reviewed the components of the *Screen Early Start Strong/Help Me Grow* resources for those that were most appropriate for child care providers. As part of the KIDOS 2.0 initiative aimed 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 importance of assuring this information is accessible, available, and valuable 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 brochures were also provided to child care licensing surveyors to be distributed to applicants during orientation.

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. Hours do apply toward annual in-service training requirements. Title V partners with Child Care Licensing, Child Care Aware of Kansas, and Kansas Children's 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

PDG Environmental and Workforce Survey: A total of 805 early childhood educators representing 84 Kansas counties took part in a statewide workforce survey. Professional voices representing early childhood convened to identify opportunities related to strengthening the early childhood workforce across the state.



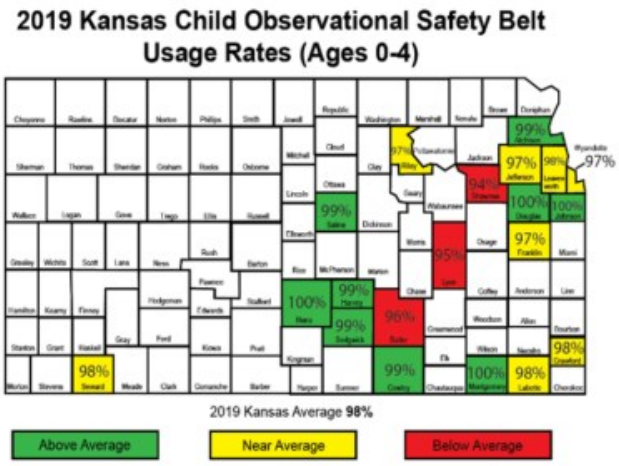
According to the survey, 41% of the current workforce travels more than 25 miles for professional development trainings. Most respondents (81%) report accessing online training. Professionals are primarily focused on completing only the required trainings for licensing purposes due to the constraints of travel and cost. The survey also revealed that 78% of respondents have 15+ years of experience in the field and are looking for more intermediate or advanced training options (building on knowledge). However, there is still a need for more entry-level training options on trauma-informed care, infant-toddler care, and early learning standards. A summary of the workforce survey is available online here: https://kschildrenscabinet.org/wp-content/uploads/2019/08/NewSurveys_Summary.pdf.

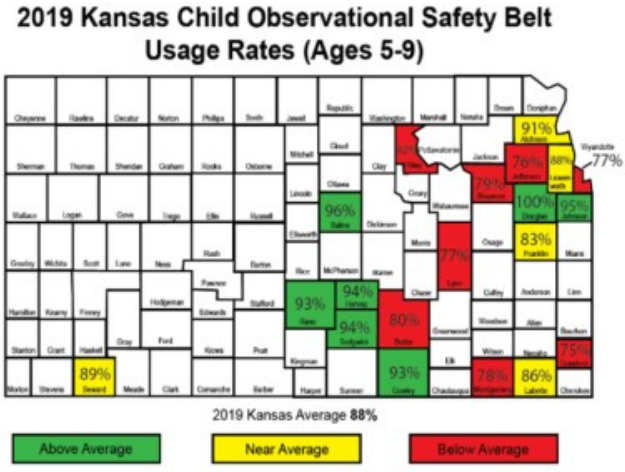
NPM 7: Child Injury (0 to 9 years)

In 2017, rates of non-fatal injuries were highest among infants less than a year old (204.9 per 100,000), followed by children ages one to four (148.3 per 100,000), and children ages five to nine (80.1 per 100,000). Non-Hispanic black children had the highest rate of non-fatal injury hospitalizations at 190.4 per 100,000, which was nearly double the rates among non-Hispanic white (116.1 per 100,000) and Hispanic (88.7 per 100,000) children. Male children are more likely than female children to sustain non-fatal injuries (134.5 per 100,000, versus 102.5 per 100,000, respectively). Children in small/medium metro areas (155.4 per 100,000) had significantly higher non-fatal injury rates than children in large metro areas (93.9 per 100,000). Rate in non-metro areas was 112.8 per 100,000.

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 & Local Partnerships: Title V has a close partnership with Safe Kids Kansas, a network of partners and local coalitions across the state dedicated to preventing childhood injury. The Safe Kids Kansas Director sits on the KMCHC and provides technical assistance to local MCH agencies on activities such as coalition development and building a car seat program (including training for potential car seat technicians). There are 13 local MCH agencies (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) that serve as members of their communities 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 continues to work with Safe Kids to uncover where there are gaps in coverage of Safe Kids Coalitions.





Title V uses curricula from the Kansas Traffic Safety Resource Office (KTSRO) for car seat safety education at the local level. Data from the KTSRO 2019 Kansas Child Seat Belt Survey revealed both successes and potential areas where MCH can target over the next year to increase seatbelt use. Of the 20 counties completing the survey, 12 saw increased use of seat belts from the previous year. Wyandotte and Harvey counties reported the highest increase of seatbelt use for children ages 0-4 years (3.66% and 3.45%). Five counties showed an increase of 5% or above in seatbelt use for children ages 5-9 years (Harvey 13.87%, Reno 11.57%, Lyon 7.25%, Labette 6.19%, Seward 5.25%). Seatbelt usage is below average in many counties.

Local MCH Agencies: Many local MCH agencies provide education on car seat installation and safety, several agencies also have staff that are Child Passenger Safety Technicians. During the report period, 3,437 car seat safety/installations

were provided to families served through MCH local agencies. One local agency, Morris County Health Department continues to have a strong Safe Kids Coalition in their community. Morris County MCH staff provide education and equipment/devices recommended by Safe Kids. They also have a Certified Car Seat Technician that installs and checks car seats during community outreach activities. Children are weighed and measured by the certified car seat technician and advised what type of car seat is recommended for each child. Certified car seat technicians with the Saline County Health Department provide training to clients on car seat safety during prenatal visits. The Cowley County Health Department MCH Home Visitor is trained as a Car Seat Technician and provides safety education on car seats, bicycle helmets, and carbon monoxide detectors to families in partnership with their Safe Kids Coalition. Kearny County Hospital staff participated in a Child Passenger Safety Technician training to assist parents with correctly installing child car seats. They have eight certified car seat technicians on staff. They hosted two free car seat check-up events with a local trooper. Car seats and booster seats were also available for children without proper seats.

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

Safe Kids Kansas Collaboration: Title V staff continue to work closely with the Bureau of Health Promotion, Injury Prevention Program and Safe Kids 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 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 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 Resources: Title V staff continued to promote poison control resources, including the *Poison Diaper Bag* (available in English and Spanish http://www.kumed.com/medical-services/poison-control/info-for-families). Home visitors are encouraged to increase awareness of the Poison Control Center Helpline (1-800-222-1222), Poison Control Center services and distribute poison control center resources such as "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 Control Center Helpline number.

Smoke and Carbon Monoxide Detectors for Families of CSHCN: In partnership with Safe Kids the KS-SHCN program offered free smoke and carbon monoxide detectors to any family served by the program. Families are asked if they have these devices in their home. If not, KS-SHCN arranges for free detectors and installation. When a custom installation is required, due to the child's health needs, KS-SHCN covers the installation expense through the Special Bequest fund. Smoke and carbon monoxide detectors are covered by Safe Kids. 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. Both programs are committed to working together to keep all Kansas children safe and healthy and to developing additional partnership projects in the future.

The KS-SHCN care coordinators share the Safe Kids safety tips with families and other information they learn with CSHCN families, and if appropriate, add child injury prevention goals to the child's Action Plans.

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.

Physical Activity Guidelines in Kansas Schools: Members of the KMCHC Child Work Group created an action plan to address the lack of physical activity in school-aged children in July 2019. Since this population spends most of their time in a school environment, the group reviewed resources on recommended recess policies based on Children Mercy Hospital's "Creating Healthy Schools" program and created action alerts to support adoption of these policies.

The three main policies consisted of: providing at least one 20-minute elementary recess daily, providing 3- to 5-minute physical activity breaks during classroom time, and not using or withholding physical activity as a punishment. Letters in support of these policies were created for school superintendents, physical education teachers, and health department staff to discuss with parents during child well visit appointments. Dissemination of letters and resources are planned during the next grant reporting year.

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.

- Morris County Health Department collaborated with the Morris County CORE Coalition to promote the Walk KS Kids

offered to children in elementary schools in the county. The agency annually offers a SAFE Kids Day featuring bicycle safety education to all 3rd grade students in their community. The mission of the Morris County CORE Coalition focuses on health and wellness, including drug and alcohol prevention.

- Sedgwick County Health Department home visiting staff work with families on developmental and physical activities to implement into their daily lives while interacting with their children. Home visiting staff use the developmental/physical activities provided by Ages and Stages Questionnaire to create action items for families.
- Wilson County Health Department partnered with the Cultivate Fredonia Healthy Living Action Team (HLAT) to engage community business and partners to conduct their Every Child Deserves a Bike program for the third year. During 2019, new bicycles and helmets were offered to all 2nd graders after a safety demonstration from local law enforcement.

Child Care Licensing: Child Care Licensing collaborated with the Bureau of Health Promotion to update a Physical Activity training available to early care professionals. The training included all ages and was developed using CDC standards and the *Let's Move!* Child Care model (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 39 child care center staff and 25 in-home early care professionals from April 2019 through April 2020.

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: 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 BaM curriculum, as part of the "relaunch" of the BaM curriculum by KPCC. 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 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: Child Care Licensing continued collaboration with KCCTO to offer online trainings to support the health and wellbeing of children while in out-of-home care, specifically around oral health needs.

- Whole Tooth and Nothing but the Tooth: This introductory course assists early care professionals in understanding the importance of good oral health. Specifically, participants learn the benefits of keeping children cavity-free, strategies for the prevention of bacterial transmission, healthy snacking tips, and how to keep teeth clean and strong as well as information on group tooth brushing. Additionally, participants are provided with numerous resources to assist them in promoting oral health in the child care setting and home setting for families. Six training sessions were offered between April 1, 2019, through April 30, 2020. The training was completed by 93 child care providers from 38 of 105 counties.
- How Teething, Weaning and Oral Habits Impact Oral Health: This introductory course addresses three events that can have a significant impact on a child's oral health. Topics included: what to expect during the teething process, how to properly wean infants and toddlers, the advantages and disadvantages of non-nutritive sucking, as well as ideas for discontinuation of oral habits such as thumb sucking and pacifier use. Eight training sessions were offered between April 1, 2019, through April 30, 2020. The training was completed by 160 child care providers from 49 of 105 counties.

Child Health - Application Year

PRIORITY 3: Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities

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)

Local MCH Reach: Based on SFY2021 MCH Aid-to-Local applications received:

- 55 of 67 grantees (82%) plan to provide services to the Child population
- 50 of 55 grantees serving the Child population (90%) plan to provide developmental screening services

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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.

Kansas has worked hard to increase the amount of early evidence-based developmental screening for children under six years. However, the national performance measure shows a downward trend of parents reporting the completion of a parent-completed child developmental screen in the past year (41.6% in 2016; 37.8% in 2017, NSCH). Title V staff will work to overcome this disconnect by increasing messaging and information to parents about the importance of developmental screening and spread use of evidence-based screening tools.

Provider & Parent Education/Training: Title V will continue to coordinate with other early childhood partners in promoting and offering additional training and technical assistance opportunities for the Ages & Stages Questionnaire (ASQ), Third Edition (ASQ-3) and ASQ Social-Emotional, Second Edition (ASQ:SE-2). Utilizing knowledge and resources acquired from the ASQ-3 and ASQ:SE Training of Trainers Institute hosted by Brooks Publishing, the Child Health Consultant will join others around the state to conduct trainings for organizations and their staff members and communities. Training participants will represent public health, family physicians, pediatricians, home visitors, child care providers, and school personnel. The goal is to spread the awareness and use of these evidence-based screening tools, how and when to conduct screenings, how to analyze and share the results, and follow-up steps if the screening shows potential developmental delays. Title V staff will encourage local MCH agencies to purchase ASQ-3 and ASQ:SE starter kits if they do not already utilize the screening tool at their location and to register any current and/or new staff members for upcoming trainings.

Parents participate in child well visits, home visitations, and local events where developmental screenings take place but may not realize or understand that the questions they are being asked or questionnaires they complete are tied to a developmental screening tool. For that reason, Title V will create one-page fact sheets and social media messaging in English and Spanish to increase caregiver/parent knowledge. Resources such as CDC's "Learn More about Your Child's Development: Developmental Monitoring and Screening" and the "ASQ for Parents: Your Quick Guide to ASQ Screening" will inspire the final products. The fact sheets and social media messages will become a quick reference and reminder of why it is important to screen, who can complete a developmental screen, names of specific evidence-based screening tools, American Academy of Pediatrics (AAP) recommendations on what age intervals a screening takes place, and what happens after the results are analyzed. The written documents will be disseminated to local MCH agencies, child care providers, libraries, healthcare workers, and home visitors to use with families. Documents will also be made available on state and local health websites for public use and at state and local community events.

Development Milestone Cards & Passports: Title V will continue to disseminate the Developmental Milestone and Activity Postcards and Developmental Screening Passports previously created through the Early Childhood Comprehensive Service (ECCS) grant for MCH programs' use with families. The 21 Developmental Milestone Postcards contain developmental milestones provided by the CDC and age-appropriate activities promoted by Vroom. The cards are shared with families to start a conversation about a child's development and to encourage a fun learning experience at home and will continue to be distributed and promoted in the upcoming grant year. The Developmental Screening Passports are helpful tools for families in tracking the number of developmental screenings their child received. More information about these tools can be found in the Child Report.

Developmental Screening Tracker (part of the Passport)

Developmental Screening Tracker

DATE	CHILD'S AGE	SCREENING TOOL USED	WHO ADMINISTERED TOOL*	NO REFERRAL	MONITORING	REFERRAL	COMMUNICATION	GROSS MOTOR	FINE MOTOR	PROBLEM SOLVING	PERSONAL-SOCIAL SELF HELP	SOCIAL-EMOTIONAL	OTHER COMMENTS

*Doctor, child care, teacher, or other

Child's Name: _____

Birth Date: _____

Parent's Name: _____

My child's care providers

Health Care Provider/Doctor: _____(Phone)

Child Care/Education Provider: _____(Phone)

Home Visitation Program: _____(Phone)

Other Provider: _____(Phone)

Other Provider: _____(Phone)

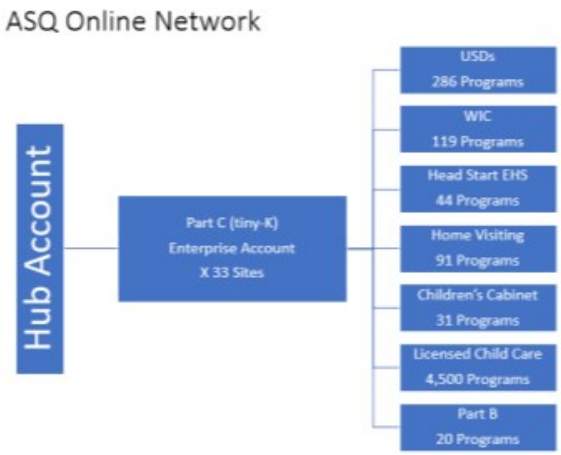
Local MCH Agencies: Local agencies will continue to provide developmental screening at least once a year to children they serve. Many local agencies use the ASQ-3 and ASQ-SE2 for developmental screenings for ages 2 to 60 months (5 years) and use the Bright Futures Pediatric Symptoms Checklist (PSC) for children over 5 years of age. Local MCH agencies will continue to provide required ASQ screenings during KanBeHealthy (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 activities are highlighted.

- Pottawatomie County plans to mail the questionnaire ahead of time for parents to complete prior to the 2, 4, 6, 9, and 12-month visits. This will be reviewed and discussed during the visit. If a child scores low on the assessment, MCH staff will refer to the Infant and Toddler program or other appropriate community services. MCH staff will continue to use the Bright Futures Toolkit and resources.
- Labette County staff will offer parents the tool to be completed on their infant/child when receiving services at the health department. The tool will be reviewed by nursing staff to identify any risk for delays and then discussed with parents highlighting any identifying delays as well as the child's strengths. Parents will receive educational information on child development. Any child who has any identifying risks will be referred to their primary healthcare provider, local Mental Health Services, Parents as Teachers, Early Head Start and/or Birth to Three. Referrals will be made directly to the health care provider or support agency using email, phone, or IRIS (Integrated Referral and Intake System).

- Nemaha County MCH nurse will screen for developmental delays at each KBH Assessment, when age appropriate. MCH nurses will score the ASQ-3, interpret the scores, and communicate results to parents. Referrals will be made to appropriate intervention services if child is not yet 3 years old (tiny-k) or special education program if child is 3 years old or older. The child's primary healthcare provider will also be notified when a referral is made due to a possible developmental delay. MCH nurses will follow-up on the referral within two weeks to ensure that services are being received. The agency clerk will maintain a follow-up system and send parents a letter when their child is due for the KBH per the Bright Futures Periodicity Schedule.
- Riley County will 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 via the IRIS referral system. MCH staff will provide KBH screenings for children from 36-71 months. Education such as safety and injury prevention are discussed during the visit. The MCH program will address child abuse prevention by promoting the protective factors and addressing prevention of Adverse Childhood Experiences (ACES) which can lead to health issues across the lifespan.
- Shawnee County will screen 100% of MCH infants and children and refer all screens that are not within normal range or if a parent has concerns about their child's development for further evaluation through the tiny-k local infant toddler network. Staff will follow-up with parents to make sure further evaluation takes place. MCH staff will distribute and educate clients about the CDC Milestone Moments booklet and what they should expect of their child's development. The Bright Futures Toolkit is used as a resource for all MCH staff providing home visits. Bright Futures handouts are utilized for distribution to families focusing on nutrition and development.

In order to support and build the capacity of local MCH agencies, Title V will provide guidance, training and technical assistance in the marketing and education to families on the importance of early and ongoing developmental screening and the use of evidenced based tools such as the ASQ-3 and ASQ SE-2. Title V will work closely with state partners to promote evidenced based programs and initiatives for community and health care providers such as: Learn the Signs, Act Early; Turn a Page, Touch a Mind; and the Dolly Parton Imagination Library.

Utilizing Statewide ASQ Data: Title V, in partnership with other state agencies, entered into an agreement with Brookes Publishing to establish a statewide ASQ Enterprise for alignment of statewide data. Successful discussions and planning strategies have been ongoing with Brookes Publishing, and a plan is now in place to consolidate multisector development screens into one statewide hub account. Below is an image of the multi-sector structure that will be in place. Once established, technical assistance will be provided to local MCH agencies on how to access the statewide ASQ Enterprise and guidance for documentation of developmental screenings and referrals into the shared data measurement system, DAISEY.



Early Childhood Systems & Collaboration: Title V will continue to partner with other early childhood agencies, including the Kansas State Department of Education (KSDE), Department for Children and Families (DCF), and Kansas Children's Cabinet & Trust Fund (KCCTF), to focus on children's developmental health and emphasize the importance of early and ongoing developmental screening. Title V is dedicated to assisting communities in creating seamless and coordinated systems that connects families to local services and resources. In addition to partnering around the ASQ screening and data utilization, Title V will build MCH capacity to support the Help Me Grow Kansas Connected Families, Connected Communities vision; facilitate access to available resources through the statewide 1-800-CHILDREN helpline; and support coordinated, two-way referrals with other providers offering community-based services through use of IRIS at the community level.

- *Help Me Grow (HMG).* Kansas adopted the national HMG framework to promote developmental screening to monitor children's developmental health and connect families to needed intervention, services, and supports. Implementation of HMG in communities across the state is ongoing; however, the use of existing developmental screening materials has been integrated. The team will continue to develop resources and tools for HMG communities and promote existing resources such as the statewide centralized access point (CAP), launched in May 2019. More information about HMG can be found in the Child Report.
- *1-800-CHILDREN/Helpline*. Administered by the Kansas Children's Service League and funded through multiple sources, the 1-800-CHILDREN helpline serves as the statewide CAP for HMG Kansas (anonymous information and referral line). Trained volunteers listen, empathize and offer support to any parent, provider, or individual who calls. The service is free and available 24/7 for English- and Spanish-speaking callers. State agencies are promoting the line as one centralized access point for services anywhere in the state.
- *Integrated Referral and Intake System (IRIS).* Kansas selected IRIS as the tool to support web-based communication for organizations to connect the families they serve to the right resources in their community. IRIS empowers communities to build a family-centered referral network based on common expectations. In the upcoming grant year, Title V will continue to promote and support communities who choose to implement IRIS. Title V staff will continue to connect communities to technical assistance and help in crafting innovative solutions for communities that currently participate in or want to explore IRIS. More information about IRIS can be found in the Child Report.

Recognizing the potential of local networks to impact health and well-being by facilitating access to resources across the lifespan, state public health leadership will address barriers limiting the participation of critical community partners such as behavioral health, primary care, and concrete supports. State public health leadership will use the rich, ever-growing data generated from IRIS networks to reveal gaps in services, identify opportunities for increased partnership at the local level as well as determine program priorities and opportunities.

Beyond the Developmental Screen: The KS-SHCN Medical Director, a retired Developmental Pediatrician contracted to advise and assist the program, will continue to offer assistance via telehealth to providers conducting developmental evaluations by providing consultation services. The contracted provider continues to follow-up with attendees who participated in the 2019 "Beyond the Developmental Screen" Project ECHO. He also provides input, feedback, and guidance to address emerging issues, such as the recent COVID-19 pandemic, to identify resources and information that program staff can share with families and Title V partners. He will continue to be consulted regarding COVID-19 concerns of the CSHCN population and provide guidance to care coordinators for children with significant medical complexities.

KS-SHCN staff remain current on statewide early childhood initiatives by providing the Title V CSHCN lens and insight for the CSHCN population on many of the early childhood workgroups. The KS-SHCN Care Coordinators continue to build relationships across the state to support collaboration, planning, and coordinated services and supports to avoid duplication of effort and assure that children are being identified early so services can begin quickly.

Other Child Health Objectives

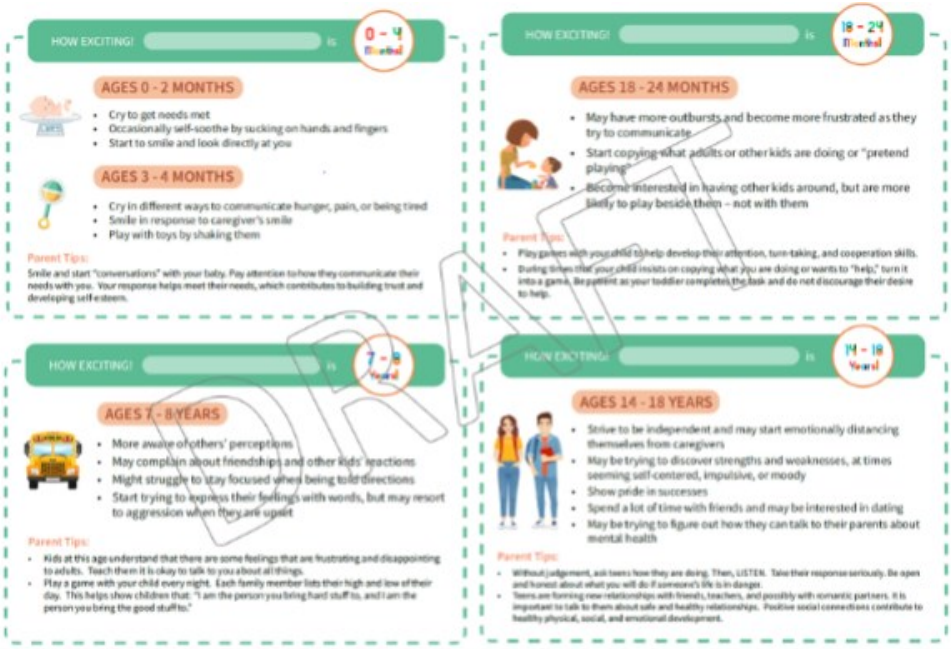
Objective: Increase the proportion of children, 6 through 11 years, with access to activities and programs that support their interests, healthy development and learning.

Title V plans to partner with local school districts and the Bureau of Health Promotion to align statewide messaging around child health initiatives. Local communities will receive guidance on healthy campaigns (e.g., Move Your Way, Let's Move; Turn a Page-Touch a Mind; Dolly Parton's Imagination Library), farmer's market resources, and other food programs that are available. Additionally, physical activity online training developed in partnership with Child Care Licensing will continue to be available to early care professionals at no cost.

Another focus is the safety and inclusiveness of school and community playgrounds. MCH local agencies will be offered resources and supports as they become active in ensuring that ALL children are able to enjoy a community play space. Many play areas are not inclusive for children with disabilities who also need to be physically active. Holding true to the BFH belief that "children with disabilities are children first," focus will be on assisting communities and schools with understanding how they can make playgrounds accessible for all children. Towards this effort, the BFH will include guidance on adapting play equipment for children with mobility and sensory needs to communities and schools.

The BFH is currently developing the *Social and Emotional Development Milestones: An Age-By-Age Guide* to be used in conjunction with the Developmental Milestone & Activity Postcards. Since behavioral health was one of the most addressed concerns in the MCH Needs Assessment, capacity-building of the MCH workforce to address behavioral health concerns has become a top priority. The Guide will be a resource that the MCH workforce can provide to families for their use, gain knowledge of healthy social-emotional development, and identify strategies to address concerns they may have. This approach will further increase early identification of social and emotional development delays, thus allowing interventions to occur earlier and families to be healthier. The Guide will offer information on developmental milestones, guidance for talking to children about their mental wellbeing, and other tips for furthering a child's development. There are 12 age groups, ranging from newborn to 18 years, in which Title V will partner with community organizations leading efforts on social-emotional health to provide programs with these resources/tools that support the encouragement and empowerment to build healthy relationships with parents/caregivers, teachers, mentors, health care providers, and peers.

Draft Social and Emotional Development Milestones: An Age-By-Age Guide cards:



Objective: Increase the proportion of MCH program participants, 1 through 11 years, receiving a quality, comprehensive annual preventive services.

KanBeHealthy Trainings & Bright Futures™: According to the 2018 National Survey of Children's Health (NSCH) 72.6% of children visited a doctor, nurse, or other health care professional for a preventative check-up. KanBeHealthy (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, developmental, and specialty services. Kansas Medicaid utilizes Bright Futures™ as the EPSDT/KBH standard of care, so all services are expected to be provided in accordance.

Feedback from local health agencies indicates a need to re-train clinical professionals on conducting KBH visits. Title V worked with a team representing state and local level agencies to review and update the current KBH training including the KBH Screening Orientation Manual. Correspondence with the regional Bright Futures representative has been underway and will continue to identify free resources, trainings, or membership opportunities for state and local MCH agencies.

KBH trainings began in 2019; however, three in-person trainings that were scheduled were postponed due to the COVID-19 pandemic. The KBH trainings will be offered regionally in the coming year in Topeka, Wichita, and Hays. This training will not only increase access to comprehensive well visits and screenings but improve the quality of services children receive.

Title V facilitated the acquisition of a statewide license for the online Bright Futures Tool and Resource Kit, 2nd Edition. The online toolkit includes resources such as: age-specific client forms that apply the Bright Futures Guidelines; supplemental and just-in-time topical handouts for parents in English and Spanish; the AAP Periodicity Schedule that includes the recommended evidence-based screening tools to be used at various ages; and guidance to implement the Bright Futures forms into electronic health record systems. All local health departments and other MCH-funded agencies were given access to the site and resources at no cost upon completion of an online course with a demonstration of navigating the toolkit. Between "go-live" in December 2019 to February 2020, MCH received 45 individual requests from 34 agencies around the state to obtain access to the toolkit. These requests have ultimately stopped due to health providers switching their time and attention to the COVID-19 response. The Child and Adolescent Health Consultant plans to reach out to representatives in each county that has not yet received access to offer the resource. The consultant will also provide ongoing technical assistance to agencies regarding the online Bright Futures Toolkit.

Title V and KDHE's Local Public Health Program (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.

Other Activities Related to Children's Developmental Health

Early Childhood Systems Building: The Preschool Development Grant Birth through Five (PDG B-5) funding provided through the Department of Health and Human Services (HHS) Administration for Children and Families (ACF) Every Student Succeeds Act (ESSA), was awarded to the Kanas State Department of Education in early 2020. The KCCTF, DCF, and BFH leveraged these funds to complete a statewide early childhood needs assessment and develop an early care and education system strategic plan. The initiative has been branded, All in for Kansas Kids, Ensuring Every Child Thrives. The comprehensive needs assessment was completed in 2019 and described in more detail in the Child Report narrative.

The Needs Assessment resulted in eight key findings (depicted below) and drove the development of the "All in for Kansas Kids" Early Childhood Strategic Plan. This plan strives to provide equitable, high-quality care and education to all Kansas families regardless of where they live. The aim is to strengthen local systems by empowering communities with the flexibility they need to deliver connected, high-quality services. The plan is grounded in data to ensure that resources are strategically directed, and the work focused to achieve the greatest impact. More about the needs assessment and strategic plan can be found in the Supporting Documents as part of this application.

As one of four state agencies involved in the early childhood systems building initiative, KDHE will serve as the lead to carry out certain work under the plan as the lead agency. There are opportunities through several of these projects to collect information/data around ACEs, potentially including education, screening, referral, and follow-up.

- *Primary Care Provider Care Coordination Expansion Project:* Supports placing holistic care coordination in the medical home in at least two pediatric offices (funds care coordinators).

- *Bridges Project*: Pilot with SHCN satellite offices focused expanding services to “bridge” services for children aging out of Part C (at age 3) through age 8 if they don’t qualify for Part B.
- *Child Care Systems Improvement Team*: Backbone support for the child care system advisory group—focus will be on review of regulations, removing regulatory barriers, and increasing access.
- *Supporting You Expansion, Promotion, and Marketing*: Peer to peer network expansion to 2 new programs/target populations (e.g., child care workers, foster parents).
- *Family Advisory Council (FAC) Expansion*: Backbone support to expand the existing KDHE FAC to include all agencies and serve as the advisory group related to standards for meaningful family and consumer

Cross-System Referrals: The KS-SHCN program will continue to expand and strengthen referral processes among other screening programs (e.g., genetic/metabolic, hearing, and heart newborn screenings), surveillance programs (e.g., birth defects), home visiting and early intervention programs (e.g., MCH UHV, MIECHV, infant-Toddler Services), and external systems (e.g., foster care, Medicaid).

Formal referral protocols are being developed for the BFH screening and surveillance programs at this time. KS-SHCN will continue to promote and use the recently developed “Decision Schema” to help them determine who to refer to the KS-SHCN program and when, specifically with the Infant-Toddler Services Program. Additionally, the KS-SHCN Care Coordinator will work in collaboration with the child’s family and any BFH referral program/service provider to make sure that the child and family’s needs are being met and that there is no duplication of services between programs. All referrals are tracked and monitored.

The realignment of the BFH in Fall 2019 created new sections and alignment across program serving shared MCH populations (both Title V and non-Title V supported). A critical shift within this realignment moved Infant-Toddler Services, KS-SHCN and MCH Home Visitor programs under the Children & Families Unit, to support stronger collaboration, coordination and referrals. Plans for the coming year include hosting collaborative training opportunities for staff to assist in facilitating better partnerships and gain a better understanding of what each program offers for children and their families. Additionally, other joint training opportunities with MCH UHV will be considered, including targeting social determinants of health in an attempted to reduce health disparities.

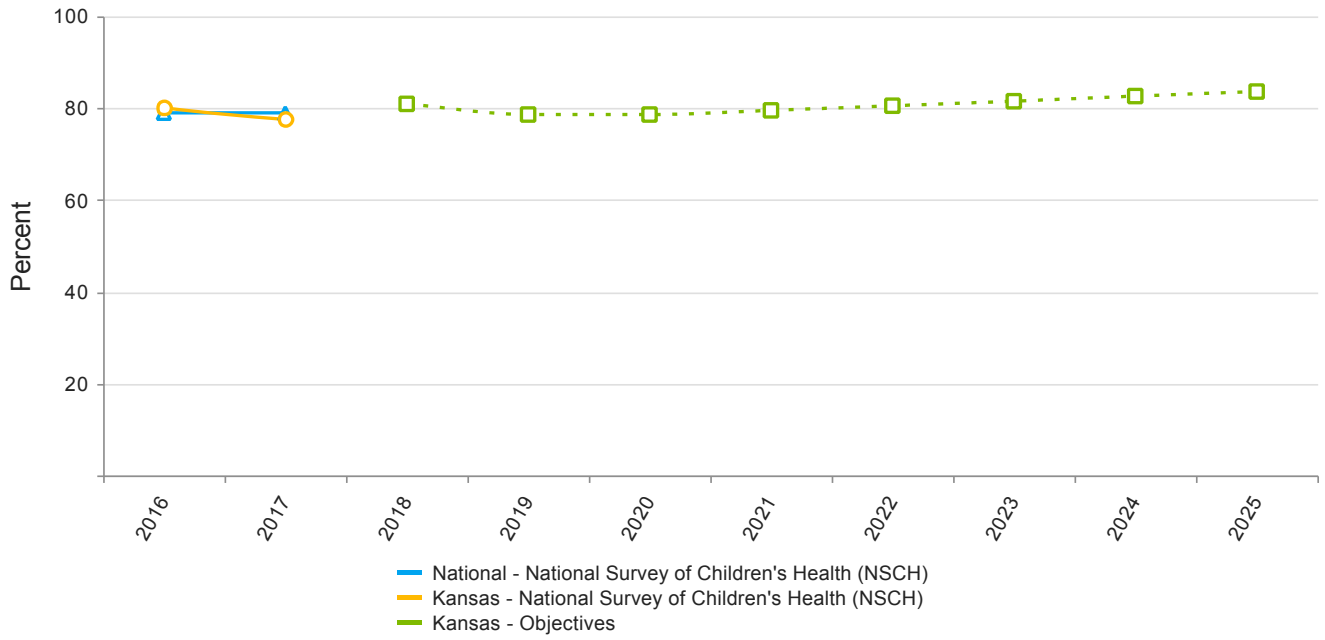
Adolescent Health

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-2018	39.9	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	14.3	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	17.8	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	52.7 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.5 %	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-2017_2018	12.2 %	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-2016	12.5 %	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-2018_2019	63.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	62.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	89.4 %	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-2018	75.3 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.0	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**	**2019**
Annual Objective			80.8	78.5
Annual Indicator		79.8	77.5	77.5
Numerator		185,414	184,888	184,888
Denominator		232,249	238,418	238,418
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
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, ages 12 through 17, that had a well-visit during the past 12 months

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	36.5
Numerator	873
Denominator	2,394
Data Source	DAISEY
Data Source Year	2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	38.3	40.2	42.3	44.4	46.6

State Action Plan Table

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

Priority Need

Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to 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

Increase the proportion MCH program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services by 5% annually through 2025.

Strategies

Engage partners to promote a stronger cross-system recommendation to conduct complete annual well visits during adolescence utilizing all elements of the Bright FuturesTM guidelines.

Conduct annual provider educational efforts to support provider knowledge acquisition regarding the importance of comprehensive, quality adolescent well visits and the Bright FuturesTM Guidelines.

Support the development of a peer-to-peer awareness campaign, developed and delivered by adolescents and young adults, to express the importance of comprehensive, quality well visits and youth-inspired environments.

Engage local health agencies to implement youth-friendly care approaches from the Adolescent Health Institute in their facilities.

ESMs	Status
ESM 10.1 - Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months	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

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

Priority Need

Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to 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

Increase the proportion of adolescents and young adults that have knowledge of and access to quality health and positive lifestyle information, prevention resources, intervention services, and supports from peers and caring adults by 10% by 2025.

Strategies

Partner with adolescents and young adults to identify, develop, and disseminate standardized guidance and educational materials focused on empowerment and health promotion (e.g., healthy living and eating, physical activity, mental health, substance use, social media, healthy relationships).

Increase awareness of adolescents and young adults about services and programs available to them in their community that are including and accessible to them through 2-1-1 and 1-800-CHILDREN resources and disseminate/share with youth-serving organizations and partners.

Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution during enrollment, orientation, and/or other appropriate events.

Partner with prevention initiatives to provide events/programs and develop community-based education classes, designed with adolescent and young adult input, to reduce risky behaviors and support youth in gaining important skills necessary for transition to adulthood (e.g., budgeting, independent living skills, furthering education, gaining employment, stress management, healthy relationships).

ESMs	Status
ESM 10.1 - Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months	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

State Action Plan Table (Kansas) - Adolescent Health - Entry 3

Priority Need

Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to 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

Increase the number of local health agencies and providers serving adolescents and young adults that screen, provide brief intervention and refer to treatment for those at risk for behavioral health conditions by 5% by 2025.

