



# Maternal and Child Health Services Title V Block Grant KANSAS

FY 2022 Application/  
FY 2020 Annual Report

**Submitted:**  
August 30, 2021

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



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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



Phone: 785-296-0461  
[www.kdheks.gov](http://www.kdheks.gov)

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

September 1, 2021

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 2022 Title V Maternal and Child Health Services Block Grant Application and FFY 2020 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](mailto: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 2021 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: January 31, 2024.

## **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: January 31, 2024.*

### 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](http://www.kdheks.gov/bfh) • [www.kansasmch.org](http://www.kansasmch.org) • [facebook.com/kansasmch](https://facebook.com/kansasmch)

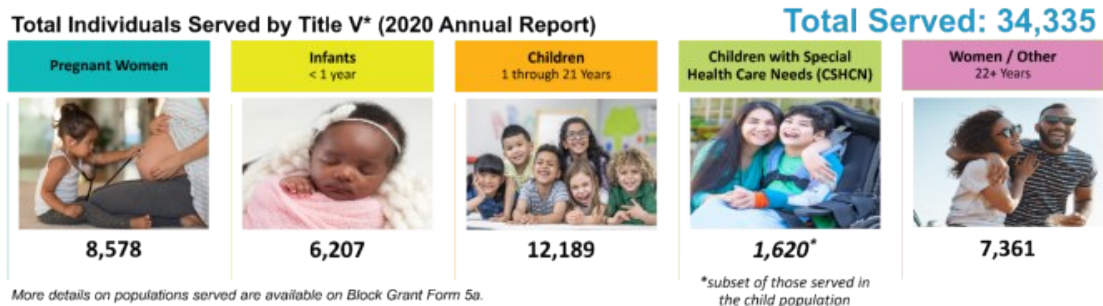
##### Title V Overview

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 627 cities. The US Census Bureau estimates there were approximately 2,913,314 residents living in the state in 2019, a 0.1% increase from 2018. Kansas has a unique geographic layout that ranges from urban to frontier counties based on population density. The population density of Kansas was 35.6 inhabitants per square mile in 2019, an 8.2% increase from 32.9 in 2000. In 2019, there was an estimated 35,325 infants or 1.2% of the total population and 833,794 children and adolescents (ages 1-21) representing 28.6%. The number of females in the reproductive/child-bearing age group (ages 15-44) was 561,891, representing 19.3%. In 2018-2019, 20.5% of children ages 0 to 17 (est. 144,750) were identified as having special health care needs. About 20.2% of males under 18 had special health care needs, compared with 20.8% of females.










## 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 2022)

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

 <b>Women/Maternal Health</b> Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	 <b>Perinatal/Infant Health</b> All infants and families have support from strong community systems to optimize infant health and well-being.
 <b>Child Health</b> Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.	 <b>Adolescent Health</b> Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.
 <b>Children with Special Health Care Needs</b> Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	 <b>Cross-Cutting #1: MCH Workforce</b> Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.
 <b>Cross-Cutting #2: Families</b> Strengths-based supports and services are available to promote healthy families and relationships.	

### Title V MCH Performance Measures (FFY 2021-2025)

Kansas selected five national and four state performance measures to address the priorities outlined above. The national performance measures (NPMs) utilize national data sources to track state-level prevalence rates to determine the impact of activities on the populations served. State must select at least one NPM for each of the maternal and child health population domains (women/maternal, perinatal/infant, child, adolescent, children with special health care needs). The state performance measures (SPMs) were selected where a NPM was not available or appropriate for the state's identified priorities or objectives. The selected measures are outlined below.

National Performance Measures (NPMs)	State Performance Measures (SPMs)
NPM1: Well-woman Visit (Women 18-44 Years)	SPM1: Postpartum Depression
NPM5: Safe Sleep	SPM2: Breastfeeding Exclusivity
NPM6: Developmental Screening	SPM3: Workforce Development
NPM10: Adolescent Preventive Medical Visit	SPM4: Strengths-based Family Supports
NPM12: Transition To Adulthood	



## 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 complete Block Grant Application and Report to learn more about these and other activities [www.kdheks.gov/c-f/mch.htm](http://www.kdheks.gov/c-f/mch.htm).

### Women/Maternal & Perinatal/Infant Health

*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?” Nearly 1 in 4 mothers who had a live birth in 2018 (23.2%) reported that their pregnancies were unintended. All local MCH programs ask the OKQ® at every client visit and use it to guide follow up and referrals.

*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 3<sup>rd</sup> trimester of pregnancy. From the time of launch in August of 2018 to October of 2020, over 309 total orders of free educational materials were made by providers, equating to 95,805 pieces of educational materials being distributed. Over 4,800 Kansans have visited the CTK website seeking more information about kick counting and more than 1,680 expectant parents have downloaded the free app to track their baby’s movements. In 2019, there were 192 stillbirths reported for Kansas resident mothers, a decrease of 2% from 2018.

*Maternal Mortality*: The [Kansas Maternal Mortality Review Committee](#) (KMMRC) is a collaboration among Title V and key partners to review pregnancy-related deaths, identify causes, and implement interventions to prevent future occurrences. The first [Kansas Maternal Mortality and Morbidity Report](#) was published in January 2021. Information and data collected from cases resulted in formal recommendations that led to the Fourth Trimester Initiative, focused on quality care and provider communication related to the transition from pregnancy through the postpartum period. Enrollment in the Alliance for Innovation on Maternal Health (AIM) is planned for fall 2021.

*Perinatal Quality & Systems of Care*: The [Kansas Perinatal Quality Collaborative](#) (KPQC) is partnership with a panel of experts to improve the safety and quality of care for mothers and infants. The KPQC focus from 2018-2020 was state-level response to address [Neonatal Abstinence Syndrome \(NAS\)](#) using the Vermont Oxford Network (VON) [NAS Training Program](#). A total of 32 hospitals enrolled, accounting for ~84% of births. All four aims related to the NAS quality initiative were met or exceeded. As of November 2020, Kansas achieved the designation of a NAS *State of Excellence* with many hospitals identified as a *Center of Excellence* (one of only two statewide collaboratives in the nation to achieve this). The Fourth Trimester Initiative, resulting from findings from the KMMRC, is the current quality initiative underway, focused on improving maternal health and preventing severe maternal morbidity and mortality.

*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 reveal 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 (KPCCs have a lower preterm birth rate than the state, 4.4% compared to 10.1%).

**Breastfeeding:** Title V works closely with partners to provide consistent messaging around breastfeeding and leverage resources at the state and local levels. 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.

**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 Network 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.

**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, the Title V Behavioral Health Consultant position oversees two federally funded projects focused on behavioral health – [Kansas Connecting Communities](#) (launched October 2018) and [KSKidsMAP to Mental Wellness](#) (launched July 2019).

**Youth Health Initiatives:** The [Youth Health Guide](#) and [WHY \(Whole Healthy You\) Campaign](#), brings attention to health awareness events and supports 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.

*Transition to Adulthood:* Throughout the Title V Needs Assessment and implementation of the HCC model, transition planning for youth and adolescents ages 12 and older has been an identified service gap. 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), Title V will work with YSHCN to develop goals that meet their needs and help with in self-care and self-advocacy.

*Systems of Care for CSHCN:* Focus remains on the implementation and advancement of the National Standards for Children with Special Health Care Needs and the [Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs](#), a road map developed in 2018 to strengthen services and supports for CSHCN and their families. To support stronger systems, Kansas Title V will continue to seek opportunities to establish local- and state-level datasets to inform about the CSHCN population and their needs.

### **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.

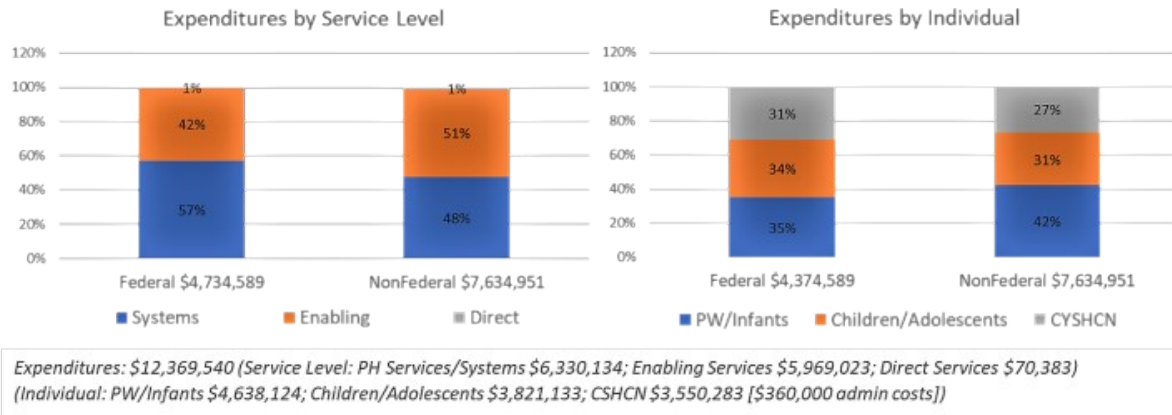
*Family & Consumer Partnership (FCP) Program:* Title V is building a formal partnership program with families through peer supports, family leadership, and advisory opportunities. This will serve as a framework for local and state Title V programs to assure families are engaged at the level they desire. 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 estimated budget for FFY2022 totals \$12,514,853 (federal funds \$4,637,310; state funds \$3,821,044; local funds \$4,056,499). Federal and State MCH funds totaling more than \$5M is allocated for FY2022 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 Complement State-Supported MCH Efforts

Activities and services funded by the Block Grant are essential to maintaining a strong infrastructure, developing and coordinating systems, and filling identified gaps. Federal funds truly complement state and local funds to support a comprehensive service delivery model that advances the State Action Plan and aims to improve outcomes across the life course. Most federal funds are utilized to support the MCH and SHCN state staff and operations along with local services through aid to local grants/programming. Nonfederal funds are utilized to meet the required federal match through state and local investments across the population domains (newborn screening, local grants, specialty services for SHCN). Local grantees are required to provide at least 40% match for grant funds which results in additional MCH system supports. The charts below display federal vs. nonfederal expenditures by service level and individual/population.



The availability of federal funds coupled with state flexibility continues to assure the health of individuals during critical periods such as preconception, pregnancy and postpartum, childhood, and adolescence/young adulthood. Critical contributions to the state's public health infrastructure are evident through the development, implementation, and ongoing sustainability of efforts aimed at:

- addressing maternal mortality, morbidity, and behavioral health;
- expanding community coordination, clinical care, and supports like home visiting during the prenatal and postnatal periods to include access to group prenatal education birth outcomes model and risk assessment, brief intervention, and referral to services;
- establishing a precedence for family and consumer partnership across all MCH population domains, among both internal and external partners;
- enhancing local communities and the statewide MCH workforce capacity to address health equity and social determinants of health through targeted technical assistance;
- enhancing local communities' capacity to develop school-based health centers to expand access to care for children and adolescents, particularly the well visit; and
- demonstrating value for a holistic approach to care coordination for the children with special health care needs population to drive change among all populations.

Families of CSHCN needs rely on Title V to continue to advocate and expand access to appropriate services. Investments from Title V allow financial assistance to fill gaps in coverage and sustain regional access points for entry into the state/federal program. The flexibility for the program to serve beyond state statutory limitations and consider gap-filling services, continues to increase access to family-centered, community-based, coordinated care.



### III.A.3. MCH Success Story

#### ***Access to Perinatal Mental Health Care in Sedgwick County***

A spotlight on one local MCH Opportunity Project

The University of Kansas Center for Community Health and Development (KU-CCHD) and Title V partnered with local MCH agencies to assure equal opportunities for MCH populations, regardless of income, education, age, race/ethnicity, or where people live. Through a learning collaborative model, Title V provided funding and KU-CCHD provided support and technical assistance utilizing the [Kansas Healthy Communities Action Toolkit](#), including capacity-building webinars with peer-to-peer learning and sharing, as well as one-on-one technical assistance.

One of these projects, collaboration between the [Center for Research for Infant Birth and Survival](#) (CRIBS), the [Kansas Infant Death and SIDS \(KIDS\) Network](#), and the Sedgwick County Health Department (SCHD), focused on improving access to perinatal mental health services for low income pregnant and postpartum women. Women with low socioeconomic status are at an increased risk for perinatal mood and anxiety disorders (PMADs), which may lead to unfavorable health outcomes during and after pregnancy. Access to mental health services is an identified barrier for these high-risk women. In Sedgwick County, it was identified that up to 1,728 perinatal women could suffer from PMADs, and that leaving even 1% of these women without treatment options could cost their community over \$375,000 a year in related costs (such as health care and employment-related losses).

To identify barriers to perinatal mental health services, interviews were collected from three groups of key stakeholders including: pregnant and postpartum women, primary care providers, and perinatal mental health care providers. Community experts reviewed the interview transcripts to identify themes by population group and develop action steps on how to improve access to perinatal mental health services. Barriers uncovered included transportation, cost/lack of insurance, access to child care, lack of knowledge (women and providers), scheduling, patient/provider communication, lack of social support, stigma, lack of collaboration among providers, and Medicaid limitations. This project team plans to continue collaborative work, with other community partners, to increase access to mental health services for vulnerable perinatal women. This MCH Opportunity Project allowed the community to collect baseline data, collaborate with community experts and develop the action steps noted below.

#### **SEDGWICK COUNTY COMMUNITY ACTION STEPS**

- Identify best practices in other states or countries for addressing perinatal mental health.
- Increase the number of providers who can screen, diagnose and treat perinatal mental health disorders (training and recruitment efforts).
- Increase health care provider knowledge of perinatal mental health resources.
- Improve communication between health care and mental health care providers.
- Enhance women's ability to identify and access perinatal health services.
- Advocate for legislative action to expand Medicaid.
- Identify and promote services that address barriers to access to care for families.
- Promote policies to support families in the perinatal period (family leave, home visits).
- Implement programs or interventions to address perinatal issues that can impact mental health (unplanned pregnancies, substance use).
- Prevent or reduce mental health issues prior to pregnancy (early screening/before pregnancy).
- Reduce stigma around mental health (normalize mental health struggles and support/acceptance of treatment).

#### **References:**

1. *Access to Perinatal Mental Health Care in Sedgwick County Community Report* prepared by Center for Research for Infant Birth and Survival, Department of Pediatrics, University of Kansas Medicine – Wichita.  
<https://wichita.kumc.edu/Documents/wichita/pediatrics/MCH%20Opportunity%20Project%20Community%20Report.pdf>
2. *Kansas MCH Opportunity Project: Access to Perinatal Mental Health Care in Sedgwick County, Final Report.*

### 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 and 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 ages 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

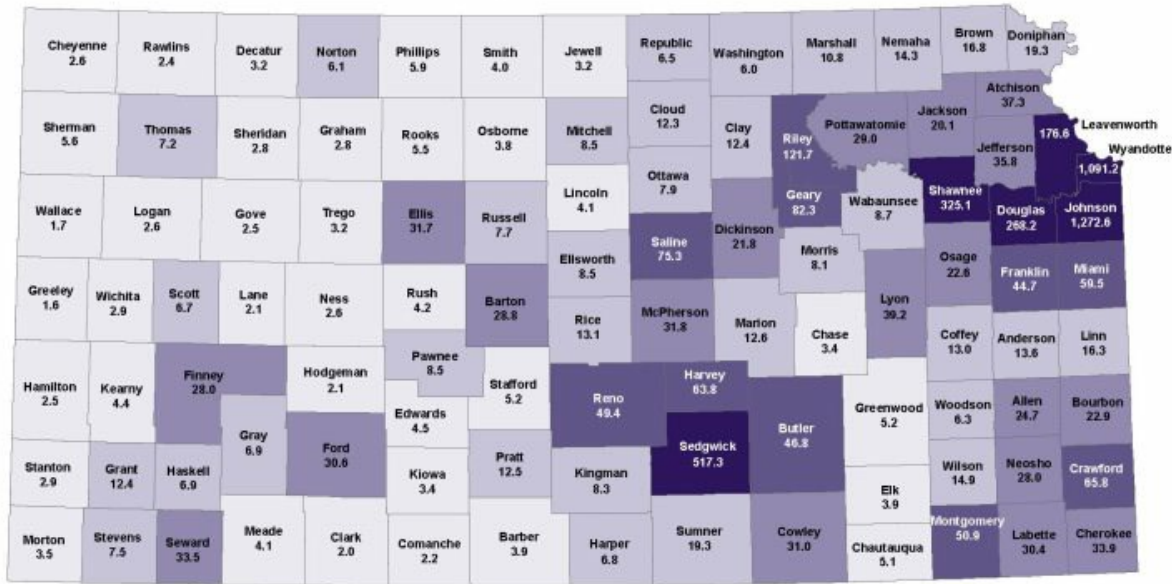
Geography/Demography: Kansas, spanning 82,278 sq. miles, is divided into 105 counties with 627 cities.<sup>1</sup> The U.S. Census Bureau estimates there are approximately 2,913,314 residents living in the state in 2019. Kansas has a unique geographic layout that ranges from urban to frontier counties. 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 389,938. Within that same region also lies Pratt with a population of 9,164. 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 presents an opportunity for sharing resources.<sup>2</sup>

Population Growth/Change: The Kansas total population increased by 8.4% between 2000-2019, including a 9.3% increase for males and a 7.5% increase for females. Population increased from 2,911,505 residents in 2018 to 2,913,314 in 2019, a 0.1% increase.<sup>2</sup> In 2019, there were an estimated 35,325 infants living in Kansas or about 1.2% of the total population (2,913,314). Women of reproductive age 15-44 accounted for 19.3% (561,891) of the population.<sup>2</sup> In 2019, there were 833,794 children and adolescents aged 1-21 years living in Kansas, which represents 28.6% of the population.<sup>3</sup> Among families with children under 18 years, 20.1% are single-parent families versus married-couple families.<sup>4</sup> According to the 2018-2019 National Survey of Children's Health, 20.5% of Kansas children aged 0 to 17 years (est. 144,750) were identified as having special health care needs (SHCN). The prevalence of children with SHCN in boys and girls under 18 years is about the same, 20.2% (est. 68,326) and 20.8% (est. 76,423), respectively.<sup>5</sup>

Population Density & Peer Groups (Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier): The population density of Kansas was 35.6 inhabitants per square mile in 2019, an 8.2% increase from 32.9 in 2000. For comparison, the population density of the U.S. increased from 76.9 to 92.9 persons per square mile from 2000 to 2019, a 16.7% increase. In 2019, 36 of

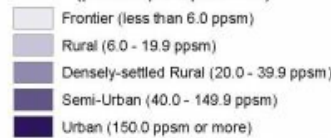
the state's 105 counties had population densities of less than 6.0. The most sparsely populated county was Greeley, with a density of 1.6. The most densely populated county was Johnson, with 1,248.8 persons per square mile. During the 2015-2019 period, the population of the urban peer group increased by 2.1%, while the frontier, rural, densely-settled rural, and semi-urban peer groups decreased by 3.9, 3.1, 2.1, and 2.2%, respectively.<sup>2</sup>

**Population Density Classifications in Kansas  
by County, 2019**



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2019.

**Population Density by Classification\*  
(persons per square mile)**



\* Kansas Department of Health and Environment classifications.

State: 35.6

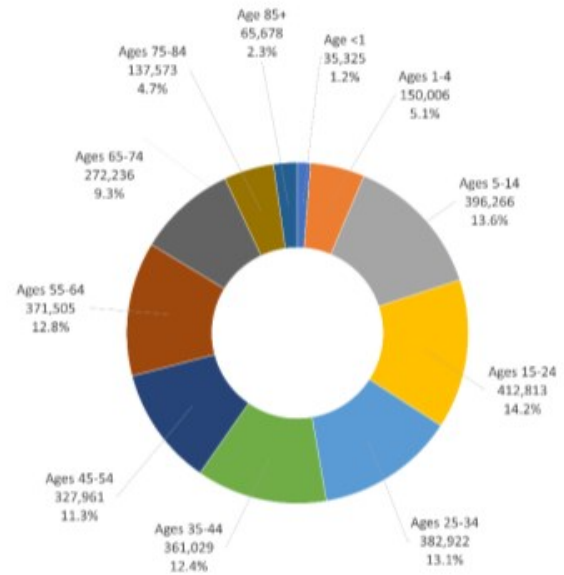
Image Credit: [University of Kansas, Institute for Policy & Social Research](#)

**Age:** The median age of Kansans in 2019 was 37.1 years, a 5.4% increase from the median age of 35.2 in 2000. The median ages of males and females in 2019 were 35.8 and 38.3, respectively. Shifts in the population distribution by age from 2000 to 2019 included a decrease in the 35-44 age group of 14.0%. This decrease, and another of 7.3% in residents 45-54 years of age and increases of 69.1% in residents 55-64 years of age, and 54.5% in residents 65-74 years of age reflected the aging of the baby boomers. There were also decreases over the same period the number of residents in the 0-4 and 5-14 age-groups, reflecting several years of declines in the Kansas birth rate. Furthermore, there were 3.3%, 9.7%, and 12.8% increases in the 15-24, 25-34, and 75 and over age-groups, respectively.<sup>2</sup>

In 2018-2019, the prevalence of SHCN within the child population increased with age, from 10.4% of children 0-5 years, 21.7% 6-11 years, and 28.5% 12-17 years.<sup>5</sup> The higher prevalence of SHCN 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 2019 Census Bureau estimates, 75.4% of Kansans were White non-Hispanic and 5.7% were Black non-Hispanic. Hispanics made up 12.2% of the population.<sup>2</sup> The race and ethnicity composition of women of childbearing age (aged 15 to 44) was estimated at 71.2% non-Hispanic white, 6.1% non-Hispanic black, 0.9% non-Hispanic Native American or Alaska Native, 4.4% non-Hispanic Asian and Pacific Islander, 3.0% non-Hispanic multiple race, and 14.3% Hispanic (any race).<sup>2</sup> The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. One-third (33.3%) of Kansas children and adolescents (1-21 years) belong to a racial or ethnic minority. Across the age groups, the percentage of young children (1-5 years) and young adults (20-21 years) that are part of a racial/ethnic minority is about one-third, at 33.5% and 31.7%, respectively. About 17.1% of Kansans aged 15-21 years are Hispanic, compared to 18.5% of young children.<sup>3</sup> In 2018-2019, the prevalence of special health care needs varied only a small amount by child's race and ethnicity. Of Kansas Hispanic children, 17.1% had special health care needs, compared with 21.6% of non-Hispanic white children.<sup>5</sup>

Kansas Age Distribution, by Selected Age Groups, 2019



Source: KDM Annual Summary of Vital Statistics, 2019

**Diversity/Languages:** According to the 2019 American Community Survey, among people at least five years old living in Kansas, 12.1% spoke a language other than English at home. Of the same, Spanish was spoken by 7.8%, and 3.1% reported that they did not speak English "very well." The Spanish speaking population has been steadily increasing, which mirrors similar trends at the national level. An estimated 92.8% of the people living in Kansas were U.S. natives. About 59.2% of these residents were living in the state in which they were born. Approximately 7.2% of residents were foreign-born. Of the foreign-born population, 41.1% are naturalized U.S. citizens, and an estimated 74.1% entered the country before the year 2010. Foreign-born residents come from different parts of the world with the majority from Latin America (53.9%), followed by Asia (30.1%), Africa (7.2%), Europe (6.8%), Northern America (1.3%) and Oceania (0.8%).<sup>4</sup>

**Education:** In 2019, Kansas compared favorably with the U.S. average in terms of educational attainment with 91.8% of people 25 years and over with a high school education or higher compared with 88.6% for the U.S. Thirty-four percent (34%) of Kansans had a bachelor's degree or higher compared with 26.3% for the U.S.<sup>4</sup> About 10.0% of children (1-17) received services under special education compared to 8.9% for the U.S. For Kansas children with SHCN, 32.0% received special education or had an individualized education plan (IEP) compared to 31.0% for the U.S.<sup>5</sup>

**Income/Poverty:** For 2019, the federal poverty level was \$25,926 for a family of four.<sup>7</sup> Research suggests that, on average, families need an income of about twice the federal poverty threshold to meet their most basic needs.<sup>8</sup> In 2019, 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 (11.3% vs. 12.3% for the U.S.) and a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (14.3% vs. 16.8% for the U.S.).<sup>9</sup> In 2019, an estimated 97,920 Kansas children under 18 years of age were living in poverty. Five counties accounted for over half of all children (51,064 children; 52.1%) in poverty: Sedgwick (21,279), Wyandotte (13,872), Johnson (7,890), Shawnee (5,344), and Douglas (2,679). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty as well. In 2019, the percent of Kansas' families living below the federal poverty level (7.5%) was lower than the U.S. (8.6%).<sup>10</sup> Poverty was more common in families headed by single females with children in the household, regardless of race or ethnicity. In 2019, the percent of female headed households with related children under 18 years living below federal poverty level (35.1%) was slightly higher the U.S. percent (33.5%).<sup>10</sup> According to the 2018-2019 National Survey of Children's Health, Kansas children living at or below poverty had an increased prevalence of SHCN. Nearly one-half (47.4%) of children with SHCN lived in families with incomes less than 200% of the federal poverty level.<sup>3</sup>



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, with the exception of 2020 (decrease of 3.0%). In 2020, in Kansas, the GDP has increased in 8 out of the 11 major industries, with declines in the utilities, nondurable goods manufacturing, and information GDP. The median annual wage in Kansas currently stands at \$38,670. The three top occupation titles in Kansas include "Office and Administrative Support" with an annual median wage of \$35,880, followed by "Sales and Related Occupations" with an annual median wage of \$29,790 and "Transportation and Material Moving Occupations" with an annual median wage of \$34,140. 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.<sup>12</sup>

COVID-19 Pandemic Impact: For the period February 17-March 15, 2021, 22% of adults living in households with children delayed getting themselves needed medical care because of the coronavirus pandemic. An additional 19% of adults living in households with children never did seek the medical care they needed because of the coronavirus pandemic. For the same time period, 15% of households with children had little or no confidence in their ability to pay the next rent or mortgage payment on time, which differed by race/ethnicity. More than one in four Hispanic (26%) households experienced this compared to 13% of non-Hispanic white households. Also, for the same time period, 12% of households with children sometimes or often did not have enough food to eat in the previous week. This differed by race and ethnicity, with more than one in four Hispanic (28%) households reporting this problem compared to 16% of non-Hispanic Black households and 8% of non-Hispanic white households.<sup>15</sup>

Kansas (along 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% compared to one-year prior in May 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 pandemic has negatively affected employment and the economy. Seasonally adjusted job estimates indicate that as of May 2020 Kansas had gained back 17% of the jobs lost in March and April due to efforts to contain the spread of COVID 19. The March 2021 seasonally adjusted rates of 3.7% indicate that Kansas has gained back the majority of jobs lost due to the pandemic, a slight increase from 3.2% in March 2020 before the pandemic.

Kansas Tribes: According to the 2019 U.S. Census Bureau, the non-Hispanic Native American population in Kansas was 23,271, 0.8% of the total population. Kansas is home to four Indian reservations: Iowa, Kickapoo, Potawatomi, and Sac and Fox. American Indians of various tribal affiliations can also be found in the towns and cities across the state.<sup>16,17</sup>

It is not a requirement that someone be Native American to live on the Indian reservations; however, a non-Native American would be unable to build a home or live in tribal housing without the head of household being a tribal member. While many of the families who inhabit tribal lands are of mixed races, the head of household must be a tribal member to utilize tribal housing. In the event the head of household were to pass away or leave, the tribe could request that the non-Native parent and Native child leave tribal housing. The Potawatomi reservation is comprised similarly to that of a checkerboard in which areas of "tribal land" are surrounded by non-Native land, or vice versa.<sup>18</sup>

It is significant to note that American Indians/Alaskan Natives (AI/AN) frequently contend with issues that prevent them from receiving quality medical care. These issues include cultural barriers, geographic isolation, inadequate sewage disposal, and low income. Some of the leading diseases and causes of death among AI/AN are heart disease, cancer, unintentional injuries (accidents), diabetes, and stroke. American Indians/Alaska Natives also have a high prevalence and risk factors for mental health related issues, suicide, unintentional injuries, obesity, substance use, sudden infant death syndrome (SIDS), teenage pregnancy, diabetes, liver disease, and hepatitis.<sup>19</sup>

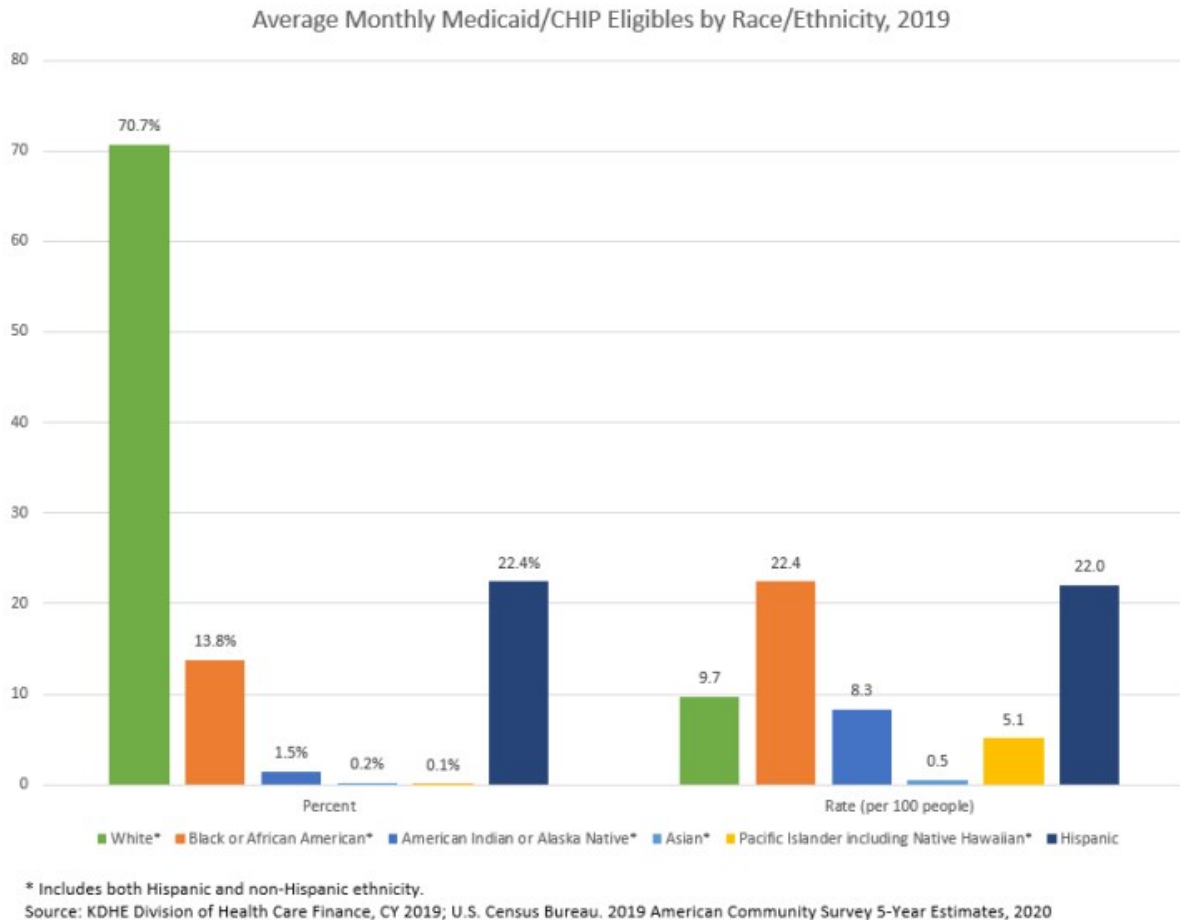
Revealing the disparities within Kansas Tribal areas by selected characteristics (2015-2109)<sup>20,21</sup>

	Iowa Reservation and Off-Reservation Trust Land, KS-NE		Kickapoo Reservation, KS		Prairie Band of Potawatomi Nation Reservation, KS		Sac and Fox Nation Reservation and Off-Reservation Trust Land, NE-KS	
	Number	%	Number	%	Number	%	Number	%
<b>Total population</b>	<b>147</b>		<b>4,022</b>		<b>1,760</b>		<b>132</b>	
Male	72	49.0	2,001	49.8	884	50.2	70	53.0
<b>Age</b>								
Median age (years)	42.5		40.8		30.5		54.7	
Under 18 years	26	17.7	1,036	25.8	632	35.9	18	13.6
18 to 44 years	50	33.9	1,121	27.9	517	29.5	38	28.8
45 to 64 years	51	34.7	1,149	28.6	342	19.5	47	35.5
65 years and older	20	13.6	716	17.8	269	15.3	29	22.0
<b>Race</b>								
One race	134	91.2	3,880	96.5	1,587	90.2	126	95.5
White	67	45.6	3,206	79.7	681	38.7	81	61.4
Black or African American	0	0.0	31	0.8	4	0.2	0	0.0
American Indian and Alaska Native	62	42.2	580	14.4	873	49.6	42	31.8
Asian	5	3.4	49	1.2	10	0.6	0	0.0
Native Hawaiian and Other Pacific Islander	0	0.0	3	0.1	13	0.7	0	0.0
Some other race	0	0.0	11	0.3	6	0.3	3	2.3
Two or more races	13	8.8	142	3.5	173	9.8	6	4.5
<b>Ethnicity</b>								
Hispanic or Latino (of any race)	7	4.8	228	5.7	181	10.3	11	8.3
Not Hispanic or Latino	140	95.2	3,794	94.3	1,579	89.7	121	91.7
<b>Educational Attainment</b>								
Population 25 years and over	102		2627		996		110	
Bachelor's degree or higher	6	5.9	439	16.7	160	16.1	22	20.0
Graduate or professional degree	4	3.9	127	4.8	47	4.7	6	5.5
<b>Income and Benefits (In 2019 inflation-adjusted dollars)</b>								
Total households	62		1,604		567		67	
Median household income (dollars)	\$51,250		\$44,931		\$63,021		\$46,964	
Mean household income (dollars)	\$60,634		\$57,822		\$71,511		\$67,021	
Less than \$10,000	4	6.5	125	7.8	32	5.6	3	4.5
\$200,000 or more	0	0.0	28	1.7	27	4.8	4	6.0
<b>People Whose Income in the Past 12 Months is Below the Poverty Level</b>								
All people	-	4.1	-	20.7	-	15.3	-	14.4
Under 18 years	-	0.0	-	35.8	-	19.6	-	16.7
18 to 64 years	-	5.9	-	17.7	-	13.6	-	17.6
65 years and over	-	0.0	-	8.6	-	10.8	-	3.4
<b>Health Insurance Coverage</b>								
Civilian noninstitutionalized population	147		3,981		1,760		132	
With health insurance coverage	124	84.4	3,606	90.6	1,616	91.8	132	87.9
With private health insurance	111	75.5	2,530	63.6	1,243	70.6	103	78.0
With public coverage	37	25.2	1,616	40.6	619	35.2	34	25.8
No health insurance coverage	23	15.6	375	9.4	144	8.2	16	12.1
Civilian noninstitutionalized population under 19 years	30		1,082		676		18	
No health insurance coverage	10	33.3	60	5.5	29	4.3	0	0.0

## Health Insurance Coverage & Medicaid/Children's Health Insurance Program (CHIP)

**Health Insurance Coverage:** Data from the Small Area Health Insurance Estimates show that the percentage of Kansas children under 19 years old without health insurance increased from 5.1% in 2015 to 5.7% in 2019. After a low of 4.5% in 2016, there was a slight increase in the uninsured population under age 19 in 2017 (5.2%), a slight decrease in 2018 (5.0%), then an increase in 2019 (5.7%).<sup>11</sup> The U.S. percentage also increased from 5.0% in 2015 to 5.6% in 2019. In 2019, nearly half (49.8%) 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 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 2018-2019 National Survey of Children's Health, in Kansas, 97.2% of CSHCN were reported to have some type of insurance at the time of the survey: 53.7% had private coverage, 34.0% had public coverage, 9.4% had both, and 2.9% had no insurance.<sup>5</sup> Based on the 2019 average monthly eligibility for Medicaid and CHIP, Blacks made up 13.8% and Hispanics made up 22.4% of eligible individuals but had rates of 22.4 per 100 people and 22.0 per 100 people, respectively. This puts the rate of Medicaid and CHIP enrollment for Blacks and Hispanics at 2.3 times higher than Whites (70.7% of enrollees) with a rate of 9.7 per 100 people.<sup>23,24</sup>



**Kansas Medicaid:** Also known as KanCare, Kansas Medicaid is administered through the KDHE Division of Health Care Finance. Medicaid provides health coverage for traditional Medicaid and 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.<sup>22</sup>

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.<sup>16</sup> See the table that follows for a 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

Image Credit: [Kansas Health Institute, 2019 Medicaid Primer](#)

Medicaid expansion is a current topic of discussion in Kansas. Kansas is only 1 of 12 states that has not expanded Medicaid coverage to all adults up to 138% of the federal poverty level. Several legislative initiatives have occurred in recent years, most recently in 2021; however, bills continue to be unsuccessful during regular legislative sessions. Other Medicaid policy initiatives listed below have been the focus for public health and Title V.

- **Postpartum Medicaid Expansion:** Extending Medicaid postpartum coverage to one full year vs. only 60 days has strong support. There is a plan to move forward with this administratively. A small Kansas team including the Title V Director, Medicaid Director, and consultants have been meeting over the last eight months to discuss the pathways and plan. Conversations with legislators and stakeholders will be taking place soon to increase understanding and gain support on the issue. The Title V team drafted an impact paper that will be utilized in conversations.
- **Maternal Depression Screening:** A new policy became effective January 1, 2021, which authorizes providers to screen for perinatal mood and anxiety disorders and bill under the child's Medicaid ID at well-child visits. Training and education for providers has been underway, and technical assistance around billing and coding is ongoing.
- **Family Planning Waiver:** An impact paper on the importance and benefits of publicly funded family planning services was drafted to begin the conversation of implementing a waiver or state plan amendment to provide affordable reproductive health to under-insured and uninsured individuals across the state.