Strategies

Develop protocols for MCH local agencies to identify when an adolescent or young adult might need behavioral health services, make referrals to treatment when needed, assure timely access to care, and offer support to families throughout the process.

Partner with other state agencies and community-based organizations to promote resources that reduce the stigma and embarrassment often perceived as associated with mental illness, emotional disturbances, and seeking treatment.

Promote evidence-based suicide prevention initiatives and accessible crisis services through school and out-of-school activities.

ESMs	Status
ESM 10.1 - Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months	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

2016-2020: National Performance Measures

Adolescent Health - Annual Report

PRIORITY 4: Communities and providers support physical, social, and emotional health

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

Local MCH Reach: During SFY2019, 55 of 71 grantees (77%) provided services to the Adolescent population.

The 2016-2017 National Survey of Children's Health (2 years combined) showed that 77.5% of Kansas adolescents, 12 through 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%).

> *Data note: 2016-2017 is the latest available due to a 2018 wording change to the item assessing receipt of medical care in the past year with the previous wording restored in 2019. Therefore, a 2018 update is not available, and reporting updates will resume next year with 2019 data.*

The focus and activity around the Kansas Title V adolescent population has increased over the last several years. The implementation of the state action plan in 2016 with greater emphasis on adolescent health has helped Title V spread and scale work in the adolescent domain. The 2016 plan reflected adolescent health needs assessment findings that revealed the need to emphasize the voice of youth, parents, and partners. Over the past grant year, Title V has addressed the disparities in the adolescent well visit by offering resources and technical assistance to local MCH agencies on conducting a quality, comprehensive visit. Many local Title V agencies are public health departments or FQHCs which provide a safety net for high risk youth (see more detail in the objectives below).

In February 2019, various tools were uploaded and shared with local partners to increase their skill and comfort level in working with high-risk adolescents. Resources were based by tracking MCH adolescent well visit goals from applications and specific technical assistance requests. Youth resources consisted of numerous topics such as:

- Kansas Distracted Driving statistics and potential peer-led initiatives through Kansas Safety Traffic Resource Office and the National Safety Council April awareness month materials
- SAMHSA Preventing Suicide Toolkit and other resources recommended by the Kansas Suicide Prevention Center
- Trauma Informed Care Implementation strategies based on the Trauma Informed Care Implementation Resource Center
- Creating and Sustaining Youth Advisory Councils

- Ideas for increasing youth engagement from the HHS Office of Adolescent Health's 2018 Think.Act.Grow Playbook & Toolkit, Relationships First by the Search Institute, and Act for Youth's Preparing for Youth Engagement: Youth Voice, Youth-Adult Partnerships, Youth Organizing
- Potential tools to become a more youth-friendly facility using pre-scripted staff meeting SPARK trainings created by the Adolescent Health Initiative, the PATCH Planning Guidebook, and youth-led health center assessment tour tools from the state of Vermont and the Adolescent Health Initiative

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

School-Based Health Centers (SBHC): Kansas MCH believes launching SBHCs is key to addressing increased access to the annual adolescent preventive medical visit, including comprehensive screening in accordance with Bright Futures$_{TM}$ guidelines. Phase 1 of this project launched in 2017 in partnership with schools, medical providers, and 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 SBHC.

It was identified that partnerships with local health departments and FQHCs as medical sponsors was key to reaching those most in need (Hispanic, low income, less educated). Initial and ongoing outcome goals of this initiative include:

1. Develop a model or structure to provide well visits for youths in school settings;
2. Reduce barriers in obtaining preventative services;
3. Provide opportunities for adolescents to obtain routine yearly exams; and
4. Increase youth/family understanding on the importance of the routine/annual well visit.

During this reporting period our SBHC Project Core Team worked to update and complete a comprehensive SBHC Guide. The guide was developed to assist Kansas 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 tool in developing a SBHC that meets the needs of the specific community. The guide defines the phases in the process of establishing a school-based health center including:

Kansas School-Based Health Center Guide
2019

- types of services;
- key partners;
- overview of target population (adolescents);
- what needs to go into a business plan;
- suggestions for professional development;
- day-to-day operations;
- importance of data collection;
- how to get started; and
- useful links, additional resources, and sample documents.

A college intern worked with MCH program in the summer of 2019 to modify the SBHC guide and develop a supplemental toolkit for communities to utilize. Potential communities for SBHCs were identified using data such as health factors, insurance coverage rates, health care access and use of current health care systems, and youth risk factors such as the percentage of students receiving free and reduced lunch. A total of 12 counties representing 26 school districts were identified as potential expansion sites.

County	School District	Adolescent Medicaid Enrollment (avg. 31.3%)	Adolescents Receiving Well-Visit (avg. 14.2%)	Free and Reduced Lunch Enrollment (avg. 47.5%)	Teen birth rate (avg. 29)	Primary Care Physician Rate (avg. 76)	Dentists Rate (avg. 57)	Mental Health Provider Rate (avg. 188)
Elk	282	**49.0%**	**5%**	61.1%	28	**39**	**0**	-
	283			**84.4%**				
Chautauqua	285	**46.2%**	11.3%	67.2%	33	**30**	**30**	-
	286			68.5%				
Allen	256	**58.4%**	10.7%	57.9%	29	63	56	120
	257			59.0%				
Brown	415	45.9%	11.7%	51.2%	45	124	41	311
	430			64.4%				
Wyandotte	202	**52.6%**	20.2%	73.4%	**54**	**42**	41	148
	204			48.6%				
	500			**76.2%**				
Seward	480	42.7%	19.8%	**83.3%**	**64**	53	**32**	**72**
	483			**78.1%**				
Barton	355	40.1%	18.8%	43.2%	37	56	45	215
	428			65.7%				
	431			58.5%				

The first Title V SBHC pilot underwent development during this reporting period. The site, Valley Center USD 262, utilized the Title V SBHC Guide throughout the process. The SBHC 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 and 5th grades), a middle school (7th and & 8th grades), and a 5A high school. The USD 262 Superintendent and a community champion (pediatrician) presented to the local Health and Wellness Task Force and the Administration Cabinet (consisting of 18 principals) and received approval to move forward in establishing a SBHC. Valley Center experienced road blocks finding a medical sponsor to commit to the project and decided to reevaluate their plan. A review of census data indicated a full service SBHC may not be the greatest need in their community, as a high percentage of their population is covered with private insurance and receives services from community providers. Analysis of data from the Communities That Care (CTC) survey, completed annually by students in 6th, 8th, 10th, and 12th grades, showed high rates of students dealing with depression, thoughts of suicide, alcohol consumption, and tobacco/other drug use.

In response to this, Valley Center refocused their attention in 2019 on applying for a Mental Health Intervention Team grant through the Kansas State Department of Education (KSDE), which was successful. The grant ($60K) will be used to establish a contractual MOU between the school district and the Community Mental Health Center (CMHC) to work collaboratively in the provision of certain behavioral, emotional, and academic services to the students. The school provides a “school liaison” and provides space for CMHC staff and students to meet and receive services. The school liaison identifies appropriate referrals and point person between school and CMHC; triage prospective referrals and deciding with the CMHC staff how to prioritize interventions for identified students; and facilitates connections between the identified student’s families and the CMHC staff. CMHC will conduct clinical assessments and make appropriate treatment recommendations.

Between the period of July 1, 2019 and December 18, 2019:

- 13 students received services by a CMHC
- 1 student was referred for services to a CMHC
- 8 students, after receiving services, have shown improved behavior

KAN-Be-Healthy (KBH) Training: Early, Periodic, Screening, Diagnosis and Testing (EPSDT), also known as Kan-Be-Healthy, provides comprehensive and preventive health care services for children, teenagers, and young adults under the age of 21 years who are enrolled in any Medicaid program. EPSDT provides medically necessary screening and services, even if the service is not available through the Kansas Medicaid plan.

Many local agencies need EPSDT training, so Title V partnered with the Bureau of Community Health Systems (BCHS) to develop and disseminate a survey to all 105 county health departments to identify training needs. A total of 167 health department staff members representing 82 counties responded. Results showed local agencies need training in three main areas: completing a head to toe examination, conducting developmental screenings, and learning how to utilize the Bright Futures resources.

Screenshot of Survey Results

Which training and information would your staff benefit from the most? (Arrange in the order of the most important to the least important)	
Ranking From Weighted Total	Training type Preference
1	Training on completing a head-to-toe exam
2	Developmental Screenings
3	Bright Future Resources
4	Form Guidance
5	Training on completing a hearing screening
6	Billing
7	MCHAT
8	Training on completing a vision screening

For which age group does you staff need training? Keep in mind this will probably entail a head to toe exam, referrals and resources. (Arrange in order of the most important to the least important)	
Ranking From Weighted Total	Type of Training
1	Early Childhood (12 Months to 4 years)
2	Middle Childhood (5 years t0 10 years)
3	Infant (Newborn to 9 months)
4	Adolescence (11 years to 21 years)

What is your preferred location for an in-person KBH training? (Pick one)		
Survey Answer	*Raw Score*	*Percentage*
Garden City	19	16.4%
Hays	29	25.0%
Topeka	31	26.7%
Wichita	37	31.9%

A team consisting representatives from KDHE (BCHS, BFH, Medicaid), American Academy of Pediatrics Kansas Chapter (KAAP), and four health departments are currently working on developing an EPSDT training that will be held in three locations around the state.

Kansas Title V purchased a Bright Futures License on October 31, 2019 which will allow local agencies access to all the tools and resources offered in the Bright Futures toolkit. Local agencies will have unlimited access to Bright Futures forms, educational handouts, presentations, and technical assistance for future use. Title V will provide training on this important resource in the upcoming year (please find more information in the Adolescent Plan section).

School Nurse Engagement: Through a collaborative partnership with the KDHE Bureau of Health Promotion (BHP), Kansas Health Institute (KHI), and Kansas School Nurse Organization (KSNO) the 2017-2018 School Nurse Survey Summary found here https://www.kdheks.gov/bhp/pan/download/2017-18_School_Nurse_Survey_Results.PDF was completed and introduced at the July 2019 School Nurse Conference. The chairperson for the Kansas School Nurse Advisory Council (SNAC) presented findings on the current school nurse workforce, management of students with chronic diseases, health screening data, and immunization policies. Key findings from the survey:

- More than 1,000 FTE health services personnel (RNs, LPNs, health aides) serve students in Kansas schools, which complies with the National Association of School Nurses recommendation based on total students.

- Asthma is the most prevalent of the five chronic health conditions measured by the survey.
- Referral completion rates for hearing and vision screenings are low (25.4% and 19.6%). These results reflect inconsistencies in how school nurses track referrals for failed screenings and completion of care.
- Issues of BMI and overweight/obesity are controversial topics in many school settings, resulting in fewer BMI screenings; therefore, fewer students are assisted with obesity than with other chronic conditions.
- Oral health screenings are lacking since school nurses and volunteers cannot conduct the screens–Kansas law requires oral health screening must be conducted by a dentist or registered dental hygienist.

Key recommendations from the survey:

- School districts are encouraged to strengthen their capacity to manage chronic diseases by implementing Electronic Health Records to accurately report on student health services and to query data at a faster rate.
- School districts are encouraged to implement standardized procedures for completing hearing and vision screening referrals and tracking completion of care.
- School nurses are encouraged to stay informed of the standardized school health data initiative through NASN's *National School Health Data Set – Every Student Counts!*

The chairperson for SNAC created a school nurse toolkit based on findings and recommendations from the 2017-2018 School Nurse Survey. Both the summary report and the toolkit will be placed on the revised KDHE Adolescent Health website in the next grant year.

Local MCH Agencies: Local MCH agencies provided 1,348 adolescent well-visits utilizing the EPSDT screening form (which includes behavioral health screening) during this report period; 665 clients were provided information and education on the importance of well visits. Bright Futures is the primary source of information that is provided to parents and adolescents, during a well visit, and many local agencies refer clients to their Title X Family Planning clinic or local providers in their community. Examples of local grantee efforts:

- Jefferson County screened all adolescent clients receiving services for a preventive medical visit in the past year. Adolescents who had not received a preventive visit were educated on the importance of such a visit and connected to resources where they could schedule.
- Rooks County increased the adolescent immunization rates as well as educated teens on the dangers of tobacco and alcohol including vaping/e-cig/Juuling. The agency also provided oral health screenings as well as education and referrals to adolescents in local schools.
- Greeley County sent letters to the parents of high school seniors that provides immunization education, schedules, and encourages parents to have their children vaccinated. The letters targeted Tdap, MenB series, and HPV vaccinations; in response to these letters, Greeley county shows higher numbers of vaccinated teens with 95.7% patients with at least one does of Tdap, 91.5% of patients with at least one dose of Meningococcal vaccine series, and 74.57% of patients with at least one valid dose in the HPV series.

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: Title V entered into an agreement with four Family and Consumer Science (FCS) educators to revise the 1995 edition of the FCS curriculum. Content for each module was developed in partnership with Kansas MCH and FCS educators, informed by a FCS Educator Survey that was conducted in Fall 2018. Topics included subject matter such as the importance of well visits, healthy relationships, building resiliency, positive youth development, mental wellness, and risky behaviors such as distracted driving and substance abuse.

The updated curriculum was completed and revealed by the four contracted educators to their colleagues across the state at the 2019 Career and Technical Education Conference on July 26, 2019. The curriculum modules include:

The curriculum is available online at: https://personalandfamilywellness.weebly.com.

Youth Engagement & Youth-Friendly Environments: The MCH 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:

- Think, Act, Grow (TAG) materials *(HHS Office of Adolescent Health)*
- TAG one-pager, 2018 Playbook, 2018 Toolkit
- 8 Steps to Engage Youth
- Preparing for Youth Engagement: Youth Voice, Youth-Adult Partnership, Youth Organizing *(Act for Youth)*
- Being Youth-Adult Partnership (Y-AP) Savvy *(Center for Nonprofits)*
- Relationships First *(Search Institute)*
- Scale of Youth Participation *(Search Institute)*

The ***youth-friendly clinic*** toolkit includes:

- SPARK trainings *(Adolescent Health Institute)*
- 7 Topics: 1) Adolescent Brain Development; 2) Being an Askable Adult; 3) Being Youth-Friendly; 4) Cultural Responsiveness; 5) Identifying and Supporting Trafficked Youth; 6) Nonverbal Communication Bias; and 7) Strength-based Approaches to Adolescent Sexual Health
- 2017 PATCH Planning Guidebook *(Wisconsin Department of Health)*
- Adolescent and Young Adult Clinical Tour Tool *(Vermont Department of Health)*
- Youth-friendly Starter Guide *(Adolescent Health Initiative)*
- Youth-led Health Center Assessment Tool (*Adolescent Health Initiative)*

Youth Focus Groups: Engaging youth and young adults in the planning and decision-making process for Title V is a Kansas MCH priority. Title V partnered with DCCCA Inc., a community organization that offers preventative programs and services for youth and adults to:

- Conduct 12 youth focus groups across the state (2 focus groups per region: NW, SW, NC, SC, NE, SE). These focus groups were diverse and included special populations within the adolescent age group such as youth in the juvenile justice system, juveniles in foster care, youth with special health care needs, youth representing the LGBTQ+ community, and youth whose primary language is not English;
- Create toolkits to support youth-serving organizations in empowering young adults to take charge of their healthcare needs;
- Research information from other states and national organizations about toolkits for health care providers on how to provide a youth-friendly environment; and
- Work with youth in Kansas and KDHE to create a youth-friendly marketing campaign focused on a) the importance of an annual adolescent well visits; and b) the difference between a sport physical and an adolescent well visit.

An online survey was also made available and the link was shared at events hosted by the STAND youth coalition, Wyandotte County Teen Pregnancy Targeted Case Management Program, Pittsburg High School Dodge Drugs, and the DEA's Teen Drug Summit. Postcards were also passed out to focus group attendees to hand out to their peers to expand the youth voice captured. This strategy caught the attention of the Association of Maternal & Child Health Programs (AMCHP) and will be highlighted in a brief on innovative techniques on engaging youth in the MCH Block Grant needs assessment process.

Youth focus Group Flyer

KEY (Kansas Empowering Youth and Young Adults) Summit: The BFH hosted the 2019 KEY Summit over the noon lunch hour June 17-21, 2019. This event was offered as a webinar series versus a two-day conference format in 2018. Participation ranged from 30-50 attendees representing BFH and University of Kansas Center for Public Partnership and Research staff and local county service agencies such as health departments, YMCA, juvenile services, behavioral health specialists, a patient navigator for the Kickapoo Tribe, library staff, schools, and churches. Participants were able to register for individual sessions. The agenda (or "menu items") featured a variety of educational and interactive sessions: young adult panel, crafting engaging messaging, tools for working with youth, adolescent brain development, and more.

Based on conference feedback, the event will return to its original format (face to face) in future years to encourage a youth-centered conference track and increase in-person attendance.

KDHE & Title V's Response to E-cigarettes, Vaping, and Juuling: As of October 2019, Kansas had two confirmed deaths related to vaping and 16 probable/confirmed vaping related cases. Of the cases, 75% were male, the collective ages ranged from 15-67 years old, and 14 of the 16 were hospitalized. There is a vaping epidemic that has rapidly intensified in Kansas and is affecting our youth. According to the 2019 Kansas CTC survey, 66.57% of middle and high school students believe that people are at great risk of harming themselves (physically or in other ways) if they smoke one or more pack of cigarettes per day. However, 34.8% have tried e-cigarettes and 10.6% report using e-cigarettes on a regular basis. KDHE issued a news release from Secretary and State Health Officer Lee Norman, M.D. on September 10, 2019, to address the issue: https://khap2.kdhe.state.ks.us/NewsRelease/PDFs/9-10-19%20vaping.pdf.

Title V staff supported the state-level work and local level community initiatives that address our youth's increased use of

electronic cigarettes, vaping, and JUULs. In June 2019, the 3rd Annual Regional Adolescent Health Conference, attended by teachers, school nurses, prevention and care providers, administrators, health professionals, counselors, and other youth community organization leaders from four states (KS, IA, MO, NE), included a presentation titled, "JUUL, Vape, E-Cigarettes: Unifying the Tobacco Prevention Approach. The session provided up-to-date information, best practices to prevent tobacco initiation among youth, and tools to engage youth and community members in policy, systems, and environmental change around tobacco.

Title V staff assisted the Tobacco Use Prevention Program in distributing a competitive grant opportunity aimed at addressing the vaping epidemic in Kansas schools. Awardees were expected to conduct vape education and outreach in their local schools, establish a RESIST chapter in the community (a statewide, youth-led movement created to fight against the tobacco industry's influence in Kansas), evaluate and update their school/district tobacco/vape policy, and host a vape awareness activity or vape-free spirit day at the local schools. The grant opportunity was sent to partners at the Kansas State Department of Education Family and Consumer Science division and to nine local MCH grantees who were focusing on adolescent risky behaviors or smoking-related goals for the project year.

Teen Pregnancy Targeted Case Management (TPTCM): During FY19, nine local programs received TPTCM funding and served 359 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. Impact of this amazing program is apparent from success stories at the local level like the one shared here.

"One of our youngest in the program, a 14-year-old girl comes into clinic thinking she is pregnant but is afraid to tell anyone. Pregnancy test positive, client was referred to the TPTCM staff, who talked to her about plans and services provided by TPTCM. Grandmother, with whom client lives with, was brought into the appointment and told about the pregnancy (per client's request) and told of all the services we could assist them with. Grandmother tearful stated that her husband is dying from cancer and she just doesn't know what to do. She also stated that she is so grateful for the services. Father of the baby also present, we discussed services that he is also in need, some referrals done upon this intake appointment. Client continues coming in for her monthly visits for TPTCM as well as all her follow up OB appointments. She has completed goal setting, created a birth plan, followed through on all referrals done such as WIC, Dental (which she has never had), Text for Baby, and has told school and has been working with the school counselor. Client has completed safe sleep training and also is wanting to breastfeed and has an upcoming appointment with a breastfeeding educator to start learning and preparing for this."

TPTCM Program Case Manager
Community Health Center of SEK

Lifting Young Families Toward Excellence (LYFTE): KDHE continued the LYFTE project, funded by the Office of Adolescent Health (OAH) Pregnancy Assistance Fund. LYFTE is an innovative youth/young adult-centered program providing case management with wraparound 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 five counties in the state and has served 175 pregnant and/or parenting females and 30 males to date. Local LYFTE programs reported the impact in their community.

"Jane," 19 years old, who has not completed her high school education, was referred to LYFTE through IRIS. After meeting the first time, I learned she and her boyfriend were new to the Wichita area and were not familiar with any of the local services. She wanted to get enrolled in prenatal education, get a job, and finish high school. We got her connected with BabyTalk and she successfully completed the six (6) prenatal education sessions. We also enrolled her in Digital Badges and completed several infant care badges, along with a few on career building. One of these badges allowed her to build a resume, which she later used to get a job. We also referred her to NexStep where she successfully completed her GED requirements within 4 months (1 month before the arrival of her baby. Now, she has plans to continue her education through a partnership between NexStep and WSU-Tech."

LYFTE Coordinator
KU School of Medicine, Wichita

In April of 2019, the Special Health Care Needs (SHCN) Program Manager shared information, data and tools around the SHCN Care Coordination project with LYFTE staff. LYFTE staff, with support from SHCN staff, will modify the SHCN tools, protocols and trainings, as needed, to meet the needs of the LYFTE program. This care coordination model will provide a holistic approach to assist the youth/young adult in addressing not only their medical needs, but their educational, social, financial, and legal needs.

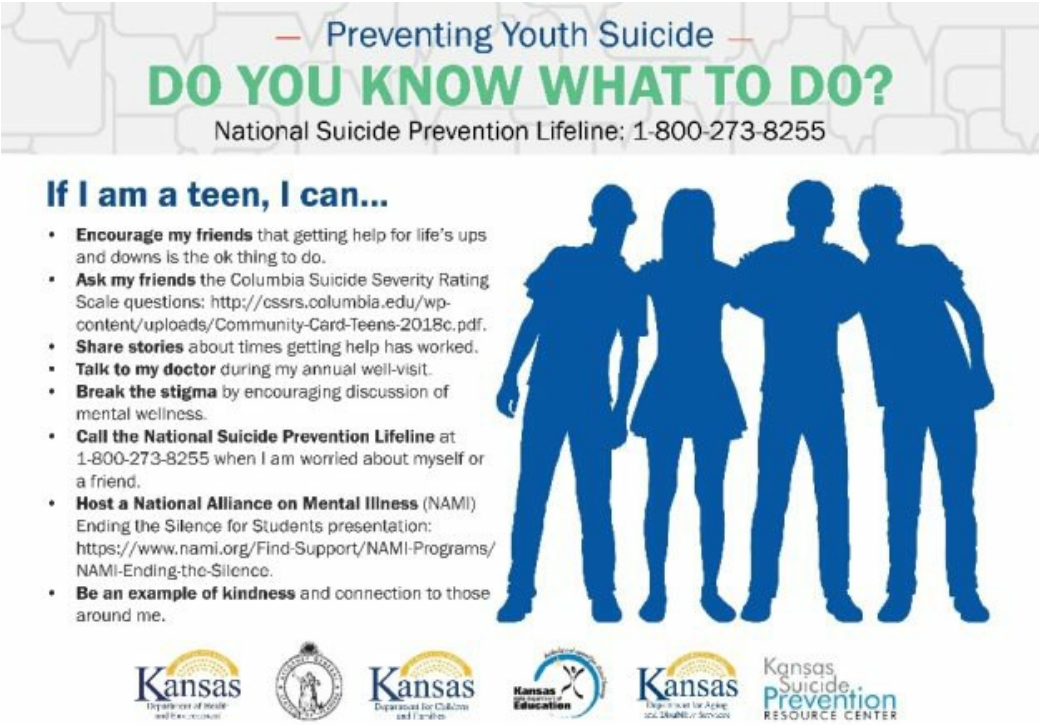
Objective: Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

Kansas Agencies Collaborating to Empower Youth & Prevent Suicide: Title V recognizes the increasing trend of suicide-related deaths nationwide. In Kansas, suicide is the second leading cause of death for age groups 15-24 and 25-44 and the third leading cause for children and youth 5-14.

State agencies understand that adolescent mental health is critical to holistic well-being and positive youth development. In response to this public health crisis, state agencies and stakeholders have assembled to draft recommendations and strategies for suicide prevention that address social-emotional development and mental well-being. State level collaboration will be necessary to effectively address the prevention of suicide related deaths and injuries.

During 2019, several state agencies convened to create a coordinated approach to youth mental health and suicide prevention strategies. As a result, the Kansas State Agencies Collaborating to Empower Youth and Prevent Suicide Workgroup was established. The workgroup includes representatives from KDHE, Kansas Department for Aging and Disability Services (KDADS), Department for Children and Families (DCF), KSDE, Attorney General's Office, and Kansas Suicide Prevention Resource Center. The primary goal of the multi-agency workgroup is to centralize all state-level suicide prevention recommendations, review current activities and spotlight gaps that must be addressed. KDHE published a news release about this workgroup: https://khap2.kdhe.state.ks.us/NewsRelease/PDFs/9-9-19%20suicide.pdf.

The workgroup was tasked with increasing awareness of suicide prevention strategies. A tip sheet and resource listing were created (see example below).



Each agency distributed the tip sheets and have made information available on their agency websites. In addition, the MCH CAHC published the tip sheets on a national State Adolescent Health Consultant listserv and immediately received correspondence from six states (Alaska, Louisiana, Nevada, New Jersey, Ohio, West Virginia) to use our youth suicide prevention tip sheets as a template for their state messaging. Sessions addressing youth mental health and suicide prevention were also presented at the 2019 Kansas Governor's Public Health Conference.

Title V Behavioral Health Investment & Expanded Programming: Title V recognizes that we cannot support individuals achieving whole health without integrating behavioral health (BH) practices and services. Therefore, additional investments have been focused on BH interventions, healthy social-emotional development, and cross-systems collaboration related to Title V and the State Action Plan. In 2018, Kansas MCH hired a Behavioral Health Consultant (BHC) to elevate coordination and increase program effectiveness. The Consultant is responsible for the planning and coordination of the second REACH Institute PPP cohort (details below). In July 2019, the KDHE BFH was awarded funding under HRSA's *Pediatric Mental Health Care Access Program Cooperative Agreement*—the BHC oversees the grant funding, activities, and alignment with Title V.

Pediatric Primary Care Fellowship Program (PPP): The REACH Institute Mental Health in PPP is the only national clinical practice transformation program that uses evidence-based change methods to help primary care providers adopt clinical practices related to assessing for and treating the behavioral health needs of children. Training consists of a three-day, 15-hour interactive course focused on building skills and confidence in diagnosing and treating pediatric behavioral health conditions. It also includes a six-month, case-based distance-learning program where participants join 1-hour group conference calls with national subject matter experts to learn how to manage pediatric behavioral health issues encountered in daily practice.

The Title V Program partnered with the University of Kansas Medical Center – Wichita Departments of Pediatrics and Psychiatry and Behavioral Health to bring PPP to Kansas. The first training was held November 30-December 2, 2018, in Wichita. Targeted to PCPs in the NE and SC areas of the state, the training reached capacity with 34 practitioners attending. A second training cohort with 22 attendees started September 13-15, 2019, with PPP in-person training held in Hays, a rural area in the western region of the state.

Local MCH Agencies: Local MCH agencies provided Bright Futures and CDC's mental health resources during physicals and adolescent well visits. Referrals were made to mental health services, crisis centers and suicide hotlines for additional resources and to report bullying. Some local MCH agencies worked with their local school districts and law enforcement agencies to educate students on bullying prevention through the year, especially during Red Ribbon Week. Many local MCH agencies offered educational materials about healthy relationships. Defining what constitutes a healthy relationship is critical to understanding physical, social and emotional health.

- Barton County Health Department, a local MCH grantee, offered a community training event that educated participants, including 170 adolescents, on Trauma Informed Systems of Care. The Suicide Prevention Task Force Central Kansas Community Partnership collaborated with the county health department to offer six showings of "Suicide: The Ripple Effect" at the local movie theater in September 2019. Therapists were available at each of these showings. Additional partners, such as Rise Up (a group of community leaders dedicated to trauma informed systems of care), provided messaging, assistance with marketing, and collected donations for door prizes. The local juvenile services agency offered education and activity. Using marijuana goggles, adolescent youth rode scooters through cones to experience the effects of impaired driving. Their local community mental health center shared suicide awareness information and organized physical activities, such as 9-square (a physical activity game) for participants.

Adolescent Health - Application Year

PRIORITY 4: Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health

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

Local MCH Reach: Based on SFY20210 MCH Aid-to-Local applications received, 38 of 67 grantees (57%) plan to provide services to the Adolescent population.

Objective: Increase the proportion of MCH Program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services.

Bright Futures$_{TM}$ as Standard of Care: Title V continues to recommend that local MCH grantees adhere to the Bright Futures guidelines for preventive care/annual well visits for adolescents. Title V will continue the partnerships outlined throughout the Child Report and Plan and Adolescent Report and will engage Kansas American Academy of Pediatrics (KAAP), Kansas Academy of Family Physicians (KAFP) and Medicaid to promote shared recommendations for health care professionals to utilize the guidelines, tools/resources, and anticipatory guidance. Often, a quality comprehensive annual preventive well visit is not delivered, and insurance doesn't require documentation of all components reflected in the claim data for reimbursement which leaves gaps in care for young adults.

Title V will reach out to state partners to meet and analyze the current messaging and policy statements to promote a stronger cross-sector recommendation to conduct complete annual well visits utilizing all elements of the Bright Futures guidelines. MCH funds were used to purchase a statewide license in 2019 for the most current edition of the Bright Futures Toolkit, eliminating cost as a barrier of conducting a complete and quality visit. The Child and Adolescent Health Consultant (CAHC) is the point of contact and available for any and all questions or requests for technical assistance related to the use of the Bright Futures toolkit and materials.

Youth-Friendly Care: Title V will use the youth-friendly care tools from the University of Michigan Adolescent Health Institute (AHI) to offer youth-friendly care quality improvement strategies to local MCH agencies that are targeting the adolescent population. Targeted technical assistance will be offered to local agencies individually and as a cohort to support them in recognizing their goals to improve adolescent health measures, identify their current position in meeting those goals, and identify realistic steps to enhance or improve policies and practices they may currently have in place. The tools from AHI will be laid out in a chart depicting the different levels of providing youth-friendly care (e.g., SPARK trainings for staff meetings, Youth-led Health Center Assessment Tool, Creating and Sustaining a Youth Advisory Council, Adolescent-Centered Environment-Assessment Process, and Becoming an Adolescent Champion Model). With this support, local MCH agencies will be equipped to confidently and clearly state their goals and identify MCH funding needs. During future Governor's Public Health Conferences, agencies and community youth will be recognized for their role in raising the level of youth-friendly care and reaching improvement milestones.

Adolescent Well Visits for Youth with SHCN: The KS-SHCN program continues to provide holistic care coordination for youth and their parents/guardians and support increasing knowledge and understanding on the importance of receiving a comprehensive, annual well visit. Families of CSHCN experience more medical appointments than peers who do not have SHCN. It's not uncommon that the annual well visit is put as a lower priority, however KS-SHCN is working with youth and families to understand that these visits can help them maintain optimal health and well-being.

KS-SHCN Care Coordinators discuss future transitions and nurturing independence in children and youth early in the child's life, but request that the youth participate in the transition planning conversations on or before the youth reaches a

developmental age of 12 years. Each youth over the age of 12 will have at least one transition goal listed on their KS-SHCN Action Plan. Care coordinators assist the adolescent in a variety of ways to help them learn how to navigate the health system independently as an adult. Some things the care coordinators might be assist the adolescent with include: developing a list of questions and concerns to share during medical visits; scheduling appointments; filling out medical paperwork; understanding insurance; planning for co-pays; understanding their disability; and advocating for their needs. Based on their individual needs and action steps outlined in the Action Plan, Care coordinators will provide applicable assistance and supports. Read more about the HCC model and KS-SHCN protocols in the CSHCN report/plan narratives.

Provider Trainings: Discussions will occur on strategies to create a more robust and unified message around the importance of taking time with youth to conduct a full wellness check. These checks should include assessing for additional supports, providing guidance on age appropriate preventative topics, building a relationship of dual trust and respect, and making the necessary referrals in a timely manner. A couple of specific training efforts include:

- *Youth-Friendly Environments.* Title V recently partnered with KAAP to host an online webinar (June 2020), offering CME credits for the medical field, on creating a youth-friendly environment and interpreting adolescent health laws. Speakers for this event were a champion pediatrician with a passion for adolescent health (who also serves as the KMCHC Chair) and a lawyer. The webinar was recorded and is available online. Medical professionals who have participated in the training will provide suggestions for additional adolescent health topics where training is limited that can be done in the future to strengthen the adolescent physician workforce.
- *KanBeHealthy (KBH)*. Trainings will be held for local health departments on the newly revised KBH Orientation Manual and the Bright Futures guidelines and toolkit. These training sessions were scheduled for the Spring of 2020; however, due to the COVID-19 pandemic these will be rescheduled for a later date. Following participation in an in-person or online training, health departments can access the online toolkit for free.

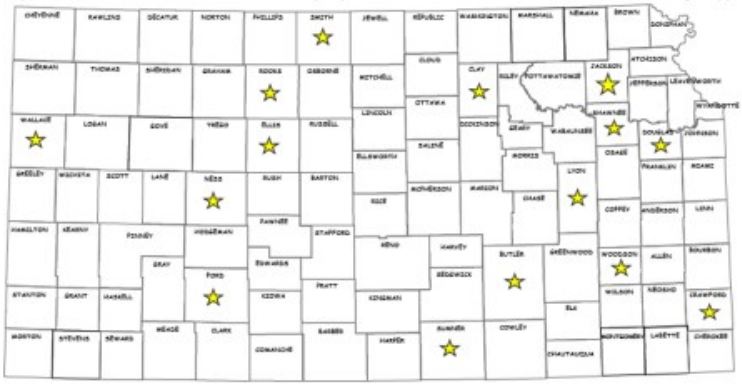
Local MCH Agencies: Local MCH agencies will continue to provide adolescent well visits and behavioral health screenings in accordance with recommendations, standards and guidelines. Smaller agencies that do not provide clinic-based services will educate parents and adolescents about the importance of the well visit and refer them to their Family Planning clinic or local providers. Title V MCH and KS-SHCN staff will create a discussion board on the MCH Workstation (an online community forum for local MCH agencies) to receive feedback and address technical assistance needs from local MCH agencies.

- Ten local health agencies with co-located MCH/TPTCM programs will provide all adolescents served, and their children, early and periodic screenings and immunizations. In addition to ensuring pregnant adolescents receive prenatal medical care, TPTCM Case Managers will educate adolescents on routine healthcare services, prevention of illness and injury, and available healthcare resources in the community. If the adolescent does not have an identified medical home, the TPTCM Case Manager will provide linkages to community healthcare providers. Case managers use evidence-based approaches, including Motivational Interviewing. These skills are used to coach adolescents in developing goals related to education, employment or financial stability.
- Barton County Health Department will screen clients who are receiving services if they have had an adolescent well visit in the past year. Clients will be encouraged to make an appointment or staff will assist with making an appointment. MCH staff will discuss the importance of annual well exams. The agency will utilize social media, a digital sign outside of the office and newsletters to help promote the importance of well visits for this population. Staff will visit with the local girls' and boys' homes to provide education on teen issues and adolescent well visits.
- Miami County Health Department will educate adolescent and young adults on the importance of annual well visits and the benefits of healthy lifestyle choices. Clients will receive information from AAP Healthy Habits and physical activity resources.
- Unified Government of Wyandotte County plans to increase the number of adolescents well visits utilizing the Bright Futures Guidelines. They will provide anticipatory guidance recommended for each age-based visit and include screenings, assessments, physical examinations, and educational information. Adolescents will be provided with support and resources to promote healthy development. Public Health Educators, specializing in adolescent/sexual health, will meet with all adolescents one-on-one at the clinic to: educate on birth control options, healthy

relationships, and safety at home and refer to in-house services (e.g., dietitian, social worker, mental health, and domestic violence services) as necessary. The agency has a strong, ongoing, relationship with the local school system to engage adolescents at all levels, including providing puberty classes and medically accurate discussion to all four school districts within Wyandotte County. The Health Educator discusses healthy relationships and sexual health quarterly with a Girls Circle group at the Juvenile Detention Center.