## Kansas Strengths & Challenges

**Health Equity & Social Determinants of Health (SDoH)/Disparities:** When looking at outcomes such as infant mortality, preterm birth, and smoking during pregnancy, we see consistent trends based on race/ethnicity (particularly non-Hispanic black and non-Hispanic white) and socioeconomic factors (particularly Medicaid vs. non-Medicaid). Non-Hispanic Blacks especially show greater risk for worse health and pregnancy related outcomes. For example, Non-Hispanic Blacks have lower prenatal care rates and higher rates of low birthweight infants, and infant mortality.<sup>15</sup>

### Adequate or Better Prenatal Care by Race of Mother (Percent - 3 yr average) in Kansas

Race and Ethnicity	2017	2018	2019
White, Non-Hispanic	87.5%	87.5%	87.6%
Black/African American, non-Hispanic	73.9%	73.6%	73.3%
Hispanic	71.3%	71.3%	72.4%
American Indian/Alaskan Native, non-Hispanic	73.4%	71.8%	69.7%
Asian/Pacific Islander, non-Hispanic	83.9%	84.1%	83.7%
Other, non-Hispanic	76.8%	76.8%	77.6%

Source: Kansas 2015-2017, 2016-2018, and 2017-2019 three-year averages, Kansas birth data (resident)



### Low Birth-Weight Babies by Race of Mother (Percent - 3 yr average) in Kansas

Race and Ethnicity	2017	2018	2019
White, Non-Hispanic	6.5%	6.6%	6.8%
Black/African American, non-Hispanic	13.3%	13.9%	14.3%
Hispanic	6.4%	6.8%	7.2%
American Indian/Alaskan Native, non-Hispanic	6.7%	6.7%	6.6%
Asian/Pacific Islander, non-Hispanic	7.6%	8.1%	8.1%
Other, non-Hispanic	8.7%	8.9%	9.5%

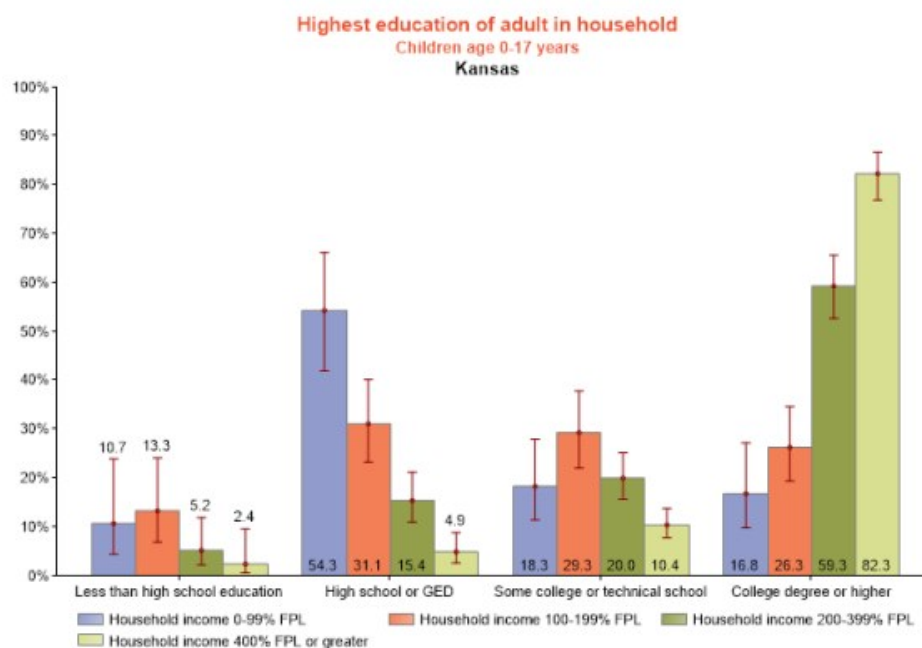
Source: Kansas 2015-2017, 2016-2018, and 2017-2019 three-year averages, Kansas birth data (resident)

### Infant Mortality by Race (Rate per 1,000 live births - 5 yr average) in Kansas

Race and Ethnicity	2017	2018	2019
White, Non-Hispanic	4.9	4.9	4.7
Black/African American, non-Hispanic	12.7	11.7	11.6
Hispanic	6.7	7.1	7.1
American Indian/Alaskan Native, non-Hispanic	8.5	7.7	7.3
Asian/Pacific Islander, non-Hispanic	4.6	4.4	3.1
Other, non-Hispanic	14.7	14.7	13.8

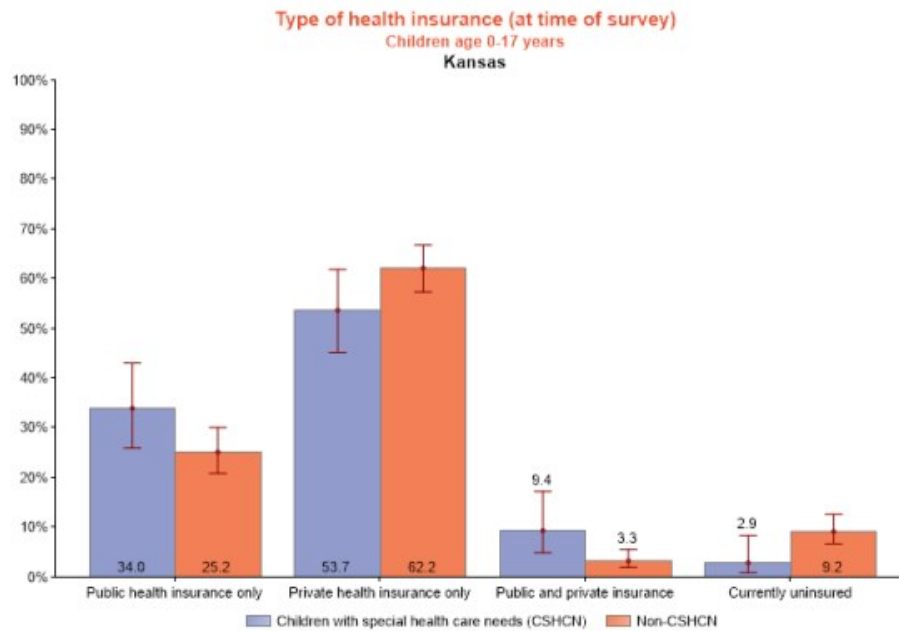
Source: Kansas 2013-2017, 2014-2018, and 2015-2019 five-year averages, Kansas death and birth data (resident)

In addition to race/ethnicity other social and physical determinants (e.g., insurance type, education level, federal poverty level, special health care needs/disability) can have a critical impact on one's ability to thrive in their environment. 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 2018-2019 National Survey of Children's Health (NSCH), households with lower income are more likely to have adults in the household with a high school diploma, GED, or less. Whereas those with higher education levels also have higher household incomes.



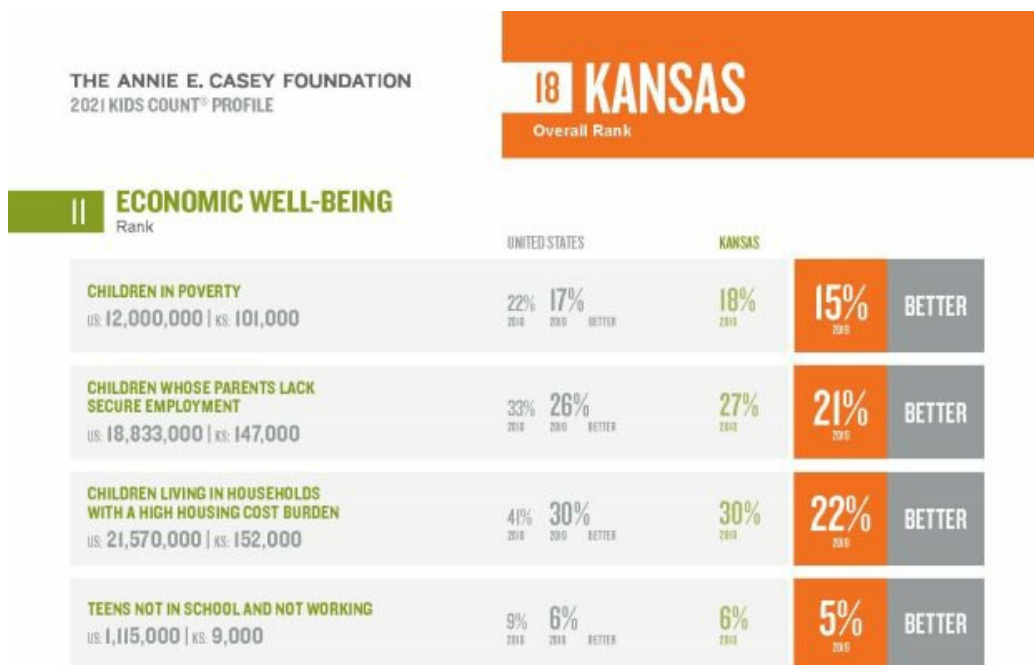
Data Source: [National Survey of Children's Health, 2018-2019 Combined, Child and Family Health Measures](#)

According to the 2018-2019 National Survey of Children's Health (NSCH), families of CSHCN utilize public insurance only at a higher rate than those without special health care needs. The uninsured rate is lower among CSHCN families.



Data Source: [National Survey of Children's Health, 2018-2019 Combined, Child and Family Health Measures](#)

The Annie E. Casey Foundation's (AECF) KIDS COUNT® Data Book uses 16 indicators to rank each state across four domains: (1) Economic Well-Being, (2) Education, (3) Health, and (4) Family and Community. These represent what children need the most to thrive. The 2021 Data Book presents state profiles with trends (comparing data from 2010 with those from 2019, whenever possible), providing a picture of child well-being prior to the COVID-19 pandemic. Kansas ranked 18<sup>th</sup> for overall child well-being, 11<sup>th</sup> in economic well-being, 23<sup>rd</sup> in education, 25<sup>th</sup> in health, and 24<sup>th</sup> in family and community. Every indicator in the economic well-being and family and community domains improved, three of the health indicators and half of the education moved in the right direction.<sup>14</sup> The following images are from the [Kansas 2021 KIDS COUNT® Profile](#).



## 23 EDUCATION

Rank

	UNITED STATES		KANSAS	
<b>YOUNG CHILDREN (AGES 3 AND 4) NOT IN SCHOOL</b> US: 4,205,000   KS: 41,000	52%	52% 2009-11 2017-18 SAME	53% 2009-11	52% 2017-18 BETTER
<b>FOURTH-GRADERS NOT PROFICIENT IN READING</b> US: N.A.   KS: N.A.	68%	66% 2009 2018 BETTER	65% 2009	66% 2018 WORSE
<b>EIGHTH-GRADERS NOT PROFICIENT IN MATH</b> US: N.A.   KS: N.A.	67%	67% 2009 2018 SAME	61% 2009	67% 2018 WORSE
<b>HIGH SCHOOL STUDENTS NOT GRADUATING ON TIME</b> US: N.A.   KS: N.A.	21%	14% 2018-19 2018-19 BETTER	17% 2018-19	13% 2018-19 BETTER

## 25 HEALTH

Rank

	UNITED STATES		KANSAS	
<b>LOW BIRTH-WEIGHT BABIES</b> US: 311,245   KS: 2,685	8.1%	8.3% 2018 2018 WORSE	7.1% 2018	7.6% 2018 WORSE
<b>CHILDREN WITHOUT HEALTH INSURANCE</b> US: 4,375,000   KS: 43,000	8%	6% 2018 2018 BETTER	9% 2018	6% 2018 BETTER
<b>CHILD AND TEEN DEATHS PER 100,000</b> US: 19,431   KS: 211	26	25 2018 2019 BETTER	33 2018	28 2018 BETTER
<b>CHILDREN AND TEENS (AGES 10 TO 17) WHO ARE OVERWEIGHT OR OBESE</b> US: N.A.   KS: N.A.	31%	31% 2018-17 2018-18 SAME	32% 2018-17	29% 2018-18 BETTER

## 24 FAMILY AND COMMUNITY

Rank

	UNITED STATES		KANSAS	
<b>CHILDREN IN SINGLE-PARENT FAMILIES</b> US: 23,756,000   KS: 200,000	34%	34% 2018 2018 SAME	31% 2018	30% 2018 BETTER
<b>CHILDREN IN FAMILIES WHERE THE HOUSEHOLD HEAD LACKS A HIGH SCHOOL DIPLOMA</b> US: 8,907,000   KS: 67,000	15%	12% 2018 2018 BETTER	12% 2018	10% 2018 BETTER
<b>CHILDREN LIVING IN HIGH-POVERTY AREAS</b> US: 6,712,000   KS: 37,000	13%	9% 2009-12 2015-18 BETTER	8% 2009-12	5% 2015-18 BETTER
<b>TEEN BIRTHS PER 1,000</b> US: 171,674   KS: 1,857	34	17 2018 2018 BETTER	39 2018	19 2018 BETTER

Health coverage is also a critical factor associated with differing health and birth outcomes. According to the US. Census's Household Pulse Survey (March 3 - March 29, 2021), based on the AECF 2021 KIDS Count Data Book, which provides a sense of the conditions that families endured throughout 2020, in Kansas, one in 10 adults with children in the household

(10%) reported a lack of health insurance; one in five adults living in households with children (20%) said they felt down, depressed or hopeless; more than one in 10 households with children (11%) said they had only slight confidence or no confidence at all that they would be able to make their next rent or mortgage payment on time; about one in 12 adults with children (8%) said their household sometimes or always did not have enough to eat in the most recent week; more than one in 10 households (11%) did not always have access to the internet and a computer for educational purposes; nearly four in ten adults (40%) who were planning to take postsecondary classes in the fall of 2020 said they would either take fewer classes than anticipated or cancelled their postsecondary education plans.<sup>14</sup> Mothers on Medicaid have a greater risk of worse health outcomes than mothers not on Medicaid.

*Kansas Birth Statistics, by Insurance Status, and Year<sup>25</sup>*

NOM#	National Outcome Measures	Medicaid Measures	2015	2016	2017	2018	2019	Trend	HP2030	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		81.7%	80.8%	81.2%	81.0%	80.9%	●	-	
	Medicaid		72.7%	70.2%	72.1%	71.7%	71.4%	●		
	Non-Medicaid		86.2%	85.8%	85.5%	85.3%	85.0%	◆*		
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		6.9%	7.0%	7.4%	7.4%	7.6%	◆*	-	
	Medicaid		8.7%	8.8%	9.5%	9.9%	9.7%	◆*		
	Non-Medicaid		6.0%	6.1%	6.4%	6.4%	6.7%	◆*		
5	Percent of preterm births (<37 weeks gestation)	P4P								1
	All		8.8%	9.1%	9.6%	9.5%	10.1%	◆*	9.4%	
	Medicaid		10.3%	10.8%	11.3%	11.4%	11.9%	◆*		
	Non-Medicaid		8.0%	8.3%	8.8%	8.6%	9.3%	◆*		
6	Percent of early term births (37, 38 weeks gestation)									1
	All		24.1%	24.4%	25.6%	26.3%	27.2%	◆*	-	
	Medicaid		26.1%	26.7%	28.3%	28.4%	29.3%	◆*		
	Non-Medicaid		23.2%	23.3%	24.4%	25.3%	26.2%	◆*		

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.

Primary Care Access & Workforce: In 2019, the supply of family practitioners per 100,000 population (18.9) was significantly lower in Kansas than the national average (33.3). In 2019, the supply of obstetricians/gynecologists (7.9) was higher than the national average (5.7). In 2019, the supply of pediatricians (3.1) in Kansas was significantly lower compared to the national average (9.1).<sup>12</sup> As of December 2020, there are eighteen (18) counties with a Geographic Primary Care Health Professional Shortage Area (HPSA) designation.

## Primary Care Health Professional Shortage Areas Geographic and Low-Income County-Level Designations December 2020

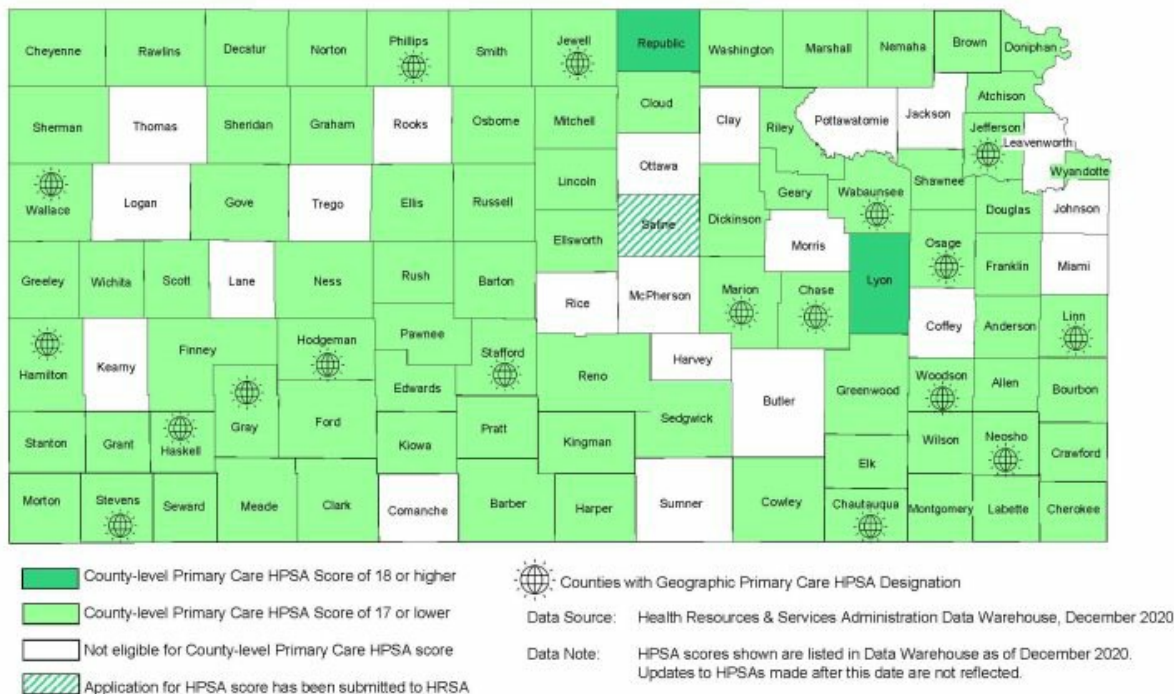


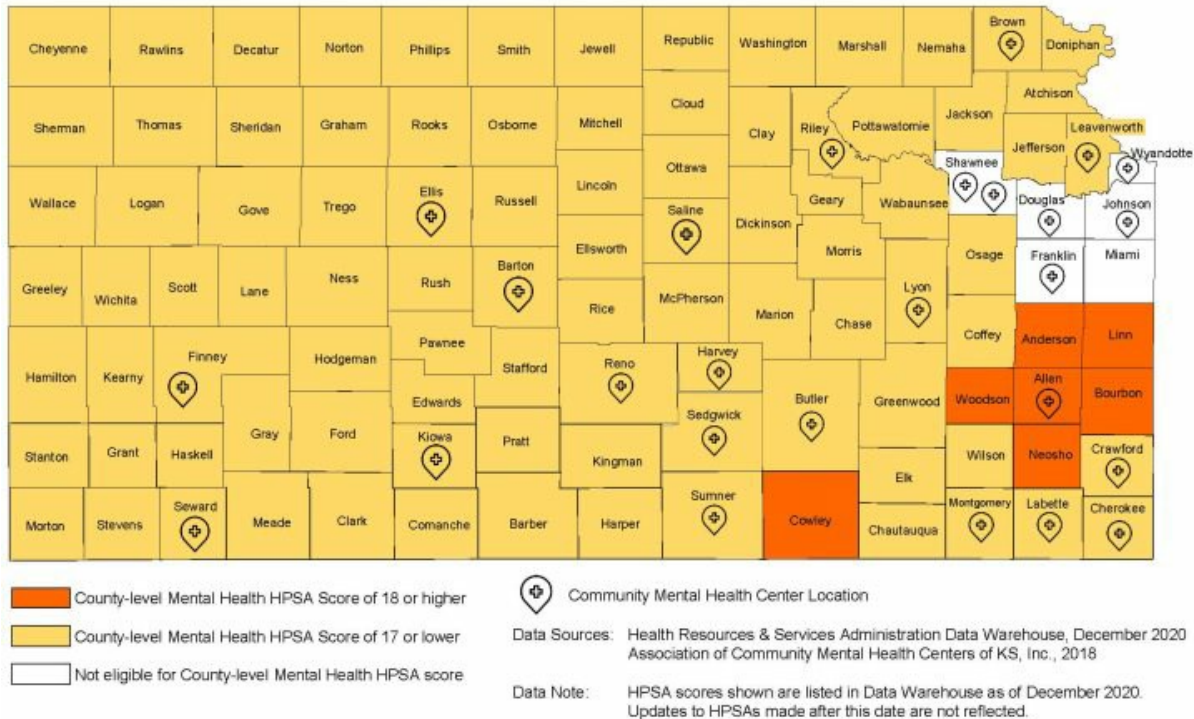
Image Credit: [KDHE, Office of Local and Rural Health](#)

**Specialty Care Access & Workforce:** 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 2018-2019 National Survey of Children's Health, in Kansas, 27.4% of CSHCN families reported that they had trouble getting specialist care versus 13.0% of non-CSHCN families.<sup>5</sup>

Estimates derived from national prevalence and 2019 US Census data suggest at least 153,355 or 21.9% of Kansas children have experienced a mental health disorder, and around 34,312 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 nearly 70% of Kansas children with unmet mental health needs.<sup>13</sup>



## Mental Health Professional Shortage Areas Geographic and Low-Income County-Level Designations December 2020



*Image Credit: [KDHE, Office of Local and Rural Health](#)*

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 (PCPs), including pediatricians, family practice physicians and non-physician PCPs who can 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.

### State Health Agency Mandated Priorities – 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 Bureau of Family Health within the Kansas Department of Health and Environment has been a leader in these efforts.

**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.

DAP	Support Available	General Guidelines (100% Coverage)
<b>Medication (DAP-Rx)</b>	Prescribed Medication (For medications not covered by insurance)	Up to \$10,000
	Nutritional Supplements, Vitamins, or OTC medications (limited to specific medical conditions)	Up to \$1000
<b>Medical Equipment and Supplies (DAP-ME/S)</b>	Prescribed Durable Medical Equipment (DME) <i>For clients who qualify at 100% coverage co-pays will be waived. For those who qualify at 50% or 25% coverage please see the co-pay guidance below.</i> <i>The client must pay a co-pay as follows</i> <i>\$25 co-pay for DME under \$500</i> <i>\$50 co-pay for DME \$501 to \$1,000</i> <i>\$100 co-pay for DME over \$1,000</i>	Up to \$5,000  Includes a minimum of one (1) or up to four (4) KS-SHCN Clinic appointments
	Medical Supplies: <ul style="list-style-type: none"> <li>- Up to a maximum of \$1,200 for up to 12 boxes of catheters.</li> <li>- Up to a maximum of \$600 for ostomy supplies.</li> <li>- Up to a maximum of \$1,500 for diabetic testing equipment and supplies (only for Cystic Fibrosis-related diabetes).</li> <li>- Up to a maximum of \$500 for diapers or pull-ups (only for age 5-21).</li> <li>- Up to a maximum of \$250 for special bottles or feeding supplies.</li> <li>- Up to a maximum of \$500 for hearing aid molds, repairs, and batteries.</li> <li>- Up to a maximum of \$1,000 for glasses, lens replacement, or prosthetic eyes.</li> <li>- Other medical supplies, not otherwise identified, up to \$250.</li> </ul>	Up to \$2,000
<b>Travel (DAP-T)</b>	Reimbursement at State rate	Up to \$1000
<b>Co-Payments/Deductibles/ Co-insurance (DAP C/D/CI)</b>	Co-Payments/Deductibles/Co-Insurance <i>Maximum amount will be based on client's portion of insurance coverage plan.</i>	Up to a Maximum of \$6,000
<b>Hemophilia (DAP-H)</b> <i>Must be diagnosed with hemophilia disorder, or other bleeding disorder, requiring treatment of factor.</i>	One (1) comprehensive treatment center visit	
	Factor (limited to \$2,500 per authorization)	Up to \$7,500
<b>Medical Services (DAP-MS)</b> <i>Must be uninsured, or ineligible for KanCare and/or insurance through the health insurance marketplace.</i>	Medical Appointments: <ul style="list-style-type: none"> <li>- One (1) well-child/well-adolescent, or preventive care, vision and dental appointments, with established providers.</li> <li>- Up to six (6) specialty care appointments</li> </ul> <i>**Client must pay a \$15 co-pay per appointment**</i>	Up to \$1000
	Medical Testing: <ul style="list-style-type: none"> <li>- Laboratory Tests</li> <li>- X-rays</li> </ul>	Up to \$500 Up to \$500
	Specialty tests	Up to \$1,500
	Hospitalization/Surgery <ul style="list-style-type: none"> <li>- Hospital Bill</li> <li>- Hospital/Surgery Related Service</li> </ul> <i>**Client must pay \$500 towards hospital bill**</i>	Up to \$4,500 Up to \$2,500
	Other Services <ul style="list-style-type: none"> <li>- Physical, Speech, Occupational Therapy</li> <li>- Interpreter Services (limited to authorized appointments)</li> </ul> <i>**Client must pay a \$15 co-pay per appointment**</i>	Up to \$1,200 Up to \$700
	Other specialty care services, not listed	Up to \$800
<b>Orthodontic Treatment Services (DAP-OTS)</b> <i>Must be diagnosed with a craniofacial anomaly, such as Cleft Lip/Cleft Palate</i>	KS-SHCN CL/CP Clinic: A minimum of one (1) or up to four (4)	
	Orthodontic Evaluation	Up to \$300
	Orthodontic Treatment Plan	Up to \$7,000
<b>Metabolic Products (DAP-MP)</b> <i>Must be diagnosed with PKU, or other amino acid disorders, requiring treatment with metabolic products.</i>	Formula (limited to \$750 per month) *PKU clients with special circumstances may be eligible for additional assistance per program approval. *	Up to \$9,000 Up to \$14,400
	**PKU clients who are pregnant or nursing (limited to \$1,200 per month)** Low-Protein Food Items (limited to individuals 18 or younger)	Up to \$1,500
<b>Caregiver Relief (DAP-CR)</b> <i>Client must be diagnosed with a complex medical condition that requires specialty medical care. Eligibility will be determined by the KS-SHCN program.</i>	Reimbursement for trained and approved care providers (limited to \$250 per month) *Services cannot be reimbursed for primary caregivers*	Up to \$2,000

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.

**Infant Mortality Reduction:** Kansas Title V is a lead partner in convening and facilitating efforts to reduce infant mortality and eliminate disparities in maternal and infant health. Over the past several years, the Title V program has invested in comprehensive approaches to 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 189 infant deaths in 2019 in Kansas, a decrease of 18.2% from 231 infant deaths in 2018. The infant mortality rate for Kansas residents in 2019 was 5.3 infant deaths per 1,000 live births, down 17.2% from 6.4 infant deaths per 1,000 live births in 2018. This meets the Healthy People 2020 target for infant deaths, 6.0 infant deaths per 1,000 live births, and was the lowest infant mortality rate for Kansas residents in the last 20 years (2000-2019). The rate for White non-Hispanic mothers in 2019 was 4.1 deaths per 1,000 live births, a decrease of 14.6% from the rate of 4.8 in 2018. The rate for Black non-Hispanic mothers was 10.7 deaths per 1,000 live births, an increase of 7.0 percent from the rate of 10.0 in 2018. The rate for Hispanic mothers was 6.4 deaths per 1,000 live births, a decrease of 28.9% from the rate of 9.0 in 2018. 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 (2000-2019). Rates for Hispanic mothers have been higher than those for White non-Hispanic mothers in most years in the period.<sup>2</sup>

**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 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), those that have Medicaid or are uninsured, and live in rural areas. Severe maternal morbidity is also monitored by Title V. It is critical to understand the patterns and contributing factors considering these are situations that result in lifelong challenges or death.

### **Kansas' Systems of Care for Underserved & 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 in support of MCH priorities. Services are delivered in compliance with Title V legislation and in accordance with the KS MCH Manual: [Kansas Health Services Manual \(kdheks.gov\)](https://www.kdheks.gov/Kansas-Health-Services-Manual). 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. Due to the pandemic, KDHE wanted to provide local agencies extra time to complete grant applications. The applications opened December 15 with a due date of March 15. 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 over 60 local agencies to provide MCH services across the population domains and most 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 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. Aid to Local (ATL) contract documents and the list of 2020 MCH grantees are included in the Supporting Documents.

**Health Equity & Disparities:** The agency has ramped up the investment into Health Equity with the creation of a dedicated staff member for health equity and the establishment of the Health Equity Action Team (HEAT). Two Bureau staff participate in the HEAT team and are actively involved in initiatives such as health equity training, hiring practices and data collection.

To address disparities in the maternal and child health population, 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 and Hispanic 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)
- Providing culturally appropriate breastfeeding support and resources in communities with demonstrated disparities (e.g., Chocolate Milk Cafes [peer support] Black Breastfeeding Coalition, a Latina Breastfeeding Coalition, Spanish language breastfeeding training for home visitors, increased breastfeeding educators and peer counselors of color)
- Assessing the need for health coverage, transportation, housing, food, education, etc. (e.g., holistic care coordination)
- Exploring and implementing telehealth to increase access to care in rural and underserved areas.
- Including an equity lens on all aspects of the Title V State Action Plan and including specific strategies to combat health inequities.
- 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
- Development of a health equity learning collaborative that allows local communities to uncover root causes of a health equity issue in their community, this collaborative called the MCH Opportunity Project is currently in cohort 2
- 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, breastfeeding education, behavioral health 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; ongoing assessment if local programs are serving those most in need and 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

Systems of Care for CSHCN: 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 [Kansas State Plan for CSHCN](#) 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. Needs Assessment

#### FY 2022 Application/FY 2020 Annual Report Update



The Kansas Title V team continued work related to the Title V Needs Assessment and State Action Plan (SAP) in partnership with many internal and external partners, the Kansas Maternal & Child Health Council (KMCHC), and the Family Advisory Council. The primary focus since completing the needs assessment and application/annual report last year has centered on the COVID-19 pandemic response. Many Title V programs and team members have had to shift focus to address the local and state needs associated with the pandemic. Early in the pandemic response we hosted a COVID-19 listening session with key stakeholders from the KMCHC and it was evident that there was a need for Title V programming to also maintain a focus on the provision of core public health services and supports to help with continuity for families and individuals. This prompted an intentional and strategic focus on supporting the pandemic response as necessary for some, while others continued to focus on the core work of Title V and the Block Grant, continuing discussions around programming, expansion, services, monitoring, evaluation, and improving access to data.

This section of the application will outline the role Title V has played in the COVID-19 response, as well as maintaining ongoing stakeholder and public input as part of an ongoing needs assessment process to monitor and assess the needs of the MCH population.

#### Changes in MCH Population Health Status & MCH Program Response

Kansas Title V has created tools used by the program to continuously monitor the Title V outcome, performance, and strategy measures.

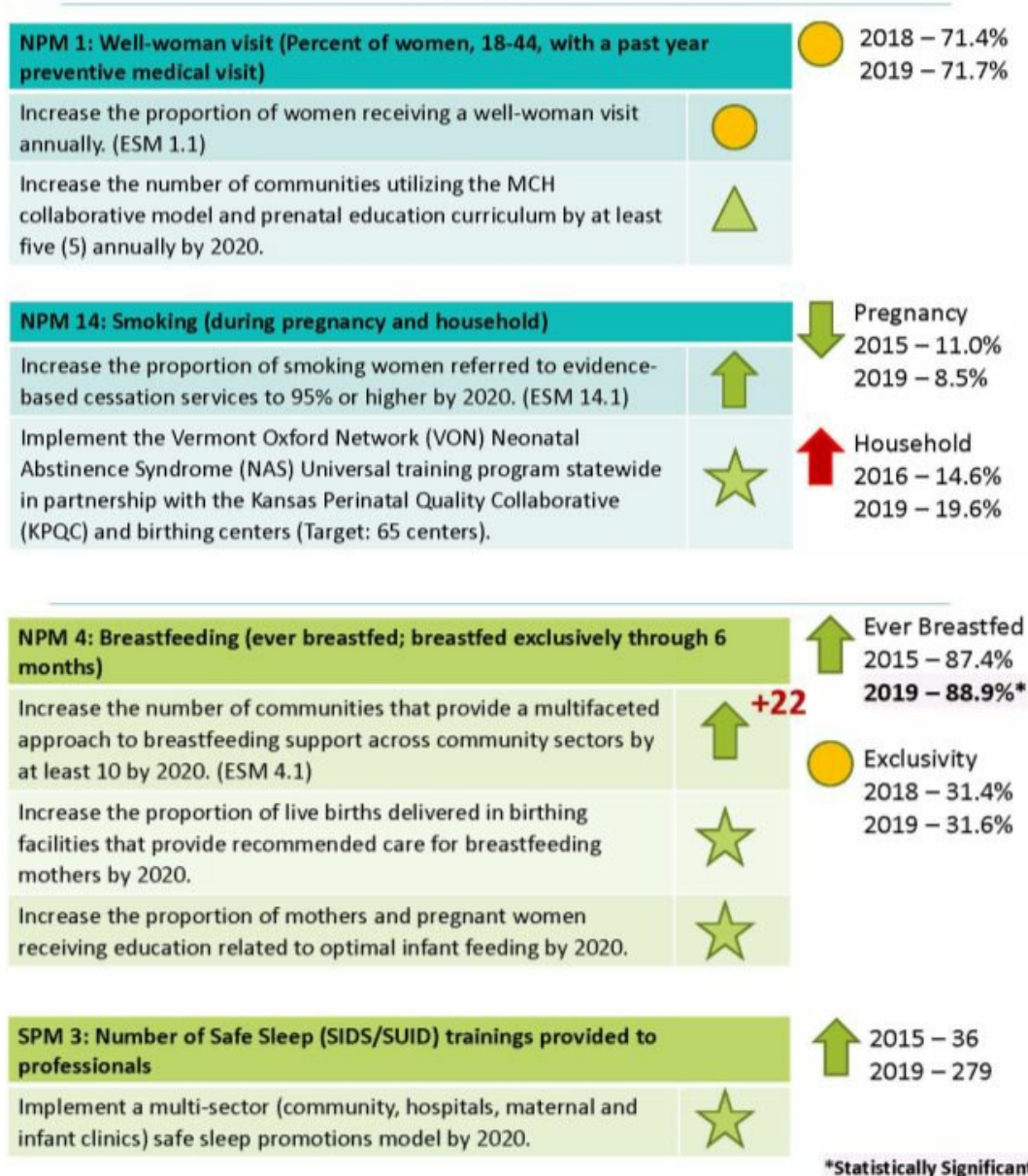
- **Performance Measure Snapshot:** This document is updated annually and reflects all Title V NOMs, NPMs, and SPMs. The document is shared and discussed with the Title V team and KMCHC throughout the year as it relates to review of the action plan and priority work. The document is made available on websites for stakeholders and the public. A sample of this snapshot is depicted below. The complete file can be found online at <https://www.kansasmch.org/guidingresources.asp>.


<div><div><b>Title V Outcome Measures and Performance Measures</b> Kansas Maternal and Child Health Services Block Grant 2022 Application/2020 Annual Report</div></div>										
NOM#	National Outcome Measures	Medicaid Measures	2015	2016	2017	2018	2019	Trend	HP2030	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		81.7%	80.8%	81.2%	81.0%	80.9%	●	-	
	Medicaid		72.7%	70.2%	72.1%	71.7%	71.4%	●		
	Non-Medicaid		86.2%	85.8%	85.5%	85.3%	85.0%	◆*		
2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations (All data were revised to reflect the new method. See notes.)		-	56.1	56.7	61.8	65.9	◆*	61.8	2
3	Maternal mortality rate per 100,000 live births (5-year average, 2014-2018)		-	-	-	14.8	16.7	◆	15.7	3
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		6.9%	7.0%	7.4%	7.4%	7.6%	◆*	-	
	Medicaid		8.7%	8.8%	9.5%	9.9%	9.7%	◆*		
	Non-Medicaid		6.0%	6.1%	6.4%	6.4%	6.7%	◆*		
5	Percent of preterm births (<37 weeks gestation)									1
	All		8.8%	9.1%	9.6%	9.5%	10.1%	◆*	9.4%	
	Medicaid		10.3%	10.8%	11.3%	11.4%	11.9%	◆*		
	Non-Medicaid		8.0%	8.3%	8.8%	8.6%	9.3%	◆*		


- **Evidence-based or informed Strategy Measures (ESM) Tracking Snapshot:** This document is updated quarterly for internal use and discussion by the Title V state team. The information is shared periodically with the KMCHC and local agencies providing MCH services in an effort to indicate the status of process measures intended to advance the NPMs.


Using these snapshots, we can easily identify trends and monitor progress related to plan measures and related objectives. The following images outline the statistically significant trends associated the Title V performance measurement framework. Utilizing these tools, we raise awareness and increase capacity for staff, stakeholders, and partners to identify and discuss emerging issues, target programming efforts, and act as appropriate.



The data snapshots of each MCH population domain below depict the 2016-2020 State Action Plan progress in action. Arrows indicate trends (up/down); stars indicate progress made (yes/no); circles indicate no significant shifts; triangles indicate a change in data source, objective, or programmatic focus.







**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)**  2015 – 41.6%  
2019 – 36.9%


Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually. (ESM 6.1)	
Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.	Review In Progress


**NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9)**  2016 – 111.9  
2019 – 131.7


Increase by 10% the number of children through age eight riding in age and size appropriate car seats per best practice recommendations by 2020. (ESM 7.1)	
Increase the proportion of families receiving education and risk assessment for home safety and injury prevention by 2020.	


**NPM 10: Adolescent preventive medical visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)**  2016 – 79.8%  
2019 – 75.8%

Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020. (ESM 10.1)	
Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.	
Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.	

**NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)**  CSHCN  
2016 – 38.6%  
2019 – 57.1%\*

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

Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.  Non-CSHCN  
2016 – 54.1%  
2019 – 52.1%

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.  All  
2016 – 50.9%  
2019 – 53.1%

*ESM 11.1: Percent of families enrolled in SHCN HCC Program that increased their ability to independently navigate the systems of care.*





**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.**

↑ 2016 – 7.2%  
2018 – 7.6%

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.	★
Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.	●
Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.	★
Increase opportunities to empower families and build strong MCH advocates by 2020.	★
Implement collaborative oral health initiatives to expand oral health screening, education, and referral by 2020.	★

**SPM 5: Number of MCH grantees, families, and partners that participated in a state sponsored workforce development event**

● 2019 - 1,126

Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.	★
Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.	★

## Title V COVID-19 Response Activities

The COVID-19 pandemic affected many people and programs within the state, including programs within the Bureau of Family Health and Title V. The engagement of Title V in initial and ongoing pandemic response efforts has provided a unique view and understanding of the needs of the populations. Additionally, involvement has provided a foundation for the Title V team to monitor and assess health outcomes following the pandemic. The team is prepared to adapt and adjust as necessary to meet the growing needs of families as the aftermath of the pandemic becomes more apparent.

In addition to providing support, technical guidance, and flexibility for our local MCH grantees, individual members of the Title V team were integral to specific COVID-19 response activities outlined below.