Peer to Peer Awareness Campaign: As part of the Needs Assessment, Title V contracted with DCCCA, Inc., an organization known for its youth-focused programs (e.g., Kansas Youth Changing Communities Conference, peer-led safety driving programs through the Kansas Traffic Safety Resource Office, foster care and family preservation trainings and support groups). DCCCA staff conducted 19 focus groups across Kansas with over 180 students in middle schools, high schools, and college participating with another 36-youth submitting an online survey answering the same questions.

Map of Counties that Hosted Focus Groups (Note: some counties hosted more than one group).



The focus groups specifically targeted at-risk populations such as tribal communities, youth with special health care needs, LGBTQ+ and/or allies, justice-involved youth, youth from Spanish-speaking or marginalized households, and youth who are currently in programs for substance use. Youth from four counties engaged in a photo youth voice project with captions detailing positive health activities in their community that also addressed health hazards. Feedback received from these events were used in developing the objectives for this population domain. The information gained through these focus groups helped inform priorities and objectives for the Title V State Action Plan as well as helped Title V know what topics are important to youth and what they would want to see in an awareness campaign.

The partnership with DCCCA will continue and they will facilitate work with a professional marketing firm to create a social media awareness campaign focused on the importance of youth-friendly environments and access to quality annual preventative well visits. The firm will work directly with youth from the focus groups who expressed interest designing messages and developing a communication plan as well as determining which social media platforms would engage youth the most. These young adults and their peers will be key to implementing the campaign strategies laid out in the communication plan and spreading the messages.

Other Adolescent Health Objectives

Objective: Increase the proportion of adolescents and young adults that have knowledge of and access to quality health and positive lifestyle information, prevention resources, intervention services and supports from peers and caring adults.

The adolescent focus groups provided data on topics youth and young adults were most interested in learning more about. One topic noted was the need for reputable and quality information, rather than taking their chances searching for information on the internet. Eight major themes emerged from the focus group data analysis:

1. Healthy Eating
2. Fitness
3. Mental Wellness
4. Substance Use Prevention

5. Managing Stress
6. Technology and Social Media Use
7. Healthy Relationships
8. Well Visits and Transitioning to Adult Care

Youth Health Guide: Based on the focus group themes, DCCCA, with the guidance of Title V, created an interactive Youth Health Guide in Spring 2020. The guide includes recommendations, QR Codes, links to video clips, games, and websites for additional information. Quality information from reputable sources such as SAMHSA, CDC, and HHS are provided in small take-away messages that are youth-friendly. Youth not only will have access to accurate information and helpful tips, but they can use this resource to support and inform their peers. The draft was reviewed by Title V staff, parents of adolescents, and adolescents, and it's currently being tested with the focus groups. Final revisions will be made by DCCCA and the link/guide will be disseminated to youth-serving organizations and networks in the near future.

Youth Transition Booklets: Several years ago the Family Advisory Council (FAC) created a series of transition planning booklets called *The Future is Now, THINK BIG!! Preparing for Transition Planning*. There are three booklets available in English and Spanish that incldue a booklet for youth/young adults ages 14 to 19 years. The booklet consists of an easy-to-use checklist on: Self-advocacy; Health & Wellness; Healthcare System; Social & Recreation, Independent Living Skills; and School & Work.

Title V will partner with schools to disseminate transition booklets to families at events such as school enrollment, orientation, and IEP meetings. KS-SHCN Care Coordinators will continue to use this booklet to help adolescents with transition discussions and the adolescents in developing goals and objectives for their Action Plan. Youth without disabilities or special health care needs can utilize these as well and it it desired to convene a group of adolesecents and families to revise these booklets to be inclusive for all youth and prepare them adulthood.

Life Skills Community-Based Education: The youth focus groups revealed a need for life skills education and a greater understanding about developmentally appropriate risk-taking vs. risky behaviors that could negatively impact youth lives. Plans are underway to partner with the foster care and juvenile justice agencies to discern what current educational offerings are available for adolscents at risk. Upon completion of the environmental scan analysis, Title V will engage youth and young adults who are currently or have previously been served by these programs and document any gaps on topics that youth wish to learn about (e.g., budgeting, independent living skills, furthering education, gaining employment, stress management, healthy relationships). Subject matter experts across the state will work together to build a curriculum that will meet the needs of youth. Title V will work to identify a community in which to pilot these skills building sessions in the coming years.

Awareness of Community Services: As adolescents learn to be more independent, knowing what community services and resources are available to them can be a daunting and overwhelming task. Title V is commited to making sure youth know where to go if they need assistance in navigating adulthood and the responsibilities that go along with transitioning into the adult stage of life. The following strategies will assist with this effort:

- *Resource and Referral Networks.* Title V staff will review the Kansas 2-1-1 and 1-800-CHILDREN referral lines to determine the network that meets the needs of adolescents. Both of these are backed by statewide and local organziations that assist with transportation, housing, education, mentoring programs, and other services that may be valuable to youth. MCH staff will identify marketing strategies through engaging youth in the decision-making, planning, and implementation of a distribution plan.
- *Teen Pregnancy Targeted Case Management (TPTCM).* In FY21, eleven local agencies across the state will provide services to an estimated 534 KanCare-eligible pregnant and/or parenting adolescents through the TPTCM program. TPTCM program goals are: to reduce negative consequences of teen pregnancy for KanCare-enrolled teens and their children to: increase levels of self-sufficiency; support youth-directed goal-setting for their and their children's futures; expand education/training opportunities; and support youth-defined successes prior to subsequent

pregnancies or until they reach 21 years of age. Ten of the TPTCM lead agencies also serve as the local MCH agency. The co-location of both MCH and TPTCM within a local agency increases opportunities to collaborate to ensure adolescents receive coordinated care and support across programs.

- *Systems Navigation Trainings & Transition*: Youth with SHCN will continue to be encouraged to participate in the *Systems Navigation Trainings* held by the KS-SHCN Program. Covering a wide variety of topics such as: communicating with providers; self-care; transition; advocacy; and local resources. Youth will be encouraged to participate in leadership programs such as the Kansas Youth Leadership Forum (YLF) and the Faces of Change program offered by the Kansas Youth Empowerment Academy, and transition workshops conducted by Families Together, Inc.

KEY (Kansas Empowering Youth & Young Adults) Summit: To provide resources and materials for providers and youth, the CAHC will continue to participate in the planning and convening of the annual KEY Summit and Adolescent Empowerment Conference. 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. For more information about these events, refer to the Adolescent Report.

Social-Emotional Learning & Development Among Middle Schoolers: Title V will partner with other federally funded initiatives to provide events and programs that promote protective factors and empower youth to reduce health risk behaviors, including bullying and suicide prevention. Title V will partner with the KDHE Bureau of Health Promotion (BHP) to expand reach to evidence-based interventions. We will work together to spread the Committee for Children's Second Step program to beyond the existing two elementary schools and implement the newly available Second Step Middle School Program for Grades 6-8. 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. Title V plans to establish strong relationships with participating schools (teachers and administrators), the Kansas School Nurse Organization (KSNO), and the Kansas State Department of Education (KSDE) School Counseling and Social-Emotional Character Development staff on this initiative.

Objective: Increase the number of local health agencies and providers serving adolescents and young adults that screen, provide brief intervention and refer and/or provide treatment for those experiencing or at risk of experiencing behavioral health conditions.

During the adolescent focus groups, youth shared that when their friends struggle with mental health issues, they seek support from each other and try their best to help. They expressed uncertainty with providing needed support for their friends because sometimes they do not have the answers they are looking for, and it can take a toll on the peer providing support. Many youth indicated that it can be awkward or embarrassing to go to adults. Youth feel that adults do not understand what they are going through and fear judgment. Title V's has a plan to address this stigma, fear, and hesitation related to reaching out.

Youth-Driven/Centered Approaches: Increasing youth voice related to planning to address youth mental health across the state is a top priority. Title V and partners will coordinate a calendar of youth-led or youth-centered events to collect youth-designed messages for their peers to be used in a statewide marketing campaign. The image to the right is from the Title V/BHP/Shawnee County Youth Suicide Prevention Coalition partnership to develop an activity for the annual Youth Resiliency Conference (April 2019). This activity encouraged young adults to write messages to their peers about what they would want them to know. The messages were sent to KDHE Communications to create a visual graphic and prepare social media messages. The youth-created messages were distributed to Kansas Department for Aging and Disability Services (KDADS), KSDE, Kansas Suicide Prevention Resource Center (SPRC), and local MCH agencies. Collaborations will be expanded to conduct this activity in other counties across the state in the future.

Peer to Peer Supports: Title V hopes to expand the Supporting You Network to include programs serving adolescents to connect youth in need with peers who can listen and identify with life's challenges, anxiety, depression, and thoughts of suicide. Supporting You is not a screening or crisis program, so it will be important that the peer volunteers are well trained on how to determine when the youth should seek professional assistance. The youth model for Supporting You stemmed from youth input where they shared that they want to talk to other peers who can understand what they are going through.

Mental Health First Aid (MHFA): MHFA has already been provided to MCH home visitors, and plans are underway to expand reach to 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 acting on their own to equip their teams and partners at the community level. As the MCH program has engaged in ongoing discussions related to increasing access to MHFA training, there is a strong desire to focus on opportunities for partners to participate in the Youth training has emerged and will be pursued.

Cross-agency Collaboration for Improved Adolescent Health & Well-being: Title V will continue to partner with KDADS Behavioral Health Commission. In the upcoming grant year, Title V will continue to build collaborations with each of the organizations listed to the right, including any others that indicate an interest in supporting youth and young adults by offering local mental health initiatives and services. Youth engagement and active youth participation in planning and conducting local resources and events will be highly encouraged. Local MCH agencies will be encouraged to partner with the community mental health center (CMHC), local prevention coalitions/collaboratives, health care providers, schools, and other community youth-serving organizations that provide education, resources, and events for youth.

Key Partners in Adolescent Health & Well-Being

State Agency Partners

- KS Behavioral Health Commission
- KS Department of Aging and Disability Services (KDADS)
- KDHE Bureau of Health Promotion (BHP)
- Office of the Attorney General (AG)
- State Department of Education (KSDE)
- Department for Children and Families (DCF)
- Department of Corrections (DOC) - Juvenile Services
- Suicide Prevention Resource Center (SPRC)

Local and Community Partners

- Health care providers
- Schools
- Community mental health centers
- Suicide Prevention Coalitions

Highly collaborative ongoing work across agencies and systems will specifically assist with the creation of a unified cross-agency standardized list of best practices to be disseminated to health care providers, CMHCs, schools, and community youth-serving organizations to support whole adolescent health in their communities. Title V is also working to improve partnerships with the Kansas Department for Children and Families (DCF) and Kansas Department of Corrections' Juvenile Justice Services, specifically to engage youth in the child welfare and/or corrections systems in MCH programs. With the upcoming initiation of the Family First Program in the state, DCF is as a critical partner to improve programming for youth and adolescents at the community level.

In addition, the KS Maternal and Child Health Council (KMCHC) is working on a "call to action," in the form of an infographic, related to youth suicide prevention. The idea is that there is something everyone can do "right now." Promoted strategies will be 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. Mental health will also be addressed during adolescent well visits conducted at local MCH agencies using Bright Futures materials.

Suicide Prevention: The KMCHC designed two series of social media posts based on the #BeThe1To's - 5 Action Steps for Helping Someone in Crisis. One series targets adults and the other adolescents; however, both have the same message: "Be the one to help save a life." These images/resources are available on the KMCHC website. Increased promotion of the images will occur during Suicide Prevention (September) and Mental Health Awareness (May) months.

Message #1, Adult Version

KANSAS MATERNAL & CHILD HEALTH

Suicide is the #2 leading cause of death for people ages 10-24 in Kansas. Learn more about how ASKING can save a life at www.BeThe1To.com

If you or someone you know is struggling, call the Lifeline at 1-800-273-8255 (TALK)

If you or someone you know is interested in mental health or substance use treatment, visit: https://findtreatment.samhsa.gov/

Message #2, Adolescent Version

KANSAS MATERNAL & CHILD HEALTH

Suicide is the #2 leading cause of death for people ages 10-24 in Kansas. Learn more about how KEEPING THEM SAFE can save a life at www.BeThe1To.com

If you or someone you know is struggling, call the Lifeline at 1-800-273-8255 (TALK)

If you or someone you know is interested in mental health or substance use treatment, visit: https://findtreatment.samhsa.gov/

Message #3, Adult Version

KANSAS MATERNAL & CHILD HEALTH

Suicide is the #2 leading cause of death for people ages 10-24 in Kansas. Learn more about how BEING THERE can save a life at www.BeThe1To.com

If you or someone you know is struggling, call the Lifeline at 1-800-273-8255 (TALK)

If you or someone you know is interested in mental health or substance use treatment, visit: https://findtreatment.samhsa.gov/

Message #4, Adolescent Version

KANSAS MATERNAL & CHILD HEALTH

Suicide is the #2 leading cause of death for people ages 10-24 in Kansas. Learn more about how HELPING THEM CONNECT can save a life at www.BeThe1To.com

If you or someone you know is struggling, call the Lifeline at 1-800-273-8255 (TALK)

If you or someone you know is interested in mental health or substance use treatment, visit: https://findtreatment.samhsa.gov/

Message #5, Adult Version

Title V will continue promoting the Adolescent Suicide Prevention Tip Sheets created in 2019 by a multi-state agency workgroup. The Tip Sheets are available targeted to a variety of audiences (teens, parents, school personnel) on the KS MCH suicide prevention resource page and include important suicide prevention resources and available crisis services, including helplines with phone and text options as well as community-based crisis services provided by Kansas CMHCs.

In partnership with the Kansas Division of Emergency Management, KDADS, and the Kansas Department of Agriculture, Title V played a lead role in securing FEMA crisis counseling program funds and creating a Crisis and Counseling Toolkit during the COVID-19 response—these resources apply to any crisis, related or unrelated to the pandemic. Read the July 2, 2020, press release and access the Kansas: Stronger Together resources online. Title V will continue promoting the information to increase awareness of available crisis supports and services. The Toolkit includes three sections:

- *Kansas Crisis & Counseling Services*: Overview of crisis services and supports (e.g., helplines and CMHC crisis services)
- *Kansas Hotlines & Helplines*: 1-page snapshot of the COVID-19 hotlines, crisis helplines, other resources/support lines, and medical provider consultation lines
- *Resource Guide*: Directory of resources, information, and other toolkits (Note: The linked toolkits offer self-help tips and ideas for maintaining positive mental wellbeing during COVID-19. Subsections of the Resource Guide include: COVID-19, Mental Health, Substance Use, Anti-Violence, and Parenting Resources.)

KSKidsMAP (Kansas' pediatric mental health care access program for primary care physicians and clinicians; more details found in the Cross-Cutting Plan) offers a TeleECHO clinic featuring case presentations by participating physicians treating children/adolescents with behavioral health conditions in their clinical practice. Patient's suicidality was presented as part of a recent case presentation. Through partnerships with the KAAP and a local CMHC, KSKidsMAP obtained existing suicide resources and promoted them within their provider network. Information will continue to be used during relevant case consultations, TeleECHO Clinic sessions, and with local MCH agencies.

Local MCH Agencies: Several Local MCH agencies are focusing efforts on positive youth activities and programs to support healthy social-emotional development. For example, they collaborate with local school districts in providing anti-bullying campaigns, education, and counseling. Local agencies are also participating in local coalitions that provide education to first-line providers, educators, and parents on mental health issues including bullying. Mental health is also addressed during adolescent well visits conducted in local MCH clinics using Bright Futures screening guidelines and anticipatory guidance. Several local MCH agencies use the PHQ-9 depression screening tool within KBHs visits for the adolescent population,

including: City-Cowley; Cloud County; Ellsworth; Finney; Labette; Community Health Center of Southeast Kansas; and Miami County Health Departments.

- Kearny County Hospital staff have been trained to present YMFHA and plans to provide training to school staff and community groups.
- Linn County plans to increase mental health awareness, providing mental health resources to adolescent clients. They also will work to increase school suicide prevention programs and actively participate in the Suicide Prevention Team in their community.
- Coffey County serves on both their communities Mental Health Board and Mental Health Collaboration team.

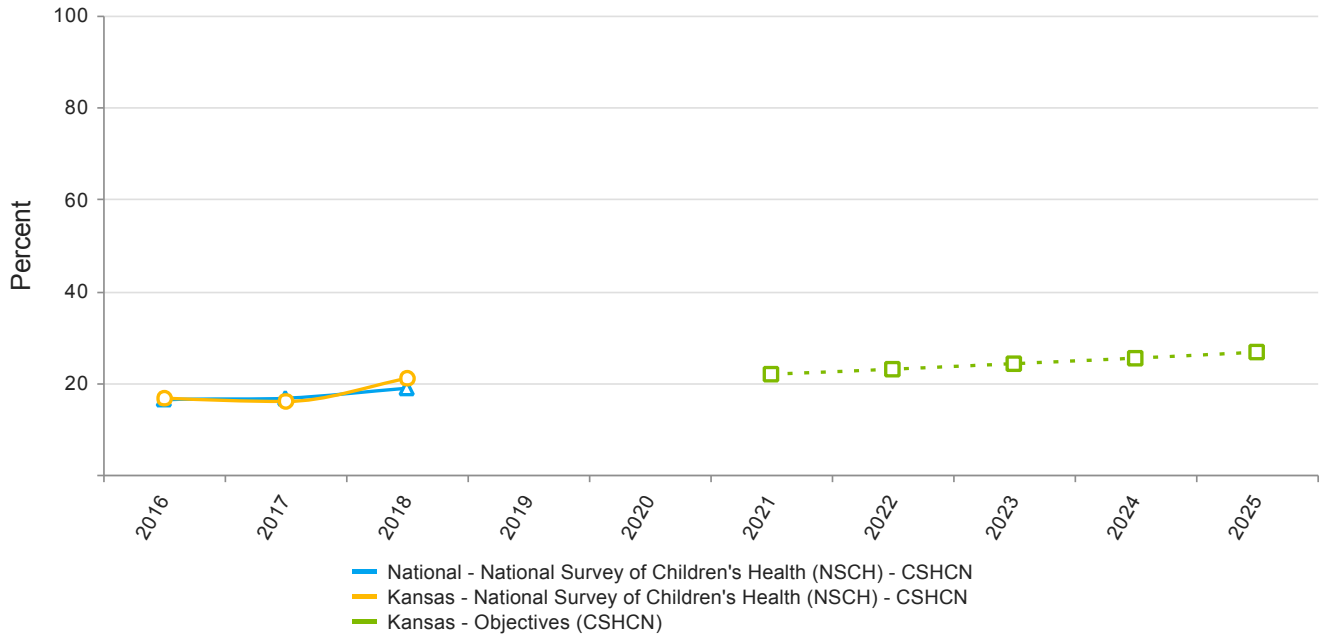
Children with Special Health Care Needs

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-2017_2018	18.8 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	52.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.5 %	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-2017_2018	2.0 %	NPM 11

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2019
Annual Objective	
Annual Indicator	20.9
Numerator	13,192
Denominator	63,103
Data Source	NSCH-CSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	21.9	23.0	24.2	25.4	26.7

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	50
Numerator	2
Denominator	4
Data Source	Welligent
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	52.5	55.1	57.9	60.8	63.8

State Action Plan Table

State Action Plan Table (Kansas) - Children with Special Health Care Needs - Entry 1

Priority Need

Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase the proportion of adolescents and young adults who actively participate with their medical home provider to assess needs and develop a plan to transition into the adult health care system by 5% by 2025.

Strategies

Provide technical assistance and support to local health agencies and medical home providers of families served through the Kansas Special Health Care Needs Program (KS-SHCN) to incorporate transition readiness education and resources for youth ages 12 and older.

Promote the implementation of evidence-based practices and policies with providers serving adolescents and young adults to support transition from pediatric to adult health systems.

Partner with health care professional organizations to engage with insurers to support adequate reimbursement for transition care services.

ESMs	Status
ESM 12.1 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date	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

State Action Plan Table (Kansas) - Children with Special Health Care Needs - Entry 2

Priority Need

Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase the proportion of families of children with special health care needs who report their child received care in a well-functioning system by 5% by 2025.

Strategies

Implement national standards through a collaborative network of programs, providers, partners, and families dedicated to advancing the Kansas State Plan for Systems of Care for Children with Special Health Care Needs (CSHCN).

Expand the partnership between Title V and Medicaid to strengthen coordinated services and supports for CSHCN in managed care and home and community-based services programs.

Assess gaps in insurance coverage, adequacy, and affordability for families of CSHCN and engage with key partners to support modification of policies and practices to advance and increase access and coverage of necessary medical and social services.

Partner with Medicaid and the behavioral health agency to implement policy change to allow family caregivers the opportunity to serve as nursing caregivers through waivers when appropriate.

Assess statewide barriers to accessing primary and specialty care services for families of CSHCN, including palliative care, multi-disciplinary specialty care teams, telehealth, and primary care medical homes.

ESMs	Status
ESM 12.1 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date	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

State Action Plan Table (Kansas) - Children with Special Health Care Needs - Entry 3

Priority Need

Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2025.

Strategies

Provide technical assistance and support to child welfare agencies working with family foster homes to improve coordination across systems and align services for CSHCN in foster care.

Expand KS-SHCN Care Coordination eligibility to support families transitioning out of early intervention services, assuring they are connected to appropriate community-based services and resources.

Provide quarterly Systems Navigation Trainings for parents of CSHCN.

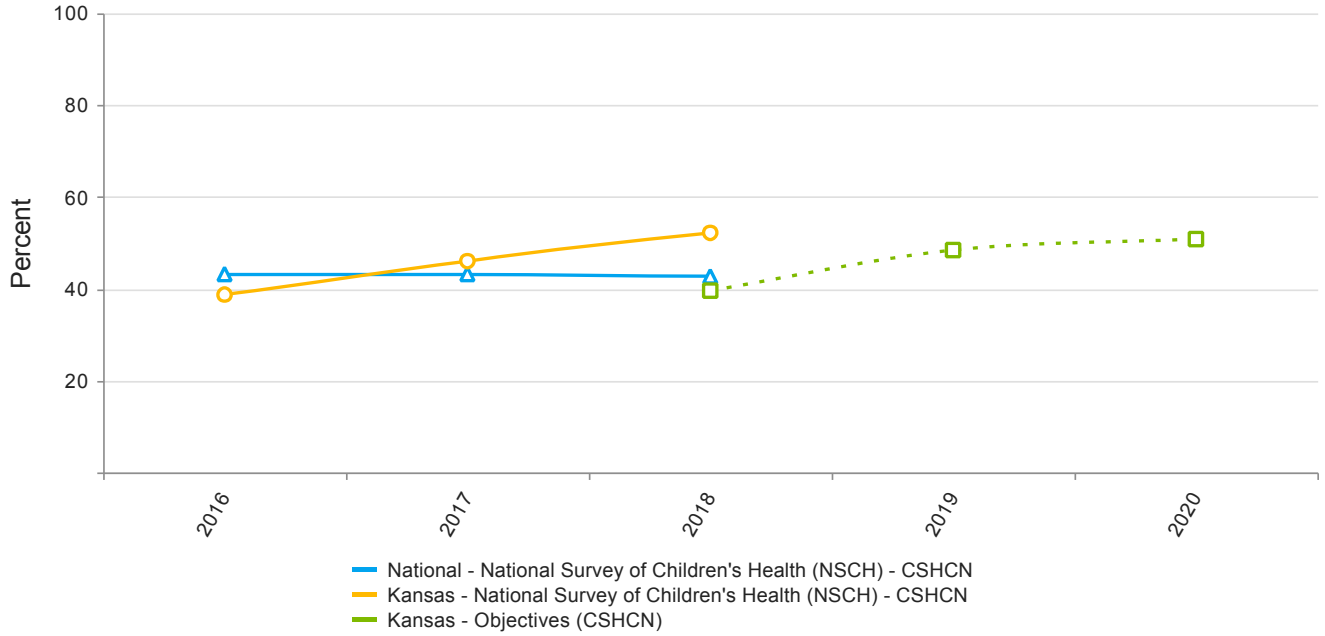
ESMs	Status
ESM 12.1 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date	Active

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

2016-2020: National Performance Measures

2016-2020: 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



2016-2020: NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			39.6	48.4
Annual Indicator		38.6	46.1	52.3
Numerator		56,808	68,059	75,646
Denominator		147,272	147,776	144,559
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**	**2019**
Annual Objective		5	5	70
Annual Indicator	0	0	66.7	62.9
Numerator			18	22
Denominator			27	35
Data Source	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Children with Special Health Care Needs - Annual Report

PRIORITY: Services are comprehensive and coordinated across systems and providers

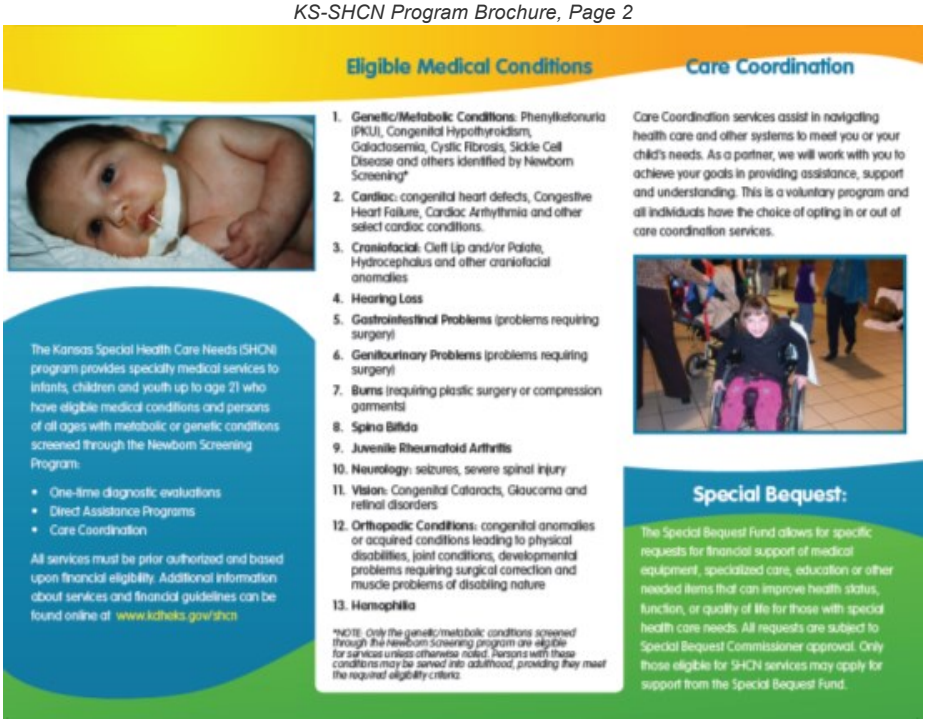
NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)

MCH Local Reach: During SFY2019, 29 of 71 grantees (41%) provided services to the Children with Special Health Care Needs (CSHCN) population; 10 agencies served as Satellite Offices for the KS Special Health Care Needs (KS-SHCN) Program.

The Title V program, within the Bureau of Family Health, has authority and provides guidance for services for children with special health care needs (CSHCN). Pursuant to Kansas Statute (K.S.A. 65-5a01, et seq), the program must meet certain expectations to provide medical treatment services to families with defined and limited diagnoses and disabilities. However, it should be noted that programmatic activities align with Title V requirements, recommendations, and guidance to engage as a key stakeholder and catalyst for improving systems of care for all CSHCN. The vision in Kansas spans far beyond the state mandate for services and aims to assess and address needs of all CSHCN through quality improvement and evaluation to advance sustainable and systemic changes.

The Kansas Special Health Care Needs program (KS-SHCN) provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions and persons of all ages with metabolic or genetic conditions screened through the newborn screen. The program assures that medical specialty services are accessible through external partnerships and contracts to provide diagnostic evaluations and treatment services, care coordination, financial assistance, and support to approximately 2,100 individuals with special health care needs and their families. Additional information about the program, including the eligible medical conditions (per KS Statute), is available on the website and throughout this report. https://www.kdheks.gov/shcn/index.htm

KS-SHCN Program Brochure, Page 2



The Kansas Special Health Care Needs (SHCN) program provides specialty medical services to infants, children and youth up to age 21 who have eligible medical conditions and persons of all ages with metabolic or genetic conditions screened through the Newborn Screening Program:

- One-time diagnostic evaluations
- Direct Assistance Programs
- Care Coordination

All services must be prior authorized and based upon financial eligibility. Additional information about services and financial guidelines can be found online at www.kdheks.gov/shcn

Eligible Medical Conditions

1. **Genetic/Metabolic Conditions:** Phenylketonuria (PKU), Congenital Hypothyroidism, Galactosemia, Cystic Fibrosis, Sickle Cell Disease and others identified by Newborn Screening*
2. **Cardiac:** congenital heart defects, Congestive Heart Failure, Cardiac Arrhythmia and other select cardiac conditions.
3. **Craniofacial:** Cleft Lip and/or Palate, Hydrocephalus and other craniofacial anomalies
4. **Hearing Loss**
5. **Gastrointestinal Problems** (problems requiring surgery)
6. **Genitourinary Problems** (problems requiring surgery)
7. **Burns** (requiring plastic surgery or compression garments)
8. **Spina Bifida**
9. **Juvenile Rheumatoid Arthritis**
10. **Neurology:** seizures, severe spinal injury
11. **Vision:** Congenital Cataracts, Glaucoma and retinal disorders
12. **Orthopedic Conditions:** congenital anomalies or acquired conditions leading to physical disabilities, joint conditions, developmental problems requiring surgical correction and muscle problems of disabling nature
13. **Hemophilia**

*NOTE: Only the genetic/metabolic conditions screened through the Newborn Screening program are eligible for services unless otherwise noted. Persons with these conditions may be served into adulthood, providing they meet the required eligibility criteria.

Care Coordination

Care Coordination services assist in navigating health care and other systems to meet you or your child's needs. As a partner, we will work with you to achieve your goals in providing assistance, support and understanding. This is a voluntary program and all individuals have the choice of opting in or out of care coordination services.

Special Bequest:

The Special Bequest Fund allows for specific requests for financial support of medical equipment, specialized care, education or other needed items that can improve health status, function, or quality of life for those with special health care needs. All requests are subject to Special Bequest Commissioner approval. Only those eligible for SHCN services may apply for support from the Special Bequest Fund.

The term “children with special health care needs” (CSHCN) will be utilized to refer to the general population as defined by Title V, as compared to the population served directly through KS-SHCN as determined by program eligibility.

Aligned and expanded from the 2020 Title V Needs Assessment and State Action Plan (SAP), the KS-SHCN Action Plan is currently in implementation year 5 of 5. This report reflects accomplishments during year 4. The full KS-SHCN Action Plan can be found as Appendix A of the State Plan for Systems of Care for CSHCN. As a critical component to the work of the program, KS-SHCN priorities and strategies are assessed each year by the Family Advisory Council (FAC) to monitor progress and make recommendations as needed.

Families continue to express the need for ongoing assistance with non-medical needs that support families in meeting their most critical health concerns. The program regularly reviews funding and support for direct services, including multi-disciplinary clinics, and makes modifications as needed.

KS-SHCN Infrastructure and Program Activities/Services

The KS-SHCN Action Plan objectives and strategies complement the Title V SAP, with many of the KS-SHCN priorities and strategies integrated across several of the domains. 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. It is important to understand the structure and function of the KS-SHCN program to fully realize the full impact and infrastructure that contributes to the overall system of care for CSHCN and their families.

KS-SHCN Workforce: KS-SHCN regularly assesses the workforce and service delivery needs of the families served through the program. Satellite offices (SO) are established across the state through local health agencies and one area children’s center that provide broader MCH services through the MCH Aid to Local (ATL) program. Each year, a review of KS-SHCN program data is conducted to assess the need for SO staffing, placement, and coverage. As a result, it is not uncommon to realign the SO service areas and in SFY2019, the program supported ten (10) SOs. These were reduced to eight (8) in SFY2020. As the number of SO’s shift, geographic lines for the regions are adjusted to assure all Kansas counties are covered. This continues to be assessed yearly and adjusted as needed dependent on client enrollment and level of care coordination needs identified.

SHCN Satellite Offices – SFY 2019

The KS-SHCN workforce consisted of a total of 26 individuals, with 5 full-time positions, and the remaining staff (SO) working an average of 10 hours or less per week. Many of the SO staff also work on other Title V programs and because of the KS-SHCN integration with the MCH ATL process, local health agencies have the opportunity to learn more about services available for the CSHCN population and the need for MCH services and supports. These efforts help increase understanding that CSHCN are children first and need the same services and supports as non-CSHCN children, while gaining awareness and appreciation for the specialized needs or challenges of the CSHCN population.

Workforce Credentials	SFY2019	SFY2020
Registered Nurses	14	10
Social Workers	4	4
Other	14	12
Total	32	26

In addition to training and support provided through the MCH ATL network, SO staff receive technical assistance and training from KS-SHCN through bi-monthly webinars or “Brain Trust” calls, site visits, and an annual in-person training.

The first KS-SHCN staff retreat was held in SFY2019 for those working in the Topeka office, providing opportunity for staff to engage in program evaluation activities, including review of program data and national/state performance measures. During the retreat, staff focused on review of the alignment across the Title V and KS-SHCN Action Plans and developing strategies to be accomplished in the coming year. Annual review of the direct assistance programs (DAP’s), care coordination services, Special Bequest, SO trainings and supports, data system enhancements, program promotion strategies, and budget were also completed that day. Personal and program goals from each team member were shared with the program manager to identify ways to better support their individual growth and system knowledge. Staff response to the retreat was positive and indicates a desire to make this an annual event. Key outcomes from the retreat:

- Changes to Direct Assistance Programs (DAPs)
- Special Bequest modification
- Cross-training for all staff over the next year
- Ideas for Title V Needs Assessment process
- Updates to the KS-SHCN Action Plan
- Individual NPM input
- Alignment of shared visions for program and staff roles

Direct Assistance Programs (DAPs): KS-SHCN provides financial assistance for direct services for families through DAPs (full list of DAPs available in the Overview of the State Section).

Staff monitor and review DAP utilization data annually to determine if any changes need to be made prior to the next program year. Changes may be based on actual or anticipated increases due to changes within the insurance industry, Medicaid/KanCare, and shifts in coverage for CSHCN services. In SFY2019, a change to the Metabolic Products DAP policy resulted in allowing clients up to $1,000 per month (an increase from the standard amount of $750) by submitting a letter from their provider providing rationale for the need (e.g., specific high cost formula). Additional changes included increasing funding amounts for the Travel DAP (DAP-T), allowing families to utilize the Co-Payment/Deductible/Co-Insurance (DAP-C/D/CI) twice in the same 12-month timeframe for assistance with out-pocket-costs associated with a high insurance deductible.

Effective July 1, 2019, KS-SHCN added a new DAP–Caregiver Relief (DAP-CR). DAP-CR allows families who have medically complex children to hire, set pay, train, and monitor care providers for their child. Care providers must be over the age of 18, have a valid drivers license and be certified in CPR and First Aid. This provides families the opportunity to address unique needs such as doctor’s appointments, mental health breaks, or other family member needs.

Since the inception of the DAPs, the program is more effective and efficient at providing services to clients, monitoring expenses, identifying gaps/barriers in service authorizations, and ensuring greater fiscal responsibility. With the DAPs in place, the program has prevented the need for waiting lists and decreasing services due to a lack of funds by only authorizing services as needed and setting limits per annual authorization. This change has resulted in better accountability and an ability to identify when funds are running low and cease authorizations for that DAP, if needed, until funds are released.

KS-SHCN Enhanced Data System: Work on the new Welligent data system (launched in 2018) continued in 2019 to ensure make sure all components of the system work efficiently. Additional enhancements continued to be developed to better assist staff in tracking all care coordination activities and reporting quality data. The Welligent system includes components needed for care coordination services such as: client demographics, applications, supporting documentation, financial calculation, authorizations, action plans, budget (client and program), DAPs, correspondence, clinic information, follow up reminders for Care Coordinators, and more. The system continues to be enhanced and refined to meet all program specifications. Staff participate in monthly training webinars to support proficiency with the system. Data is reviewed regularly to identify areas for improvement. Welligent improvement activities are expected to be an ongoing activity to meet program changes as they occur. Staff report the new system has allowed for improved and timely services for clients and a better coordination in workflow for the KS-SHCN care coordination staff.