- **KDHE Incident Command and Response**. The BFH/Title V MCH Director has been a part of the agency response team since Incident Command was established and the statewide emergency was declared by the Governor in March 2020. Activities include/have included but are not limited to:
  - participating in incident command briefings three times weekly, local public health updates/webinars (previously daily, then three times weekly, now once weekly), and weekly calls with providers;
  - providing updates to the Governor, State Health Officer/Secretary, and/or response team related to all aspects affecting the MCH populations, with special emphasis on pregnant women, infants, young children, individuals with special health care needs, schools, and child care facilities;
  - coordinating the drafting, updating, approving, and posting of COVID-19 guidance for all BFH programs and public health priority areas of work and COVID-19 response (e.g., exposure, testing, vaccine) for a variety of audiences including other state agencies, public health workforce, providers, families, and the public;
  - monitoring the impact on pregnancy health and birth outcomes (internally and with MCH partners including members of the perinatal quality collaborative executive team);

- initiating and maintaining collaboration and communication across state agencies as it pertains to developing guidance, proposals/plans, response, accommodations, and more;
- serving as member of the Navigating 2020 Department of Education workgroup focused on developing guidance for schools to safely operate during the pandemic using a variety of methods (in person, virtual/remote, hybrid); and
- participating in ongoing conversations related to allocating/investing federal relief funds originating from a variety of sources and federal legislation focused on public health, child care, and behavioral health.
- [Kansas: Stronger Together](#). At the onset of the pandemic, an overwhelming amount of information related to COVID-19 was available in every media outlet. As part of the initial state response, a collaborative effort began across state agencies such as the Kansas Department for Aging and Disability Services, Kansas Department of Health and Environment, Kansas Department of Agriculture, and Kansas Division of Emergency Management to create the [Kansas Resource Guide for COVID-19](#) that was shared widely with state, local, and community partners to increase both knowledge and availability of resources and services during COVID-19. Title V staff were involved in this effort to share accurate and timely information and resources, specifically information and resources for the physical, mental, and emotional well-being of citizens. A primary goal was to alleviate stress and anxiety and reduce the spread of misinformation. The guide included information and resources related to topics such as: COVID-19, Mental Health, Substance Use, Anti-Violence, Parenting, Household, Agriculture, Information, and Business and Legal. The guide, and later a website, phone number, social media campaign, and broader outreach program emerged – all together known as *Kansas: Stronger Together* crisis counseling program. The program is authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) Crisis Counseling Regular Services Program, funded by the Federal Emergency Management Agency (FEMA).
- *Coronavirus Relief Fund (CARES Act) Programs*. The Title V MCH Director was assigned to a cross-agency workgroup established by the Governor's Office in July 2020 to make recommendations about how to allocate/invest relief dollars. Workgroups submitted proposals to the Strengthening People and Revitalizing Kansas (SPARK) task force; approved recommendations were sent on to the State Finance Council for approval and implementation beginning August 2020. Planning and drafting of proposals was completed collaboratively with other state agency directors from the Children's Cabinet, Department for Children & Families, and Department of Education. Focus was on identifying immediate and ongoing needs of MCH populations and families, with emphasis on the early childhood workforce and young children. Three projects were assigned to the Title V MCH Director and implemented with Bureau of Family Health (BFH) staff and partners.
  - The [Child Care Health Consultant Network](#) was implemented in partnership with Child Care Aware of KS and to assist licensed child care providers with mitigating the spread of COVID-19 and continue safe operation. Between September and December 2020, approximately \$2.5M in funding was awarded to 440 home and center-based facilities across the state, reaching nearly 12,000 children in care (infant through school age). The program continues with alternate funding.
  - [BFH Special Health Care Needs](#) administered the COVID-19 Essential Worker Health Fund (WHF) (<http://ksherorelief.com>) between August 2020 and January 2021. The fund was established to provide assistance for essential workers (e.g., first responders, medical personnel, teachers, grocery workers, maintenance workers, military, child care providers) who contracted COVID-19. The program's existing infrastructure was uniquely positioned to implement and oversee the fund which included \$3M set aside for early childhood professionals and \$5M for other essential workers. Once an individual was eligible, they were linked to a care coordinator who provided the appropriate referrals/linkages/reimbursement. Kansas workers received financial support for medical expenses, lost wages, and miscellaneous expenses incurred due to COVID-19. The program processed 690 applications. Approximately 500 Kansans qualified and received payments totaling \$1.6M.
  - The Technology for Families (TFF) program was implemented in partnership with the Children's Cabinet and the University of Kansas Center for Public Partnerships and Research. Existing home visiting programs funded by state agencies were engaged to identify families across the state who were vulnerable for health



and social hardships due to a lack of digital connectivity. The local programs then applied for funding to purchase and distribute devices (tablets, laptop computers and mobile phones) as well as internet connection via internet service plans, hot spots, and data cards. A total of 49 programs received more than \$750,000 and delivered 1,567 devices and 1,621 instances of connectivity to 1,584 households with 3,280 young children in 71 of 105 counties (35% rural).

- *Infant Toddler Medicaid COVID-19 Policies:* With support and guidance from the Title V Director and the Children and Families Unit Director, the Kansas Infant Toddler Services (ITS) team worked closely with the Medicaid program to reimburse early intervention services provided via telemedicine. This collaboration was critical to supporting sustainability of services during the pandemic. In addition, during spring of 2021, BFH and Medicaid partnered to update the [Kansas Medical Assistance Program \(KMAP\) Manual for Early Childhood Intervention](#) to support correct billing procedures and enhance systems alignment.

***COVID-19 Health Disparities:*** Kansas recently applied for the Centers for Disease Control and Prevention “National Initiative to Address COVID-19 Health Disparities Among Population at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities” grant (\$31M). Due to the vast health disparities (e.g., racial inequities; socioeconomic disparities; lack of culturally accessible care; living, working, and health conditions) exacerbated during the pandemic, Kansas identified four strategies to reduce disparities and increase capacity for current and future responses. These include: chronic disease prevention and management programming established in eight communities; expansion of Local Health Equity Action teams (LHEAT); state and county equity-related infrastructure across cross-jurisdictional Districts, including bilingual communication support and health equity champions; and the creation of the Office of Diversity, Equity, and Inclusion (DEI) at KDHE. The Office of DEI will support statewide efforts and create/sustain a culture where DEI frames every public health initiative during COVID and beyond. The Title V MCH Director was instrumental in the development of the project narrative and provided expertise, guidance, and alignment support.

## Internal Coordination Efforts

Internal Title V/MCH team meetings are held regularly, coordinated by the MCH Block Grant Coordinator, to ensure the teams remain on target with priority work and relevant efforts. A system was developed by the team for ongoing assessment to track progress with measures and identify program responses based on the data (Ex: develop a TA webinar, conduct site visits, provide resources/materials, and plan a conference or skills building session).

***MCH Leadership Meetings:*** MCH Leadership meetings are convened and coordinated by the Block Grant Coordinator among the Title V MCH and CSHCN Directors and the Children & Families and System of Supports Section Directors. At this time, the Block Grant Coordinator, CSHCN Director, and System of Supports Section Director is represented by one individual. MCH Epidemiologists and Bureau Unit Directors (e.g., Community Partnerships, Title V Consultants) are invited as appropriate to agenda items and leadership discussions. The purpose of these meetings is to ensure communication regarding Block Grant activities and oversight, address systems and cross-section collaboration activities and needs.

Purpose	Key Activities and Discussion Points
Title V Oversight	<ul style="list-style-type: none"> <li>• Broad monitoring of aligned efforts</li> <li>• Updates and guidance as needed</li> <li>• Monitor Block Grant submission activities</li> </ul>
Cross-Section Collaboration / Activities	<ul style="list-style-type: none"> <li>• Discuss Title V workforce needs (e.g., staffing needs/gaps, training, guidance, supports)</li> <li>• Identify needed support for collaboration activities</li> </ul>
System Needs	<ul style="list-style-type: none"> <li>• Discuss system needs (e.g., new partnerships, fiscal resources, new initiatives, statewide activities)</li> </ul>

***MCH Coordination Meetings:*** Convened by Block Grant Coordinator with intentional alignment and coordination with MCH

Leadership and the planning teams for the Kansas Maternal and Child Health and Family Advisory Councils. These are action-oriented working meetings among core Title V staff and intended to support transparent, collaborative processes and shared decision-making around the Block Grant and MCH service delivery systems. Other subject matter experts, program partners, and consultants are invited as appropriate to agenda items.

Purpose	Key Activities and Discussion Points
MCH & Block Grant Core Functions	<ul style="list-style-type: none"> <li>Ongoing needs assessment, emerging issues, data/measure trends, disparities/inequities, BG report/application (e.g., guidance, timelines, submission needs, writing assignments, staff support needs)</li> <li>Aid to Local (MCH &amp; SHCN) network: funding/awards/monitoring and shared decision making</li> <li>Title V coordination and collaboration needs related to other BFH programming (e.g., ITS, WIC, CCL, NBS, BDS, Title X), other bureaus (BHP, BDCP, BOH, BEPHI), and divisions (DHCF/Medicaid)</li> <li>Family &amp; Consumer Partnership/Engagement</li> </ul>
Monitoring & Evaluation	<ul style="list-style-type: none"> <li>Review data trends (e.g., presentations by Epis, data from Title V programming/projects, emerging national data and comparisons with KS, spotlight on disparities by population domain)</li> <li>SAP Monitoring (high-level, focus on coordination/collaboration)</li> <li>BG Evaluation Plan (as related to coordination or collaboration activities or how the data reflects our progress)</li> <li>CCB utilization and sensemaking reflection/needs</li> </ul>
Workforce Development	<ul style="list-style-type: none"> <li>KMCHC and FAC Meetings (e.g., alignment, agenda development, Council activities/work group feedback; debriefs and action items)</li> <li>BFH Staff needs (e.g., emerging issues, training needs, expanded skill development)</li> <li>ATL network and other partner needs, including families/consumers</li> </ul>

Key topics of conversation during MCH Coordination meetings this past year include: planning for federal Block Grant review; expansion of family engagement and consumer partnership efforts; revisions and utilization of the Community Check Box; alignment and collaborative review of final new 5-years SAP (including an internal monitoring spreadsheet to share key progress and future plans among the team); special presentation from community partners (e.g., 1-800-CHILDREN); KMCHC and FAC planning efforts; evaluation skills-building workshop; MCH/SHCN Aid to Local funding recommendations; preparations for Block Grant public input processes; among other alignment, partnership, and collaboration discussions.

*Community Checkbox Sensemaking Sessions:* In coordination with the KU Center for Community Health and Development (KU-CCHD), the core Title V team is convened to review the data available through the KS MCH Community Check Box, which includes looking at accomplishments entered to date and engaging in a systematic reflection on patterns in MCH activities and indicators, asking questions such as:

- What we are seeing?
- What it means? (e.g., enabling/impeding factors or activities associated with increases/decreases)
- Implications for adjustment

Purpose	Key Activities and Discussion Points
Accomplishment Review	<ul style="list-style-type: none"> <li>Discuss Inputs/Process Activities (e.g., quantity/timing, distribution, impacting factors)</li> <li>Review aggregate accomplishments data (e.g., what can we learn from our activities, actions, and reach)</li> <li>Evaluate aggregate accomplishments data (e.g., what does the data tell us about reach and impact)</li> </ul>
Activity-Level Evaluation	<ul style="list-style-type: none"> <li>SAP Monitoring (activity-level, focused on completion and reach of specific activities)</li> <li>BG Evaluation (as related to coordination or collaboration activities or how the data reflects our progress)</li> </ul>

## External Coordination Efforts

**Kansas Maternal & Child Health Council (KMCHC):** The KMCHC serves in an advisory capacity to the Title V Program on ways to improve the health of families in Kansas, focusing on the MCH population. The Kansas Chapter of the American Academy of Pediatrics (KAAP) serves as the lead agency and fiscal agent for the Council. As a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians, and other professionals dedicated to promoting improved maternal and child health and delivery of care, KAAP is poised to support Title V in this capacity.

Guided by the Title V Needs Assessment and SAP, the Council strives to assure access to high quality MCH services and improved outcomes for Kansas women, children, and families. The structure of the quarterly council meetings is key to advancing the plan. Each meeting entails large group discussions and presentations on MCH investments/initiatives (e.g., safe sleep, birth outcomes, breastfeeding, school health) and/or workforce development topics (e.g., life course, human trafficking, family and consumer partnership/engagement) as well as small group sessions focused on domain action plans/efforts.

Title V Population Work Groups are critical to the infrastructure of the Council. These small groups are charged with prioritizing focus for the assigned target population, providing recommendations, informing of gaps in service delivery systems, refining objectives and strategies to remain relevant and support effective/efficient MCH services, identifying partnership needs, discussing capacity concerns, among other tasks. The full council membership participates in small groups as part of each meeting. In 2020, the Council expanded from four work groups, focused on the core MCH population domains (women/maternal, perinatal/infant, child, adolescent) to seven work groups to include dedicated space and monitoring of each of the seven state priorities under the SAP and the specific targeted population for each.

Council membership is comprised of a multidisciplinary team of professionals with expertise in MCH. Membership is divided into four primary membership types: community/state partner, health care provider, family/consumer, and staff. At the time of this report, there were a total of 59 members of the Council, including 31 community/state partners, 8 health care providers, 5 family/consumer members, and 15 MCH/Title V staff. Learn more about the MCH Council, review membership, and access materials and resources online: [www.kansasmch.org](http://www.kansasmch.org).

**Kansas Family Advisory Council (FAC):** The FAC is designed to assure the needs of families and consumers are central to programming, initiatives, and special projects. In other words, making sure the needs of families are first and foremost in our minds in all we do. The main goal is to learn from family and consumer experiences to make better program decisions and run programs with the needs of the family/consumer at the center of what we do. The purpose of the FAC is directly aligned with the purpose of the KMCHC to support partnership and collaboration across these groups. To further support alignment and coordination, the mission of the Title V is carried out in the mission statement for both the FAC and KMCHC.

The FAC expanded dramatically in this past year, from ten active members focused primarily on the CSHCN population, to at the time of this report, thirty members representing each MCH population domain. This supports the vision of the FAC

where “individuals and families are (1) engaged in program planning, evaluation, service delivery, and policy development; (2) partners in advocacy; and (3) leaders in their communities.” To accomplish this, the FAC will establish five core work groups (Women/Maternal, Early Childhood, Child, Adolescence, and CSHCN) that will provide space for families to focus on specific areas of the Title V SAP. Members of the FAC are valuable partners in the Title V work (read more about the FAC in the Family Partnership Section).

### Role of KMCHC & FAC Members in Monitoring & Assessing Title V Activities

The KMCHC and FAC actively participate in monitoring of the SAP and assists with prioritization and assessment of progress on a regular basis. This is evident in the way agendas are developed, with intent to provide expanded knowledge and understanding of MCH issues affecting populations (large group work) and review of the state action plan (small group work) as it pertained to progress with domain priorities, objectives, and strategies. The small groups are based on the population domains and Kansas priorities and offer a platform for members to learn about progress within the SAP, discuss emerging issues, recommended changes, new partnerships or expanded collaboration opportunities. Summaries of agendas and crucial work performed by each Council can be found in Supporting Documents submitted with this application.

### **Title V MCH Promotion & Outreach**

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

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

Facebook: [www.facebook.com/kansasmch](http://www.facebook.com/kansasmch)

**MCH Facebook Page Insights:** The following insights are from the MCH Facebook Page for the reporting timeframe of this Application/Annual Report (October 1, 2019 to September 30, 2020). Consistent promotion of the Facebook page, along with sharing regularly through KDHE Social Media activities as well has supported a continued growth as evident in the image below with a 41% increase in the number of page likes.

## Facebook Page Likes: October 1, 2019 – September 30, 2020

October 1, 2019	468 Likes
September 30, 2020	661 Likes (+193)



Our partners with Envisage Consulting, Inc., who maintain and facilitate the KS MCH website and Facebook page created 283 separate posts during the reporting period, with an average of 23.5 posts to the MCH Facebook page. Several posts reached a high number of users, received a high level of “likes” and/or interaction (shares) from users. Below are the “Top 10” or “Most Popular” posts from the reporting period. Not surprisingly, five are related to COVID-19. The other five are focused on healthy pregnancies, safe sleep, pregnancy loss, and mental health awareness.



4/24/20  
Reach: 1,031  
Shares: 4  
Reactions: 6

“Do you have questions about your children wearing masks to prevent the spread of COVID-19? Find answers in this FAQs document made by the [Kansas Chapter, American Academy of Pediatrics](https://www.coronavirus.kdheks.gov/L/ChildrenandMasksPDF...) <https://www.coronavirus.kdheks.gov/L/ChildrenandMasksPDF...>”



6/2/20  
Reach: 2,319  
Shares: 13  
Reactions: 28

“Vaccinating babies and children on time is the best way to protect them from vaccine preventable diseases. Talk with your doctor today to see how they’re making clinics safe during #COVID19. #CallYourPediatrician”



3/23/20  
Reach: 1,021  
Shares: 6  
Reactions: 14

“Washing your hands protects you and your loved ones from many different illnesses, including the flu and COVID-19”



10/15/2019  
Reach: 1,244  
Shares: 13  
Reactions: 28

“Since children younger than 6 months cannot get a flu vaccine, the best way to protect them is to make sure people around them are vaccinated against the flu this season. <https://go.usa.gov/fB6c>”



3/30/20  
Reach: 16,754  
Shares: 99  
Reactions: 115

“Find answers to frequently asked questions about COVID-19 for the perinatal and infant populations with this information provided by the Kansas Department of Health and Environment. [http://www.kdheks.gov/coronavirus/download/FAQs\\_for\\_Pregnant\\_Moms.pdf](http://www.kdheks.gov/coronavirus/download/FAQs_for_Pregnant_Moms.pdf)”





2/19/20  
Reach: 1,388  
Shares: 15  
Reactions: 21

"Did you know that it is safe and important to get your flu shot during pregnancy? Check out this infographic for more facts about healthy pregnancies!"



2/12/20  
Reach: 1,044  
Shares: 12  
Reactions: 33

"What do these babies all have in common? They are in safe sleep environments! They are sleeping alone, on their backs, and in a clutter-free crib to reduce the risk of sudden infant death syndrome (SIDS). Learn more at [www.kids.org/safe-sleep](http://www.kids.org/safe-sleep)."



6/12/2020  
Reach: 1,081  
Shares: 8  
Reactions: 17

"Smoking during pregnancy is dangerous for you and your baby. If you use cigarettes or e-cigarettes, now is the time to quit."

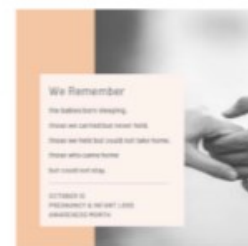


5/26/20  
Reach: 1,760  
Shares: 13  
Reactions: 19

"#BeThe1to Follow Up - it can make all the difference.

Following up reminds them they are #NotAlone.

This Mental Health Awareness Month, learn 5 steps you can take for communicating with someone who may be suicidal at [www.Bethe1to.com](http://www.Bethe1to.com)



10/6/2019  
Reach: 1,760  
Shares: 11  
Reactions: 81

- Kansas MCH Website Insights (Google Analytics): From October 2019-September 2020, the site had an average 224 users each month who viewed an average 2.6 pages during each session. Website activity has been generally constant with periods of greater activity coinciding with information campaigns, initiatives, and council meetings. User Demographics:
- Users visit the site on desktops (82%), mobile devices (16%), and tablets (1%).
  - Users visit the site using Chrome (71%), Safari (8%), and Microsoft Edge (5%).
  - Most users are in Topeka, followed by Wichita and Lawrence.
  - 87% of site visitors are new, 12% are returning visitors.
  - 76% of visitors are women and 23% are men.

## Kansas MCH Council Website

(One Year: October 1, 2019 – September 30, 2020)

<http://kansasmch.org/>

Data from Google Analytics



### Definitions

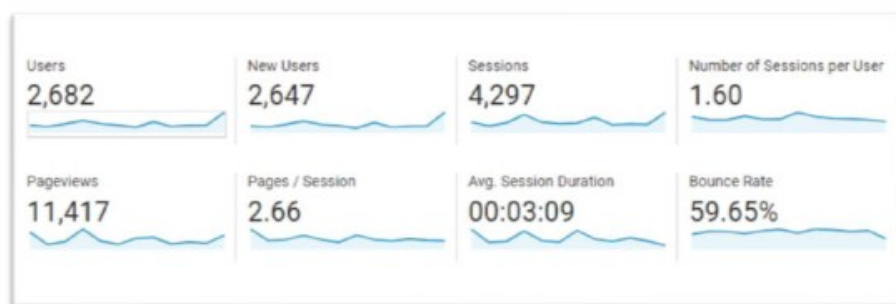
**Pageviews:** The total number of pages viewed. Repeated views of a single page are counted.

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

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

**Bounce Rate:** The percentage of all sessions where users only viewed a single page on your website.

### Data Dashboard



### Most Viewed Pages:

- Following the home page: Maternal Mortality Review, Resource, and Adolescent Mental Health/Suicide Prevention.
- Top 3 Action Alerts:
  - [Action Alerts Homepage](#) = 369 views
  - [Adolescent Mental Health and Suicide Prevention](#) = 340 views
  - [Women's Health Month Toolkit](#) = 216 views

## 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.

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**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.

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**Kansas Chapter of the American Academy of Pediatrics (KAAP)**

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

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**EnVisage Consulting, Inc.**

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

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**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 collect 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<sup>®</sup> 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.

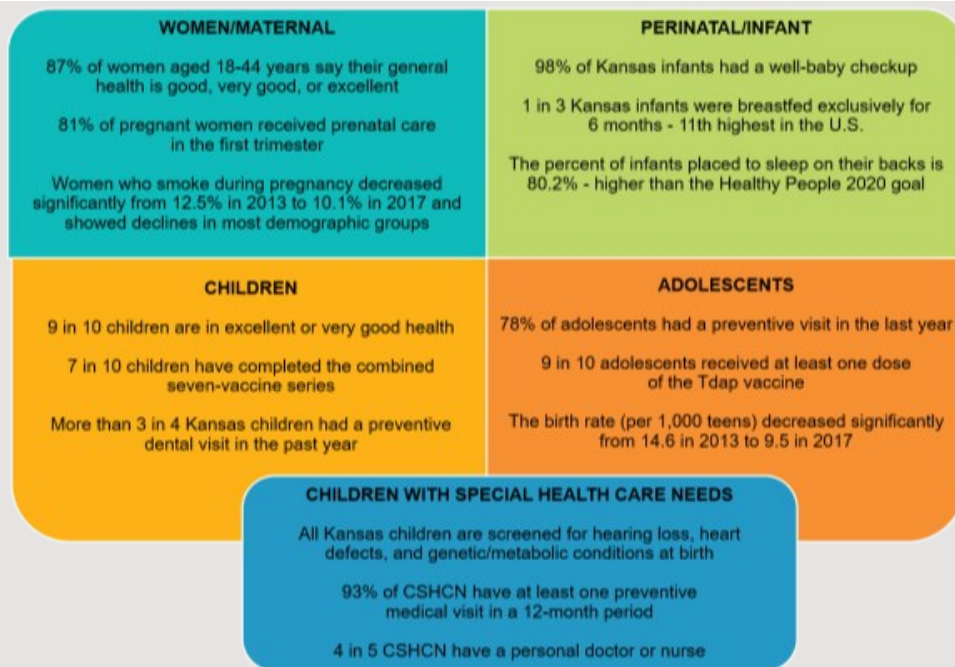
### **III.C.2.b. Findings**

#### **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.





## 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.



## 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**

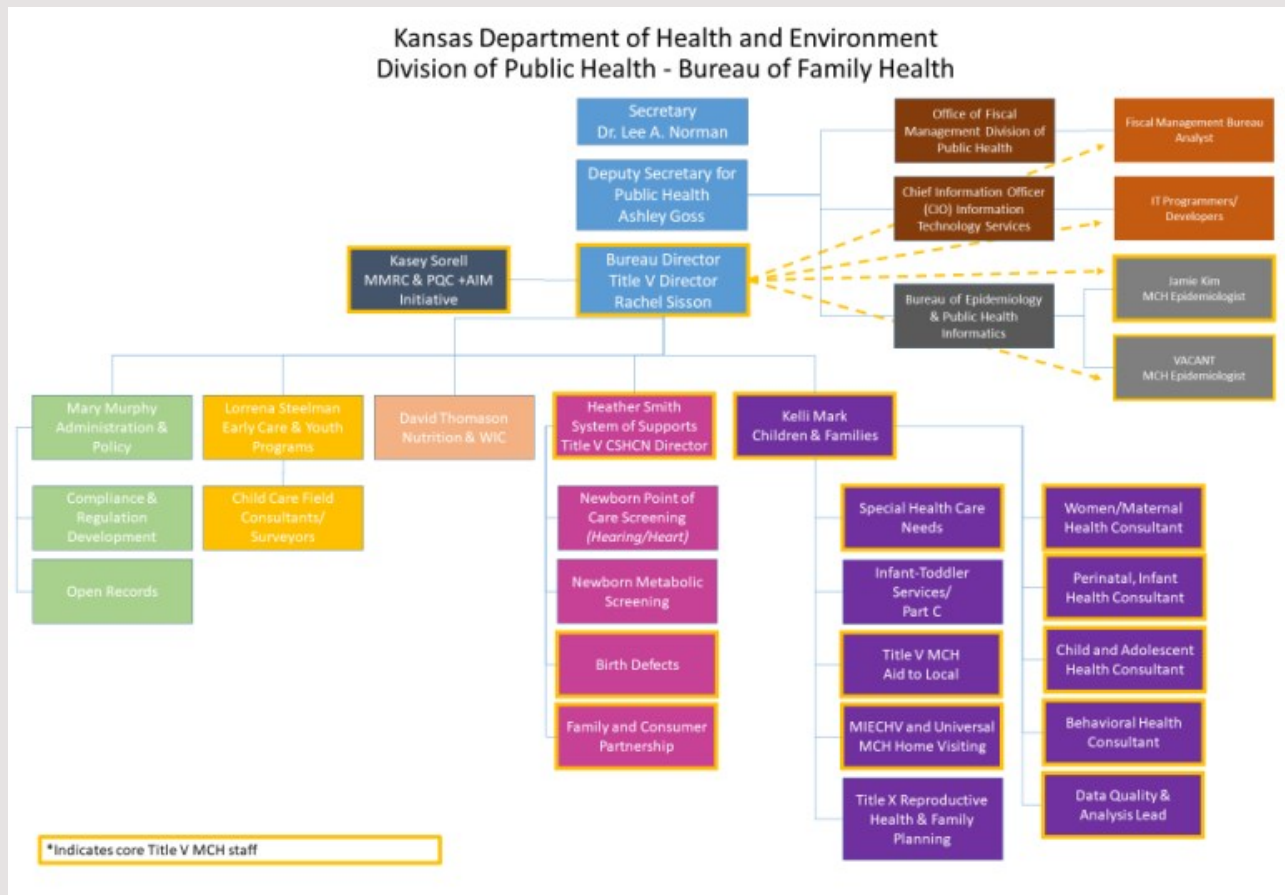
#### **III.C.2.b.ii.a. Organizational Structure**

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	<ul style="list-style-type: none"> <li>• W/M Consultant</li> <li>• Maternal Mortality Review Committee (MMRC) Consultant*</li> </ul>
Perinatal/ Infant	<ul style="list-style-type: none"> <li>• P/I Consultant</li> <li>• KS Perinatal Quality Collaborative (KPQC) Consultant*</li> </ul>
Child/ Adolescent	<ul style="list-style-type: none"> <li>• C/A Consultant</li> </ul>
CSHCN	<ul style="list-style-type: none"> <li>• Behavioral Health Consultant</li> <li>• Birth Defects Coordinator</li> <li>• Screening &amp; Surveillance Unit Director</li> <li>• 2 Bilingual SHCN Care Coordinators</li> </ul>

\*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://knap2.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
CSHCN Specialty Care Contracts	34	5.8
PMI	67	13.6
TPTCM	55	10.6
LYFTE	18	5.5
<b>TOTAL</b>	<b>658</b>	<b>160.2</b>
*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
<b>Total</b>	<b>108</b>	<b>658</b>	<b>160.2</b>

### 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 Wolt, 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.

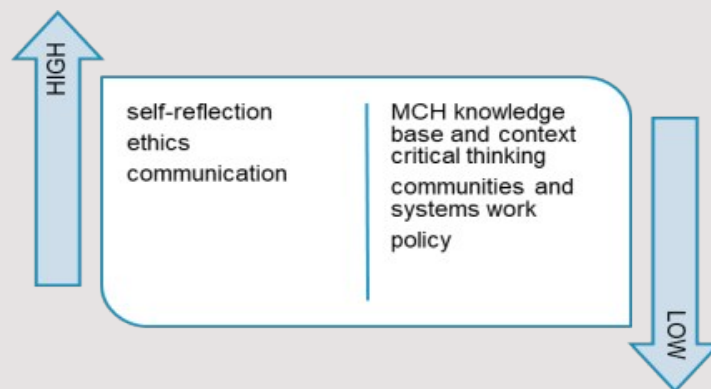
### Additional MCH Workforce Information

**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. <i>*REVISED*</i>	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
<i>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.</i>	
Perinatal/Infant Health Priorities	
All infants and families have support from strong community systems to optimize infant health and well-being. <i>*NEW*</i>	Families are empowered to make educated choices about infant health and well-being. <i>*DISCONTINUED*</i>
<i>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.</i>	

Child Health Priorities	
Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities. <i>*REVISED*</i>	Developmentally appropriate care and services are provided across the lifespan.
<i>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.</i>	

Adolescent Health Priorities	
Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health. <i>*REVISED*</i>	Communities and providers support physical, social and emotional health.
<i>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.</i>	

Children with Special Health Care Needs Priorities	
Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities. <i>*NEW*</i>	Services are comprehensive and coordinated across systems and providers. <i>*DISCONTINUED*</i>
<i>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.</i>	

Cross-Cutting/Systems Building Priorities	
Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations. <i>*REVISED*</i>	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. <i>*NEW*</i>	Information is available to support informed, healthy decisions and choices. <i>*DISCONTINUED*</i>
<i>Key Changes: The revised priority captures the intent to expand knowledge and skills <u>and</u> 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.</i>	

### 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

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$4,651,427	\$4,777,544	\$4,756,879	\$4,773,454
State Funds	\$3,531,773	\$3,800,940	\$3,531,621	\$3,642,252
Local Funds	\$3,906,504	\$5,186,201	\$3,911,125	\$5,853,388
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$12,089,704	\$13,764,685	\$12,199,625	\$14,269,094
Other Federal Funds	\$71,105,934	\$70,975,390	\$69,627,621	\$66,751,514
Total	\$83,195,638	\$84,740,075	\$81,827,246	\$81,020,608
	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$4,780,598	\$4,734,589	\$4,719,472	
State Funds	\$3,949,804	\$3,642,701	\$3,610,958	
Local Funds	\$3,992,669	\$3,992,250	\$4,056,499	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$12,723,071	\$12,369,540	\$12,386,929	
Other Federal Funds	\$70,031,333	\$63,802,894	\$65,973,561	
Total	\$82,754,404	\$76,172,434	\$78,360,490	

	2022	
	Budgeted	Expended
Federal Allocation	\$4,737,310	
State Funds	\$3,821,044	
Local Funds	\$4,056,499	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$12,614,853	
Other Federal Funds	\$63,331,794	
Total	\$75,946,647	



### 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) 2020 is reflected on Forms 3a and 3b.

**2020 Expenditures:** The FY 2020 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 \$12,369,540: \$4,734,589 federal; \$3,642,701 state; and \$3,992,250 local. Other federal funds overseen by the Title V Director totaled expenditures of \$63,802,894 for a grand total FY 2020 amount of \$76,172,434.

The total FY 2020, federal only spending to support MCH and CSHCN initiatives within the state health department included:

- \$64,691 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics;
- \$43,741 Local Public Health program;
- \$16,950 Child Care Licensing;
- \$745,760 Title V Administration/Staffing;
- \$510,340 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;
- \$2,257,665 MCH Aid to Local payments to local agencies for services;
- \$648,022 Special Health Care Needs (SHCN) staff, operating costs, contracts and supplies;
- \$34,316 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) \$4,817; Hospital \$4,039; Pharmacy \$8,722 Physician/Office Charges \$15,749; Labs \$33; Other \$956 (audiology).
- \$1,511 Newborn Screening Follow Up
- \$51,594 Fiscal Management
- \$360,000 Administrative Costs

Form 2 Expenditures Details: Form 2 reveals the Title V expenditures for FY 2020 comply with the 30% - 30% requirements for priority populations: preventive and primary care for children \$1,468,750 (31.0%) and children with special health care needs \$1,469,248 (31.0%), similar to previous reporting periods. Other requirements related to expenditures such as administrative costs at \$360,000 (7.6%) (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 2020 are \$63,802,894 and include the following: Women, Infants, and Children (WIC) \$49,196,374; Breastfeeding Peer Counselor Program \$447,987; Early Childhood Comprehensive Systems \$411,485; Newborn Hearing Screening \$238,286; Newborn Hearing Screening Data Enhancement \$117,942; Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula \$4,123,412; MIECHV Innovation \$12,182; Part C Infant-Toddler Services \$4,304,078; Title X Family Planning \$2,808,025; Toxic Substances (Lead Hazard) \$127,558 (transferred to another agency Bureau – last reporting year); Pregnancy Assistance Fund – Lifting Young Families Toward Excellence (YFTE) \$891,652 (ended June 2020); Safeguarding Two Lives Maternal Behavioral Health (Kansas Connecting Communities) \$540,120; Pediatric Mental Health (KSKidsMAP to Mental Wellness) \$352,277; Newborn Screening \$81,473 (state evaluation \$14,035; new condition implementation/SMA \$67,438); ERASE - Maternal Mortality Review and Action \$150,043.

Form 3a Expenditures by Types of Individuals Served: All Block Grant partnership expenditures (federal, state, and local) total \$12,009,540 (\$4,374,589 federal/\$7,634,951 non-federal), not including administrative costs of \$360,000. Expenditures

by "Types of Individuals Served" (MCH population groups) includes: Pregnant Women and Infants <1 Year \$1,436,591 federal/\$3,201,533 non-federal; Children & Adolescents 1-22 Years \$1,468,750 federal/\$2,352,383 non-federal; and CSHCN \$1,469,248 federal/\$2,081,035 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 \$12,369,540 (including administrative costs). Expenditures by "Types of Services" (MCH pyramid) include: Direct Services \$70,383 (\$34,316 federal/\$36,067 non-federal) (<1%); Enabling Services \$5,969,023 (\$1,998,589 federal/\$3,970,434 non-federal) (48%); and Public Health Services and Systems \$6,330,134 (\$2,701,684 federal/\$3,628,450 non-federal) (51%). 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 \$4,734,589 in FY 2020. Kansas meets its match requirement with State funds that support MCH 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 MCH Council and programs provide input about 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.

**2022 Budget:** The total state budget submitted for Federal Fiscal Year (FFY) 2022 and detailed on Form 2 is \$75,946,647. 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 \$4,737,310 (based on the allocated amounts in the State budget and a final authorized federal MCH award amounts for FFY 2020 and FFY 2021); state MCH funds \$3,821,044; local MCH funds \$4,056,499; and estimated other federal funds \$63,331,794. 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 include the following:

- Women, Infants, and Children (WIC) \$49,713,148;
- Breastfeeding Peer Counselor Program \$536,298;
- Early Childhood Comprehensive Systems \$18,429 (new application year);
- Safeguarding Two Lives Maternal Behavioral Health (KS project: Kansas Connecting Communities) \$316,545;
- Pediatric Mental Health Care Access (KS project: KSKidsMAP to Mental Wellness) \$444,868;
- Universal Newborn Hearing Screening \$232,582;
- Newborn Hearing Screening Data Enhancement \$160,000;
- Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula \$4,792,517;
- Part C Infant-Toddler Services \$4,282,434;
- Title X Family Planning \$2,535,491; and
- ERASE/Reducing Maternal Deaths: Maternal Mortality Review \$299,482.

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 (approximately \$100,000) supports MCH Epidemiology and data capacity activities.

Form 2 MCH Budget Details. Overall, Kansas' MCH federal-state-local partnership budget for FFY 2022 totals \$12,614,853 (federal MCH funds \$4,737,310; state MCH funds \$3,821,044; 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 \$134,043; Local Public Health Program \$49,562. 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); \$718,905 for MCH section staffing, MCH aid to local programming/monitoring, and other operations; \$405,707 for Bureau/Title V director, Deputy Director and staff, Bureau assistant, and fiscal support; \$935,003 for SHCN staffing, programming, outreach, and direct services (federal portion of direct services totals \$50,236; estimate is based on FY2020 expenditures and authorized plans); \$226,000 for vendor contracts (MCH Council, DAISEY, MCH Check Box), and interventions/programming related to the state action plan (stillbirth prevention); \$1,873,090 for local MCH agencies providing community-based, family centered services including home visiting (local public health departments, community health centers, hospitals, health foundations); and \$375,000 for administration costs.

The Kansas budget for FFY 2022 meets the maintenance of effort requirement of \$2,352,511. The Title V match

requirement is achieved through projected State matching funds budgeted at \$3,821,044 which include \$30,000 for MCH aid to local operations; \$96,374 for Kansas Infant Death and SIDS (KIDS) Network and \$250,000 for Universal Home Visiting (foundational support allocated through the Governor's Budget from the Children's Cabinet and Trust Fund for the KDHE Bureau of Family Health); \$452,526 for newborn screening follow up; \$319,719 for SHCN administration, case management, care coordination, and direct services (\$40,867); \$2,169,614 for MCH aid to local programming; \$303,537 for SHCN seating clinics; and \$199,274 for PKU direct services. Local match is projected to total \$4,056,499. NOTE: The amount of local match for State FY 2019 exceeded the typical amount of match documented over the past several years by more than \$1M. Match amounts for FY 2020 dropped to levels in line with the prior five years. 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 2022 was estimated based on an average of actual match reported by local grantees/agencies during the past few years. The local match for State FY 2021 is in line with the trend of typical local investment regardless of the COVID-19 pandemic.

The Title V budget and funding allocations are in compliance with the 30% - 30% requirements: preventive and primary care for children \$1,510,122 (31.8%) and children with special health care needs \$1,461,952 (30.8%), similar to previous reporting periods (see Form 2). Other requirements related to budget categories such as administrative costs (\$375,000; 8.0%) are less than 10% as required and maintenance of effort is maintained. The indirect cost rate for KDHE is 13.8% effective July 1, 2021-June 30, 2022, an additional decrease compared to the previous rate of 15.0% (and 20.3% prior to that).

Form 3a Budget by Types of Individuals Served. Considering the total budget of \$12,614,853 (\$12,239,853 excluding budgeted administration costs of \$375,000), Form 3a details the (federal/nonfederal) budgeted amounts by types of individuals served including \$1,390,236 federal and \$3,358,814 nonfederal for pregnant women and infants under 1 year of age; \$1,510,122 federal and \$2,941,804 nonfederal for children and adolescents 1-22 years; \$1,461,952 federal and \$1,576,925 nonfederal for children with special health care needs (CSHCN).

Form 3b Budget by Types of Services. Form 3b details the total (federal/nonfederal) budgeted amount of \$12,614,853 by type of service: \$50,236 federal and \$40,867 nonfederal for direct services (<1%); \$1,944,036 federal and \$4,589,691 nonfederal for enabling services (51.7%); and \$2,743,038 federal and \$3,246,985 nonfederal for public health services and systems (47.5%). 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.