Aid-To-Local (ATL) Funding Process: KS-SHCN provided an opportunity for community partners to apply for funding through an online application and reporting system, Kansas Grant Management System (KGMS). Applicants were provided the KS-SHCN key priorities and objectives and asked to share the "problem" or "community need" they can best impact, as related to the plan. For each objective addressed by the applicant strategies or activities were to be described to implement to address the need(s) identified, anticipated health outcomes, and long-term sustainability plans. A review team was developed to review all applications consisting of the Title V CSHCN Director, KS-SHCN Program Manager, SHS program leads, KS-SHCN Topeka team, and FAC members. Each proposal was evaluated by at least four members of the review team, including one family reviewer. Reviewers were provided webinar trainings on the review process, timeline, and reviewer expectations.

All reviewers were provided a scoring rubric which can be found in the SHCN supplement document, with their assigned ATL application(s) and deadline for completion. Responses from the scoring rubric are compiled, calculated and comments noted prior to internal review by program staff. Internal reviewers discuss each proposal and make one of the following recommendations: do not fund, fund with conditions, or fund as written. In FY2019, the KS-SHCN program awarded seven grants. A summary follows.

SFY2019 ATL Grantees

Specialty and Outreach Clinical Services

- *Kansas City clinics:* Cystic Fibrosis and Cleft Lip/Palate
- *Wichita clinics:* PKU, Cleft Lip/Palate, Cerebral Paley/Medically Complex*, and Wheelchair Seating
  - **This clinic will be providing a holistic care coordination approach that aligns with the KS-SHCN program model.*
- *Outreach clinics:* Wheelchair Seating

Care Coordination Activities

- *Connecting the Docs:* Support for a full-time Care Coordinator in the FQHC in Southeast Kansas to provide serves to low-income special needs children. Ultimately, this will lead to the development of a replicable model to implement Phase 3 of the KS-SHCN Care Coordination program.

Youth Leadership Development

- *Faces of Change:* A seven-month leadership program for youth with disabilities that foster attitudes of civic engagement and services through the development of leadership skills.

Throughout the reporting year, the KS-SHCN Program Manager and Grants Coordinator met with each partner twice (fall and spring) to monitor progress on funded projects and to build stronger collaborative relationship. During these in-person meetings, program updates, grantee project progress, technical assistance needs, and next steps were discussed. The program worked with grantees to identify additional collaboration opportunities to meet the needs of the CSHCN population. Outcomes of these discussions led to the following changes:

- The KS-SHCN Care Coordination model piloted within the CP/MC clinic for FY2019, with plans to continue in FY2020.
- During FY2019, a KS-SHCN Care Coordinator, who specializes in PKU, began attending the Wichita PKU clinic regularly to work directly with clients on their Action Plans.
- The KS-SHCN Program Manager and Title V Adolescent Health Consultant were invited to participate in the Faces of Change youth leadership training session. Additionally, the Title V CSHCN Director attended the Fall 2018 Faces of Change Graduation Ceremony.

Grantees were required to submit quarterly reports and the KS-SHCN Program Manager provided written feedback to build better partnerships. Upon request of the Title V FAC, the program created a SFY2019 Special Health Care Needs Program Annual Report that highlights funding, objectives and outcomes, and key accomplishments of each grant initiative. The Annual Report financial summary below outlines activities and outcomes from some of the program grantees.

GRANTEE	TOTAL AWARD	TOTAL SPENT	BALANCE	% SPENT
CPRF	$ 155,705	$ 155,705	$ -	100%
KUMCRI - Outreach	$ 9,906	$ 3,155	$ 6,751	32%
KUMCRI - Specialty	$ 31,175	$ 24,880	$ 6,295	80%
KUMCRI - CP/MC	$ 150,000	$ 150,000	$ -	100%
KUMCRI - Genetics	$ 97,480	$ 97,341	$ 139	100%
KYEA	$ 30,394	$ 19,709	$ 10,685	65%
Southeast Kansas	$ 39,060	$ 39,060	$ -	100%
Wichita Cleft Lip	$ 14,500	$ 14,500	$ -	100%
TOTAL	$ 528,220	$ 504,350	$ 23,870	95%

Wheelchair Seating Services: The Cerebral Palsy Research Foundation (CPRF) Wheelchair Seating Clinics provide critical wheelchair/posture-seating services in Wichita and satellite outreach clinics. To assure the quality standards of its program, CPRF focuses on three means of feedback: family satisfaction surveys (following each clinical visit and longer-term assessment of clinic services); process measures; and long-standing collaborative partnerships (e.g., medical professionals, nonprofit disability services providers, durable medical equipment providers, public school districts, and the Wichita State University College of Engineering). Key data from the CPRF efforts are outlined below.

"Pre-" and "Post-" tests completed by Occupational Therapists (OTs) and Physical Therapists (PTs)

Data	1st. Quarter		2nd. Quarter		3rd. Quarter		4th. Quarter	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Goal #1	2.45	4.45	2.33	4.37	2.34	4.33	2.48	4.35
Goal #2	2.53	4.61	2.51	4.43	2.49	4.51	2.59	4.63
Goal #3	2.80	4.76	3.02	4.73	3.14	4.69	3.38	4.87
Goal #4	2.46	4.72	2.52	4.69	2.35	4.71	2.55	4.72

Seating and Outreach Clinic Service Data

CPRF Seating Clinics			
Quarter	# Patients Served	# Unduplicated	# SHCN Served
First	222	166	37
Second	183	144	19
Third	194	148	30
Fourth	203	150	29
TOTAL	802	608	115

	CPRF Outreach Seating Clinics			
Quarter	# of Clinics	# Patients Served	# Unduplicated	# SHCN Served
First	2	11	11	0
Second	2	11	11	1
Third	2	12	12	0
Fourth	3	16	16	3
TOTAL	9	50	50	4

Population Health and CSHCN: In April 2019, the Kansas Maternal Child Health Council (KMCHC) meeting focused on developing a deeper understanding of the CSHCN population and work surrounding alignment and integration among other Title V MCH activities. KMCHC members received an overview of the Title V and KS statutorily-defined populations, a review of the federal CSHCN population health technical report, and the Kansas Title V vision for CSHCN within the context of population health. Case studies were presented to the group to discuss service navigation, referral to services, or other supports. Each KMCHC domain work group received additional details from facilitators, customized to each MCH population domain and aligned with the Title V State Action Plan priorities, objectives, and strategies. Each group was challenged to think differently about their work and how MCH services are provided, considering potential accommodations needed for individuals or families of CSHCN. A copy of the agenda and meeting materials can be accessed on the Kansas MCH website: http://www.kansasmch.org/pastmeetings.asp.

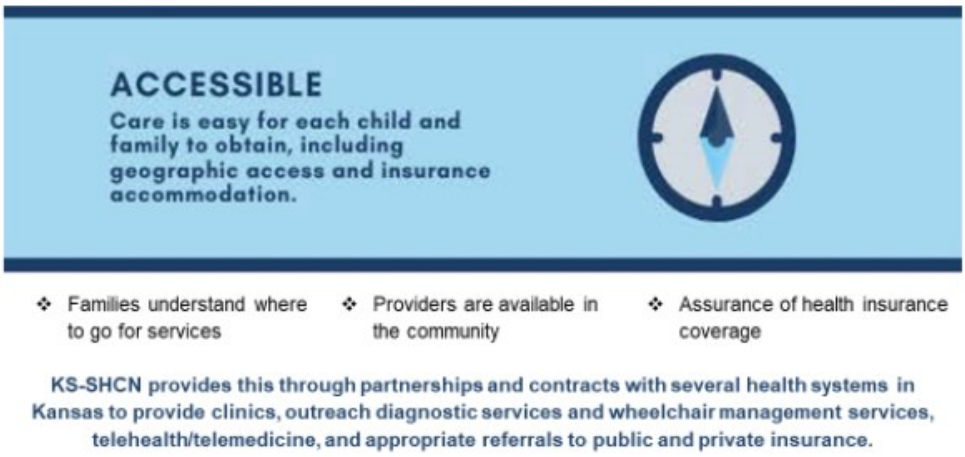
KS-SHCN and Medicaid Partnership: The KS-SHCN program has built a strong partnership with Medicaid and the Managed Care Organizations (MCOs) to support a holistic approach to care coordination. The program shares a monthly report with each MCO to identify dually enrolled clients MCO case managers and KS-SHCN Care Coordinators can work collaboratively to provide quality services for the clients without duplication of effort or service. The Care Coordinators work with the clients to assist with filling any gaps not addressed by the MCO's (e.g., appointment scheduling, filling prescriptions, effectively communicating with providers). The partnership between the MCO Case Managers and the KS-SHCN Care Coordinators has helped maximize resources and provide quality services for CSHCN.

The KS-SHCN Program, upon request, presents information about the program to the MCO case managers to further improve collaboration. During SFY2019, the KS-SHCN Program Manager presented an overview to MCO staff to strengthen and grow the partnership. The program continues to collaborate with the assigned State Medicaid liaison to assure services are not duplicated and identify gaps or barriers that could be addressed between the two programs to improve services for CSHCN. This partnership continues to grow each year with improved outcomes for children. Improvements in services from both programs have been identified, including but not limited to a decrease in client denials for services, reduced wait times related to the appeal and approval process, and development of a single case agreement.

NPM 11: Medical Home (Percent of children with special health care needs having a medical home)

The 2017-2018 National Survey of Children's Health (2 years combined) showed the care received by 51.9% of Kansas children under the age of 18 met medical home criteria. Both children with special health care needs (52.3%, 95% Confidence Interval [CI], 42.7% - 61.8%) and children without special health care needs (51.9%, 95% Confidence Interval [CI], 47.1% - 56.6%) received services through a medical home at a comparable rate. Receipt of care from a medical home varied by age, race/ethnicity, and primary household language. Children aged 0–5 years (51.6%) and 6-11 years (53.3%) were slightly more likely to have a medical home than children aged 12–17 years (50.6%). Hispanic children (37.5%) were less likely to have a medical home than non-Hispanic white children (55.1%). Children living in a household with English as the primary language were more likely to have a medical home than children living in a household with a primary language other than English (52.6% and34.4 %, respectively). Children living in a household with two parents (currently married) were more likely to have a medical home than those with two parents (not currently married), those with only a mother or father, and those with all other family structures (56.3% compared to 48.2%, and 35.4%, respectively). Medical home access also varied by socioeconomic status. Receipt of care in a medical home also increased with household income: 38.9% of children living in households with incomes less than 200% of poverty had a medical home compared to 63.9% of children living in households with incomes of 400% or more of poverty. The difference was significant.

The medical home, a foundational concept for building stronger systems of care for CSHCN in the state drives the work of the KS-SHCN program. The KS-SHCN Holistic Care Coordination model is designed to support each of the seven components of the medical home in some way (depicted in the graphics that follow). As a foundational concept for building stronger systems of care for CSHCN in our state, the Family Advisory Council (FAC) continues to provide input and expertise to assure an ongoing focus on coordinated and holistic approach to providing services in Kansas. The infographics that follow outline how the KS-SHCN Program serves families under the medical home framework. The FAC provided significant input and expertise in developing the new direction of the KS-SHCN program, therefore the new priorities expand beyond the medical home approach and focus on an even more coordinated and holistic approach to providing services.



FAMILY-CENTERED

Each family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family.

- Families are recognized as the expert
- Families are acknowledged as the strength, knowledge and support for the individual
- The family voice is valued

Nearly all activities provided by KS-SHCN are designed to be patient/family-centered. KS-SHCN adopts the mantra, "Nothing about us, without us" from the disability movement as services are planned for and provided. Therefore, consumers and families are engaged at all levels and central to the success of any initiative.

CONTINUOUS

The same primary care clinician care for the child from infancy through young adulthood, providing assistance and support to transition to adult care.

- Consistent health care professionals from infancy through adolescence
- Smooth and successful transitions
- Transition prepares youth for the adult health care system and is calculated and planned

KS-SHCN care coordinators work with youth and their families to assure services are obtained prior to aging out of the program. Assist the youth in developing Action Plan goals to address transition activities to prepare them in learning how to navigate the systems of care.

COMPREHENSIVE

Preventative, primary, and specialty care are provided to each child and family.

- A team of care providers is accountable for a patient's health
- Physical and mental health care needs are a focus
- Prevention and wellness, acute care, and chronic care are integrated

KS-SHCN continues to focus on comprehensive supports and care, assuring the child and family's needs are identified and addressed. The KS-SHCN Holistic Care Coordination program is very comprehensive in terms of coordination and assistance, with the goal to support families in receiving comprehensive medical care.

COORDINATED

A care plan is created in partnership with each family and communicated with all health care clinicians and necessary community agencies and organizations.

- Care plans are created in partnership with the patient/family
- Effective communication among all health care provides is evident
- Necessary community agencies and organizations are informed

KS-SHCN Action Plans are developed with the patient or family engaged and at the center of the plan and shared with all care providers involved with that patient's care. Care Coordinators work with families to communicate with community service providers and external care coordinators to assure coordinated care across all sectors and all needs are addressed.

COMPASSIONATE

Genuine concern for the well-being of each child and family are emphasized and addressed.

- Well-being of the patient and family is the central focus
- Services are available to strengthen and support healthy families

KS-SHCN has engaged in a variety of activities to support this component of the medical home, most notably around adverse childhood experiences, trauma informed care/approaches, and resiliency. Ultimately, all of this is to support staff and providers in better understanding and empathizing with the patient and their family.

CULTURALLY EFFECTIVE

Each family and child's culture, language, beliefs, and traditions are recognized, valued, and respected.

- Materials are provided in languages spoken by individuals served
- Beliefs are recognized and respected
- Value is placed on cultural traditions as it impacts one's health

KS-SHCN are provides written materials in Spanish to address the needs of nearly 20% of those served through Holistic Care Coordination and direct financial assistance. The individual believes and values of the patient or family is considered and integrated into the client's Action Plan. KS-SHCN receive annual training on the needs of the diverse populations served.

To assist in increasing children with special health care needs ability to access a medical home, the KS-SHCN program partnered with a developmental pediatrician, the staff at the Cerebral Palsy/Medically Complex clinic in Wichita, a Palliative Care Social Worker/parent of a child with special health care needs, a leader in the Early Childhood Collaborative Systems

(ECCS) work, and the University of Kansas Project ECHO team to provide a 4-part learning series for providers across the state. The series, titled *Beyond the Developmental Screen*, focused on the importance of screening, frequency, tools, referral sources if the child flags for developmental delays, how to communicate with families about possible delays, who/where to go for a diagnosis, and more. More about this training can be found in the Child Report. The pediatrician is funded through a contract with KS-SHCN program and available upon request via telemedicine to support providers conducting developmental evaluations.

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

Family satisfaction with communication amongst their child's health providers continues to be a priority for the KS-SHCN care coordination staff. Families are assisted with communicating their hopes, dreams and concerns for their child with providers and advocating for provider cross-communication, reducing duplication of treatment and improving services. KS-SHCN Care Coordinators assist the family in identifying what information they need/want to share with their child's provider and what questions they want to ask the provider to have a better understanding of their child's medical needs. By helping families prepare prior to appointment, parents/caregivers can assist the medical providers in understanding their child's needs, so they can collaboratively develop the best plan possible for the child. By identifying questions prior to the appointment, families leave appointments with more clarity about treatment, services and next steps in their child's care. Giving families these supports help them feel empowered in their ability to navigate the systems of care independently in the future. A case example of this is shared below:

Jen had not expected to be a mom at eighteen and did not have a relationship or any support from the child's father. Due to pregnancy complications, the child was born with multiple disabilities. Mom was in denial of what supports her child was going to need and the 24/7 care it was going to take. She was going through many emotional stages and learning to adjust to a new way of life, which was not the one she dreamed about. After a referral from a one of their therapists I was able to connect with her to help her understand there were supports available for her and her family. She was very reserved, as she already had so many therapists, case managers and medical specialists to keep track of. After sharing the program benefits and supports, offering ideas, and creating an atmosphere of trust, she now knows I will be a constant support and continue to meet her where she is at on this journey. Our relationship has grown, and we continue to discover ways to work with other organizations to acquire equipment and services for her child.

One instance that brings a smile to my face was the acquisition of a specialized shower chair, that ensured a safe and fun bathing time for mom and child, but also had an additional perk. One hot summer day, mom could tell her child so wanted to be playing in the sprinkler with the neighbor children, instead of sitting on the side lines in her stroller, watching. That's when a big "Ah Ha" moment dawned on her. The shower chair looked just like a lawn chair! Mom ran in to get the shower chair, placed it under the sprinkler and sat her child in it. Who would have thought? On this day, her child was finally one of crowd, laughing and enjoying summer. Assisting this family has showed me what Special Health Care Needs is all about. It's not only assisting in the physical needs of the child but building relationships with the whole family to ensure quality of all aspects of life.

Sharon Thompson, SHCN Care Coordinator

Family Care Coordination Training: The Family Care Coordination Training (FCCT) is designed to assist parents/caregivers in increasing their knowledge of medical homes, Shared Plan of Care (SPoC), transition, community services and supports, obtaining insurance coverage, advocacy, self-care, and to develop skills to better partner with their child's providers. As the trainers are parents of a special needs child themselves, the trainings begin with the staff sharing their personal story to help families feel comfortable sharing hopes, dreams, and daily struggles of being a parent of a child with special health care needs. Participant response to the program has been favorable. Participants complete a pre/posttest and one-year evaluation, providing information that can be used to improve the training experience. Clients are encouraged to attend these training to assist them in preparing for their transition to adulthood.

Understanding the importance of these trainings, the KS-SHCN Program Manager focused on developing a “train-the trainer” model through the reporting period. Along with a KS-SHCN staff member the FAC members who have children with special health care needs have been asked to complete the training. This model is also being developed in Spanish.

Local MCH/SO Agency Strategies: Two KS-SHCN satellite offices (Pittsburg and Hays) continue to participate in the Help Me Grow (HMG) initiative in their local communities. By partnering in this work, they will continue to improve services and supports for infants and children through early identification and timely referrals. As early childhood work continues to grow in Kansas and the HMG framework is utilized in other communities, all satellite offices will eventually be in communities working to implement the framework.

Saline County Health Department Satellite Office has continued to provide outreach and care coordination option to families through Telehealth. The KS-SHCN Care Coordinator is trained in the use of the telehealth equipment and offers these services to the clients/families she works with. The telehealth equipment was provided a couple of years ago through funding from the KS-SHCN program.

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 Holistic Care Coordination (HCC) program assists clients and their families in navigating health care and other systems to meet their or their child’s needs. The goal of HCC is to empower individuals to feel confident in navigating services and supports for themselves or their child while having a consistent person available to them for assistance, support, and understanding as they meet their goals. Care coordination is offered free to any individual and their family who has a special health care need or disability who qualify for the KS-SHCN program.

Clients and families have individual needs and require services and supports tailored to meet those needs. Care Coordinators work with families to identify needs and wants and develop an action plan when applicable to help them achieve positive goals while providing the desired level of support. Care Coordinators partner with families in finding and accessing needed services and resources across medical, education, and community systems. They work with the family to assure the child is receiving the services needed to achieve optimal health outcomes. Families are educated on the various systems and how each function to effectively and independently navigate these systems in the future.

As part of care coordination services clients/families are supported in working collaboratively with their doctors and other service provider to best meet the client’s needs using a holistic approach. Providers have access to the client’s Care Coordinator for support and assistance, when needed and approved by families, to support the best possible health outcomes for the client. Families are reminded about the need for their child’s yearly EPSDT (KanBeHealthy) appointment and assisted in scheduling the appointment if necessary. This is monitored as part of the client’s Action Plan. If a client is uninsured the client/family is assisted in identifying and applying for insurance to best meet their needs. For youth (14 and older) transition activities are included in their action plan. Youth are encouraged to work collaboratively with their parent/caregiver and the Care Coordinator to develop and follow their action plan. Care Coordinators work with the youth to help them identify where they are in the transition process and assist them in developing action plan goals to address transition activities to prepare them in learning how to navigate the systems of care. All client needs are addressed in a holistic way within their individual action plan.

This is a voluntary program and all individuals have the option of opting out or back in at any time. The informational flyer for the approach is below.

KS-SHCN Care Coordination

The Kansas Special Health Care Needs program (KS-SHCN) Care Coordination model assists clients and families in navigating health care and other systems to achieve a holistic approach in meeting their or their child's health needs.

Care Coordinators:

- Find and access services and resources
- Assure receipt of needed services to achieve optimal health outcomes
- Assist in understanding the various systems
- Support effective and independent system navigation
- Develop an action plan based on family/child needs
- Help families achieve their goals

Application Accepted
- Has met medical and financial eligibility

Initial Assessment by Lead Care Coordinator
- Level of support identified and supported "hand-off" to assigned Care Coordinator

Determine Services to be Provided
- Direct Assistance, Care Coordination, Special Bequest, etc

Development of Action Plan
- Based on family needs, wants, desires, and goals

Ongoing support, monitoring, and assistance
- Based on the family's comfort level

This program is offered free to any individual and their family who have a SHCN or disability.
This is a voluntary program and all individuals have the option of opting out or back in at any time.

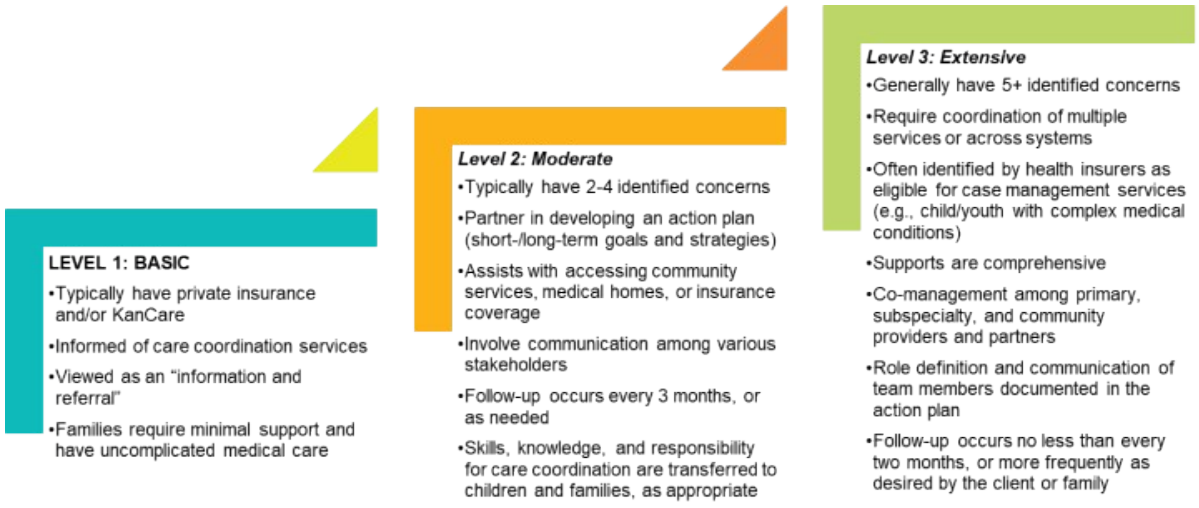
Special Health Care Needs

Our goal is to empower families and individuals to feel confident in navigating services and supports while having a consistent person available to them for assistance, support, and understanding as they meet their goals.

Kansas Department of Health and Environment

Kansas Special Health Care Needs Program
1000 SW Jackson, Suite 220, Topeka, KS 66612-1274
785-296-1313 / 1-800-332-6262

Levels of Care Coordination: To support the provision of supports and education to clients and families, the KS-SHCN Care Coordinators provide HCC through three defined "levels" of care coordination, outlined below:



Once the client receives the initial Care Coordination Assessment (CCA), they are identified to need HCC services at one of these levels. In partnership with the family and other members of the care team, the KS-SHCN Care Coordinators determine the appropriate methods of and intervals for communication and coordination, as well as assessments of progress and outcomes. In SFY19, 110 clients received care coordination services (an increase from 54 in SFY18). Data for SFY19 is not yet available, however data from SFY18 indicates the HCC model is successful. Of the 54 clients served, 35% were at level 1 (lowest level of coordination needed). The remaining were at a Level 2 or 3 (of which 70% showed improvements and moved from a more intensive level of HCC to a less intensive level. The remaining 30% maintained their current level.

Care Coordination Through Satellite Offices (SOs): The SOs serve as the entry-point into the KS-SHCN program, working directly with families throughout the application process, assisting them with applications, and answering questions. They also share information about the KS-SHCN program with families, community organizations and providers in their region to help increase the number of clients on the program.

Staff at each SO provide basic services at the local level and their key responsibilities include monitoring client status, communicating needs to families, managing client records, conducting follow-up appointments with families regularly in accordance with the Action Plan, and providing additional supports and services determined by the family. All SO staff receive bi-monthly technical assistance trainings from the Topeka team, site visits, and an annual in-person SO trainings. In SFY2019, all SO's provided holistic care coordination services with support from the Topeka office for KS-SHCN. This allows the program to concentrate on expanding our service delivery models and fostering new partnerships. Plans began in SFY 2019 to expand the KS-SHCN Care Coordination model to the Lifting Young Families to Excellence (LYFTE) program. For detail information on this project please refer to the Adolescent health section.

Care Coordination Through Clinical Models: A partnership with the Community Health Center for Southeast Kansas (CHC-SEK) provided opportunity for the KS-SHCN HCC model to be piloted within a federally qualified health center (FQHC). CHC-SEK is the largest provider of pediatric services in rural southeast Kansas, serving more than 16,000 children annually. A dedicated full-time Special Needs Care Coordinator serves low-income CSHCN throughout the region. CHC-SEK worked with 148 families during the SFY2019 contract to connect them with resources, including the KS-SCHN program, and ensure children had an established culturally competent primary medical, dental and, if needed, behavioral health home. Special Needs Care Coordinators assisted families in navigating access to services and resources based on eligibility. A total of 154 office visits, 196 telephone encounters, 24 school visits, and 41 specialty behavioral health telehealth visits were provided.

With most of this region critically underserved, limited public transportation, aging medical and dental community, and declining number of providers accepting Medicaid, gaps in service delivery are steadily increasing. Many of the families of these children struggle to meet basic needs, let alone adequately provide all the resources that would benefit and improve the quality of life of their child and their family. Through care coordination and assisting families in navigating the ever-increasing complexities of the healthcare system, disparities in the care to low-income children with special needs will be reduced and, in many cases eliminated. Below is a chart showing the number of SPoCs provided by the CHC-SEK in SFY 2019.

SHARED PLAN OF CARE

Annual Data Report

		ADHD	Asthma	Autism	Colitis	Developmental Delay	Down Syndrome	Failure to Thrive	Fetal Alcohol Syndr	Hearing Loss	Heart Disorder	Intellectual Disability	Mental Health Disorder	Obesity	Seizure Disorder	Sensory Processing Disord	Tramatic Brain Injur	
Standard Sub-Measures	Number of CYSHCN with a POC **developed** by the PCP with input from specialist	1	4	8	1	33	3	2	2	1	1	2	10	2	0	2	1	73
	Number of CYSHCN with a POC **developed** by the POC with input from family	1	4	8	1	33	3	2	2	1	1	2	10	2	0	2	1	73
Additional Sub-Measures (adding on new measures as appropriate and based upon capacity of clinic.)	Number of CYSHCN with a POC that includes family preferences and strengths	1	4	8	1	33	3	2	2	1	1	2	10	2	0	2	1	73
	Number of CYSHCN with a POC that includes chronic condition protocols	0	4	0	1	11	1	2	0	0	0	0	1	0	0	1	0	21
	Number of CYSHCN with a POC that includes an emergency plan	0	2	3	1	11	1	2	2	1	0	2	10	0	0	1	1	37
	Number of CYSHCN with a POC that includes legal documents (advance directives, DNR, guardianship, medical authority/power of	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	2
	Number of CYSHCN with a POC that includes clinical goals	1	4	8	1	33	3	2	2	1	1	2	10	6	0	2	1	77
	Number of CYSHCN with a POC that includes family personal goals	1	4	8	1	33	3	2	2	1	1	2	10	2	0	2	1	73

OUTCOMES

	Prevented #	Prevented Description	Occurred #	Occurred Description
1st. Quarter	1 1 19 2	ER Visit Hospitalization Subspecialist Visit Specialized therapies (PT, OT, etc.)	11 5 7	Advocacy for family/patient Met family's immediate needs, questions, concerns Referral to community agency
Patients Seen	**23**		**23**	
2nd. Quarter	18	Subspecialist Visit	7 8 3	Advocacy for family/patient Met family's immediate needs, questions, concerns Referral to community agency
Patients Seen	**18**		**18**	
3rd. Quarter	2 13	Specialized Therapies (PT, OT, etc.) Subspecialist Visit	2 7 6	Advocacy for family/patient Met family's immediate needs, questions, concerns Referral to community agency
Patients Seen	**15**		**15**	
4th. Quarter	2 15	Specialized Therapies (PT, OT, etc.) Subspecialist Visit	2 7 7 1	Advocacy for family/patient Met family's immediate needs, questions, concerns Referral to community agency Referral to Specialized Therapies
Patients Seen	**17**		**17**	
Total Patients Seen:	**73**		**73**	

A stronger partnership began January 2019 with the Cerebral Palsy/Medically Complex (CP/MC) Clinic in Wichita to provide care coordination services in line with the KS-SHCN model. This clinic has been supported by the KS-SHCN program for many years. With this improved partnership, better collaboration occurs frequently, leading to better service outcomes for

those clients who attend clinic. In this collaborative partnership, the Topeka office processes the applications, does the initial care coordination assessment, and, if the client attends clinic, assigns the client to the proper clinic staff for care coordination services and provides ongoing technical assistance support to the CP/MC clinic staff, as needed. The clinic Care Coordinator also participated in all Satellite office (SO) trainings and shared information during the in-person training, with all SO staff about the clinic and how to connect clients with them.

Below is an excerpt from the KS-SHCN ATL Contract SFY19 Annual Report regarding the accomplishments of the CP/MC clinic.

Quarter	# of Clinics	# of Patients Served	# of SHCN Served	# Unduplicated
First	9	75	17	72
Second	8	57	9	55
Third	9	60	6	59
Fourth	10	71	7	71
TOTAL	**60**	**208**	**189**	**12**

What was accomplished ...

- Referrals were made to the appropriate specialists including 37 patients to neurology, endocrinology, urology, cardiology, and speech, 8 patients to dietician, 5 to genetics, and 9 to orthopedics.
- Ten (10) applications were sent to families to form the Family Advisory Board.
- Patient/family satisfaction surveys were given to every patient that attended clinic. Each survey was reviewed by the CPMC Clinic team and changes were made accordingly where possible.
- 406 Kansas School Nurse contacts received electronically the CP/MC brochure. The purpose was to make them aware of the program, that way they would refer those children that need CP/MC services.
- Possible SHCN clients were identified through assessment at the beginning of each clinic, as this discussion helped families talk about their needs including diagnostic, treatment, and possible case management services.
- Dr. Melissa Hopper was a new partner with the CPMC clinic. She attended every clinic to evaluate the family support needed to care for a child with medically complex conditions.
- Some CP/MC partnerships included: Neurology, Orthopedics, Occupational, Physical, and Speech Therapy, USD 259 Wichita Public Schools, CPRF, Grace Med Dental Clinic, Families Together, Orthotist, and Dietician.
- The CP/MC Clinic staff worked along with the SHCN Care Coordinators to assist families in need.
- One hundred percent (100%) of patients seen in CPMC clinic had progress notes faxed to their primary care physician within one week following clinic.
- Qualified patients received their CareING notebooks provided by Families Together.

Families as Care Coordinators: To fill a gap in care coordination services in the south-central region of the state, a contract was established with a FAC member in 2018 to provide KS-SHCN HCC services to clients in that area. The KS-SHCN Program Manager and Lead Care Coordinator provided trainings on the KS-SHCN model and continue to provide technical assistance as needed. The contractor has a child with special needs and understands the importance of clients and families learning how to navigate the systems of care as well as how that can be achieved through care coordination methods. The contractor will complete the FCCT training in 2020 and will begin assisting the KS-SHCN Program Manager

in conducting the trainings across the state in the coming year. Read more about the partnership with this family leader in the CSHCN Plan narrative.

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.

KS-SHCN continues to identify opportunities to align with the MCH programs and services across the state. A huge part of this includes a shared message that "children with special health care needs are children first" and that infants, children, and adolescents served through MCH services may also have a special health care need, even if not connected to the KS-SHCN program or served by a specialty clinic. Therefore, efforts to educate MCH staff and grantees and align KS-SHCN and MCH services continued to be a focus over the past year.

Cross-System Coordination: The KS-SHCN program continues to be engaged with the Kansas Help Me Grow (HMG) work (described in further detail in the Child Report/Plan narratives). The HMG model provides opportunity to coordinate across service delivery systems and engage providers in supporting the needs of families of CSHCN. The KS-SHCN Program Manager provided training to Parent Helpline (1-800-CHILDREN) volunteers, as part of the HMG Centralized Access Point (CAP) effort, to equip them to provide resources for the CSHCN population. The HMG framework, as aligned with the medical home framework described earlier in this section, is a positive step towards improving services and supports for CSHCN. Read more about cross-system coordination plans in the CSHCN Plan narrative.

Expansion in program partnerships through the past year has been a focus in order to strengthen the services and supports provided to KS-SHCN clients. Key partnerships include:

- *Foster Care Services* – Discussions focused on respite care offered to foster families and ways the KS-SHCN program can align the Caregiver Relief Direct Assistance Program (DAP-CR) without duplicating efforts. This led to development of a new KS-SHCN policy, so children in foster care could also utilize this DAP leading to better support for children with SHCN who are in the foster system.
- *National Alliance of Mental Illness (NAMI)* – Exchange of information across programs took place to increase support for clients who have mental illness. Many KS-SHCN program clients not only have a qualifying medical condition, but many have a secondary condition of mental illness that Care Coordinators must address. A local SO offered a NAMI presentation during a training webinar to increase staff understanding of the services that NAMI provides and how they can support dual clients and their families.

KS-SHCN staff attended the Kansas Academy of Family Physicians (KAFP) conference to network with physicians from across the state, share information about program services, and recruit physicians to serve as KS-SHCN providers.

Bureau Partnerships: KS-SHCN works closely with staff from the Newborn Screening (genetic/metabolic, hearing, and heart), Infant-Toddler (Part C) and the Birth Defects programs. Infants identified through the newborn screening programs medically qualify for KS-SHCN services; therefore, a referral process has been developed to ensure families are introduced to the KS-SHCN program. Not all children who qualify for Infant-Toddler Services or identified by the Birth Defects program will qualify for the KS-SHCN program, however these programs are working to develop referral protocols and messaging to support increased referrals to KS-SHCN. To better support the referral process, a *Decision Schema* was developed and shared with other BFH and Title V MCH programs and partners.

The KS-SHCN Program Manager participated in the NBS Spinal Muscular Atrophy (SMA) sub-committee calls to identify and monitor steps related to adding SMA as a new condition to the Kansas Newborn Screening core panel. By understanding and monitoring the pilot process and learning about the recommended treatment options, the KS-SHCN program is aligned to add this diagnosis to the list of conditions covered by the program for services and supports upon the "go-live" date (early 2020).

To improve communication between SOs and grantees, the KS-SHCN program developed an electronic newsletter (viewable online at https://bit.ly/2NrZNVy) distributing the first edition in October 2019 to all SO staff and partners. The newsletter contains the following sections:

- Care Coordination Corner: information, tips and resources for HCC activities shared by the Lead Care Coordinator
- Satellite Office Spotlight: highlights of one of the local SO services provided, with a message from the SO Care Coordinator
- Calendar of Events: upcoming training and technical assistance offerings, as well as special awareness dates relevant to the CSHCN population
- ATL Partner Spotlight: highlights of one of the ATL partners with services provided
- HCC Success Story: stories from families or Care Coordinators about KS-SHCN services and supports
- Welligent Wisdom: tips and tricks on utilizing the KS-SHCN Welligent data system
- FAQ's: highlights the top technical assistance questions received by SOs

Supporting You: The KS-SHCN program assisted in the development of the Supporting You peer to peer network and launched their own network program in December 2018, opening the system for enrollment of Support Peers. More information about Supporting You can be found in the Cross-Cutting Report and Plan narratives.

Children with Special Health Care Needs - Application Year

PRIORITY 5: Communities, families, and providers have the knowledge, skills and comfort to support transitions and empowerment opportunities

NPM 12: Transition: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care.

Local MCH Reach: Based on SFY2021 MCH Aid-to-Local applications received:

- 8 of 67 grantees (12%) plan to provide services to the Children with Special Health Care Needs (CSHCN) population
- 8 agencies plan to serve as a KS-SHCN Satellite Office

Objective: Increase the proportion of adolescents and young adults who actively participate with their medical home provider to assess needs and develop a plan to transition into adult health care systems.

The partnerships and supports developed through the KS-SHCN Holistic Care Coordination (HCC) model provides a strong foundation and infrastructure to maintain the focus of assuring CSHCN have access to medical homes, however the program evaluation and the needs assessment process indicated that a stronger focus needed to occur around transitions for the CSHCN population in the future. moving forward. Transition to adulthood for youth with SHCN is one of the many components of a comprehensive and coordinated medical home and the new priority focus will integrate and align nicely with the existing HCC model and assist with strengthening the overall system of care.

Throughout the Needs Assessment and implementation of the HCC model, transition planning for youth and adolescents ages 12 and older has been identified as a gap. Youth with special health care needs (YSCHN) and their families generally do not receive guidance on transition planning from their health care providers or other support systems. Additionally, health professionals continue to note the importance of health care transition (HCT), but many have struggled to incorporate transition planning into their practices. Many providers have stated that they lack the capacity and resources to effectively plan for transition with their adolescent patients, despite an interest in doing so.

Transition discussions generally begin around age 12, however the KS-SHCN program policy requires that at least one transition goal for any client with an action plan age 14 to 21 years. To align with NPM 12 and national recommendations, KS-SHCN will shift for the 2021-2025 grant period to require the transition goals for those over the developmental age of 12.

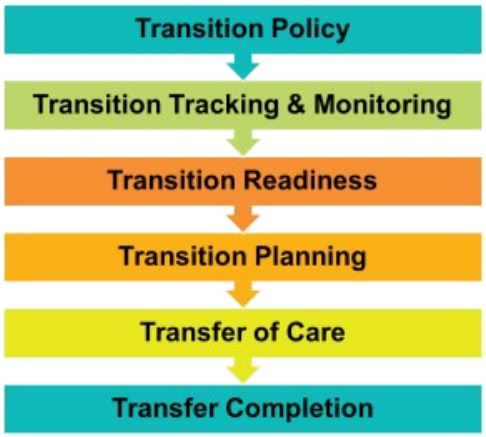
GotTransition Recommended HCT Timeline

As per the holistic care coordination model, transition is not only focused on transitioning from pediatric to adult health care systems but transitioning in all aspects of life (e.g., self-advocacy, health and wellness, health care systems, social and recreation, independent living skills, education). Care Coordinators work YSHCN and family to develop goals that meet their needs and help them grow and become proficient in self-care and advocacy.

Health Care Transition (HCT) Planning: To develop a comprehensive transition plan in health care practices, providers must engage the youth and their caregivers in the planning process. Transition discussions can be a sensitive subject, especially for YSCHN entering unknown territory, and many challenges may present themselves:

- YSHCN may be concerned about what more will be expected of them.
- Parents/caregivers can have trouble "letting go," as so much of their life has been focused on caring for the adolescent.
- Adult health care providers can be hard to find (particularly in rural areas).
- Hesitant adult providers due to lack of experience in serving YSCHN.
- YSCHN may be struggling to find flexibility in employment schedules and/or concerns about missing school.
- YSHCN transition planning takes additional time and resource for busy provider practices, where reimbursement for transition is not widely available.
- Pediatric and adult providers may need several consultation visits or move slowly to support the YSHCN and their family.

KS-SHCN will research evidence-based models, such as the Six Core Elements of Health Care Transition 2.0 through GotTransition.org, that provide practical guidelines and recommendations to providers when developing their own transition planning protocols or curriculum around these six core elements.



KS-SHCN will conduct a review of existing transition materials and tools utilized by the Care Coordinators to streamline transition practices across Satellite Offices (SOs) and develop technical assistance supports for providers across the state. KS-SHCN Care Coordinators and staff will be available to offer these supports to providers of mutual clients, assisting them to problem solve challenges and barriers to creating transition plans for their YSHCN patients.

Title V is continuing to engage in state-level discussions around telemedicine for all populations, and the KS-SHCN program will engage in this effort as related to the direct 1:1 Care Coordination supports for YSCHN and families to support program transition planning, as well as include this as part of the technical assistance offered to health care providers. It is the programs staff's belief that telehealth is a great way to reach adolescents and provide the transition assistance they may need in an easy and comprehensive manner. KS-SHCN will pursue technology advancements within the program, considering integrated telemedicine possibilities within the KS-SHCN electronic records system, Welligent.

As part of the HCC model expansion (described in more detail in the Cross-Cutting Plan narrative), KS-SHCN will engage in the development of the transition components to that expansion effort, supporting providers who want to build HCC and transition programs within their practice.

Transfer of Care: Once an adult provider is identified, the pediatric provider should begin the transfer of client information, including up-to-date medical records, to ensure a smooth transition of care. Communication between the two providers should also occur to make sure everything is consistent and as easy as possible for the clients. The HCC provided through KS-SHCN can support this by utilizing strategies and tools identified through GotTransition.org.

Identification of quality transition readiness tools will also be a part of this process. As KS-SHCN staff review transition tools and resources that can be shared with provider, health agencies, and families but especially adolescents, it will be important that tools and resources follow evidence-based practices and policies. The more a youth can assess where they are in the transition journey and have tools and resources to help guide them as they move through this process, the higher their success rate will be.

HCT Systems of Care: Title V will continue to monitor insurance and financing needs related to HCT and work with both public and private insurers to support adequate reimbursement rates for transition. HCT practices require additional time during medical appointments and wrap around supports to help guide youth and families through this process. Providers have shared that without adequate reimbursement it is challenging to take the time to work on effective HCT planning. However, it is recognized that truly effective transition planning, supporting the full needs of the youth/family, can't solely focus on the health care component, and must look more holistically. There are many other aspects to consider when supporting YSHCN in their transition journey (e.g., education, social, housing, work). KS-SHCN Care Coordinators will work with YSHCN to set holistic goals to help them reach their full potential and ensure a smooth transition into adult living.

This holistic approach will take alignment with many other systems and agencies. Utilizing *The 2020 Federal Youth Transition Plan: A Federal Interagency Strategy* as a guide, Title V will engage in efforts across systems to support the vision outlined in this plan. It should be noted that this plan is presented by the Federal Partners in Transition (FPT) Workgroup and is reflective of a cross-systems approach to provide supports and services to youth with disabilities. Several federal departments and agencies were involved, including the Departments of Education, Health and Human Services, Labor, and the Social Security Administration. While Title V is not named specifically in this plan, there is clear alignment to the Kansas Title V vision for supporting transition through the population health/system of care lens.

Excerpt from Federal Plan Executive Summary

To support positive outcomes for youth with disabilities, FPT is committed to partnering with experts across multiple federal agencies and their respective programs, including both disability and mainstream programs, to ensure that they are universally designed and accessible. As a result, youth with disabilities and all youth will have an equal opportunity to:

- **Access health care services and integrated work-based experiences in high school** to better understand how to manage their physical, mental, and emotional well-being, to enhance their job-readiness skills and career planning, and to make a successful transition from school to work and greater independence;
- **Develop self-determination and engage in self-directed individualized planning** to prepare them for postsecondary education, health care management, vocational training, and/or employment;
- **Be connected to programs, services, activities, information, and supports** for which they are eligible tha prepare them to self-manage their health and wellness, pursue meaningful careers, become financially literate and capable, and make informed choices about their lives;
- **Develop leadership and advocacy skills** needed to exercise informed decision-making and personal and community leadership; and
- **Have involvement from families and other caring adults with high expectations** to support them in achieving their goals.

Additionally, the 2020 Plan highlights FPT's shared vision and current federal cross-systems initiatives that align with compatible outcome goals, as well as policy priorities that will inform FPT's work going forward. The FPT timeline for achieving the five compatible outcome goals is 2020.

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

Holistic Care Coordination: The KS-SHCN program will continue to provide HCC services as described in the CSHCN Report. More information about program expansion efforts for KS-SHCN can be found below and information about the HCC statewide expansion, replicating the KS-SHCN model in other programs, can be found in the Cross-Cutting Plan.

Bridges Pilot Program: KS-SHCN and the Part C tiny-k program (early intervention) identified a service gap for children and their families moving from Part C services to 619 Part B/community services. This can be a very difficult and stressful time for both the child and family and with the loss of the Part C/tiny-k Family Service Coordinator (FSC) many families find it difficult to navigate the various systems of care, such as medical, educational, social, legal and financial. To address this, KS-SHCN and tiny-k are working on a formal partnership to "bridge" this gap and support families. Referred to as Bridges, this will be a new program that falls under the KS-SHCN services.

Bridges is currently under development and will provide HCC to any child served through tiny-k that is exiting services until the child reached 8 years of age, regardless of movement to school-based early childhood special education programs (Part B/619) or community services. These services are voluntary, and families can opt out at any time. Recruitment of pilot sites (both tiny-k and SHCN SOs) will occur in the fall of 2020. Additional training for the SHCN Care Coordinators (SHCN-CC) will be expanded to include more detailed information on school assessments, Individual Family Service Plans (IFSP), Individual Education Plans (IEP), 504 Plans, and Individual health Care Plans (IHP) etc. Other program activities under development include: service protocols; informational materials; data collection efforts; evaluation/monitoring activities; and a family survey.

The pilot is expected to begin later this year (Fall 2020) with services being offered to families by the tiny-k FSC, who will identify children aging out of tiny-k services 3 months prior to the child's 3rd birthday. The FSC will share information with the child's family about the Bridges Program and ask them if they would like to participate. If so, the family would complete a brief application form and a Release of Information so that the tiny-k providers and SHCN-CC can communicate necessary information to help transition be as seamless as possible.

Moving forward, program leadership for both KS-SHCN and tiny-k will engage in regular data quality improvement activities to design the most beneficial program for children and families. Data collected will be synthesized and reviewed quarterly to identify the following: gaps, staff training and capacity needs, program cost analysis, and family feedback. By careful monitoring, data collection, use of quality improvements measures, and listening to the families it is hoped that within one year, the program will be refined and transition from a pilot project to a main part of the KS-SHCN program service menu.

CSHCN Systems Alignment and Integration: Title V CSHCN Leadership, including the Title V CSHCN Director, Children & Families Unit Director and KS-SHCN Program Manager, will continue to focus efforts this year on partnerships among addressing the behavioral health and foster care systems to support expansion of the KS-SHCN HCC model. In partnership with the Child/Adolescent Health and Behavioral Health Consultants, the program will collaboratively build partnerships across agencies and providers in these systems across Kansas. 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 and referral sources is critical to meeting the needs of the CSHCN population.

It's recognized that the CSHCN population is considered an at-risk, vulnerable population; however, there are additional factors that put the CSHCN population at greater risk for inequities and disparities. In addition to the traditional social determinants of health a population-health approach, there are other risk factors that put CSHCN at greater risk (e.g., adverse childhood experiences, food insufficiency, foster care, access to behavioral health services).

According to the National Survey for Children's Health (NSCH) 2017-2018 combined data indicate that CSHCN experience two or more ACEs at a much greater rate (42.1%), as compared to non-CSHCN (14.3). Additionally, only 39.4% of families of CSHCN reported no ACEs, as compared to 60.7% of non-CSHCN families. Families of CSHCN experience food insufficiency/insecurity at higher rates than non-CSHCN families with nearly half (47.1%) of CSHCN families reporting they had trouble eating good, nutritious meals in some way. Almost 10% of CSHCN families reported they sometimes or often could not afford enough to eat (2.6% for non-CSHCN families). Access to mental health treatment or counseling is also more challenging for the CSHCN population, with almost 20% reporting it was very difficult or not possible to obtain care (twice as many as the non-CSHCN population).

The Title V CSHCN program will work to identify opportunities to partner and strategies to deploy to help address some of these disparities and partner with organizations that are working on family resiliency to address the impact and availability of support for CSHCN with high ACEs and food insufficiencies. KS-SHCN and the Title V Family Advisory Council (FAC) have been working on efforts to partner more with the behavioral/mental health community to provide stronger supports to families, specifically to work on access to service concerns noted by families.

Another great concern from a systems perspective are CSHCN in the foster care system. The FAC members have reported concerns with the lack of dedicated training, supports, and consideration of the specialized needs of the CSHCN population in the foster system. KS-SHCN has expanded eligibility criteria to support the automatic qualification of foster children into the program who meet medical eligibility criteria. Since this policy was put in place, KS-SHCN Care Coordinators have seen a significant increase of applications for children within the foster system and expect this trend to continue. KS-SHCN provides HCC services to children/youth in the foster system and strive to follow them as they transition from foster care to reintegration or adoptive homes. KS-SHCN will continue to work on building stronger partnerships with foster agencies to support their understanding of the program's services and supports. Additionally, it is desired to develop shared protocols or processes between Title V and the foster system (e.g., KS-SHCN Care Coordinator and Foster Care Case Manager communication) to lessen the case managers burden and assist in navigating the various systems of care for the child/youth/family.

Family Systems Navigation Trainings: Formerly known as the Family Care Coordination Trainings (FCCT), the FAC requested a title change to the training to better support marketing and recruitment. It was felt that the focus on care coordination in the title made it more challenging for families to engage and see why this was for them. They felt that family recruitment was challenging due to the name of the training. A newly designed flyer was also created and will continue to be used to draw more attention to the training. This can be found in the Supporting Documents.

This past year, a train-the-trainer curriculum was developed and will continue to expand until there are a total of six trainers (three English and three Spanish-speaking). New trainers will be recruited first from the FAC for those interested in conducting these trainings for families and youth. Trainers are provided training, tools, resources, compensation and on-going support from KS-SHCN. This further extends the capacity of the KS-SHCN program while supporting family professional development and allowing a peer-to-peer model to learning. KS-SHCN bi-lingual staff are translating all materials, tools and the PowerPoint presentation modules into Spanish.

KS-SHCN planned to offer quarterly trainings across the state, but due to COVID-19, adjustments are expected. This intensive in-person training does not lend itself to a virtual model. KS-SHCN will work with community partners, grantees, partners, and SO staff to plan and implement these trainings at different location across that state.

Other CSHCN Health Objectives

Objective: Increase the proportion of children with special health care needs who report their child received care in a well-functioning system.

Title V CSHCN has fully embraced the implementation and advancement of the National Standards for Children with Special Health Care Needs. Guiding the development of the State Plan for Systems of Care for Children and Youth with Special Health Care Needs. The Bureau realignment described in the Workforce Development and Capacity section has created new capacity for the Title V CSHCN Director and Children and Families Unit Director to engage in higher systems level discussions to advance systems of care work and better support the KS-SHCN program. This allows the program to focus on state mandated work and align with federally mandated expectations. Throughout the 2021-2025 reporting period, the State Plan will be reviewed annually with the FAC and priority areas will be identified for the program to work on. In FFY21, the focus will be on identifying gaps in the plan, specifically noted is within the insurance and financing domain, and will build a collaborative network of programs, providers, partners and families dedicated to advancing the systems of care to best meet the needs of the CSHCN population. The current state plan is viewed as a road map to strengthen services and supports for CSHCN and their families.

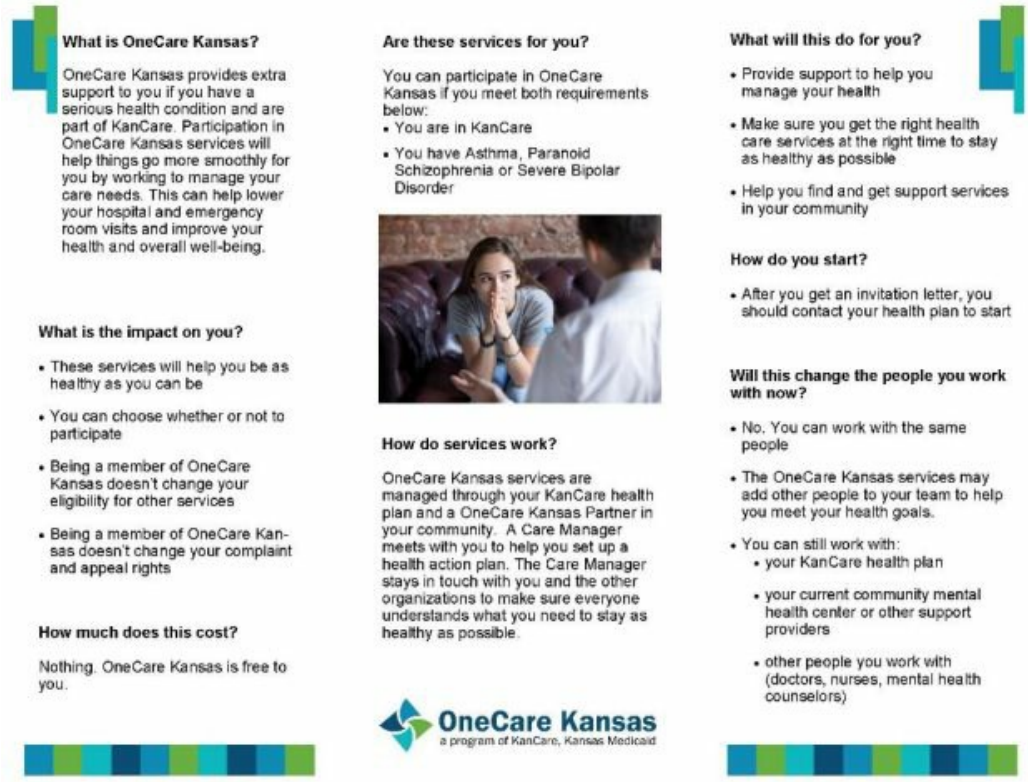
KS-SHCN and Medicaid Partnership: KS-SHCN will continue to work collaboratively with Medicaid and MCO partners to assure clients are receiving appropriate services, and filling gaps in the services and supports provided by the MCO for dually enrolled clients. Partnerships between the MCO Case Managers and the KS-SHCN Care Coordinators, while strong,

will continue to be a focus for partnership growth in the coming year. Turnover within the MCO staffing, as well as the need to continue to expand referral networks for KS-SHCN necessitate ongoing collaborative efforts. Formal partnerships with the MCOs are desired to support inclusion and expectation of KS-SHCN partnership during MCH Case Manager training and onboarding procedures. KS-SHCN will continue to offer educational presentations to MCO staff upon request, to provide a better understanding of the program and how complimentary the programs can be to each other, while reducing duplication.

Conversations with Division of Health Care Finance (DHCF) staff will continue to discuss shared Title V and Medicaid objectives. Building from the relationships created with the KS-SHCN program with DHCF/Medicaid staff around improving support services for clients with cleft lip/cleft palate, Medicaid is requesting a fiscal review to determine if the current reimbursement rate is enough to cover the services provided by dental and orthodontic providers. This is the first step towards a desired partnership with Medicaid to reduce the barriers and challenges typically faced by families in obtaining approval and coverage for these services. Kansas Medicaid policy indicates these are medically necessary. The SHCN programs would like open discussion with Medicaid to consider a carve out for these children that could be administered by KS-SHCN and eliminate long waits for approval and repeated appeal processes for families.

Another partnership area of interest is reimbursement for care coordination services. Research across care coordination financing models will take place in the coming year and will drive discussions with DHCF and private insurers. Data collected through the primary care HCC expansion pilot (described in the Cross-Cutting Plan) will also be utilized to identify needs and adequate reimbursement rates to support these services across the state. It is believed the adequate reimbursement will help providers bring in the revenue to support having a Care Coordinator on staff to work with families and assist in their goals of establishing a comprehensive medical home. Under the OneCare Kansas approach to service coordination, it is believed that this same model could be established for the general child population.

OneCare Kansas Brochure



What is OneCare Kansas?

OneCare Kansas provides extra support to you if you have a serious health condition and are part of KanCare. Participation in OneCare Kansas services will help things go more smoothly for you by working to manage your care needs. This can help lower your hospital and emergency room visits and improve your health and overall well-being.

What is the impact on you?

- These services will help you be as healthy as you can be
- You can choose whether or not to participate
- Being a member of OneCare Kansas doesn't change your eligibility for other services
- Being a member of OneCare Kansas doesn't change your complaint and appeal rights

How much does this cost?

Nothing. OneCare Kansas is free to you.

Are these services for you?

You can participate in OneCare Kansas if you meet both requirements below:

- You are in KanCare
- You have Asthma, Paranoid Schizophrenia or Severe Bipolar Disorder

How do services work?

OneCare Kansas services are managed through your KanCare health plan and a OneCare Kansas Partner in your community. A Care Manager meets with you to help you set up a health action plan. The Care Manager stays in touch with you and the other organizations to make sure everyone understands what you need to stay as healthy as possible.

OneCare Kansas
a program of KanCare, Kansas Medicaid

What will this do for you?

- Provide support to help you manage your health
- Make sure you get the right health care services at the right time to stay as healthy as possible
- Help you find and get support services in your community

How do you start?

- After you get an invitation letter, you should contact your health plan to start

Will this change the people you work with now?

- No. You can work with the same people
- The OneCare Kansas services may add other people to your team to help you meet your health goals.
- You can still work with:
  - your KanCare health plan
  - your current community mental health center or other support providers
  - other people you work with (doctors, nurses, mental health counselors)

Insurance and Financing Systems of Care for CSHCN: The KS-SHCN program continues to see gaps in services for the CSHCN population due to their unique health care needs. Beginning in SFY21 Title V and KS-SHCN program staff will put together a plan to identify gaps in insurance coverage, inadequacies across coverage options, and review the affordability of coverage for CSHCN. Aligning with the National Standards, building from the System of Care State Plan, and engaging key partners, families, and communities, Title V will build strategies, partnerships and policies to overcome these challenges.

To date, KS-SHCN has identified the following considerations for this work: coverage and availability of DME's and medications; proper provider reimbursement; necessary medical supplies; reimbursement for telehealth, care coordination and transition services; and adequacy of family-friendly Medicaid policies. Staff know that there are many other things that will be added to the list and will need to work with families and consumer to determine priorities for the CSHCN population and actions to be taken.

Other KS-SHCN Program Activities

The KS-SHCN program will continue to: provide HCC services to those with medically eligible conditions; financial assistance through the Direct Assistance Programs (DAPs) and Special Bequest, meeting eligibility requirements; program strategic planning; staff workforce development; data system enhancements; quality improvement activities; peer supports; and family and consumer engagement efforts. Read more about these efforts in the CSHCN Report narrative.

Peer Supports for CSHCN: KS-SHCN will continue to engage as a Supporting You Network Program within Supporting You. Read more about Supporting You in the Cross-Cutting Report and Plan. Specifically, KS-SHCN would like to offer both English and Spanish support peers and will work with the Network to determine the feasibility of doing this.

Per interest and recommendation from the FAC, KS-SHCN plans to partner with the Kansas Chapter of the National Alliance for Mental Illness (NAMI) to provide the *Ending the Silence* training for adolescents experiencing mental health needs.

Currently, NAMI provides trainings in school settings to support adolescents in understanding the importance of taking care of their mental health needs, when to seek help, and resources/tools to respond in a positive manner to those experiencing a mental health situation. This will help to decrease stigma associated with mental health conditions, providing an outlet for adolescents needing supports to reach out. Additionally, youth may be more likely to provide support for their peers when they feel more equipped or have a better understanding of where they are coming from.

From NAMI Kansas Offering Brochure about the Ending the Silence Presentation

NAMI Ending the Silence

National Alliance on Mental Illness

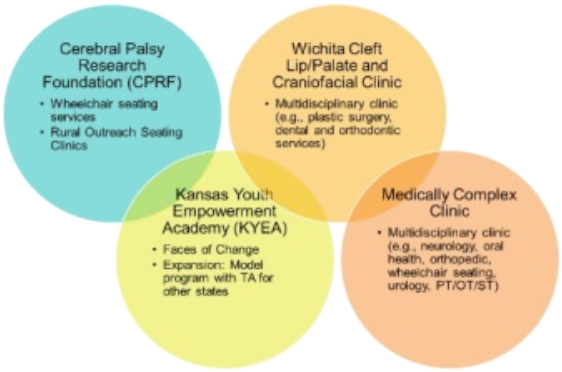
NAMI Ending the Silence Presentation is a 50-minute in-school interactive presentation that helps teens, ages 13-18, learn about the warning signs of mental health conditions and what steps they can take to find support for themselves or their friends.
Who can participate?

NAMI Ending the Silence is designed for middle and high school-age youth. The program is typically presented in a health, science or psychology class, but may also be provided to youth groups, clubs and after-school programs.

Care Coordinator Training and Workforce Development: The annual SO training for SFY21 will be a series of webinars/zoom meetings, rather than a two-day in-person meeting. One topic of interest is Mental Health First Aid – Youth. The program will continue the tradition of the bi-monthly webinars, with guest speakers regarding services and supports available across the state, and "brain trust calls," to allow peer support/learning with the presentation of case examples to help brainstorm ideas and solutions that can address the needs of specific problems.

Service Coordination, Referrals, and Marketing: KS-SHCN continues to increase collaboration and coordination with service delivery systems that often serve as a referral point for the program. Recent organizational shifts within the Bureau of Family Health aligned the MCH and KS-SHCN programs under the Children and Families Unit and Section. One major benefit to this organization is the ability to strengthen collaboration across all program and work on shared protocols to support strong referral practices and assure families receive timely, appropriate, and complete referrals for services and supports. Other initiatives that support stronger service coordination and referrals are outlined below.

- *Annual Report*. The KS-SHCN Annual Report will be compiled and disseminated as an effort to highlight key programmatic activities throughout the year and progress status towards program goals and objectives. The Annual Report can enhance effort towards building new partnerships and promote the work of the program, raising awareness of the services provided and reach of the program.
- *Clinic and Community Supports.* KS-SHCN has awarded local grants to provide infrastructure and administrative supports for three health clinics (e.g., wheelchair seating; cleft lip/cleft palate clinic; and medical complexities clinic) and a youth leadership development program. These are ongoing initiatives with more information outlined in the CSHCN Report narrative.



- *Marketing Campaign.* Recent programmatic changes, to better support families and address needs, have not resulted in greater reach of the population. Therefore, a robust marketing campaign will position the program to increase awareness of program services and connect more families through community-based referrals. The campaign will target healthcare providers, home visitors local ITS programs, and families. The KS-SHCN Decision Schema developed in 2019 will be a central part of this campaign. The campaign will also help to differentiate KS-SHCN from KanCare and help families recognize the added supports available.

Program Policy & Service Delivery Changes: Remaining relevant among ongoing shifts to the health care industry and changing needs of communities is critical for a program like KS-SHCN. The program reviews program data annually to adapt and provide meaningful and coordinated supports to families. This generally includes: HCC data review; a determination of statewide or local clinical support needs; DAP service utilization; and policy revisions.

- *New HCC Eligibility.* KS-SHCN is now offering HCC service to applicants who qualify medically, removing financial eligibility requirements. Prospective clients will still be required to complete the full application, to provide opportunity for the Care Coordinators to determine if they are eligible for other supports too, however this is expected to increase the number of families the program can reach. Careful monitoring will assure program staffing capacity is assessed regularly to meet the needs of the additional clients.
- *SO Changes.* Data is reviewed annually around the reach and impact of each SO, to determine if a shift in staffing, regional boundaries, or resources is needed. While the number of SOs will remain the same, to determine if a shift in regional SO boundaries is warranted one past SO (Wyandotte) will discontinue services June 30, 2020 and a new one (Neosho) will begin providing services July 1, 2020. Upon assessment of the population served, including geographical location and language(s) spoken, the new SO will provide an additional bi-lingual staff to serve the roughly 20% Spanish-speaking clientele, improving service delivery and reducing burden for state bilingual Care Coordinators.
- *Service Changes.* Annually, the program reviews the utilization and funding needed for each DAP to determine if new services need to be offered to address service gaps. This review can also help identify if a DAP may not be needed any longer, due to poor utilization. While there are no proposed DAP changes, a significant program change includes changes to service eligibility. As of July 1, 2020, the KS-SHCN will no longer accept applications for individuals beyond 21 years of age, with the exception of applications from adults requesting metabolic treatment product assistance for the conditions of PKU or MSUD. Historically, the program has provided all services to those with metabolic/genetic disorders (screened through the newborn screen) into adulthood. The Newborn Screening expansion efforts to conditions like spinal muscular atrophy (SMA) or severe combined immunodeficiency disease (SCID), with high cost treatments, have posed a challenge to a program with limited fiscal resources to provide services to all adults with these conditions as well. Therefore, discontinuing adult services can ensure funding can be used for the intended target population, children with special health care needs.
- *Enhanced Data Capacity.* KS-SHCN will work with the data vendor to continue enhanced data reporting and evaluation capacity, specifically tracking and monitoring direct and indirect care coordination activities, referral sources, outcome measures and other data elements. Additionally, the program plans to develop a family portal for the system, so families can access key program information and documents (e.g., action plans, service authorizations), update their application, and send secure messages directly to their Care Coordinator.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Percent of participants that report increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	70.0	75.0	80.0	85.0	90.0

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	55.9
Numerator	389,023
Denominator	695,564
Data Source	NSCH
Data Source Year	2017-2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	58.7	51.6	64.7	67.9	71.3

State Action Plan Table

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations.

SPM

SPM 3 - Percent of participants that report increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

Objectives

Increase the proportion of providers with increased comfort to address the behavioral health needs of MCH populations by 5% by 2025.

Strategies

Provide skills-building training and case consultation opportunities for the MCH workforce to increase knowledge, skill, and comfort to identify behavioral health conditions and risks, facilitate effective brief interventions, and complete referrals to treatment/further assessment following best practice guidelines.

Partner with organizations interested in reducing the number of children exposed to adverse childhood experience to assure knowledge, skills, and comfort among MCH programs to support parental and child resilience through the strengthening families approach.

Develop guidance on developing effective community partnerships to identify and address behavioral health needs within the community using a streamlined, collaborative approach.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations.

SPM

SPM 3 - Percent of participants that report increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

Objectives

Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction, and healthier work environments by 5% annually through 2025.

Strategies

Incorporate state and local MCH agency training to build efficacy in translating knowledge into practice for trauma-informed and hope-infused approaches.

Provide technical assistance and resources to support MCH local agencies in becoming trauma-informed organizations following national standards focused on safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; respect for cultural, historical, and gender issues.

Partner with MCH local agencies to conduct a self-assessment to help them find improvement opportunities, clarify current practices, and develop a work plan to provide services through trauma informed approaches.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations.

SPM

SPM 3 - Percent of participants that report increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

Objectives

Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations by 15% annually through 2025.

Strategies

Develop guidance and trainings for local health agencies and providers to ensure that providers can promote and address diversity and inclusion, integrate supports in the provision of services for high-risk populations in Kansas, and reduce health disparities through responsive policy change initiatives.

Integrate chronic disease education and prevention activities into existing community collaboratives to engage in system and environmental changes to address locally identified disparities.

Implement annual community awareness campaign for the prevention of birth defects, targeting messages to address disparities due to social determinants of health in local communities.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 4

Priority Need

Strengths-based services and supports are available to promote healthy families and relationships.

SPM

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

Objectives

Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP) to 75% by 2025.

Strategies

Develop the Title V Family and Consumer Partnership (FCP) Program, including a resource toolkit for engaging and partnering with families across MCH domains.

Provide training to MCH programs on the importance of family-centered services and supports to: strengthen families; promote strong, healthy, and safe family environments; address diverse needs of families; and build supportive communities.

Align the FCP guidance and evaluation activities with the Standards for Quality for Family Strengthening and Support as a model of quality and evaluation.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 5

Priority Need

Strengths-based services and supports are available to promote healthy families and relationships.

SPM

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

Objectives

Increase the number of individuals receiving peer supports through Title V-sponsored programs by 5% annually through 2025.

Strategies

Expand the Supporting You Network through programmatic partnerships, adding at least two new programs a year and providing expanded trainings, resources, and technical assistance to the provision of a peer-to-peer support program.

Identify and implement evidence-based peer support models for intentional engagement of non-traditional MCH populations (e.g. fathers, siblings of CSHCN, relative caregivers) across MCH programs.

Develop and offer a marketing package, inclusive of printable flyers, mailers, business cards, and social media messages, tailored to the target populations of the participating programs and providing an opportunity to engage in audio and video promotional activities as a network.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 6

Priority Need

Strengths-based services and supports are available to promote healthy families and relationships.

SPM

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

Objectives

Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program by 5% annually through 2025.

Strategies

Expand the Title V Family Delegate Program to support a personalized leadership plan based upon the interests of the family leaders, such as core MCH learning curriculums and skills-building opportunities.

Create MCH learning pathways to support engagement and leadership at all levels, based upon individual goals and interests, as part of the partnership and engagement toolkit.

Expand opportunities across all MCH programs to engage families and consumers with lived experiences as program evaluators, co-trainers, interns, paid staff or consultants, mentors, grant reviewers, active participants in assessment processes, and more.

Expand the existing Family Advisory Council model to engage families across all MCH domains, including integration of Title V activities with the All in for Kansas Kids strategic plan activities associated with family advisory and leadership teams.

State Action Plan Table (Kansas) - Cross-Cutting/Systems Building - Entry 7

Priority Need

Strengths-based services and supports are available to promote healthy families and relationships.

SPM

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

Objectives

Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration by three through 2025.

Strategies

Develop an implementation toolkit to spread and scale holistic care coordination services across MCH programming.

Expand existing partnerships among public health, primary care, behavioral health providers, and managed care organizations to support the behavioral health needs of the family.

Implement a robust continuing education curriculum for ongoing learning for case managers, care coordinators, and community health workers on the provision of holistic care coordination services.

2016-2020: State Performance Measures

2016-2020: 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**	**2019**
Annual Objective		44.7	7	6.8
Annual Indicator	47	7.2	7.9	7.9
Numerator	987,775			
Denominator	2,101,649			
Data Source	Kaiser Family Foundation	BRFSS	BRFSS	BRFSS
Data Source Year	2008	2016	2018	2018
Provisional or Final ?	Provisional	Final	Final	Final

2016-2020: SPM 6 - Number of MCH grantees, families and partners that participated in a state sponsored workforce development event

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			1,000
Annual Indicator			1,126
Numerator			
Denominator			
Data Source			State sponsored workforce development events
Data Source Year			2019
Provisional or Final ?			Final

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

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Local MCH Reach: During SFY2019, 37 of 71 grantees (52%) provided services that align with the Cross-Cutting/Systems Building domain.

The focus of this state priority is health literacy, defined by the Institute of Medicine 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 2018 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?"
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 5.7% (95% Confidence Interval [CI] 4.9%-6.6%) 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; 7.9% (6.9%-8.9%) reported that it is somewhat difficult or very difficult to understand information that doctors, nurses, and other health professionals tell them; and 6.6% (5.7%-7.5%) 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/clinic.

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: Local MCH agency staff recognize health literacy is essential to promoting healthy choices for individuals, families, and communities. Local MCH agencies promote the *"What To Do When Your Child Gets Sick"* books and curriculum are discussed with families during clinic visits, home visits and/or after completion of the Kansas Perinatal Community Collaborative (KPCC) prenatal education sessions. This provides information about the management of more than 50 common childhood illnesses, injuries, and health problems in an easy to read and use book for all literacy levels.

Additionally, staff acknowledge that health literacy is a primary factor behind health disparities. Local MCH agencies routinely assess written materials for widespread use regardless of reading/health literacy level 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. Local agencies explain medical information with clients and parents if they report not understanding something. Some local agencies provide a Spanish translator at MCH and WIC visits as needed to enable and strengthen communication between staff and the clients. Local 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.

Holistic SHCN Care Coordination: The KS-SHCN Holistic Care Coordination (HCC) program assists clients and their /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 participate in health literacy trainings, including role playing activities to help them identify the families'/clients' literacy abilities and modify their assistance, so needs are properly being addressed.

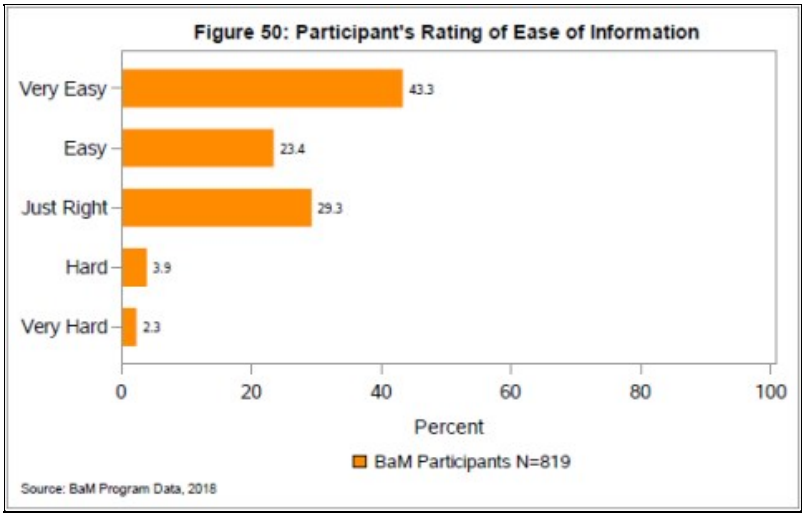
MCH-Affiliated Programs – Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI): Case management provided through the TPTCM and PMI programs allows the opportunity to provide health information education to clients through one-on-one sessions and in group settings 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 designed 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. During quarterly local agency Advisory Group meetings, case managers encourage client participation to foster leadership opportunities, a platform to be positive role models to peers, and to provide feedback on program evaluation. A success story from Wyandotte County is below.