##### MCH Conceptual Models in Kansas

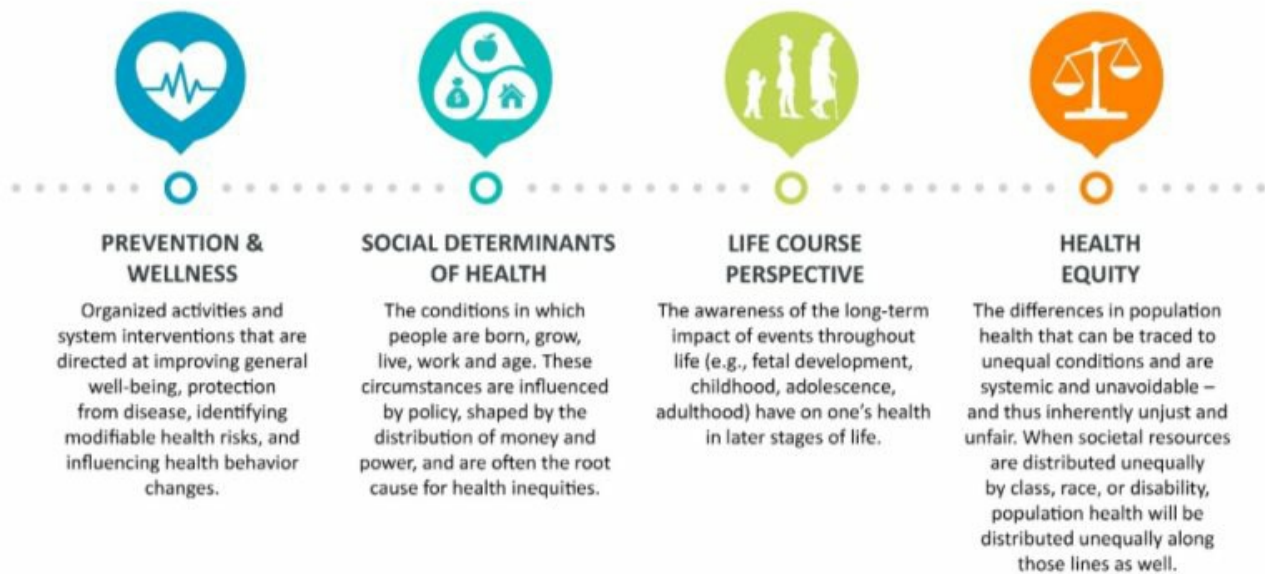
Title V recognizes and understands the connections between priorities across MCH population domains. Kansas' approach is supported by the tangible and intangible elements of collaboration, relationship building, and innovation. Four overarching themes have been identified as **guiding principles** that 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.

##### *KS Title V Guiding Principles*

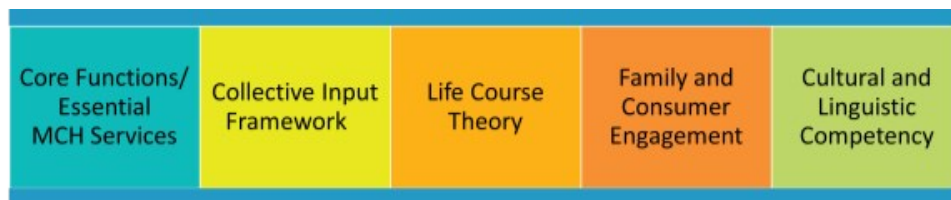


The Title V Program depends on the following **core values** when approaching all phases of work: planning, design, implementation, and ongoing assessment/monitoring/evaluation.

#### KS Title V Core Values



Kansas Title V applies the following **conceptual models** in our approach to addressing the priorities, needs, and challenges of target populations.



**Core Public Health Functions/Essential MCH Services:** Striving to assure everyone has the same opportunity to achieve optimal health and well-being, the Kansas Department of Health and Environment (KDHE) mission, “*To protect and improve the health and environment of all Kansans*” is directly aligned with the purpose of the [10 Essential Public Health Services](#) and core public health functions of assessment, policy development, and assurance. The essential services promote policies, systems, and community conditions. They were established to provide a framework for public health entities to follow that supports the breakdown and eradication of systemic and structural barriers that have resulted in health inequities (e.g., poverty, racism, discrimination). Kansas follows this framework and the MCH service delivery pyramid regarding the provision of direct health services, coordination of enabling services, and the infrastructure of public health services and systems.

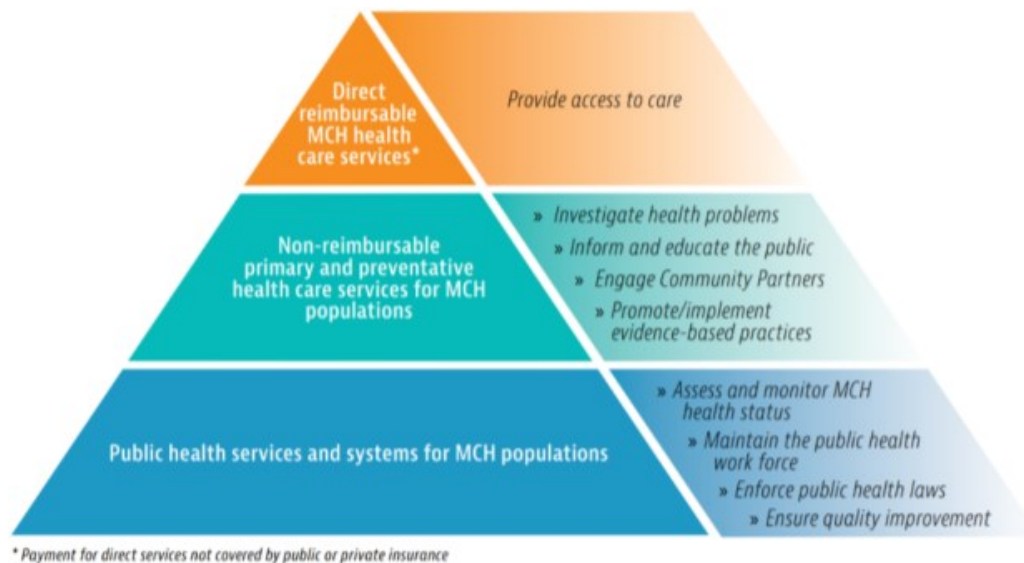


Image Credit: [MCH 2025 Title V Needs Assessment](#)

**Collective Impact Framework:** This framework is modeled throughout program development, implementation, and assessment activities to approach complex partnerships, collaboration efforts, or community support needs. Considering the focus on cross-system collaborative work, Title V has intentionally aligned five-year needs assessment processes and community collaboratives (e.g., [KS Perinatal Community Collaboratives](#)) with this framework to support significant and lasting social change. Kansas Title V leadership models the core belief that a one-size-fits-all solution/single policy/individual government entity/specific organization or program cannot meet the complex needs of the population alone. Rather, through coordination and collaboration across agencies and organizations, where each engaged partner agrees to a common agenda, shared measurement, and alignment of efforts, we can realize improvements to problems we face as a society.

**Life Course Theory:** Essential to approaching health and related services from a life course approach (e.g., integrated continuum, social and environmental “interplay,” across the life span) is a focus on four key concepts: timeline, timing, environment, and equity. Recognizing that what happens today influences one’s health in the future, critical periods of development and transitions across the life span set a trajectory for the life phase that follows (i.e., timing), community and environment affects one’s health (i.e., environment), and social determinants impact health just as much as genetic makeup or personal choice (i.e., equity). Kansas applies these concepts to MCH service delivery and promotes this framework among partners and grantees, encouraging them to systemically and strategically address social determinants of health and create plans to reduce disparities across population groups and generations.

**Family & Consumer Engagement:** There are many frameworks at the state and national levels that focus on engagement and partnership of families and consumers. Each offers various components that may be valuable to the work we do and supports our efforts to engage and partner in different ways, including foundational principles, quality standards, engagement strategies, and evaluation/assessment approaches. The table below provides a crosswalk of the key content supporting the Title V vision for family and consumer partnership across five notable frameworks.

Framework	Key Content
Levels of Family Engagement in Title V	Levels of Engagement <i>Input, Advisory (Self), Advisory (System), Leadership Roles</i>
Kansas Family Engagement and Partnership Standards for Early Childhood	Guidance for Engagement <i>Families as...Foundation, Communicators, Advocates, Partners, Community Members</i>
Standards of Quality for Family Strengthening and Support	Quality Standards for Family Support <i>Family Centeredness, Family Strengthening, Embracing Diversity, Community Building, Evaluation</i>
A Framework for Understanding the Elements and Developing Interventions and Policies	Continuum of Family Engagement <i>Consultation, Involvement, Partnership and Shared Leadership</i>
A Framework for Assessing Family Engagement in Systems Change	Assessment Tools for Engagement at the Systems Level <i>Commitment, Transparency, Representation, Impact</i>

**Cultural & Linguistic Competency:** Kansas believes that building relationships and partnerships with those we serve is essential to ensuring needs are met. Communication and interactions must be responsive to the individual experiences and perspectives (e.g., abilities, culture, education, race/ethnicity, gender, age, language and literacy, religious affiliation, sexual orientation, socioeconomic status, values). Decreasing health disparities and improving equitable access to services and care is possible when communities exhibit cultural (including linguistic) competence through intentional actions related to program design, delivery, and evaluation. Title V staff and partners receive support to engage in workforce development activities to build strong MCH leaders who apply knowledge and skills associated with this [MCH Leadership Competency](#). Kansas applies these beliefs and actions during ongoing organizational assessments, family/consumer engagement efforts, public health service delivery, and measurement and evaluation activities.

### Addressing MCH Population Needs Through Title V Leadership

Title V in Kansas serves in a variety of leadership roles (e.g., convener/facilitator, collaborator, partner/funder) to address the needs of the MCH populations. Our vision and strategic, intentional approach have not only significantly contributed to building and sustaining relationships over the years, leading to growth and success, but have also positioned the Title V program to face ongoing challenges and emerging issues.

- **Title V as a Convener:** Engaging stakeholders, providers, and consumers/families is essential to success. Title V often facilitates the convening of stakeholders across service delivery systems that engage and interact with women, children, and families. Communication is critical to planning and addressing the needs of MCH populations.
- **Title V as a Collaborator:** A major focus of Title V and BFH policy and program initiatives is collaborative relationships. Commitment to collaboration is evident across engagement and participation in a variety of statewide initiatives in a collaborative role, to support alignment and integration of MCH practices, principles, and initiatives with related partners and programming and to ensure coordination of the health components of the MCH system. Collective impact is the framework.
- **Title V as a Partner:** Partnerships are essential to the delivery of high-quality MCH services and establishment of an equitable and competent system to address the needs of the population. Organizational partnerships support expanded capacity across communities and systems. All partnerships are mutually beneficial. Some partnerships involve formal agreements and funding to address gaps and services.

The state Title V 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). Our partners support this approach and has proven time and again they stand ready to work on issues when called upon.



Title V is truly the leading vision for MCH in Kansas, 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.

### Title V Partnerships & Collaboration = Access & Delivery of Quality Services

*Kansas Perinatal Community Collaboratives:* The [Kansas Perinatal Community Collaborative \(KPCC\)](#) model assures comprehensive and coordinated perinatal supports through shared risks, resources, and rewards. Bringing prenatal education and clinical prenatal care together to create a comprehensive program model helps communities leverage existing resources (e.g., staff, space, patients/clients, programmatic and educational materials, toolkits) and funding to more effectively serve a common set of perinatal clients. When the KPCC model is implemented, perinatal systems of care are redesigned and institutionalized as partners come together to meet local needs. The model and affiliated programming is targeted at communities with demonstrated birth outcome and infant mortality disparities, both racial/ethnic and socioeconomic.



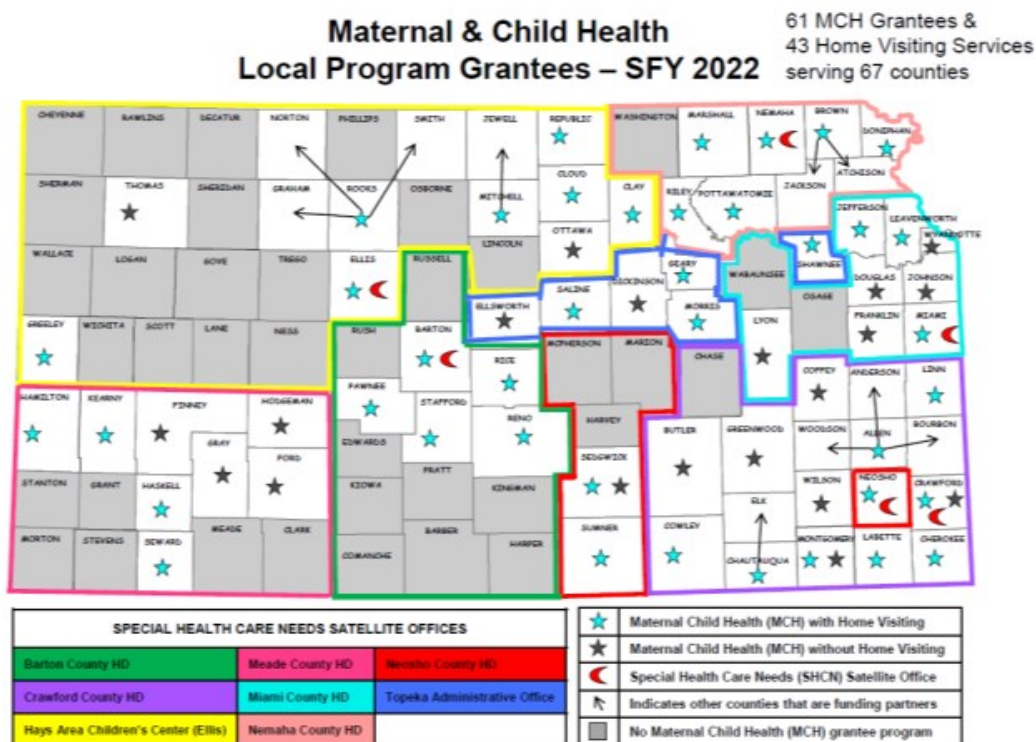
Following the release of the Kansas Blue Ribbon Panel on Infant Mortality recommendations in 2010, the March of Dimes (MOD) Greater Kansas Chapter developed a community collaborative model in partnership with KDHE that was designed to implement the Becoming a Mom/Comenzando bien® (BaM/Cb) basic prenatal education curriculum. This serves as the foundational prenatal education component of the collaborative model to ensure program fidelity across communities. During the several years, resources needed for statewide expansion with protections of program fidelity and a MOD trademark agreement have been developed and include:

- Supplemental prenatal education content;
- Guidance documents and training videos;
- Standardized program resources such as session slides/PowerPoints, lesson plans, activity plans and supplemental handouts;
- Promotional material templates; and
- A private website portal to provide direct access to these resources.

All supplements to the MOD curriculum have been translated to Spanish in partnership with the KU School of Medicine-Wichita, Department of Pediatrics and a workgroup with representation from five Spanish dialects. These tools and resources have provided the mechanism for statewide expansion and support both growth and future sustainability. Local community sites interested in establishing this model are required to enter a memorandum of understanding with KDHE/Title V in order to gain access to training and programmatic resources. Title V has established referral and evaluation systems to support collaboration and outcome measurement among sites, in partnership with the University of Kansas Center for Public Partnerships and Research. Shared measurement is made possible by [DAISEY](#).

Kansas Title V has invested extensive resources to position the state and communities for this model, with the primary goal to expand in both rural and urban communities and build capacity for existing collaborations. Driven by private and public partnerships at both state and local levels (e.g., Title V MCH, Medicaid, private foundations, local health departments, federally qualified health centers, clinical providers, local hospitals, community and faith-based organizations), this model supports permanent MCH infrastructure, leveraged and shared resources, changes in the prenatal care delivery system, a vehicle to identify community needs, a standardized evaluation and shared measurement system, and new opportunities for achieving community collective impact and improved birth outcomes. This can also serve as the backbone for dissemination of targeted public health programming and affords communities with a successful vehicle for future sustainability. Standardization of screening, referral, education, and outcome measurement processes has been pivotal to Kansas expansion efforts. KPCC initiatives and activities are integrated strategically throughout in the State Action Plan Domain Narratives to reflect the reach and impacts this model across the life course.

**Local MCH Grantees:** In addition to partnerships with state-level organizations working directly with communities, Title V contracts with local health agencies offering a wide range of MCH services, including home visiting. Reach for these services can change from year to year based on local community needs and capacity. The services delivered by local agencies are designed to address ongoing needs and those identified by the most recent needs assessment. Most local programs funded in part 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. A map displaying local grantees is included below. The counties shaded in gray are not covered by a lead agency.



Title V contracted with 67 local agencies in SFY21, serving 79 counties. The SFY22 contracts were awarded effective July 1, and there are currently 61 MCH grantees serving 67 counties. We have seen a decrease in applicants over the years due to competing priorities at the local level for community organizations. Ensuring coverage and access to supports and services is a priority for the State Title V program. The funding structure and approach will need transformed to address this long-standing issue. Unfortunately, not all local MCH lead agencies can provide the services that we know make a difference such as: home visiting, the KPCC birth outcomes model, and holistic care coordination. In fact, only 53 offered home visiting services and only 8 have signed on to provide holistic care coordination through the SHCN program.

To assure Title V is supporting widespread access to evidence-based, high-quality services, we are committed to a comprehensive review of our aid to local structure. This will help identify opportunities for statewide reach and address findings from two separate statewide needs assessments (Title V and Early Childhood Systems) that noted access to services and programming across the state is not equitable. These activities highlighted things we already knew: there are large health inequities in the state, and inequities are exacerbated by social determinants of health. Many families indicated through the early childhood systems work (supported by the Preschool Development Grant – PDG) that they are “barely surviving,” and this was before the COVID-19 pandemic. Families should not have to fight to get their basic needs met, worry about where their next meal is coming from, or how they will be able to work because they can’t find child care. Fighting to survive often worsens “diseases of despair” and we have seen huge increases in behavioral health concerns such as mental health disorders, substance use, excessive alcohol use, suicides, and intimate partner violence.

*Systems of Care for CSHCN:* Title V strives to expand upon and support a cohesive, integrated, and supportive system of care (SOC) for children with special health care needs (CSHCN) and their families. The [Kansas State Plan for Systems of Care for CSHCN](#) (2017) is intended for agencies and organizations serving CSHCN and stakeholders, including parents, caregivers, and individuals, in supporting Kansas to achieve the Standards for Systems of Care for CSHCN to strengthen collaboration, support systems integration and improve service delivery for CSHCN. Kansas engaged in and has adopted the National Standards for Care Coordination for CSHCN as the foundation for activities to expand holistic care coordination to all MCH populations.

Title V believes that expanded partnerships and strong collaboration are needed to improve and integrate systems of care for CSHCN. It remains evident that this cannot be met by one program, state agency, non-profit organization, or national entity alone. It will take all working together, in tandem and in collaboration, to assure a quality system of care for children and youth with special health care needs. The National Standards and related state plan are only guiding documents for CSHCN partners, to help support actions and priorities. It is desired that all CSHCN-serving agencies, organizations, and providers will see their role and shared responsibility in building and cultivating partnerships across systems, essentially improving outcomes and supports for families within a well-functioning system of care, so that CSHCN and their families can thrive and succeed in our communities. Title V is committed to engaging in these vital conversations and establishing a shared vision for systems of care for CSHCN.

*MCH Integration Toolkits:* To better assist local communities in serving populations, Integration Toolkits are being developed for identified priority areas within the MCH State Action Plan. They are intended for use in the public health setting, as well as being shared with community partners and providers who are serving the same MCH population across different settings. Through collaborative efforts focused on targeted interventions, we can begin improving outcomes for the MCH population in local communities and across the state, leading to greater collective impact.

The toolkits are designed to be a collection of resources, brought together into one centralized location, to assist in work around targeted Title V priorities. Resources include the latest research, recommendations, opinion statements and practice guidelines, as well as numerous tools, templates, and training opportunities. Toolkits are based on sound research and recommendations from leading experts in the field and are created in collaboration with many state and local partners that have a shared interest in providing coordinated and comprehensive services to women and families before, during, and after pregnancy.