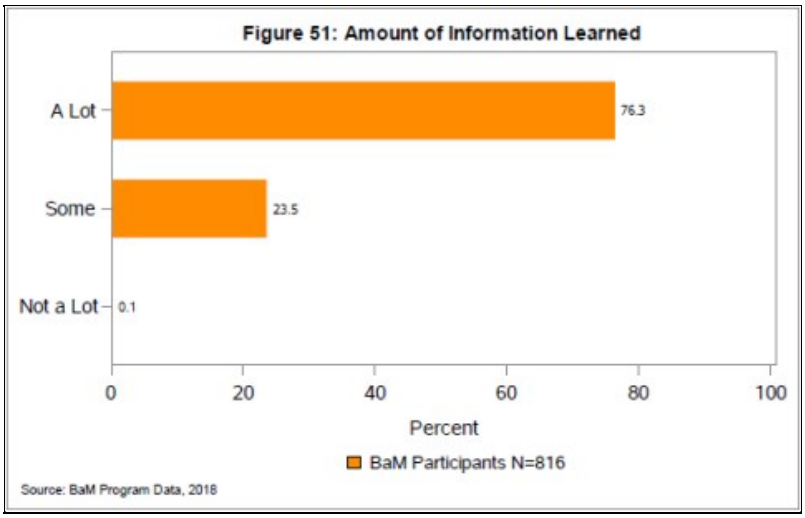
"Andrea" is a 20 years old mother who is in her third trimester. She dropped out of high school to take care of a sick parent and has had numerous setbacks trying to continue her education. Once enrolled into the TPTCM program, the case manager connected her to local community resources and set her up with an online GED program. Andrea like the support the TPTCM program provides because she can ask questions regarding her pregnancy and health. The case manager and client communicate and meet monthly to work on identified goals. The case manager referred Andrea to the March of Dimes Becoming a Mom prenatal education classes, helped her complete a Medicaid application, and find prenatal care in the first trimester, Andrea is committed to be the best parent she can be, despite existing barriers and stressors. With the support and encouragement from the TPTCM program, Andrea was able to regain focus on completing her education."

TPTCM Program
Wyandotte County Health Department

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 began in 2017; the improvements continue to be implemented. As a result of work completed by focus groups and the curriculum review committee, numerous supplemental handouts were added to the original curriculum in an effort to better inform and prepare participants to be 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.

An additional goal of the KPCC/BaM program model is to continually improve clients' ability to comprehend and relate to the curriculum. The figures below, based on the 2018 evaluation results, demonstrate success with this. While the population served is largely undereducated (about 29% reported having a college degree, 42.9% reported having a high school degree or less), most reported relative ease in understanding the content and a high level of information learned.





Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

Youth Empowerment and Leadership: The KS-SHCN program continued to support the Kansas Youth Empowerment Academy (KYEA) Faces of Change program, a cross-disability, statewide program focused on youth leadership development through civic engagement. Examples of the topics discussed during the seven monthly sessions include authentic leadership, leader expectations, and effective communication—with an emphasis on health, such as self-care and managing emotions—encourage youth leaders to think about their own personal and professional health practices.

The program began in 2016 focused solely on youth with disabilities and has successfully graduated four cohorts of youth from the 7-month program and is currently recruiting for its 5th cohort. In FY2019, for the first time in the program's history, recruitment focused on both youth with and without disabilities. Target population for recruitment consists of youth ranging from age 17 to 25. Members must have existing leadership skills and be looking to enhance those skills to become effective leaders on a local, state, and national level.

Additionally, youth are required to complete a Community Change Project–a local activity that each member will create, implement, and lead in their own community. Upon graduation from the program, youth receive a follow-up evaluation to see how they have continued to use their leadership skills. Alumni from the previous sessions are featured as guest speakers for subsequent sessions. Below is an overview of the projects completed in November 2019.

Participant's Name	Location	Project
Ashlee	Kansas City / Wichita	Implemented a group for incoming freshman at Wichita State University to provide support through their transition from high school to college.
Makayla	Beloit	Provided appreciation gifts/gestures to her local firefighters, EMT's, and law enforcement.
Madison	Florida	Developed a monthly movie night in which there was an opportunity for her community to met new people and build support networks.
Noah	Newton	Implemented a clothing drive for the local foster care agency in his area.
Sean	Topeka	Developed a youth advisory group where youth with disabilities learn how to participate in advocacy opportunities.
Gabe	Lawrence	Implemented a voter registration drive.
Rachel	Rozalia	Coordinated and implemented a diaper drive for a specific non-profit agency in her area.
Nicole	Junction City	Painted and wrote inspirational quotes on rocks and gave them out to people in her town.

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

MCH Local Agency Monitoring Visits: Technical assistance and training were provided directly to local MCH agencies/grantees by state MCH staff through check-in calls and on-site visits. State staff regularly offer technical assistance to local agency staff on their MCH work plan as well as discuss their strengths, challenges, and any other needs. Staff utilize DAISEY data to monitor who is served, services provided, and referrals made/completed. Discussions focus on any issues founds in the data with local agencies during technical assistance contacts. State MCH staff conduct site visits when needs are identified and upon request. State MCH staff continuously work to develop relationships and increase availability and opportunities for local agencies to strengthen their MCH programs and show the impact they are making in their communities. Copies of the data collection and monitoring visit tools and materials are available upon request.

MCH Local Agency Technical Assistance Webinars: State 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; and/or identified need for assistance with screening, intervention, education, referral or other services or supports provided at the local level. A variety of topics were presented during FY19 (see table below).

Date	Title/Topic	Attendees
9/27/2019	LARC Learning Collaborative Lunch and Learn	28
8/26/2019	BaM Quarterly Webinar - Overview of BaM DAISEY Dashborad Report	35
4/29/2019	BaM Quarterly Webinar - Overview of 2019 Curriculum Updates	25
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

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

Family Empowerment and Engagement Among MCH-Affiliated Programs:

- *MCH Universal Home Visiting*: The Title V Home Visiting Program engages with families with trained family support staff who answer questions, provide information and resources and offer guidance. Home Visitors play an important role in empowering families to make educated choices about their and their families health and well-being.
- *TPTCM and PMI: C*ase management provided through the TPTCM/PMI programs allow the opportunity to provide health information education to clients. Case managers work to empower their clients to be strong MCH advocates by fostering leadership opportunities, offering a platform to be positive role models to peers, and giving clients the opportunity to provide feedback on program evaluation.
- *Holistic Care Coordination:* Building strong MCH advocates and empowering families is also a goal of the KS SHCN Holistic Care Coordination program. By working one on one with families, Care Coordinators help families learn to navigate the health system on their own and provides the family with skills on how to be an advocate for themselves and their children.
- *Kansas Perinatal Community Collaboratives:* The KPCCs also work to empower families to be strong MCH advocates. KPCCs provide in depth education and resources to pregnant moms and their support systems - arming moms with knowledge empowers them and their support persons to advocate for their own health and the health of those in their community.

- *Count the Kicks Ambassador:* A major goal of this initiative is to empower moms to: make informed decisions about their health and the health of their baby; reach out to their physician if they notice changes in their baby's movement; advocate for the CTK program; and educate other moms and health care providers about CTK. The newest Kansas CTK Ambassador, Deanna Cummings, saved her baby's life with the program and now serves on the KMCHC and works with Title V to spread the word about Count the Kicks and the chance to save babies in Kansas.
- *Family Adivosory Council (FAC) Alumni and Mentorship Program (AMP):* Described in the Family Partnership narrative, AMP provides opportunity for family leaders to engage beyond their formal council membership roles, either through extneded engagement with Title V or as a mentor for others. There are currently eight FAC Alumni members, of which two remain actively enaged in most FAC activities, two continue to serve on the KMCHC, two have begun serving as a family leader on the Kansas Council for Developmental Disabilities, and all remain informed of Title V and BFH initiatives with opportunity to engage at any time.

- *Title V Family Delegate:* Cassandra Sines has served as the current Title V Family Delegate since October 2018 and will conclude her first official term in 2021 and then serve one year as "Past-Delegate" as a support for the family leader who succeeds her. Plans for this program are described in further detail in the Cross-Cutting Plan narrative. Cassandra also serves on the FAC Executive Committee, the KS-SHCN Sedgwick County Care Coordinator, the KS-SHCN Supporting You Peer Support Administrator, and a family trainer for the FCCT. In addition to that work, she has served on the Governor's Subcommittee for Children's Mental Health and is serving as a family leader on the Early Childhood Recommendations Panel and the Kansas Pediatrics Supporting Parents (PSP) initiative.

Family Advisory Council (FAC): The FAC meets regularly to support Title V efforts and engage in ongoing training opportunities to educate the family leaders on systemic needs, the changing landscape of service delivery, emerging issues/trends, and more to support the advancement of the Title V State Action Plan. Typically, the FAC meets every ten weeks, or five times a year. The membership or Title V leadership may call a special meeting to discuss emerging needs. During the reporting period, the FAC met 6 times, including two, 2-day retreats in October 2018 and September 2019. The meetings are typically in person on Saturdays from 9:30 am to 4:00 pm. Special meetings are typically held as half-day virtual meetings, as are meetings generally falling in the first couple of months of the calendar year (January/February) as the weather in Kansas is unpredictable and can be dangerous for family members to travel across the state. Below is a recap of the FAC meeting agendas and outcomes during the reporting period to support the objective to empower families and build strong MCH advocates.

OCTOBER 2018 (2-DAY RETREAT)

Primary Topic(s)	Key Activities	Next Steps
Special Presentations: - Health Equity - Palliative Care	Special presentation from the University of Kansas Center for Community Health and Development around Health Equity and special considerations for the CSHCN population. Presentation on new initiatives, led by the KDHE Bureau of Health Promotion, around legislation and the development of a Palliative Care Education Program.	FAC to use health equity knowledge to have clearer outcomes in their work for the state. Palliative Care to be considered to explore for future FAC projects.
Kansas Council for Developmental Disabilities (KCDD) 5-Year Plan	The Executive Director attended the meeting to learn more about Title V and the FAC. This also provided opportunity to discuss alignment across the DD Council and Title V plans.	The FAC identified several alignment opportunities for KCDD and Title V, such as strengthening the presence child- and health-focused initiatives in the KCDD plan.
FAC Strategic Planning	Presentations from each of the Special Health Services programs (KS-SHCN, Infant-Toddler Services, Hearing Screening, Metabolic Screening, and Birth Defects) to support strategic planning for the programs. The Infant-Toddler Program launched a strategic planning initiative in 2018 and solicited input from the FAC on a specific data collection effort called SenseMaker. The FAC reviewed the Title V State Action Plan and discussed possible impact of developmental screening for the CSHCN population.	The FAC to decided that it made sense to incorporate all SHS programs for future FAC focus, rather than only focused on KS-SHCN. ITS to be a more hands on partner with the FAC, will be utilizing the life knowledge of FAC members in the future. FAC will continue to assist in providing feedback on Title V activities and select a project focus area at the next meeting.

DECEMBER 2018 – Special Virtual Meeting

Primary Topic(s)	Key Activities	Next Steps
Supporting You Administration Overview	The FAC called a special virtual meeting to review the SY Network Administration and Support Peer Handbooks, Support Peer trainings, and marketing materials. The FAC approved everything and made some recommendations for future enhancements (such as online training platforms).	The FAC passed future development of the Network to KDHE, however requested regular updates to monitor the fidelity of the model.

JANUARY 2019 – Virtual Meeting

Primary Topic(s)	Key Activities	Next Steps
Legislative Advocacy	The Title V CSHCN Director provided an overview of the legislative process in support of the upcoming session. The group also received and 'Advocacy 101' presentation with discussion from FAC members.	The FAC expressed an interest in holding the legislative and advocacy trainings annually to support the group's ability to advocate for issues the FAC is working to overcome.
Standards of Quality for Family Strengthening and Support	An overview of the Standards was presented and the group discussed the alignment of the Principles of Family Support Practice as the foundation for onboarding future Supporting You programs.	The FAC recommended Title V adopt these Standards a guide for family engagement and support and a focus of the upcoming Title V Needs Assessment.

MARCH 2019

Primary Topic(s)	Key Activities	Next Steps
Special Presentations - Title V Behavioral Health - Immunize Kansas Kids	The new Title V Behavioral Health Consultant provided an overview of the position and two grant projects around maternal depression screening and pediatric mental health access. A large discussion on self-care for families of CSHCN. The IKK Coalition presented about immunization efforts in the state, leading a discussion around the importance of immunizations and the impact on the CSHCN population.	The FAC requested a focus on addressing behavioral health needs for children in foster care, including working on continuity of care. FAC members to identify self-care resources in the coming year. The FAC expressed interested in staying informed of the IKKC work.
FAC Strategic Planning	Each year the FAC selects a focus for the year and works towards shared goals with tangible outcomes. The focus of this year's discussion was on impacting and driving effective policy change that supports Title V initiatives.	Create family stories for SHS programs program impact from a family perspective. Desire for policy work for 2019.

JUNE 2019

Primary Topic(s)	Key Activities	Next Steps
Social Determinants of Health for CSHCN	The FAC viewed the "Health in 3D: Diversity, Disparities, and Social Determinants" video developed by KDHE Bureau of Community Health Systems. Discussion focused on the social determinants CSHCN experience and what "population health" means to families.	Consider social determinants and population health needs as the group sets a policy agenda for the coming year.
Setting a Policy Agenda	Presentation on setting a policy by Title V CSHCN Director, utilizing the University of Kansas Center for Community Health and Development's Policy Change Toolkit. The group engaged in quality improvement brainstorming and prioritizing activities.	More work to be done in narrowing down the policy focus. The FAC will research topics and issues to focus on for a possible formal policy agenda.

SEPTEMBER 2019 (2-DAY RETREAT)

Primary Topic(s)	Key Activities	Next Steps
Special Presentations: - Early Childhood System & Infant Toddler Needs Assessments - Palliative Care Program	Presentation/ discussion with the Kansas Children's Cabinet and Trust Fund (KCCTF), University of Kansas Center for Public Partnership and Research (KU-CPPR), and State Interagency Coordinating Council (SICC) around the Early Childhood System and Infant Toddler Needs Assessments. Focus group/discussion lead by the new Palliative Care Education Program Director.	FAC to help give feedback on the Early Childhood Systems Assessment. FAC would like to continue the discussion of palliative care and look for opportunities to educate the public.
Title V, Life Course, and MCH 2025 Needs Assessment	Overview of Title V, the Life Course Framework, and the Title V 5-Year Needs Assessment Process. Discussions, focus groups, and strategic planning around the upcoming Title V Needs Assessment, led by KU-CPPR (contractor hired to facilitate Needs Assessment).	FAC to continue to give feedback and guidance based on work for family engagement.
Policy Discussion	Overview on policy topics and discussion. Visioning and feasibility. Policy selection matrix	FAC members to research their desired policy to make a case to the rest of the FAC why they should pursue that specific item
Upcoming System Initiatives	Discussed the BFH re-alignment, CSHCN population and system of financing needs, and family engagement activities.	The FAC expressed willingness to engage anywhere needed to advance these efforts.

Supporting You: Since peer-to-peer support is identified as one of the strongest measures of individual/family support, the KS Title V goal is to assure that every individual/family in Kansas will have the opportunity to connect with a trained peer who can provide emotional support, referrals to resources, and a listening ear – by others who have experienced similar situations where they can express their grief, concerns and questions, without feeling judged.

Based on feedback throughout the former KS-SHCN strategic planning process and the and Title V Needs Assessment efforts, the need for a family peer mentor support program – where families/individuals 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, BFH programs worked together to develop a family support network called Supporting You Network. Through this Network, Title V strives to provide opportunity for every individual or family in Kansas connect with a trained peer who can provide emotional support, referrals to resources, and a listening ear.

Supporting You was designed as a global support network for a variety of peer support program options. Supporting You is an opportunity for individuals to gain support from caring and compassionate peers who have experienced similar situations and/or circumstances in life, without feeling judged. The peers provide space for individuals to express their grief, concerns and questions with someone who can share their own personal story – helping them know they are not alone in this journey. This is an important component that can lead to improved mental health and development of the skills needed to navigate systems of care. https://www.supportingyoukansas.org/

Currently, "Supporting You" consists of two pilot Network Programs, KS-SHCN and the Kansas School for the Deaf. Since the Network Programs serve targeted population, Title V is contracting with one FAC member to serve as a Peer Support Administrator (PSA) to operate a "program" to catch anyone that might sign up that doesn't align with one of the existing Network Programs. However, Supporting You was not designed to only meet the needs of the CSHCN population, which is why it was developed with the opportunity for expansion and inclusion of other community or state programs. The Network has the partnership capabilities to engage multiple organizations to "administer" their own peer support program, with the potential to connect with supporting parents across the overall network. This model will allow for expansion in the future. Read more about this in the Cross-Cutting Plan narrative.

The KS-SHCN Program Manager serves as the Network Program Coordinator and has assigned the PSA role to the family leader contracted to provide KS-SHCN HCC to clients in the Sedgwick County area. To provide capacity for the Network, the part-time staff has been identified as the Network Administrator, with support and oversight from the Title V CSHCN Director, to monitor all aspects of the Network, including program onboarding; technical assistance and trainings; marketing and recruitment efforts; network and data system updates; guidance and protocols for Network Programs; and evaluation and fidelity monitoring.

Referred peers can be connected to supporting peers (parents, caregivers, individuals, or siblings) who have similar experiences or needs. A web-based system will support matching parents based on a questionnaire about experiences and desired supports. The system can match on any criteria asked on the questionnaire. The program officially launched in October 2018 with two statewide programs: KS-SHCN and the School for the Deaf. Additionally, the SHS-FAC serves as a "safety-net" program for conditions not covered by the other two programs. Recruitment efforts for Support Peers is ongoing. A Support Peer Handbook has been developed and go to webinar trainings have been developed to train Support Peers. Once there are enough trained Supporting Peers registration will be opened for Connected Peers in 2020. Once Connected Peers can become matched with others who have similar life experiences the program will begin a recruitment process to onboard other new programs. At the time of this report, there were 44 Support Peers enrolled (11 KS-SHCN, 18, KSD, 14 FAC, 1 Unassigned). Extensive work has been done to develop the data system, trainings, promotion, protocols, policies and onboarding criteria.

Supporting You is not only reflective of the needs of the SHCN program population, which is why it is being developed with the opportunity for expansion and inclusion of other community or state programs. The "network" has the partnership capabilities to engage multiple organizations to "administer" their own family support program, with the potential to connect with supporting parents across the overall network. This model will allow opportunities to expand in the future to allow for other partnering organizations across the state to participate in these efforts. This also provides the framework and possible supports for broader utilization across MCH populations, such as the creating of peer-support programs for pregnant women, adolescents, foster children/parents, etc. Ultimately, there will be three key responsibilities: System Administration (KDHE), Program Administration (partnering organization/program), and Peer Support Administration (partnering organization/program). An Administrator Handbook is being developed to support onboarding of additional programs.

Key activities for Supporting You have revolved around the initial development of the model, evaluation and performance measures to monitor the fidelity and impact of the network, and marketing/branding (such as a flyer, postcard). These materials can be found in the Supporting Documents as part of this application. A promotional video was developed and can be found online at www.supportingyoukansas.org, along other information about Supporting You.

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 were completed by MCH in partnership with OKH during FY19 in an effort to improve awareness of the importance of good oral health to overall health and wellbeing.

- The article "Cavity Free and Ready to Learn" was featured in the summer 2019 issue of *Kansas Child Magazine*. The article highlighted oral health and school readiness, offering tips on improving oral health awareness and access to services, consistent evidence-based messaging, and advocacy talking points.
- An oral health awareness campaign was launched to include interactive "hidden picture" oral health posters and social media toolkits. The first poster "What's in Your Mouth" and instructions for social media were released in February 2019. In the fall of 2019, a second poster, "Ready for School?" was distributed to all MCH partners.
- A 2-hour oral health workshop was offered for child care providers. Content included oral health education and information on how providers can integrate strong oral health practices into the child care setting.
- Presented a 90-minute workshop to 30 child care providers. The workshop objectives aimed to increase knowledge around the importance of oral health to overall health, causes of dental decay, and prevention strategies providers can integrate into the child care setting to keep children cavity-free. Participants received oral health resources and supplies.
- Oral health materials used by MCH partners were evaluated to ensure they were up to date and accurate. An online searchable database/tool was created for MCH partners to easily find quality materials on specific oral health topics.

In addition to supporting local advocacy activities/efforts, OHK partnered with the rural Geary County early childhood community to incorporate oral health screenings into developmental screening events. The dental partners were invited to participate in the Geary County IRIS (http://connectwithiris.org/) community/referral network to support access to dental service referrals.

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.

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 specific to local health departments (LHDs). Note: this is not a comprehensive list of partnership activities.

- 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.
- Convened and conducted 36 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.

- Partnered with HRSA to co-host a one-day Grants 101 Workshop (attended by 75 community partners) on May 20, 2019 in Manhattan, Kansas.
- Led the planning and implementation of the 2019 Governor's Public Health Conference.

2019 Governor's Public Health Conference: Title V staff provided extensive support for the Annual Kansas Governor's Public Health Conference which included a pre-conference session held April 2-4, 2019. The preconference (April 2nd) offered three different options for attendees: a day of interactive, skills-building sessions on using MCH data, a day of information focused on drug endangered children, or a workshop on community engagement and coalition building related to substance misuse. The MCH Skill-Building session (133 attendees) promoted data-driven planning, evaluation, and quality improvement—all very important and related to a changing health care system—and focused on building competence and confidence in utilizing data to inform program development. There were opportunities for participants to gain hands-on practice and share stories. Attendees learned how to utilize and apply a framework to make meaningful health practice decisions at the community level. Local agencies used their MCH program data from DAISEY to generate questions that would help them understand the populations they serve and services they provide. A panel of local agencies that participated in the DAISEY Learning Collaborative presented on how they use DAISEY data and Plan-Do-Study-Act (PDSA) cycles to make small technical changes to advance goals.

A wide selection of breakout sessions, tailored to meet the changing needs of the populations served through public health programs, were offered during the conference.

An Integrated Approach to Addressing the Social, Emotional, and Mental Health Needs of Students
Youth Engagement in Reno County
STI Trends and Emergent Issues
Why Are So Many Children and Teens Experiencing Suicidal Thoughts and Actions? Helping to Identify and Support Vulnerable Kids
Engaging and Retaining Families in Home Visiting
The Case for LARC
Health Equity: Assuring Equal Opportunities for Health
Intimate Partner Violence: Turning a Public Problem into a Public Health Priority
Ready to Learn: The Role of School-Based Health Services
Understanding the Teen Brain
How to Integrate SBIRT and Mental Health Screening into Comprehensive Women's Care
Tobacco Free: Supporting Smoking Cessation for Pregnant Women
Using Data and Technology to Connect Families to Services in Connected Communities
Sex Trafficking: Hidden in Plain Sight and the Role of Social Media

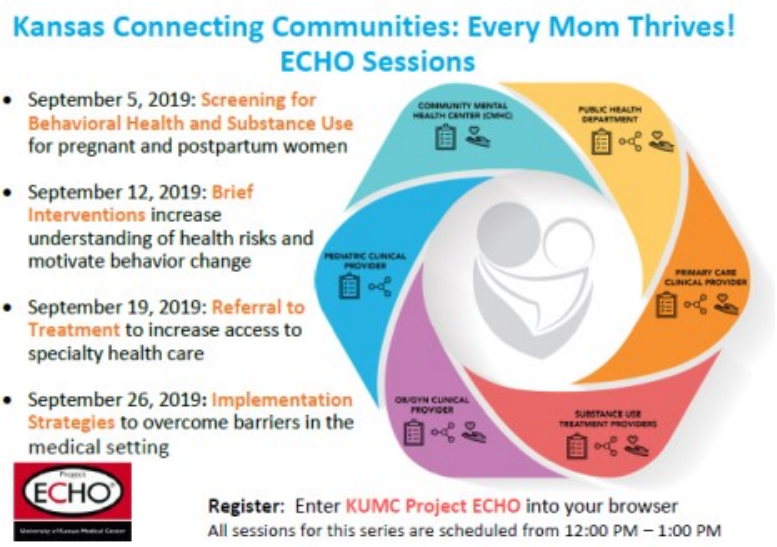
Public Health Connections: LPHP develops and distributes the monthly newsletter, Public Health Connections, sent to approximately 1,000 professionals, including staff of LHDs, KDHE, FQHCs, public health partner organizations, and other community organizations. Public Health Connections provides Kansas 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 such as: special MCH initiatives; new MCH programming; State of Breastfeeding report; webinars; Safe Kids awareness information; advocacy tools; health literacy and trauma informed systems of care education; and much more.

Objective: Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.

KDHE BFH was awarded the HRSA Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement funding in October 2018. 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. Title V leads the vision for this project (from application to implementation) titled Kansas Connecting Communities (KCC), which is directed/managed by the BFH/Title V Behavioral Health Consultant. Through this alignment, the KCC workforce capacity opportunities were made available to local MCH agencies.

In July 2019, KCC held the first Every Mom Thrives! Regional Training Event. The training focused on building skills to implement mental health and substance use screening, referral, and treatment support into participants' organizations. The 6-hour training was facilitated by Melissa Hoffman, DNP, APRN, PMHNP-BC, and Christina Boyd, LSCSW, LCAC. In September 2019, KCC held its first Project ECHO Series. Through partnership with the University of Kansas Medical Center, KCC offered training and case-based learning using the Project Extension for Community Healthcare Outcomes (ECHO). ECHO uses video-conferencing technology as a platform for collaborative education, experts to mentor and share their expertise across a virtual network, and network and democratize and de-monopolize knowledge linking interdisciplinary specialty team with multiple primary care clinicians. The model has proven to help provide better access for patients in rural and underserved communities, reduce treatment disparities, and promote consistency in care and practice. The first KCC Project ECHO Series was held over the noon hour on Thursdays in September 2019. The 4-session series focused on screening, brief interventions, referrals to treatment and implementation strategies related to perinatal behavioral health. An average of 58 providers attended each session.



KDHE BFH was awarded the HRSA Pediatric Mental Health Care Access Program Cooperative Agreement in July 2019. The funding/project provides the opportunity to promote behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs. The Kansas project, KSKidsMAP to Mental Wellness (KSKidsMAP), has led to the establishment of a pediatric practitioner consultation line, training, technical assistance, and care coordination for primary care providers to diagnose, treat, and refer children with behavioral health conditions.

KSKidsMAP will collaborate with the practitioners who attended the REACH trainings for a soft-launch of consultation line services. The anticipated start date for the soft-launch is December 2019. More information about the REACH trainings is available in the Adolescent Report.

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 agencies of the need for focused initiatives in this area. The 2019 Governor's Public Health Conference included breakout sessions supporting increased knowledge of social determinants of health; addressing the social, emotional, and mental health needs of students; suicidal thoughts and actions among children and teens; engaging and retaining families in home visiting; Long Acting Reversible Contraception (LARC); health equity; Intimate Partner Violence (IPV); and smoking cessation for pregnant women.

During the 2019 SHCN Satellite Office Meeting, the BFH Behavioral Health Consultant provided a presentation to help the Care Coordinators in: identifying mental health conditions; recognizing stigmatizing language to avoid when working with families; understanding the impact of trauma on health; developing strategies to prevent triggering or re-traumatizing activities; increasing awareness of secondhand trauma and the importance of self-care.

NOTE: Refer to other domain plan narratives to read more about workforce development opportunities specifically related to mental health services targeted to women, pregnant women, children, and adolescents.

Local Public Health Partnership: LPHP staff helped coordinate a week-long Mental Health First Aid 'train the trainer' event for staff from local health departments and other community organizations. In partnership with Wichita State University, Kansas Association of Local Health Departments (KAHLD), and Saline County Local Health Department, 30 participants focused on systems thinking. The team received training from the National Network of Public Health Institutes (NNPHI) and the Association of State and Territorial Health Officials (ASTHO) in June 2019. LPHP staff facilitated a Behavioral Health Community Planning Day designed to inform local health departments, including local MCH agencies, on how to convene cross-sector meetings to address behavioral health concerns in their communities and share ideas of how to integrate behavioral health screenings into clinical practice.

Family Advisory Council (FAC): Information was shared with the FAC about the role of the BFH Behavioral Health Consultant during the March 2019 FAC meeting. The group worked with the Consultant to review some self-care materials, selected behavioral health as a policy agenda area of interested, and requested an agenda focused on the behavioral health systems of care (held in December 2019). The agenda included updates about behavioral health integration activities with Title V programs, a systems panel, and an advocacy panel.

Cross-Cutting/Systems Building - Application Year

PRIORITY: Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations

SPM 3: Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

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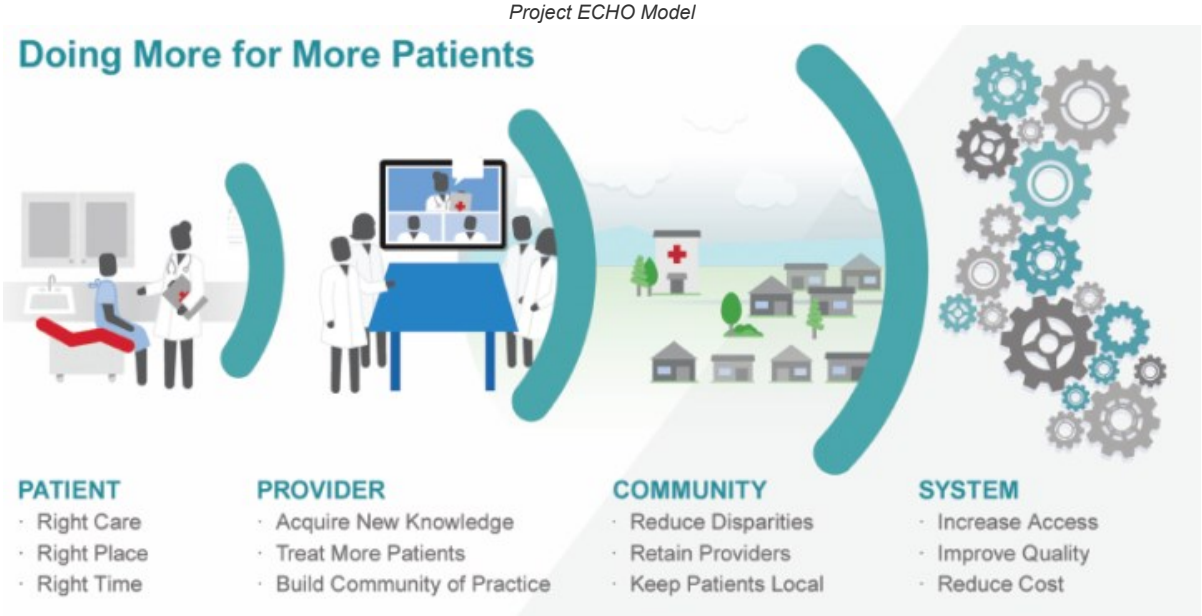
Objective: Increase the proportion of providers with increased comfort to address the behavioral health needs of MCH populations.

Pediatric Behavioral Health: KSKidsMAP to Mental Wellness: The Title V Behavioral Health Consultant serves as the project director for Kansas' Pediatric Mental Health Access Program, KSKidsMAP to Mental Wellness (KSKidsMAP). The program has established an expert pediatric mental health care team that supports Primary Care Physicians (PCPs) and clinicians in treating behavioral health conditions within their clinical practice. To achieve this, a centralized telehealth network was established that includes a TeleECHO Clinic and a provider consultation line.

The TeleECHO Clinic is a virtual clinic (meets twice a month) for case consultation and didactic learning on childhood/adolescent mental health needs in primary care settings. The TeleECHO Clinic philosophy is "enhancing primary care by moving knowledge, not patients," and aims to create an "all teach/all learn" environment for PCPs to learn how to provide the best care for children and adolescents with behavioral health concerns.

Project ECHO Model



The KSKidsMAP team facilitates the TeleECHO Clinic sessions and offers mentorship to support knowledge in practice. Each participant has the opportunity to present a case and receive feedback and recommendations from other TeleECHO Clinic participants as well as the KSKidsMAP team. Following each TeleECHO Clinic session, the recommendations are summarized, and additional resources are compiled and emailed to all session participants.

KSKidsMAP TeleECHO Clinic is an ongoing virtual clinic: Sessions will be the first and third Tuesdays of the month from noon-1 p.m. CDT • **Beginning April 21, 2020**

Following engagement in KSKidsMAP TeleECHO Clinic, participants should be able to identify, screen, assess, diagnose, and treat children and adolescents in their primary care setting for:

- Depression
- Anxiety
- ADHD
- Other noncomplex mental health needs

You will be able to incorporate evidence-based best practices addressing:

- First line pharmacotherapy
- Dosage adjustment and medication changes
- Self-harm, suicidality and referrals
- Trauma
- Sleep hygiene
- Aggression

KSKidsMAP TeleECHO Clinic

Enhancing Primary Care by Moving Knowledge, Not Patients

TeleECHO Model builds community through virtual interactive case-based learning. Together we can build new skills, share ideas, teach one another, and solve problems to treat children and adolescents with mental and behavioral needs.

The KSKidsMAP TeleECHO Clinic:

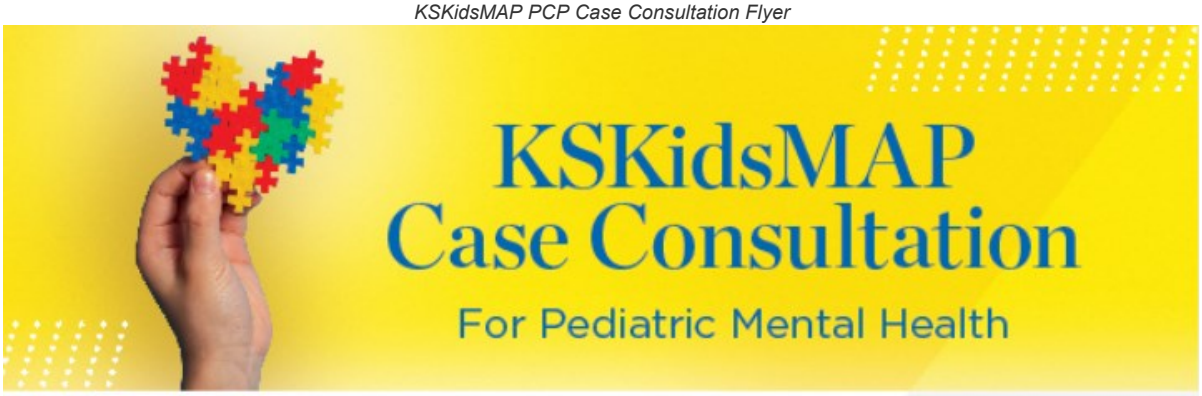
- Enhances access for patients in rural and underserved communities
- Promotes consistency in patient care and practice
- Democratizes and demonopolizes medical knowledge and links interdisciplinary teams with primary care physicians
- Provides rapid dissemination of new knowledge
- Promotes consistency in care and practice
- Spreads knowledge, expands capacity and collective wisdom
- Provides a collaborative case-based learning environment

The KSKidsMAP Pediatric Mental Health Team, collaborating with participating physicians and other clinicians, will meet virtually for case presentation and a short didactic. With a minimum of a six-month commitment, each participant will be expected to submit at least one case, provide feedback, learn from others, and receive treatment recommendations centered around a specific mental and behavioral health concern for children and adolescents. Free continuing education credits including CME and CEU will be provided.

The KSKidsMAP Provider Consultation Line is staffed weekdays from 8 am-5 pm by a Social Work Care Coordinator. The Care Coordinator can assist PCPs by providing mental health and community resources, toolkits, best practice guidelines, referral information, and physician wellness recommendations. The Care Coordinator is also responsible for coordinating case consultations with the pediatric mental health team, which includes board-certified child and adolescent psychiatrist, child and adolescent psychologist, pediatrician, and the social work Care Coordinator. When a case consultation is requested, the team reviews available behavioral health and psychiatric symptoms/concerns and makes recommendation

for intervention treatment strategies. Psychiatric consults for medication management is also made available. The team works directly with the PCP during the case consultation. The PCP then provides care and treatment to the child/adolescent within their clinical practice.

KSKidsMAP PCP Case Consultation Flyer



KSKidsMAP Case Consultation

For Pediatric Mental Health

The KSKidsMAP pediatric mental health team provides consultative support to primary care physicians (PCPs) and other clinicians as an integrated team. KSKidsMAP staff include a board-certified child and adolescent psychiatrist, a board-certified child and adolescent psychologist, a board-certified pediatrician and a licensed social work care coordinator.

What is the purpose of a psychiatric consult?

- Supports PCPs in the early identification, diagnosis, treatment and referrals for children and adolescents with mental and behavioral health concerns.
- Provides recommendations based on best practices to support PCPs in the treatment of children and adolescents with mental and behavioral concerns within their practices.
- Assists PCPs in identifying treatment services for children and adolescents with more complex behavioral health concerns who may require referrals to specialists.

Why consultation services are important?

- Over 60% of Kansas adolescents between the ages of 12-17 with a major depressive episode did not receive treatment from depression.
- An estimated 22% of Kansas children have suffered from a mental disorder in their lifetime, and about 5% meet the criteria for severe impairment.
- Of Kansas' 105 counties, 99 are designated as mental health professional shortage areas ; this shortage leaves more than 70% of Kansas children with unmet mental health needs.
- PCPs have become the first responders in mental and behavioral health identification and service provision. Consultation services can be utilized to support efforts in treatment.

What questions can I ask?

Anything related to mental and behavioral health treatment:

- Medication
- Diagnostic
- Screening tools
- Treatment protocols
- Locations of mental health clinicians
- Community resources

How can I receive more information? Please contact:

Polly Freeman, LBSW, MSW,
social work care coordinator
Consultation line: 1-800-332-6262
KSKidsMAP@kumc.edu
wichita.kumc.edu/KSKidsMAP

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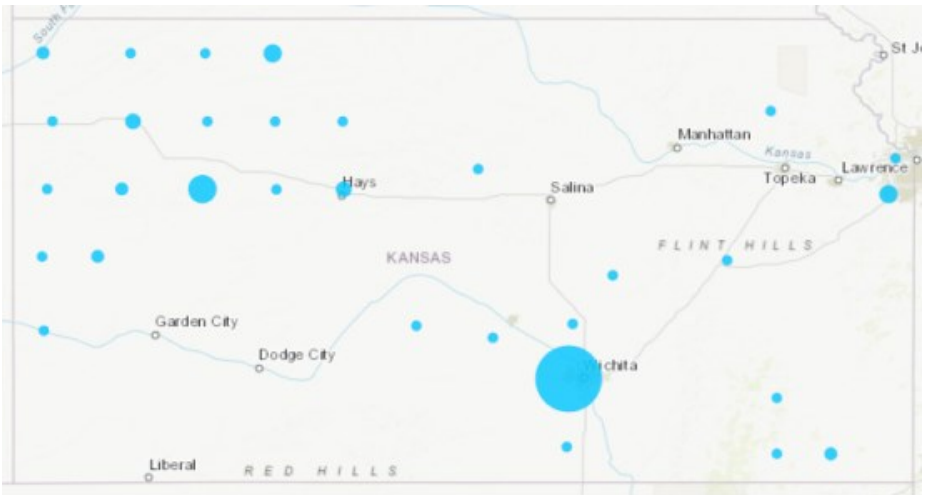
More than 70% of Kansas children live with unmet mental health needs as most counties (99 of 105) are designated as mental health professional shortage areas. Twenty-three of these 99 counties have PCPs filling the gap. KSKidsMAP had a very successful first year; multimodality outreach efforts (e.g., email/mail, in-person meetings and presentations, media releases, videoconference meetings) resulted in the enrollment of 50 physicians/clinicians who serve children and adolescents in 31 counties within the first four months of the KSKidsMAP Consultation Line launch.

KSKidsMAP will continue to identify innovative outreach methods to increase provider enrollment, including presenting at conferences geared towards PCP engagement (e.g., American Academy of Pediatrics). Leveraging partnership with the Kansas Title V program, KSKidsMAP will expand outreach efforts beyond PCP clinics to local MCH programs. Efforts will be focused on the MCH programs who provide well-child/adolescent visit services.

First 50 KSKidsMAP enrolled providers' location and provider type

Table 1. KSKidsMAP Enrollment

Enrollee Type	N(%)
Physician/clinician	35 (70%)
Nurse Practitioner	10 (20%)
Registered Nurse	1 (2%)
Physician Assistant	1 (2%)
Psychologist	2 (8%)
Social Work	1 (2%)
Total	50 (100%)



To further incentivize provider enrollment into the program, KSKidsMAP plans to offer Improving Professional Practice and Quality Improvement of Maintenance of Certification (MOC Part 4 Credit). This certification helps programs assess and improve the quality of patient care and processes that will lead to improved child health. Pending approval, MOC Part 4 Credit will be available to practitioners enrolled in KSKidsMAP for their meaningful participation in a child/adolescent depression screening quality improvement project. Project participants would use the Patient Health Questionnaire (PHQ-9) as the depression screening tool.

Perinatal Behavioral Health: There are four key initiatives planned to help increase workforce capacity to screen, facilitate brief interventions, make referrals to treatment, and provide education and resources to their perinatal patients at risk of behavioral health conditions:

1. *Pediatrics Supporting Parents (PSP) Workgroup*: A new payment policy has been drafted and submitted to Medicaid to cover maternal depression screening (pending July 2020). The drafted policy allows for screenings and subsequent treatment services to be billed under the child's Medicaid plan, up to 12-months post-delivery, supporting child social and emotional development and healthy family functioning. If approved, BFH will support implementation by assisting with any necessary guidance to providers, as well as in the development of training materials.
2. *Kansas Connecting Communities (KCC):* Through KCC, a Perinatal Provider Consultation Line has been established to assist through case consultations and best-practices information and multiple training opportunities are available for perinatal providers. This effort directly supports increasing health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders.
3. *Communities Supporting Perinatal Behavioral Health Community Collaborative (CSPBH-CC):* This effort focuses on implementing perinatal behavioral health screenings, brief interventions, and referrals to treatment into five local MCH agencies clinical practices. Additionally, the Community Collaborative will help MCH agencies enhance the overall quality of perinatal behavioral health services and programs.
4. *Paternal Postpartum Depression (PPD):* Title V will support creation of a PPD package to: increase provider awareness about prevalence; educate about symptoms; inform on the difference of PPD and maternal depression; guide implementation of paternal screenings into clinic workflow; offer programming considerations; and provide resources for fathers who might be experiencing postpartum depression.

More information about these initiatives is available in the Woman/Maternal Plan.

Effective Community Partnerships: Universal behavioral health screening is most effective when providers work collaboratively to ensure adequate systems of care are in place supporting accurate diagnostic assessments, appropriate treatment, and essential follow-up. In a 2020 survey of Kansas local health departments, only 59% of respondents reported having a "mostly positive" relationship with the community mental health center (CMHC) in their area. BFH will work in collaboration with the Kansas Department for Aging and Disability Services (KDADS), the state agency responsible for the provision of mental health services in local communities, to develop guidance for building effective community partnerships, especially with CMHCs.

The CSPBH-CC will serve as a pilot in determining effectiveness of these community partnerships when formal agreements are in place. Participating agencies will be encouraged and supported in their efforts to establish formal agreements with a local community mental health treatment provider, including the CMHC. Agencies will also establish a local system of care for perinatal women and their families, which should include (where available), but not limited to: MCH programs; obstetrician/gynecologist; pediatrician/family physician; mental health treatment provider; and persons with lived experiences. This group will work to establish "community standards" that include building and maintaining a non-judgmental culture of safety and care.

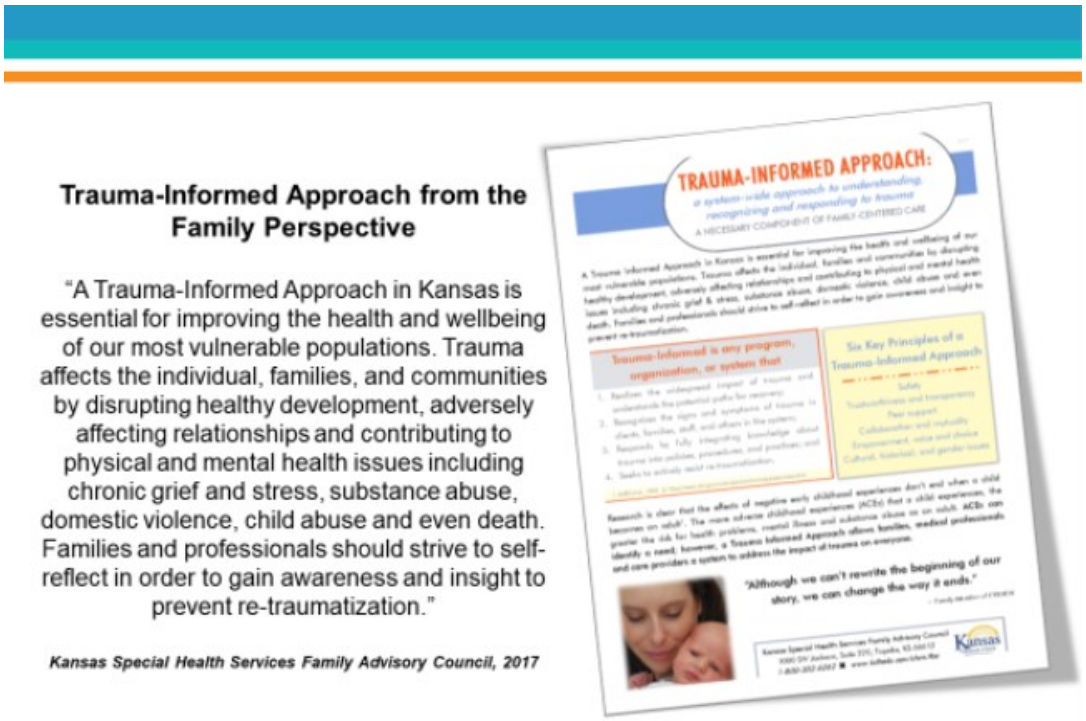
Objective: Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction and healthier work environments.

It is important now, more than ever, to assure the MCH workforce recognizes how trauma and stress related to both their "normal" clinical practice and the impact of COVID-19 affects their wellbeing. To be successful in addressing the needs of the MCH populations within their community, they must be well.

Being "trauma informed" is much more than being sensitive or emphatic during an office visit. Addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment (SAMHSA, July 2014). SAMHSA has outlined the trauma-informed approach, as well as established principles:

In 2017, FAC families developed the a Trauma-Informed Approach Fact Sheet specifically to address the importance of providers utilizing trauma-informed approaches when working with families. This fact sheet will be integrated into the workforce development efforts written in this narrative.

Slide on FAC Trauma-Informed Fact Sheet



Through partnership with local MCH agencies, Title V will utilize the SAMHSA Culture of Wellness Organizational Self-Assessment (COW-OSA) to gather baseline information. The COW-OSA includes ten domains and related standards that are characteristic of an organizational culture of wellness. MCH agencies can use this self-assessment to identify wellness-related strengths and areas requiring further exploration and development. Title V will analyze assessment results and develop an action plan. This plan will include using the results to identify improvement opportunities, clarify current practices, and develop a work plan to enhance their organization's trauma-informed approach. Title V will provide support to local agencies accordingly, as well as identify support opportunities for the entire MCH network.

Title V will create a resource guide that includes the following: guidance on trauma-informed patient care; model standards for serving victims of crime; training opportunities; peer-reviewed articles on the neurobiology of trauma; resources around building a resilient workforce; and research related to COVID-19 and trauma. The guide will be distributed to local partners and one-on-one technical assistance will be available upon request.

Lemonade for Life: Lemonade for Life (LFL) is a promising approach developed by the University of Kansas Center for Public Partnerships & Research (KU-CPPR) around ACEs prevention and intervention. LFL trains professionals on using the ACEs Questionnaire to prevent future exposure to ACEs, while promoting resiliency and hope. The program helps individuals understand how early life experiences have a long-lasting effect on interactions in future relationships. LFL training conveys that individuals "cannot rewrite the beginning of their story, but they can change how it ends," instilling hope and responsibility for change and an important factor in individuals building self-sufficiency.

Title V, in partnership with the Bureau of Health Promotion (BHP) and KU-CPPR, plan to host LFL training for MCH Universal Home Visitors and invest in a pilot LFL Learning Collaborative delivered through home visiting programs. 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 and one group coaching call (45-60 days post training)
- Participate in evaluation of Lemonade for Life Curriculum
- Commit to showing the Brain Builder video during the first three months (before the 6th visit) to all prenatal clients and clients with children birth to 3
- Commit to introducing ACEs Questionnaire (following video completion)
- 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
- 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

Objective: Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations.

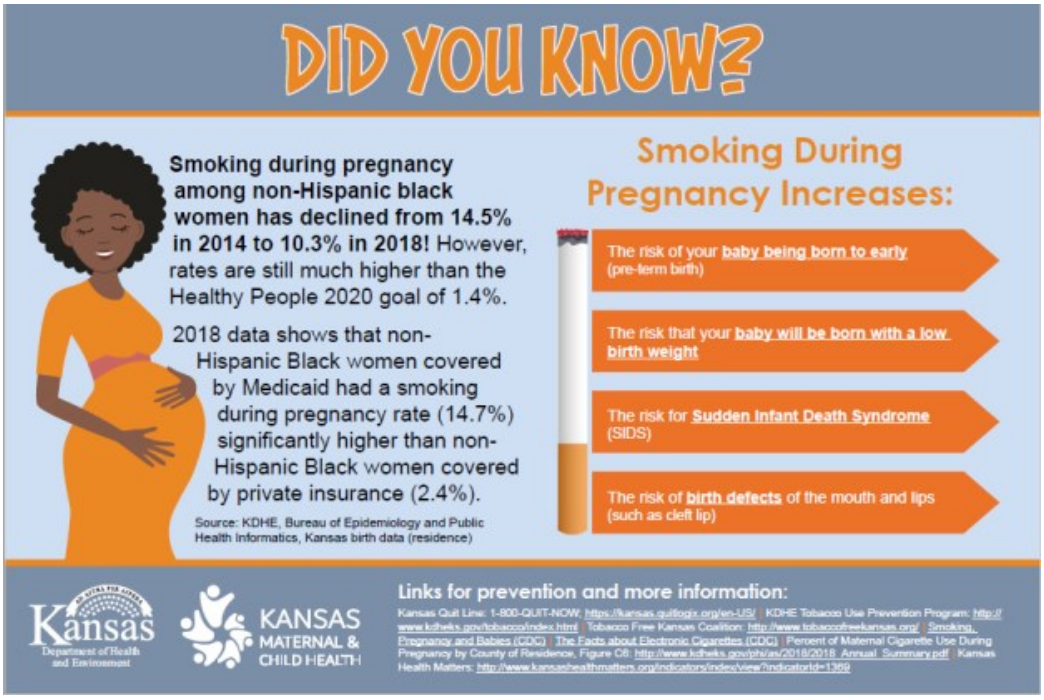
MCH (Health Equity) Opportunity Project: Addressing health equity requires identifying and removing obstacles to health (e.g., lack of access to good jobs, quality education, safe housing and environments, fresh food, health care) to assure everyone has a fair and just opportunity to be healthy. In 2019, Title V partnered 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.

Title V worked with seven local MCH agencies 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. The 2nd cohort of the MCHOP will be conducted in the coming year, utilizing the Kansas Healthy Communities Action Toolkit to encourage action in building 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.

Black Infant Mortality: Title V recognizes that stark disparities exist between black infant mortality rates and mortality rates for infants of other races. Black infants in Kansas are nearly three times more likely to die than white or Hispanic infants[1]. In order to increase the awareness of the disparities in health outcomes that black women face, Title V entered into a partnership with The Kansas African American Affairs Commission in 2020. A marketing campaign with the tag line "Did You Know" began in January of 2020 and will continue through the end of the year. This campaign is designed to raise

awareness in the black community and offer prevention and educational information where people can learn more. Topics featured in the campaign will include black infant mortality, leading causes of death of black infants, smoking during pregnancy, being active and healthy, mental health, breastfeeding, safe sleep, maternal mortality and others. The collective of these infographics can be found in the Supporting Documents section of this application.

April 2020 Did You Know – Smoking During Pregnancy



To strategically address this issue in an informed and meaningful way, Title V will be creating a request for proposals to contract with an organization that will conduct virtual focus groups and individual interviews to solicit data and feedback from black women throughout Kansas. This data will be used to identify action steps that can be taken by state and community partners to better support black mothers and caregivers in the postpartum period. These action items will help create a roadmap that will address the causes of black infant death and lead to better outcomes for both mother and baby.

Other MCH Workforce Development Activities

The MCH Navigator and online MCH Assessment will continue to be utilized in the professional development planning and performance reviews for all staff. All MCH program staff and supervisors must complete two MCH courses (MCH 101 and MCH Orientation) via the online MCH Navigator, within three months of grant award or hire, whichever applies. 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. In addition to basic training and orientation, local program staff are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination). Ongoing training requirements for all local MCH staff include technical assistance calls/webinars and may include trainings on the various integration toolkits outlined through this narrative. The annual Governor's Public Health Conference serves as another opportunity to engage the MCH workforce.

Annual Home Visitor Training: Kansas Title V provides an annual workforce development event for all MCH Universal Home Visitors and MIECHV Home Visitors. For the FY21 grant year, this training will occur in November 2020. The training will be delivered virtually this year, as a series of five, one-hour Lunch and Learns to take place concurrently throughout one week.

This year's subject matter will all center around the importance of the post-partum period and the transitioning from post-partum care to well woman care.

DAISEY Learning Collaborative: Plans are in place to continue the DAISEY Learning Collaborative with the 3rd cohort of this project. (Cohort 1: 2018, Cohort 2: 2019). This project encourages utilization and application of MCH data at the local level with up to 5 local MCH agencies to collaborate and explore ways to impact their programs and practices with DAISEY data. Each of participating agencies will be 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 will use their local DAISEY data to identify an area of opportunity for improvement within their practice. They will implement a Plan-Do-Study-Act (PDSA) cycle/s to make small-scale changes and then used DAISEY data to measure the impact. This project will kick 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 will be 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 will present a summary of their project and impact, what they learned and along with challenges they encountered had to their peers at the 2021 Governor's Public Health Conference Pre-session. Information about the Collaborative can be found in the Supporting Documents as part of this application.

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:

- 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 webinars for local health department staff and other public health system partners
- Plan and deliver of the 2021 Governor's Public Health Conference to meet the workforce needs of Kansas local

health departments, including MCH workforce
- 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
- Organize KanBeHealthy (EPSDT) trainings for public health staff
- Collaborate with the KS Public Health Workforce Development Coordinating Council
- Develop/provide quality improvement training for KDHE staff and local health departments

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PRIORITY: Strengths-based supports and services are available to promote healthy families and relationships.

SPM 4: Percent of children whose family members know all the time they have strengths to draw on when the family faces problems

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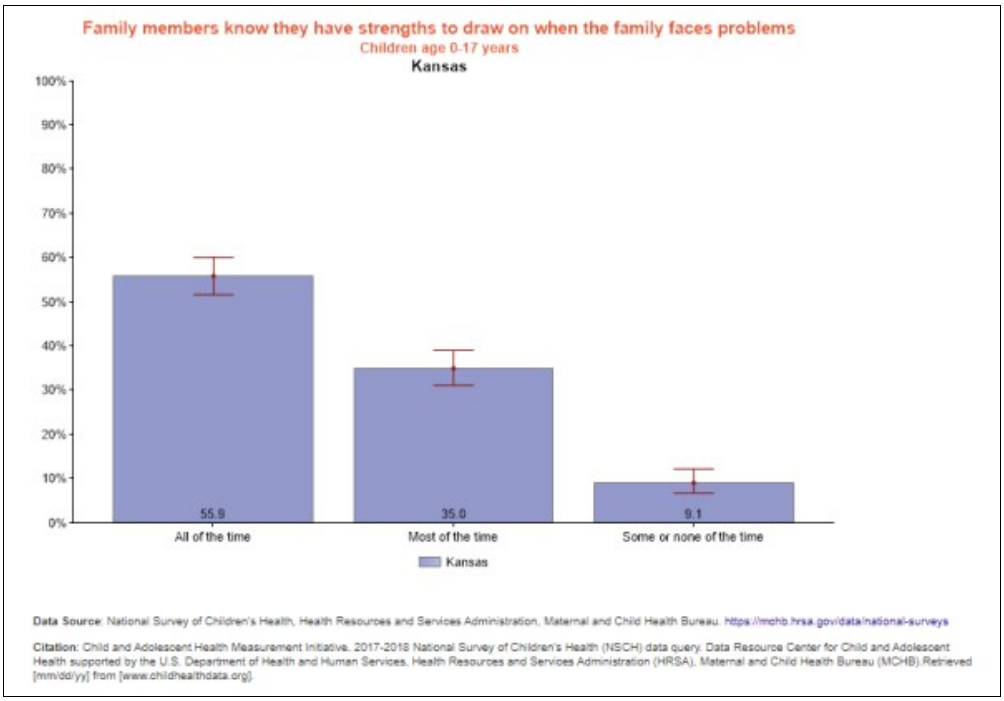
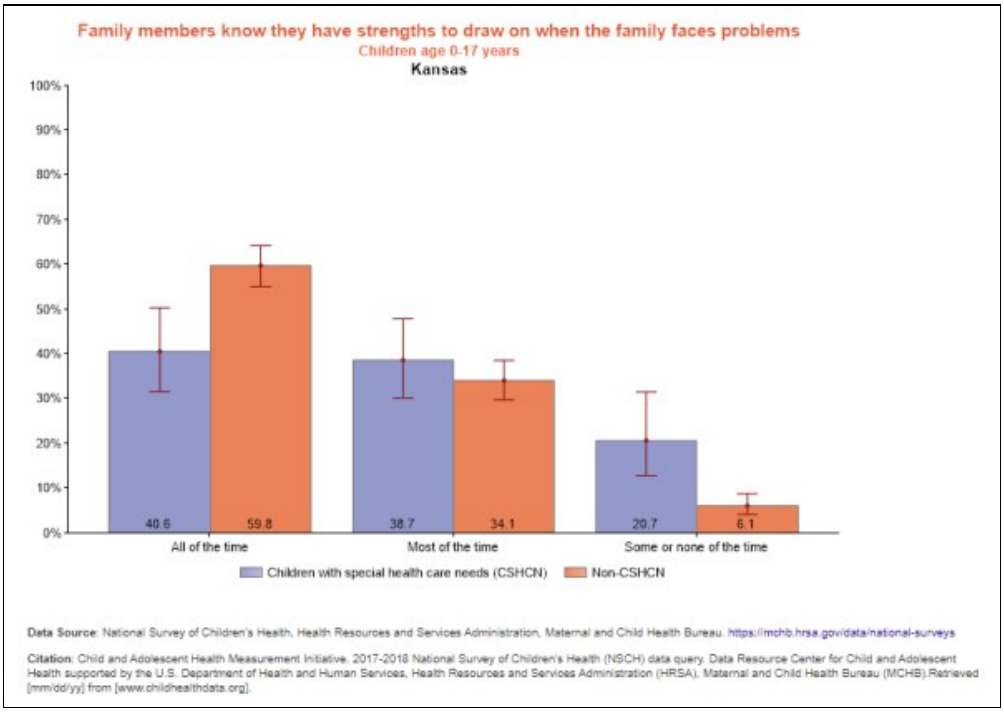
Kansas selected this new priority focused on family engagement and supporting families from a strengths-based perspective. This further solidifies the long-standing priority that Kansas has had on family engagement and consumer partnership. It is well known that when families are strong, connected, and healthy, the family members and their surrounding community thrive. Title V is distinctly poised to strengthening self-efficacy and self-determination among families by assuring: MCH-led activities and services (informed by family needs and desires, centered on the family voice, and representative of diverse values and ideals); family/consumer peer support opportunities; family/consumer leadership activities; and expansion of holistic care coordination services across Title V populations. These things collectively will provide multiple areas where families can be supported and feel like they have strengths to draw on when faced with challenges. According to the National Survey of Children's Health, 56% of respondents reported knowing "all of the time" that their family has strengths to draw on when their family faced problems. While most of the general population (91%) responded with "all" or "most" of the time, there appears to be a greater disparity among families of children with special health care needs (CSHCN), with 1 in 5 families of CSHCN reporting "some of none of the time" to this same question (20.7%).





Objective: Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP).

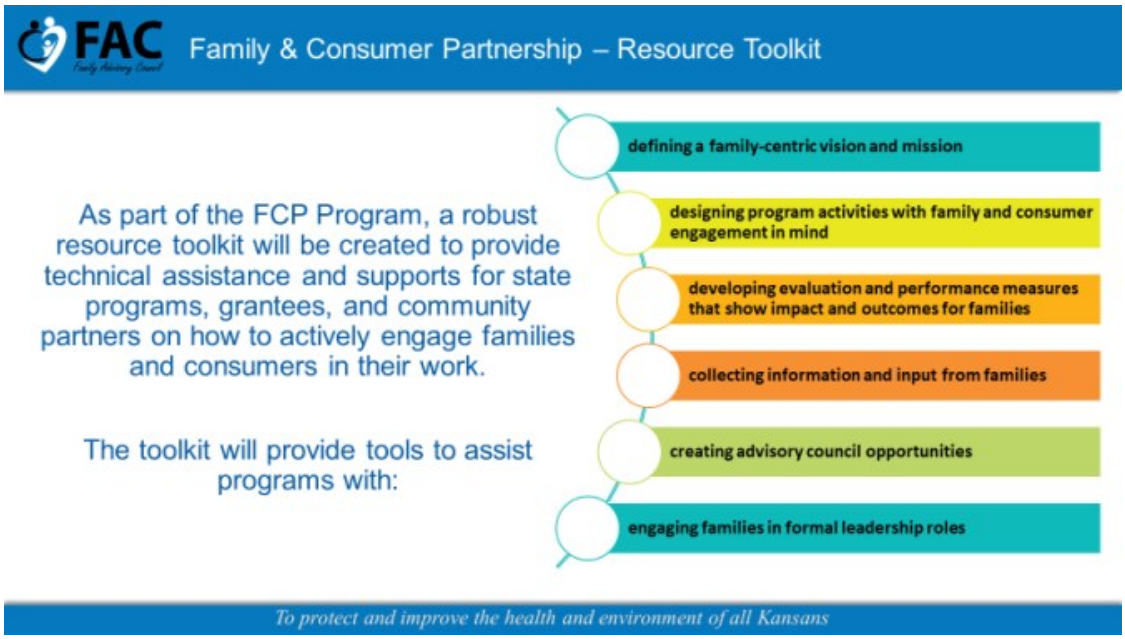
MCHB defines family partnership as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy-making -to improve health and health care." While the Kansas vision has always included family-centered approaches and the assurance of family engagement at various levels, programs have struggled with operationalizing family and consumer engagement opportunities. Kansas Title V adopted consumer engagement as a guiding principle several years ago; however, we have seen little advancement of integrated, coordinated, and intentional activities at all levels across programs outside of the CSHCN program/population.

With the adoption of this priority, the Title V Family and Consumer Partnership (FCP) Program will be developed and housed in the System of Supports Section to provide capacity and support to Title V staff/partners. The focus is on understanding the need for FCP and supporting programs and services to engage with families and consumers in their daily work and fully embrace the "nothing about and for us, without us" philosophy. The FCP Program will ultimately build strong partnerships with families through:

1. Peer Supports, such as the Supporting You: Peer-to-Peer Network;
2. Family Leadership Programs, such as the Title V Family Delegate Program; and
3. Advisory Opportunities, such as advisory councils.

This also includes a framework and technical assistance for local and state Title V programs to assure families are engaged at the level they desire and assure families are provided opportunities to assist with planning, implementation, and evaluation of the services and programs they engage with, as well as policy at the local, state, and national levels. The FCP Resource Toolkit will be developed and integrated across MCH to:

Overview of Resource Toolkit from FAC Meeting, June 2020



The toolkit will align with the MCH Leadership Competencies and integrate a variety of family-engagement resources and frameworks, including the Kansas Family Engagement and Partnership Standards for Early Childhood, the Principles of Family Support Practice, and the Strengthening Families Approach/Protective Factors Framework. The toolkit will also integrate the Standards for Quality for Family Strengthening and Support as adopted by the National Family Support Network. The toolkit will be developed with strong input from the Kansas Maternal and Child Health Council (KMCHC) and Family Advisory Council (FAC) members and will incorporate input and data received from the recent Title V and Early Childhood Care and Education Needs Assessments.

Throughout the development of the toolkit, a series of trainings will be provided to state and local program staff to begin learning about the importance of and the programmatic and community benefits of FCP. Training topics will include the importance of family-centered services and supports to: strengthen families; promote strong, healthy, and safe family environments; address diverse needs of families; and build supportive communities. Discussion and feedback from these trainings will guide the development of the toolkit and assist with prioritizing development efforts. Dissemination and integration of the FCP Toolkit will begin with state program staff, including integration of FCP principles and resources and provision of training for grantee networks and core partners. Additionally, FCP plans will be expected as part of funding and grant opportunities in the future and the toolkit will be provided as a technical assistance resource to support the creation and development of these plans over time.

Objective: Increase the number of individuals receiving peer supports through Title V-sponsored programs.

Ongoing enhancements and expansion efforts continue for the Supporting You Network This include adding two new Network Programs and enhancing the online data system. Desired enhancements for the coming year include: the development of data dashboards for the Network Administrator, Program Coordinator, and Peer Support Administrators; profile pages for Connected and Support Peers; revised Peer registration interface; a connection dashboard for Support Peers; an integrated training platform; and performance and evaluation metrics.

Data Dashboards	• Data snapshots (as desired and tailored to the individual role/program need) • Quick links to next steps or necessary actions
Profile Pages	• Recap of key information entered into the system by the Support or Connected Peer • Downloadable and used by PSA for matches
Peer Registration Interface	• Improved user-friendly interface • Section tabs for easier navigation • Easier registration update process
Support Peer Connection Dashboard	• Information, profiles, and activity logs • Easy access to matched peers • Long-term goal: interactive, integrated communication system
Integrated Training Platform	• Trainings integrated into the peer registration platform (current: GoToStage) • Easier Network oversight and tracking and training communications
Performance & Evaluation Metrics	• Multi-tiered evaluation plan to evaluate user experience/satisfaction and Network processes and activities • Post-Connection Satisfaction Survey (SP/CP); Annual Survey (SP)

In addition to Network enhancements, Supporting You will also expand through the addition of at least two additional programs to connect (1) pregnant and post-partum women experiencing PMADs, and (2) youth/adolescents. New programs will engage in a three-phase onboarding process, as outlined below.

- *Phase 1: Exploration.* During this phase, prospective partners will engage in an introductory meeting to discuss the network, expectations of Network Programs, and identify the target population the new program will work with. Following this discussion, the partner will either move forward as a Network Program (NP) or will move forward as a Promotional Partner (PP).
    - NPs will operate a peer-to-peer matching program under the network umbrella of Supporting You. NPs will be added as appropriate to address a unique population not currently being served through Supporting You. A formal agreement will follow to assure alignment with the model and fidelity of the network, including training, peer matching, evaluation, and measurement.
    - PPs will not directly match peers, rather will serve as a partner to support recruitment of peers in partnership with an existing program or the overall network. This designation will likely be assigned due to duplication of the unique target population associated with the partner. PP's can receive customized recruitment materials and will be asked to submit data around recruitment activity.

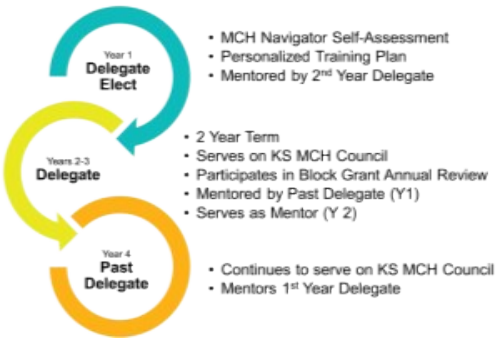
- *Phase 2: Program Design.* During the phase, NPs will engage in a series of strategic planning meetings that will incrementally walk them through the development of their registration questionnaire, the structure and logistics of a SY program, staffing needs, training requirements, marketing needs, and shared data/evaluation measures.
- *Phase 3: Development.* During this phase, NPs will engage with: The Supporting You Data Vendor to develop the database components needed for the new program; KDHE Communications to develop customized marketing materials; and internal/external stakeholders to develop specific training plans.
- *Phase 4: Implementation.* During this phase, NPs will conduct a pilot, or soft-launch, to test the system and their processes – including Support Peer onboarding – and a media event with KDHE to formally launch the program.

Objective: Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program.

Family Delegate Program: Expanding family leadership efforts across Title V programs is a high priority and supporting stronger efforts to equip and empower families to engage as partners with the MCH workforce. As part of this effort, there will be continued focus on the Kansas AMCHP Family Delegate program, under the FCP Program. The Delegate role will be more formalized and include dedicated training, coaching, and professional development activities. The Delegate will be asked to complete the MCH Navigator Self-Assessment and develop a personalized leadership plan to work on core MCH competencies as identified as priority interests for the Delegate. Additionally, the Delegate has been added as a standing member of the KMCHC Council and will continue to serve on that Council as an expectation of the Delegate role.

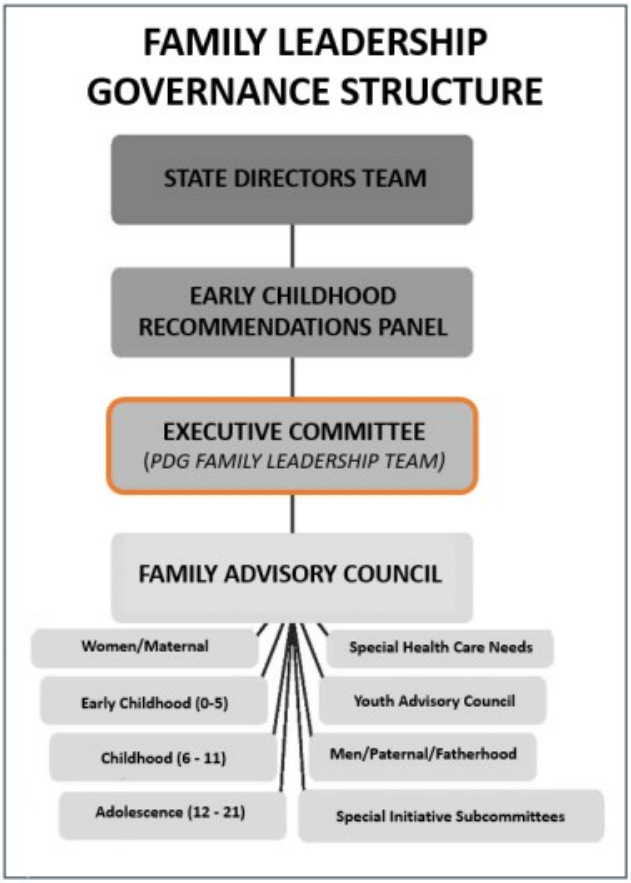
Additional enhancements to this program will be pursued this coming year, including a progressive succession and transition plan for incoming and outgoing Delegates. It is desired to shift the Delegate position to a four-year term, recruiting every other year. This will allow for a progressive and more intensive training and mentorship opportunity and support continuity among the family leader representing Title V. Formal supports will be available to two family leaders each year to engage in this work, including a Delegate stipend for meetings, travel supports and assistance, trainings, and professional coaching models. The competitive application process will continue, however will recruit for the Delegate Elect position for the first year.

- *Delegate Elect.* The family leader will engage in specific trainings and discussions with Title V staff to build foundational knowledge of Title V that will assist them during their term as the Delegate. The Delegate Elect will be encouraged to participate in KMCHC Council activities; it is an optional engagement during this first year.
- *Delegate.* The family leader will identify an area they'd like to build their skills and competency within Title V and will work closely with the Title V Domain Consultant or program staff to learn more and assist them with expanding family and consumer engagement efforts within those programs.
- *Past Delegate.* The family leader will remain on the KMCHC Council and represent the family/consumer voice on the KMCHC Council Executive Committee.



Family Advisory Council (FAC): Building from the existing structures of Title V advisory groups (e.g., FAC, KMCHC), the FAC will be expanded to support opportunity across all MCH domain populations. This transition will also lay the foundation for future implementation of the FCP Toolkit and offer opportunities for MCH programs to engage families and consumer with lived experiences at all levels: as program evaluators, co-trainers, interns, paid staff or consultants, mentors, grant reviewer, active participants in assessment processes, and more.

The formal plan on this expansion will be developed in partnership with existing FAC members throughout Summer 2020 with expansion implementation by early 2021; the goal is to frame the FAC as outlined in the diagram below.



In addition to the expansion across MCH domain populations, there is an alignment initiative around the early childhood care and education systems work to be completed under the newly awarded Preschool Development Grant Birth through Five (PDG B-5) renewal grant. As part of this work, Kansas will be improving parent engagement and leadership through the development and coordination of a Family Leadership Team (FLT) to unify parent voice, diversify representation, and maximize influence in the decision-making process. The FLT will be represented on the Early Childhood Advisory Council (ECAC) and tasked to assist in monitoring and evaluation activities to inform decisions and improve programs based on parent experiences and choices.

Objective: Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration.

Holistic Care Coordination (HCC) Implementation Toolkit: As the desire to expand the HCC model across Title V and MCH programs and beyond the formal Title V program delivery, such as provision of technical assistance for primary care and community health providers, it is recognized that the model implemented by the KS-SHCN program is a replicable model, that has shown to be effective in meeting the needs of those engaged in care coordination. In the coming year, an implementation toolkit will be developed and available to assist programs, partners, and providers to develop or implement HCC for their clients or patients. The toolkit will include foundational information and resources to support the development of a care coordination program, sample job descriptions for Care Coordinators, training plans with a formal curriculum, and other resources to support needed technical assistance. In partnership with the LYFTE program, a video series on HCC Coordination is under development and will be utilized to bring awareness to the holistic approach to the Title V model, spark interest among providers or partners, and begin dialogue on how to replicate this model across other populations and provider settings.

Care Coordination Training Curriculum: Title V will be developing a robust continuing education curriculum for case managers, Care Coordinators, and community health workers on the provision of holistic care coordination services, adapted from the training conducted with the KS-SHCN Care Coordinators. The training modules will utilize both virtual and in-person learning and skills-building opportunities and will be included as a portion of the HCC Implementation Toolkit.

At a minimum, the training modules will cover the following topics, however will be adapted and expanded throughout the development phase with input from patients and providers:

- *Building Patient/Family-centered Care Coordination Through Ongoing Delivery System Design.* Describe key components of a high performing care coordination model; compare existing care coordination models or efforts; assist learners in recognizing opportunities for improvement; and encourage learners to develop action steps for improving collaboration and teamwork
- *Care Coordination as a Continuous Partnership:* Explore the nature and dynamics of different kinds of "care coordination partnership relationships; define the core components of building partnerships with families; and inform practices going forward
- *Integrating Care Coordination into our Everyday Work:* Focus on longitudinal care; improve communication and accountability among providers; embrace the role of Care Coordinator as an agent of change; recognize patients/families as members of the medical home; and integrate patient/family input, appreciating that family satisfaction is central to successful care coordination
- *Strategies to Assess and Address in the Family-Centered Medical Home:* Social determinants of health; social service systems, supports, and common needs; barriers to assessing unmet needs; and strategies to address unmet needs

Trainings will also be developed to provide in depth review of a variety of established protocols and tools used in providing HCC to families. This will include a detailed overview of the KS-SHCN HCC Structure and processes for those that are replicating this model. Additionally, all trainings will be based upon the National Care Coordination Standards CSHCN currently under development with strategies, techniques, and recommended guidance to deliver HCC services at the highest standard.

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[1] Infant Mortality Kansas, 2016 Research Brief. Kansas Department of Health and Environment.

III.F. Public Input

FFY2021 Title V Block Grant Application/FFY2019 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: July 20 through August 14, 2020

Methods

Post Card: A post card was developed and distributed to partners and MCH Council members via email and in-person meetings.

Message to Partners: 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 2021 Application and 2019 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 **July 30** 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, Inc.
- 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 45 responses were received. Although we had a low number of responses, the location of respondents seemed to be evenly spread throughout the state. Nearly half (47.6%) responded that this was their first-time providing feedback on a draft MCH Application/Annual Report.

Based on the information contained in the draft 2021 Application/2019 Annual Report, most of the respondents strongly agreed or agreed that they had a better understanding of the state MCH Priorities and plans for the MCH population domains and Cross-Cutting:

Answers Choices	Strongly Agree	Agree	Disagree	Strongly Disagree	Total	Weighted Average
Women/Maternal Health (100%)	12	13	0	0	25	3.48
Perinatal/Infant Health (96%)	12	12	1	0	25	3.44
Child Health (100%)	11	14	0	0	25	3.44
Adolescent Health (100%)	9	16	0	0	25	3.36
Children with Special Health Care Needs (100%)	8	17	0	0	25	3.32
Cross-Cutting (72%)	8	10	5	0	23	3.13
answered question					25	
skipped question					20	

After reviewing "Five Year State Action Plan" and "Financial Narrative," the majority responded the following sections were

adequately addressed:

- State Title V Program Purpose and Design (87%);
- MCH Workforce Development, Family Partnership, State Systems Development Initiative and Other MCH Data Capacity Efforts, and Health Care Delivery System (95.7%); and
- Resource Allocation/Expenditures (95%).

The majority (92.3%) responded that the 2021 Application/2019 Annual Report (1) clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities, and (2) Accurately reflects the capacity/work/activities across Kansas as they relate to the state priorities. Additionally, 96.2% of those responding to this question expressed that the draft document demonstrates a strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas.

Answer Choices	Strongly Agree	Agree	Disagree	Strongly Disagree	Total	Weighted Average
Clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities.	9	15	2	0	26	3.27
Demonstrates strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas.	9	16	1	0	26	3.31
Accurately reflects the capacity/work/activities across Kansas as they relate to the state priorities.	8	16	2	0	26	3.23
answered question					26	
skipped question					19	

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 CSHCN Population

As the Kansas Special Health Care Needs (KS-SHCN) program has transformed and transitioned to a focus on community-based services and supports, therefore 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 (CSHCN) population. The recent shift in capturing data for CSHCN 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 CSHCN 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 CSHCN 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. Evaluation of the KS-SHCN Care Coordination model is extensive, however it is unclear how to fully measure the impact of families of CSHCN not formally being served by KS-SHCN, such as those served through community partnerships, local MCH grantees, and those not connected to Title V-supported programming. Technical assistance in local or state CSHCN data collection could assist Title V to better understand, in real-time, the needs of the CSHCN 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 CSHCN-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 both 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

More than half of the Title V Block Grant funds that Kansas receives pass through directly to local communities as part of a centralized agency process referred to as Aid-to-local (ATL). 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 and ensure statewide access and equity of MCH services. 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. An efficiency study, comparing the median social cost of delivering services vs the median social benefit of receiving services could greatly impact Kansas MCH service delivery with the goal of increasing the reach and impact of Kansas MCH with existing/available funds and determining an approach that is sustainable, equitable, and efficient.

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
- 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 FINAL-Ready.pdf

V. Supporting Documents

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

Supporting Document #01 - SuppDoc1_P-M-SAP.pdf

Supporting Document #02 - SuppDoc2_ATL.pdf

Supporting Document #03 - SuppDoc3_WM-PI.pdf

Supporting Document #04 - SuppDoc4_C-A-CSHCN.pdf

Supporting Document #05 - SuppDoc5_FCP-Advisory.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Organizational Chart REV 8-31-20.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Kansas

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,719,472	
A. Preventive and Primary Care for Children	$ 1,501,567	(31.8%)
B. Children with Special Health Care Needs	$ 1,462,990	(30.9%)
C. Title V Administrative Costs	$ 330,000	(7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,294,557	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,610,958	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 4,056,499	
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)	$ 7,667,457	
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)	$ 12,386,929	
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)	$ 65,973,561	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 78,360,490	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 132,904
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 299,493
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 410,740
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,032,531
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 56,904
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 444,576
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health	$ 647,824
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 247,767
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,494,996
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,208,479
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 51,411,436
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 432,341
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 4,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Newborn Screening New Condition Implementation (SMA)	$ 149,070

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,756,879		$ 4,773,454	
A. Preventive and Primary Care for Children	$ 1,447,463	(30.4%)	$ 1,469,985	(30.7%)
B. Children with Special Health Care Needs	$ 1,455,545	(30.6%)	$ 1,493,918	(31.2%)
C. Title V Administrative Costs	$ 223,000	(4.7%)	$ 360,000	(7.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,126,008		$ 3,323,903	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,531,621		$ 3,642,252	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,911,125		$ 5,853,388	
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)	$ 7,442,746		$ 9,495,640	
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)	$ 12,199,625		$ 14,269,094	
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)	$ 69,577,045		$ 66,751,514	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 81,827,246		$ 81,020,608	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 410,710	$ 407,356
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 586,765	$ 418,188
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 56,664,702	$ 51,207,354
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,378,186	$ 4,416,629
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,514,742	$ 2,479,088
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,531	$ 258,795
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,771,630	$ 4,622,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 292,096	$ 409,924
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 559,056	$ 50,618
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,127,101	$ 1,003,096
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 135,900	$ 150,407
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	$ 326,031	$ 368,215

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 559,595	$ 480,951
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > NBS State Evaluation		$ 45,477
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > NBS New Condition Implementation (SMA)		$ 28,930
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > NBS 4915		$ 43,515
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives		$ 360,597

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: At the time of submission, 100% of the funds have been obligated or expended. Less than 10% of the $4,773,454 total award remains obligated but not yet expended. All funds will be expended/paid out within the required time frame.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The agency's indirect cost rate increased after the budget was developed so actual amount expended was more than estimated.	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Local agencies contributed a higher amount into their Aid to Local match than budgeted/anticipated.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Did not qualify for the new grant under the renewal criteria.	

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 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 712,457	$ 724,775
2. Infants < 1 year	$ 712,458	$ 724,776
3. Children 1 through 21 Years	$ 1,501,567	$ 1,469,985
4. CSHCN	$ 1,462,990	$ 1,493,918
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 4,389,472	$ 4,413,454

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 1,614,823	$ 1,937,878
2. Infants < 1 year	$ 1,614,823	$ 1,937,878
3. Children 1 through 21 Years	$ 3,020,524	$ 3,057,432
4. CSHCN	$ 1,417,287	$ 2,562,452
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 7,667,457	$ 9,495,640
Federal State MCH Block Grant Partnership Total	$ 12,056,929	$ 13,909,094

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 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 65,450	$ 46,805
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	$ 65,450	$ 46,805
2. Enabling Services	$ 1,467,308	$ 1,697,630
3. Public Health Services and Systems	$ 3,186,714	$ 3,029,019
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		$ 12,017
Physician/Office Services		$ 12,532
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 15,886
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 3,722
Laboratory Services		$ 0
Other		
Audiology		$ 610
Interpreter, travel, honorariums		$ 2,038
Direct Services Line 4 Expended Total		$ 46,805
Federal Total	$ 4,719,472	$ 4,773,454

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 49,413	$ 14,321
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	$ 14,321
2. Enabling Services	$ 4,371,274	$ 4,977,889
3. Public Health Services and Systems	$ 3,246,770	$ 4,503,430
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		$ 478
Physician/Office Services		$ 5,488
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 601
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 4,990
Laboratory Services		$ 60
Other		
Audiology		$ 87
Interpreter, travel, honorariums		$ 2,617
Direct Services Line 4 Expended Total		$ 14,321
Non-Federal Total	$ 7,667,457	$ 9,495,640

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: 37,771 **Data Source Year: 2018**

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	37,480 (99.2%)	835	155	155 (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 (KS-SHCN/Title V) 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 KS-SHCN program and supports that they can offer. A KS-SHCN application for assistance is enclosed. If the family applies for assistance through the KS-SHCN program and are financially eligible for assistance, they are assigned a KS-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:**	**Data Source Year**
	Fiscal Year:	**2019**
	Column Name:	**Data Source Year Notes**
	Field Note: Data Source Year = Calendar Year 2018 (January 1, 2018 through December 31, 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 2019

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	6,616	41.2	0.1	26.3	26.6	5.8
2. Infants < 1 Year of Age	3,779	53.6	0.3	30.8	11.5	3.8
3. Children 1 through 21 Years of Age	18,009	42.4	1.4	20.8	27.4	8.0
3a. Children with Special Health Care Needs	2,102	52.8	0.1	22.2	4.2	20.7
4. Others	5,753	32.2	0.1	28.9	17.8	21.0
Total	34,157					

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	36,261	No	40,115	92	36,906	6,616
2. Infants < 1 Year of Age	37,770	No	37,771	100	37,771	3,779
3. Children 1 through 21 Years of Age	837,605	Yes	837,605	21	175,897	18,009
3a. Children with Special Health Care Needs	167,605	Yes	167,605	3	5,028	2,102
4. Others	2,037,461	Yes	2,037,461	14	285,245	5,753

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**

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.

Programs and services included: MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a
Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) and MCH DAISEY non-direct entry grantees' aggregate reports.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**

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.

Programs and services included: MCH DAISEY direct entry grantees (MCH, Universal Home Visiting), MCH DAISEY non-direct entry grantees' aggregate reports, newborn metabolic screening follow-ups, critical congenital heart defects follow-ups, and newborn hearing follow-ups.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**

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.

Programs and services included: MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a
Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management), MCH DAISEY non-direct entry grantees' aggregate reports, and children and youth with special health care needs in the Kansas Special Health Care Needs (SHCN) Program.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
Children and youth special health care needs (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.

Programs and services included: CYSHCN in the Kansas Special Health Care Needs (SHCN) Program, MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) and MCH DAISEY non-direct entry grantees' aggregate reports.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**

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.

Programs and services included: MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a
Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) and MCH DAISEY non-direct entry grantees' aggregate reports.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**

Field Note:
Numerator: Outreach by MCH grantees (22,000) + Kansas Infant Death and SIDS Network (1,172) + Kansas Breastfeedin Coalition (7,216) + direct/enabling services (6,616) = 37,004

Denominator: 2018 Pregnancy outcomes (live births + stillbirths + abortions) = 40,115

Total % Served = 37,004 / 40,115 = 92.0%

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**

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:	**2019**

Field Note:
Numerator: Outreach by MCH grantees (79,389) + Direct/enabling services (18,009) = 176,787

Denominator: Reference Data = US Census Bureau Population Estimates, 2018= 837,605

Total % Served = 176,787 / 837,605 = 21%

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
Numerator: SHCN outreach through presentations and booths (Kansas Youth Leadership Forum, TARC, Sunflower MCO, Fort Riley Family Conference, KS Vision Summit, Safe Kids Day at the Zoo, Child Abuse and Neglect Conference, etc.) (2,102) + SHCN Direct/enabling services (2,635) = 4,737

Denominator: Reference Data = National Survey of Children's Health CSHCN Prevalence Estimates 1-17 (2017-2018) multiplied by US Census Bureau Population Estimates 1-21, 2018 = 167,605

Total % Served = 4,737 / 167,605 = 2.8%
Note: TVIS allows only integer... thereby 2.8% was rounded to 3%. 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:	**2019**

Field Note:
Numerator: Outreach by MCH Grantees (22,621) + Direct service (5,753) = 28,374

Denominator: Reference Data = 2,037,461

Total % Served = 28,374 / 2,037,461 = 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 2019

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	37,958	26,302	2,783	6,196	148	1,226	71	289	943
Title V Served	6,616	3,804	488	1,877	32	136	21	145	113
Eligible for Title XIX	11,185	6,499	1,605	2,154	169	2	12	0	744
2. Total Infants in State	37,771	26,186	2,764	6,159	148	1,223	69	285	937
Title V Served	3,779	2,032	288	1,132	20	83	8	81	135
Eligible for Title XIX	15,690	1,881	659	1,592	21	1	0	0	11,536

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	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 244-5373	(800) 244-5373
2. State MCH Toll-Free "Hotline" Name	1-800-CHILDREN, Parent Helpline	1-800-CHILDREN; Parent Helpline
3. Name of Contact Person for State MCH "Hotline"	Kelli Mark	Kelli Mark
4. Contact Person's Telephone Number	(785) 296-6136	(785) 296-6316
5. Number of Calls Received on the State MCH "Hotline"		1,495

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names		
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		102

Form Notes for Form 7:

The State MCH 'hotline' transitioned from the Kansas Resource Guide to the Parent Helpline (1-800-CHILDREN) through the Kansas Service Children's League in November 2018. Data included for the number of calls to the "hotline" are potentially duplicated counts from:
- KRG from October 2018 through December 2018 (51 calls)
- KCSL from November 2018 through September 2019 (1,444 calls)

Hits to the MCH Website (www.kansasmch.org) are listed as "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 the website (e.g. browses pages, downloads resources, purchase products) before they leave equals one session. Sessions during State Fiscal Year (SFY19) was 3,664.

Hits to Facebook page (www.facebook.com/kansasmch) are reported as the difference of the number of "Likes" to the Facebook page at the beginning and end of the reporting period. (October 2018 - 365, September 2019 - 467, difference of 102 "new" likes).

Alternatively, the top 10 MCH Facebook Posts reached 13,516 Views, 150 Shares, and 202 Reactions.

Form 8
State MCH and CSHCN Directors Contact Information

State: Kansas

1. Title V Maternal and Child Health (MCH) Director	
Name	Rachel Sisson
Title	Bureau of Family Health Director
Address 1	1000 SW Jackson Street
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	System of Supports Section Director
Address 1	1000 SW Jackson Street
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 Leader/Delegate
Address 1	11008 W. Greenspoint
Address 2	
City/State/Zip	Wichita / KS / 67205
Telephone	(316) 573-7097
Extension	
Email	cassandra.sines@gmail.com

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Kansas

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	Revised
2.	All infants and families have support from strong community systems to optimize infant health and well-being.	New
3.	Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.	Revised
4.	Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health.	Revised
5.	Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	New
6.	Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations.	Revised
7.	Strengths-based services and supports are available to promote healthy families and relationships.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

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
2018	83.4 %	0.2 %	30,043	36,025
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
2017	55.9	4.1	190	33,975
2016	54.7	4.0	192	35,104
2015	69.1	5.1	184	26,635
2014	60.4	4.1	215	35,615
2013	61.1	4.2	216	35,360
2012	59.5	4.0	218	36,663
2011	59.6	4.1	217	36,411
2010	57.5	3.9	214	37,231
2009	55.7	3.8	215	38,634
2008	46.0	3.4	180	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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	14.8	2.8	28	189,210

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - 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
2018	7.4 %	0.1 %	2,676	36,239
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
2018	9.5 %	0.2 %	3,440	36,241
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
2018	26.3 %	0.2 %	9,524	36,241
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
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
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:

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
2017	6.0	0.4	218	36,609
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
2017	6.0	0.4	220	36,519
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
2017	4.3	0.3	156	36,519
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
2017	1.8	0.2	64	36,519
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
2017	210.8	24.1	77	36,519
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
2017	104.1	16.9	38	36,519
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. We are looking into adding the question in the PRAMS Phase 9 questionnaire as a supplemental question, since it is supposed to be in the same skip pattern with the other alcohol questions we ask.

Please note that the CDC PRAMS was planning to deploy Phase 9 of the PRAMS survey in 2022. However, for the following reasons, the questionnaire revision will be delayed beyond a 2022 deployment:

• CDC is undertaking an agency-wide IT modernization initiative to improve surveillance tools and technology, which may have implications for PRAMS
• COVID-19 pandemic response activities are causing disruption in the availability of CDC staff and partners who will need to be involved in the questionnaire development process

CDC does not have a new target date for when the Phase 9 questionnaire will be implemented at this time.

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
2017	3.7	0.3	124	33,485
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
2017_2018	10.5 %	1.3 %	69,556	662,016
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
2018	16.3	2.2	57	350,517
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
2018	39.9	3.2	160	400,720
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
2016_2018	14.3	1.5	86	601,067
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
2016_2018	17.8	1.7	107	601,067
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
2017_2018	20.3 %	1.8 %	144,559	710,381
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
2017_2018	18.8 %	3.5 %	27,244	144,559
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
2017_2018	2.4 %	0.9 %	13,979	588,013
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
2017_2018	10.0 %	1.3 %	58,095	583,358
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
2017_2018	52.7 %	6.3 %	48,827	92,697
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
2017_2018	93.5 %	1.2 %	663,109	709,356
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
2016	12.5 %	0.2 %	3,032	24,306
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 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: 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
2017_2018	12.2 %	2.2 %	35,950	295,757
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
2018	5.0 %	0.5 %	35,488	703,140
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
2018	74.7 %	3.9 %	42,106	56,384
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 width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable 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
2018_2019	63.3 %	2.0 %	422,840	667,678
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 because the relative standard error is >0.3.

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
2018	62.3 %	3.4 %	123,056	197,586
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	89.4 %	2.2 %	176,610	197,586
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	75.3 %	3.0 %	148,781	197,586
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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 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
2018	20.0	0.5	1,933	96,791
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
2018	14.7 %	1.6 %	4,930	33,605
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
2017_2018	2.0 %	0.5 %	13,994	708,029
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**	**2019**
Annual Objective	73.7	75.7	63.6	65.7
Annual Indicator	65.1	61.0	64.8	71.4
Numerator	317,072	294,297	311,046	351,350
Denominator	486,998	482,804	480,042	492,351
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	73.4	74.4	75.4	76.5	77.5	78.5

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	84.8
Numerator	28,021
Denominator	33,030
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	86.1	87.4	88.7	90.0	91.4

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	37.0
Numerator	11,666
Denominator	31,547
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	38.9	40.8	42.8	45.0	47.2

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	49.1
Numerator	15,627
Denominator	31,810
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	51.6	54.1	56.8	59.7	62.7

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**	**2019**
Annual Objective			43.7	39.7
Annual Indicator		41.6	37.8	34.6
Numerator		33,290	30,554	27,890
Denominator		79,958	80,931	80,611
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	36.3	38.1	40.1	42.1	44.2	46.4

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**	**2019**
Annual Objective			80.8	78.5
Annual Indicator		79.8	77.5	77.5
Numerator		185,414	184,888	184,888
Denominator		232,249	238,418	238,418
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	78.5	79.4	80.4	81.4	82.5	83.5

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2019
Annual Objective	
Annual Indicator	20.9
Numerator	13,192
Denominator	63,103
Data Source	NSCH-CSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	21.9	23.0	24.2	25.4	26.7

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Kansas

2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	87.2	88.6	90	89.7
Annual Indicator	83.8	77.1	83.6	88.0
Numerator	32,783	29,183	30,314	29,928
Denominator	39,126	37,866	36,276	34,017
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective	87.2	88.6	90	89.7
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	

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	27.7	29.4	26	26.8
Annual Indicator	23.4	24.5	26.1	31.4
Numerator	9,025	9,095	9,159	10,404
Denominator	38,643	37,166	35,100	33,125
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	80.9	75.1	114.5	113.4
Annual Indicator	80.8	135.5	116.4	119.1
Numerator	325	406	461	468
Denominator	402,420	299,709	395,930	392,943
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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**	**2019**
Annual Objective			39.6	48.4
Annual Indicator		38.6	46.1	52.3
Numerator		56,808	68,059	75,646
Denominator		147,272	147,776	144,559
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	11.4	10.7	9.5	9.4
Annual Indicator	11.0	10.2	10.1	9.5
Numerator	4,298	3,877	3,683	3,440
Denominator	39,083	37,965	36,434	36,155
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective	11.4	10.7	9.5	9.4
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	

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Kansas

SPM 1 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	14.7
Numerator	4,930
Denominator	33,605
Data Source	PRAMS
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	14.0	13.3	12.6	12.0	11.4

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	31.4
Numerator	10,404
Denominator	33,125
Data Source	NIS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	32.2	33.0	33.8	34.7	35.5

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of participants that report increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	70.0	75.0	80.0	85.0	90.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data Source: MCH sponsored workforce post-event surveys (To be developed)

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	55.9
Numerator	389,023
Denominator	695,564
Data Source	NSCH
Data Source Year	2017-2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	58.7	51.6	64.7	67.9	71.3

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of preterm births (<37 weeks gestation)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		8.3	8.9	9.1
Annual Indicator	8.8	9.1	9.6	9.5
Numerator	3,426	3,457	3,492	3,440
Denominator	39,105	38,033	36,440	36,239
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: 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**	**2019**
Annual Objective		29.6	35.4	28
Annual Indicator	28.2	32	26.7	26.8
Numerator	133,276	77,678	60,041	63,077
Denominator	473,426	242,379	224,657	234,934
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2016	2016-2017	2017-2018
Provisional or Final ?	Final	Final	Final	Final

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.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: NSCH 2016, 2016-2017, and 2017-2018 data cannot be compared with previous years.	

2016-2020: SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			55	100
Annual Indicator	36	50	93	76
Numerator				
Denominator				
Data Source	KIDS Network	KIDS Network	KIDS Network	KIDS Network
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: 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**	**2019**
Annual Objective		44.7	7	6.8
Annual Indicator	47	7.2	7.9	7.9
Numerator	987,775			
Denominator	2,101,649			
Data Source	Kaiser Family Foundation	BRFSS	BRFSS	BRFSS
Data Source Year	2008	2016	2018	2018
Provisional or Final ?	Provisional	Final	Final	Final

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.

2016-2020: SPM 6 - Number of MCH grantees, families and partners that participated in a state sponsored workforce development event

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			1,000
Annual Indicator			1,126
Numerator			
Denominator			
Data Source			State sponsored workforce development events
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
State sponsored workforce development events include:
* Kansas Connecting Communities (KCC) Every Mom Thrives Regional Training Event
* Kansas Connecting Communities (KCC) Project ECHO Series:
ECHO Session 1: Screening for Behavioral Health and Substance Use for Pregnant and Postpartum Women
ECHO Session 2: Brief Interventions
ECHO Session 3: Referral to Treatment
ECHO Session 4: Implementation Strategies to Overcome Barriers in the Medical Setting
* REACH Institute's Patient-Centered Mental Health in Pediatric Primary Care: A mini-fellowship program for medical professionals
* MCH TA Webinars (workforce development)
* MCH Check-In Meetings (one-on-one)
* MCH Site Visits (one-on-one)
* MCH-HV Fall Trainings (workforce development)
* Regional C&F Meeting (workforce development)
* Governor's Public Health Conference (workforce development)

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Kansas

ESM 1.1 - Percent of women program participants (18-44 years) with a preventive medical visit in the past year

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	78.5
Numerator	5,412
Denominator	6,896
Data Source	DAISEY
Data Source Year	2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	80.5	82.5	84.5	86.6	88.8

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Preliminary data subject to change
   Include: MCH, Kansas Perinatal Community Collaborative (Becoming a Mom), Pregnancy Maintenance Initiative, and Teen Pregnancy Targeted Case Management Program

ESM 5.1 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	93.3
Numerator	223
Denominator	239
Data Source	DAISEY
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	94.2	95.2	96.1	97.1	98.1

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Preliminary data as of 6/17/2020 - subject to change

ESM 5.2 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (B) in a crib/bassinet or portable crib

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	89.5
Numerator	214
Denominator	239
Data Source	DAISEY
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	91.3	93.1	95.0	96.9	98.8

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Preliminary data as of 6/17/2020 - subject to change

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

Measure Status:				Active
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		90	72.7	25
Annual Indicator	12.7	21.4	22.3	15
Numerator	243	347	340	256
Denominator	1,907	1,621	1,524	1,707
Data Source	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	27.5	30.0	32.5	35.0	37.5	40.0

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	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Preliminary data subject to change CY2019: MCH service data	

ESM 10.1 - Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	36.5
Numerator	873
Denominator	2,394
Data Source	DAISEY
Data Source Year	2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	38.3	40.2	42.3	44.4	46.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Preliminary data subject to change
CY2019: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data

ESM 12.1 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	50
Numerator	2
Denominator	4
Data Source	Welligent
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	52.5	55.1	57.9	60.8	63.8

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: SFY2019	

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: 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**	**2019**
Annual Objective		20	30	30
Annual Indicator	24.7	28	25.9	25.1
Numerator	1,604	1,773	1,702	2,147
Denominator	6,496	6,335	6,578	8,570
Data Source	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

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.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Preliminary data - subject to change CY2019: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom data	

2016-2020: 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**	**2019**
Annual Objective		22.5	15	17.5
Annual Indicator	14.1	13.9	13.7	13.1
Numerator	943	990	966	1,319
Denominator	6,671	7,121	7,075	10,035
Data Source	KWIC	KWIC	KWIC	KWIC
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	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)

2.	**Field Name:**	**2017**
	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)

3.	**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)

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Preliminary data - subject to change

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)

2016-2020: 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**	**2019**
Annual Objective		1,050	1,100	1,000
Annual Indicator	969	1,094	961	1,019
Numerator				
Denominator				
Data Source	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office	Kansas Traffic Safety Resource Office
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.1 - Percent of adolescent program participants, ages 12 through 21, that had a well-visit during the past 12 months

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		30	40.3	32.5
Annual Indicator	24.4	32.6	30.3	48.1
Numerator	1,098	1,318	1,118	1,919
Denominator	4,492	4,042	3,690	3,986
Data Source	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

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	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Preliminary data subject to change CY2019: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data	

2016-2020: 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**	**2019**
Annual Objective		5	5	70
Annual Indicator	0	0	66.7	62.9
Numerator			18	22
Denominator			27	35
Data Source	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

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.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: SFY2019	

2016-2020: 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**	**2019**
Annual Objective		15	30	50
Annual Indicator	31.1	38.9	43.5	32
Numerator	42	96	104	89
Denominator	135	247	239	278
Data Source	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

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	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Preliminary data - subject to change CY2019: 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 women who experience postpartum depressive symptoms following a recent live birth
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the prevalence of postpartum depression
Definition:	**Numerator:** Number of women who report postpartum depressive symptoms following a recent live birth (defined as reporting always/often feeling down, depressed, hopeless or always/often having little interest or little pleasure in doing things) **Denominator:** Number of women with a recent live birth **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) 34: Decrease the proportion of women delivering a live birth who experience postpartum depressive sympoms (Developmental)
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Postpartum depression is common, affecting as many as 1 in 7 mothers. It occurs when brief “baby blue” symptoms of crying, sadness, and irritability become severe and result in depressed mood and loss of interest in activities for more than two weeks. Postpartum depression is associated with poor maternal-infant bonding and may negatively influence child development. Universal screening and treatment for pregnant and postpartum women is recommended by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force. Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. American Journal of Obstetrics & Gynecology. 2009;200(4):357-364. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3918890/ Screening for perinatal depression. Committee Opinion No. 630. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:1268–71. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

SPM 2 - Percent of infants breastfed exclusively through 6 months
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the proportion of infants who are breastfed exclusively through 6 months
Definition:	**Numerator:** Number of infants breastfed exclusively through 6 months **Denominator:** Number of infants born in a calendar year **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 21.1: Increase the proportion of children who are ever breastfed (Baseline: 74% in 2006, Target: 81.9%) Related to Maternal, Infant, and Child Health (MICH) Objective 21.5: Increase the proportion of children who are breastfed exclusively at (Baseline: 14.1% in 2006, Target: 25.5%)
Data Sources and Data Issues:	National Immunization Survey (NIS)
Significance:	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer. American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics. 2012 Mar;129(3):e827-41. http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552

SPM 3 - Percent of participants that report increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the number of MCH grantees, families and partners who report increased self-efficacy in translating knowledge into practice
Definition:	

Numerator:	Number of participants who reported increased self-efficacy after attending a state sponsored workforce development event
Denominator:	Number of participants who attended a state sponsored workforce development event
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	Related to Public Health Infrastructure (PHI) 2: Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals.
Data Sources and Data Issues:	MCH Sponsored Workforce Post-Event Surveys (To be developed)
Significance:	For providers, families, and stakeholders, it is critical that new information be incorporated and applied to gain the most benefit. Knowledge translation (translating education and knowledge into practice) is therefore an important element of training and education to improve care provision and healthcare outcomes for the maternal and child health population.

SPM 4 - Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To ensure supportive programs for families of children (age 0-17) that face problems
Definition:	**Numerator:** Children whose family members know all of the time they have strengths to draw on when the family faces problems **Denominator:** Children age 0-17 years **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Children and families representing all types of demographics and socioeconomic backgrounds will experience stress. Resilience is a key factor that helps to determine how a family can navigate the stress that rises when a family faces a problem. Resilience is critical to a child's ability to navigate through stressful events – even those that are traumatic – successfully. Resilience provides a buffer between the child and the traumatic event, mitigating the negative effects that could result, such as physical, emotional, and behavioral health issues that can last even into adulthood. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Promoting-Resilience.aspx Having strengths such as developmental knowledge, good parental mental health and coping mechanisms, positive social connections, concrete supports in times of need (e.g., food, developmental services) can all help families to face problems as they arise which helps both the family and children better cope with stressors that emerge when families face problems. https://www.aap.org/en-us/Documents/resilience_messaging-at-the-intersections.pdf

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: 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.

2016-2020: 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.

2016-2020: 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.

2016-2020: 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.

2016-2020: 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) with a preventive medical 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 increase the number of women that receive well visits/preventive health care
Definition:	**Numerator:** Number of women program participants (18-44 years) who have had a well visit during the last 12 months **Denominator:** Number of women program participants (18-44 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:	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, immunizations, screening, education, and counseling.

ESM 5.1 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the percent of infants placed to sleep on their backs and on a separate approved surface, without soft objects or loose bedding
Definition:	

Numerator:	A) Number of mothers reporting that they place their baby to sleep on their back
Denominator:	Number of infants with information reported
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Kansas Perinatal Community Collaborative (KPCC)/Becoming a Mom (BaM) Birth Outcome Card
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. http://pediatrics.aappublications.org/content/128/5/1030

ESM 5.2 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (B) in a crib/bassinet or portable crib
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the percent of infants placed to sleep on their backs and on a separate approved surface, without soft objects or loose bedding
Definition:	**Numerator:** B) Mothers reporting that their baby sleeps in a crib/bassinet, or portable crib **Denominator:** Infants with information reported **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Kansas Perinatal Community Collaborative (KPCC)/Becoming a Mom (BaM) Birth Outcome Card
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. http://pediatrics.aappublications.org/content/128/5/1030

ESM 6.1 - Percent of children, ages 9 through 35 months, who received a parent-completed developmental screen during an infant or child visit provided by a participating program
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 increase the percent of children who receive a developmental screening
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
Denominator:	Number of children, age 9 through 35 months
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:	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 (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006 Jul;118(1):405-20. http://pediatrics.aappublications.org/content/118/1/405

ESM 10.1 - Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase the percent of adolescents who have a preventive medical visit
Definition:	**Numerator:** Adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months **Denominator:** Adolescent program participants, ages 12 through 17 **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 a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. The Bright Futures guidelines recommends that adolescents have an annual checkup from age 11 through 21. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety. The adolescent well-care visit measure for health plans is part of the core measure sets for Medicaid and the National Committee for Quality Assurance. National Adolescent and Young Adult Health Information Center (2016). Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to age 18. http://nahic.ucsf.edu/adolescentguidelines.

ESM 12.1 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To ensure that youth with special health care needs are better equipped to transition into adult life
Definition:	

Numerator:	Number of youth program participants with special healthcare needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date
Denominator:	Number of youth program participants with special healthcare needs, ages 12 to 21
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	KS-SHCN Care Coordination Measurement Tool (Welligent)
Significance:	The transition of youth to adulthood, including the movement from a child to an adult model of healthcare, has become a priority issue nationwide as evidenced by the 2011 clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Poor health has the potential to impact negatively the youth and young adults' academic and vocational outcomes. Over 90 percent of children with special health care needs now live to adulthood but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. American Academy of Pediatrics; American Academy of Family Physicians; American College of Physicians-American Society of Internal Medicine. A consensus statement on health care transitions for young adults with special health care needs. Pediatrics. 2002 Dec;110(6 Pt 2):1304-6. http://pediatrics.aappublications.org/content/110/Supplement_3/1304.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: 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.

2016-2020: ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding
2016-2020: 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.

2016-2020: ESM 7.1.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians
2016-2020: 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.

2016-2020: ESM 10.1 - Percent of adolescent program participants, ages 12 through 21, that had a well-visit during the past 12 months
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase the percent of adolescents who have a preventive medical visit
Definition:	**Numerator:** Number of adolescent program participants, ages 12 through 21, that had a well-visit during the past 12 months **Denominator:** Number of adolescent program participants, ages 12 through 21 **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 a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. The Bright Futures guidelines recommends that adolescents have an annual checkup from age 11 through 21. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety. The adolescent well-care visit measure for health plans is part of the core measure sets for Medicaid and the National Committee for Quality Assurance. National Adolescent and Young Adult Health Information Center (2016). Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to age 18. http://nahic.ucsf.edu/adolescentguidelines.

2016-2020: 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.
2016-2020: 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.

2016-2020: ESM 14.1.1 - Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services
2016-2020: 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