- [Long Acting Reversible Contraceptive \(LARC\)](#)

- [Maternal Warning Signs](#)
- [Mental Health](#)
- Oral Health
  - [Oral Health Education Resources Searchable Database](#)
  - [Hot off the Press! Fluoride Facts and Oral Health Resources Database Training Webinar](#)
- Provider Resources
  - [Health Equity](#)
  - [Action Alerts and Infographics](#) (2020 Spotlight on Black Maternal Health)
- [Reproductive Life Plan](#)
- [Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#)
- Well-Woman Visit
  - [Woman Visit Toolkit: Providers](#)
  - [Well-Woman Visit Toolkit: Communities](#)

Available toolkits can be found on the [MCH Integration Toolkits](#) page on the KDHE website.

### III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

#### 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 and support for facilitation of conversations and activities necessary to address the needs of MCH populations. Effective September 2021, BFH has approximately 95 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 (administration, SHCN and MCH staff, and Epidemiologists).

#### CORE TITLE V STAFF

Senior Leadership (3)	Consultants & Middle Management (8)	Data Supports (3)	Special Health Care Needs (6)	Maternal and Child Health (4)
<ul style="list-style-type: none"><li>• Title V MCH Director*</li><li>• Title V CSHCN Director*</li><li>• Children &amp; Families (C&amp;F) Section Director</li></ul>	<ul style="list-style-type: none"><li>• Community Partnerships Unit Director</li><li>• W/M Consultant</li><li>• P/I Consultant (2)</li><li>• C/A Consultant</li></ul> <p><i>Funded through other sources:</i></p> <ul style="list-style-type: none"><li>• Behavioral Health Consultant</li><li>• Clinical School Health Consultant</li><li>• Maternal Mortality &amp; Perinatal Quality Consultant</li></ul>	<ul style="list-style-type: none"><li>• MCH Senior Epidemiologists (2)</li><li>• MCH Data Analyst</li></ul> <p><b>System of Supports (2)</b></p> <ul style="list-style-type: none"><li>• Family/Consumer Partnership Consultant</li><li>• System of Care Consultant</li></ul>	<ul style="list-style-type: none"><li>• SHCN Program Manager</li><li>• SHCN Lead Care Coordinator</li><li>• SHCN Care Coordinators (3)</li><li>• SHCN Administrative Specialist</li></ul>	<ul style="list-style-type: none"><li>• MCH Program Manager</li><li>• MCH ATL Consultant</li><li>• MCH Home Visiting</li><li>• MCH Administrative Assistant</li></ul>

*\*Both Title V Directors serve in dual roles. The Title V MCH Director serves as the agency's Bureau of Family Health Director, overseeing wide-spread public health programming for maternal and child health populations. The Title V CSHCN Director serves as the Block Grant Coordinator.*

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, and private and public partners. Innovative approaches to shared staffing, when and where appropriate, has supported success. In addition to funding core Title V MCH and SHCN staff/programming, a small amount block grant funding supports the BFH Child Care Licensing Program to advance state action plan objectives targeted to early care settings (breastfeeding, oral health, physical activity). Within the Division of Public Health, other bureaus that receive regular support include Community Health Systems (BCHS) (local workforce development, training, capacity building, systems development) and Epidemiology and Public Health Informatics (BEPHI) (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 Epi 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, providers, and family leaders make up the broader workforce. Read more about the Title V workforce, program partnerships, and collaboration in other sections.

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 initiatives led by Title V that impact both state and community policies and systems. Therefore, focus has been in recruiting (and retaining) the right people to sustain and expand efforts. 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.

All BFH staff, including Title V team members, complete the CliftonStrengths assessment upon hire to discover their strengths and learn how to develop their talent (utilizing their strengths). Supervisors and managers are encouraged to establish coaching plans and supports for employees to maximize ability and plan programmatic activities by utilizing various team members’ strengths. All staff are encouraged to post their top five strengths in their office or cubicles and refer to them often. The team regularly engages in training and professional development activities around how to best utilize their strengths. In addition to utilizing this assessment with Bureau staff, all Kansas Family Advisory Council members receive a copy of the CliftonStrengths book and are asked to complete the assessment, which is used to support distribution across the four domains: executing, influencing, relationship building, and strategic thinking. BFH is partnering with [Gallup, Inc.](#) to take team strengths to a new level. Additional training for staff is scheduled for September 2021.

The [MCH Navigator](#) and online [MCH Self-Assessment](#) are utilized and fully integrated into professional development planning and performance reviews for all state MCH staff and local staff. Local MCH program staff must complete MCH trainings ([MCH 101](#) and [MCH Orientation](#)) through the Navigator within three months of grant award or hire. Local program staff delivering certain messages or services, including education, are required to complete other related trainings (e.g., tobacco, breastfeeding, safe sleep, care coordination). Ongoing training requirements for local MCH staff include technical assistance calls/webinars throughout the year led by the state MCH team and the annual Governor’s Public Health Conference. Home Visitors are required to attend state-sponsored annual training. Other courses selected for professional development must be identified on the “personalized learning plan” as a result of completing self-assessment.

The National Center for Education in Maternal and Child Health (NCEMCH), who oversees the MCH Navigator, provided a report of professionals in Kansas who have taken the online self-assessment from 2014-2020. This provides valuable information about the workforce and serves as a snapshot of demographics and knowledge/skills across the MCH Leadership Competencies. The following chart analyzes the Kansas knowledge and skill scores for each of the 12 MCH Leadership Competencies. As outlined in the report, these are in line with national data trends—cultural competency had the largest gap in knowledge and skills and policy had the lowest knowledge and skills scores across competencies.

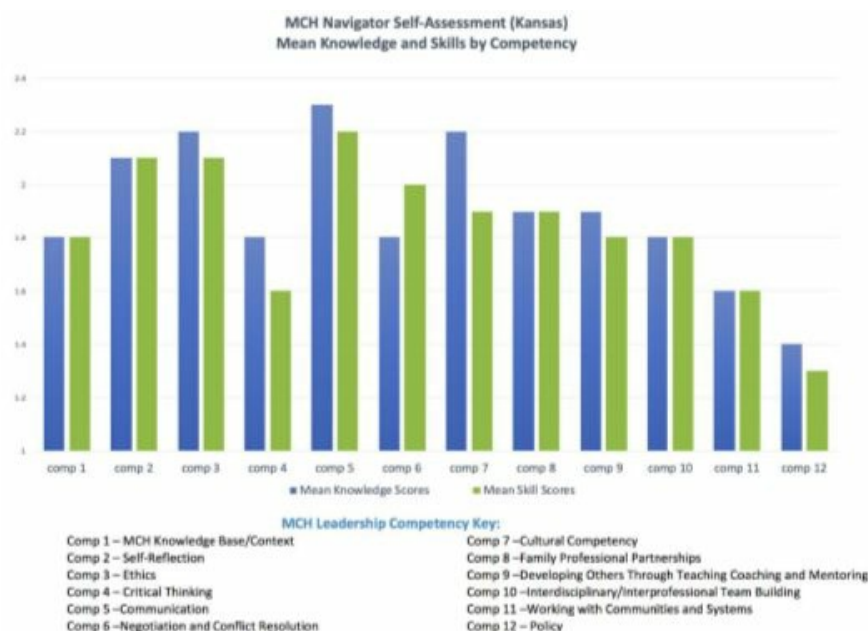


Image Credit: [MCH Navigator Kansas Workforce Snapshot, Self-Assessment Data 2014-2020](#)

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

Months prior to onset of the COVID-19 Pandemic, the Bureau engaged in a realignment among staff and programs/teams, especially related to core programming and services for MCH and early childhood. This was to support increased capacity, communication, and coordination, specifically around building/expanding state-local partnerships necessary to advance the MCH state action plan.



As part of this realignment, we moved core public health service-delivery based programs, such as Infant-Toddler Services and Special Health Care Needs into a newly formed Community Partnerships Unit with the other core MCH programming/staffing 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. A middle manager position was created to ensure the capacity and leadership/supervision was in place to ensure ongoing alignment and implementation of shared approaches including but not limited to screening, referral, and family/consumer partnership. This Unit now includes Title V MCH and SHCN services, Home Visiting, Title X/Family Planning, Part C/Infant-Toddler Services, child and adolescent health programs, and programs for pregnant and parenting teens/young adults.

Formalizing capacity for broader Title V cross-system initiatives (e.g., Systems of Care, family and consumer partnership/engagement, holistic care coordination) under the System of Supports Section (formerly Special Health Services) allows us to build and maintain strong foundations of support for Kansas families. This Section also includes the Screening & Surveillance (S&S) Unit (newborn screening programs, birth defects surveillance) to align foundational data and education efforts to support public health implementation and practice. This realignment supported long-term sustainability and clears the path for growth and advancement for Kansas children, families, and communities. An updated organizational chart is included as part of this application.

### State Title V Workforce

In the last year, Title V has encountered the following key staffing changes. Of particular note, two of the positions listed below are new positions, designed and filled to add capacity and support to targeted work (e.g., Perinatal Health, School Health) within the program. Some of these changes have resulted in added capacity, while others have left significant gaps in capacity, supervision, leadership, and support.

- *Children & Families (C&F) Section Director – Vacant June 2021; Filled September 2021:* The C&F Section houses the core MCH/Title V programming. In June 2021, the Section Director resigned and took a position as the BFH Administration and Policy Section Director, responsible for overseeing workforce development, legislative tracking, regulation promulgation, policy development, and open records. Recruitment concluded in August, and a new director starts on September 20.
- *2<sup>nd</sup> Senior Epidemiologist – Filled January 2021:* This position provides epidemiological support to all MCH programs with focus on alignment and data sharing with Medicaid. The position was vacant from August through December 2020. More information about the new Epidemiologist is available in the MCH Epidemiology Capacity narrative.
- *MCH Data Analyst – Vacant May 2021:* This position was the primary point of contact for the MCH service-level data system (i.e., DAISEY) and supported the Title V data reporting requirements. In May 2021, the former Data Analyst

resigned and took a position in the Bureau of Epidemiology and Public Health Informatics. Recruitment is underway; the position has been posted twice with no qualified candidates.

- *Clinical School Health Consultant – Filled February 2021; Vacant August 2021:* During the COVID-19 pandemic it became clear that schools/education system had critical and ongoing needs for public health support. In response, the agency hired a Clinical School Health Consultant. The position is housed in the BFH with the other Domain Consultants; however, the position is “shared” and highly collaborative within the agency as necessary to address school health goals. Since hire, the position has been engaged 100% in the response; as of July 2021, the position has started to focus more on programmatic efforts. Expanding school-based health services and health centers has been the priority focus; new CDC public health workforce funding will support expansion of SBHCs over the next two years. A second school health consultant (non-clinical/project manager) will be hired to support the work. As of August 2021, the incumbent resigned. Recruitment is underway.
- *Perinatal Health Consultant – Filled January 2021:* A second Perinatal Health Consultant position was created to provide additional support to the Clinical Perinatal Health Consultant in the ongoing work related to expanding the KS Perinatal Community Collaboratives in new areas of the state, among other critical perinatal/infant initiatives.

Beyond the changes within core Title V staffing, other key staffing changes occurred within the BFH, impacting capacity for collaboration and continuity in programming.

- Family Planning and Reproductive Health Program Manager (vacant since April 2021)
- Screening & Surveillance Data Analyst (vacant since May 2021)
- Home Visiting Program Manager (vacant October 2020; filled June 2021)
- Infant-Toddler Program Coordinator (vacant February 2021; filled June 2021)

*Recruitment & Retention:* During the 2019 Bureau Reorganization, dedicated capacity through the Administration and Policy Section was established to support recruitment, orientation/onboarding, workforce development, and staff retention.

Following the [2019 State of Kansas Employee Survey](#) disseminated by the Governor, the Bureau identified a specific need to work on recruitment and retention of a qualified workforce. Some bright spots from the BFH survey results:

- 97.7% of employees believe that the work they do furthers the agency’s mission.
- 91.7% of employees believe that their immediate supervisor appreciates their work.
- 87.2% of employees believe that their work is evaluated fairly.
- 83% of employees reported being satisfied to very satisfied with their current position.
- 80% of employees would like to finish their public service career with KDHE.

While the data was overwhelmingly positive, there were some areas that presented opportunities for improvement, specifically regarding communication, compensation/benefits, equipment/resources, and rewards/recognition.

- 46.8% of employees believe communication between work units/divisions is good.
- 8.5% of employees do not feel they are reasonably compensated for the work they do.
- 52% of employees felt their workload/caseload was manageable.
- 66.7% of employees reported having received adequate training to do their job.
- While most BFH employees (91.7%) felt that their immediate supervisor appreciated their work, only 62.2% felt that senior managers appreciated their work.

Upon review of the Bureau-level data, the Administration and Policy Team proposed the following project objectives to build a culture of support and mentorship, focus on effective communication, and foster collaboration across Sections and Programs. The goal is to assure all team members have the tools and resources necessary to be successful in their positions, be afforded professional growth opportunities, and see a clear pathway for advancement.

To date, several conversations have taken place and tools have been developed to support supervisors during the recruitment, hiring, and orientation processes. Specifically, a standard Bureau orientation process was established for program managers and leadership to assure a more intentional approach to orientation to BFH and programs as well as the

use of peer mentors to help navigate those first days and weeks on the job. Additional proposed strategies include: an annual assessment or review of position descriptions and position manuals; standardized separation interview (separate from any formal human resources exit interview processes); and ongoing recruitment strategies (e.g., interaction with candidates, screening criteria/scoring, interview questions).

To date, supervisors have begun utilizing the new BFH Orientation Checklist and Onboarding Tool. Plans are underway to partner with [Gallup, Inc.](#) to implement a package of strengths-based workplace efforts to improve organizational wellness and help employees thrive. Some of the targeted investments include discovery of employees' strengths, exploring how to utilize strengths in work and life, and coaching for supervisors/managers. The future involves establishing and connecting peer learning groups.

**Development & Training Activities:** In addition to required agency training programs like Public Health Quality Improvement, the Bureau and Title V state staff participate in annual training events that apply to all staff in the Bureau. Trainings/topics have included Change Cycle, Leadership, Mindset, and more. See list of topics by year in the table below.

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	StrengthsFinder Health Equity Hope is Contagious
2018	Importance & 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

***Due to the COVID-19 Pandemic, the 2020 Bureau retreat was cancelled.  
This activity is expected to resume in 2021 in some capacity, planning is underway.***

During the first annual BFH staff-development event, the BFH Rules of Engagement (image below) were developed and continue to be used today in new staff orientation, coaching, and staffing/leadership discussions around challenges and decision making.





The BFH annual staff development event will continue 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, public health assessment/evaluation (data-driven decision making), and telehealth. In addition, there is special emphasis on training the local workforce on these same topics, especially the importance of data-driven decisions and use of data to advance public health, including sharing data and integrating systems.

## Local MCH Workforce Development

In support of local staff, the KDHE MCH staff hosted a COVID-19 listening session where grantees had the opportunity to share how they are responding to the urgent needs during the pandemic. The local MCH grantee workforce has faced many challenges throughout the pandemic and almost all grantees have reported staffing shortages due to quarantines, high turnover rates, and burn out. This has been especially problematic when trying to accommodate for vacancies related to COVID-19 (e.g., quarantine, hospitalizations, caring for loved ones affected) and unrelated to COVID-19 (e.g., maternity leave, medical leave). Local grantees have also struggled with hiring and staff turnover, leading to long-term vacancies. Additionally, some even reported that during the pandemic, their funding (and staffing) was reduced for traditional services, while others added new staff who were unable to be properly trained due to the high demand of COVID-19 responsibilities. The majority of MCH grantees reported having to shift staffing, or completely re-focus from MCH activities to COVID-19 response (e.g., contact tracing, testing, administering vaccinations, special drive-thru events, telehealth visits). As such, staff morale has suffered, increased stress has been endured, and the burden of the pandemic weighs heavily on the emotional and mental health of those still working within the local public health agency. Examples of creative solutions to problems presented by COVID are provided throughout the application.

Development & Training Activities: Traditionally, Title V would provide a wide variety of development and training activities for the local MCH workforce. Due to the COVID-19 pandemic in-person technical assistance and trainings and site visits were not possible, and webinar offerings were limited to respect the need for local staff to focus on their individual community needs and attempt to maintain whatever level of continuity of care for the MCH population they serve that they could. A few of the offerings this year are outlined below.

- Mental Health First Aid (MHFA):** Growing concerns of the impact on one's behavioral and mental health during the pandemic prompted virtual training to learn how to support/help someone who may be experiencing a mental health related crisis. A total of sixteen sessions were held (10 adult; 6 youth). The primary difference between the adult and youth trainings is the audience/provider of services. A total of 166 attendees participated (Adults Sessions = 122, Youth Sessions = 44).
- KS-SHCN Care Coordinator Training:** Due to the COVID-19 pandemic, the traditional in-person training was not held this past year, however the SFY22 training is expected in the fall of 2021. This is likely to be held virtually to assure the safety of attendees and will center around expanding knowledge of resources, system navigation, relationship and partnership building activities, and family engagement techniques. A key focus for the upcoming training includes: HCC protocols and procedures, transition planning, new protocols and procedures around transition for those aged 12-21. SO's will be surveyed on any additional trainings they feel will be beneficial and provided during the SFY22 year.
- KS-SHCN Care Coordinator Monthly Webinars:** Ongoing TA efforts include bi-monthly webinars/brain trust calls where the state 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. During

FY20 Mental Health First Aid (MHFA) Trainings Offerings	
Adult Session Topics	Youth Session Topics
<ul style="list-style-type: none"> <li>Anxiety</li> <li>Depression</li> <li>Psychosis</li> <li>Addictions</li> </ul>	<ul style="list-style-type: none"> <li>Anxiety</li> <li>Depression</li> <li>Substance use</li> <li>Disorders in which psychosis may occur</li> <li>Disruptive behavior disorders (including AD/HD)</li> <li>Eating disorders.</li> </ul>
<small>Note: The youth MHFA training is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. The youth course also introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations.</small>	



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 not only been highly beneficial for serving the KS-SHCN clients, but for staff unity and team building. Unfortunately, due to SO staff having to focus on COVID relief efforts, they were not able to participate in these bi-monthly meetings this year. These will resume in SFY22, with presentations on transition planning, advocacy, waivers, guardianship, and supported decision making.

- *SHCN Satellite Office (SO) Site Visits:* In addition to engaging with the MCH TA efforts, KS-SHCN provides ongoing training, supports, and technical assistance to those grantees who also serve as KS-SHCN SO's to support the partnership and learning/growth for SO staff. On-site visits were not provided in SFY21, however, are anticipated to resume in SFY22. Site visit agendas and quantity vary based on how long the program has engaged as a SO, however a typical agenda may include:
  - Program policy/process review
  - Application processing and financial eligibility calculations
  - Data system
  - Holistic care coordination (HCC) services (e.g., role playing, documentation, building trust and rapport).
- *Bridges Program Care Coordinator Trainings:* As part of the training offerings to those piloting the Bridges Program (more information about this program in the CSHCN domain narratives), the KS Special Health Care Needs (KS-SHCN) program partnered with Families Together and Wichita State University to host two virtual trainings on Charting the Life Course and the Impact of Toxic Stress. KS-SHCN internal staff, along with SO care coordinators, were invited to attend several trainings, regardless of their engagement in the Bridges Program pilot group.
- *2020 MCH Home Visiting Fall Training:* Seventy-six (76) MCH Home Visitors participated in a virtual training opportunity focused on: Well Woman Integration Toolkit; KPQC Maternal Quality Initiative; Maternal Warning Signs; Reproductive Life Plan; and Behavioral Health. The 2021 [Kansas Home Visiting](#) Conference is scheduled to be held virtually September 27-28. The conference will feature keynote speaker Dr. Joan Duwve, Deputy State Health Officer, discussing COVID-19 (myths and facts) as it relates to home visitors and the families they serve.

*Addressing Anticipated Training Needs:* Title V staff will host monthly “Lunch and Learn” webinars to support ongoing engagement and technical assistance around topics relevant to the Title V State Action Plan, specifically to support knowledge acquisition, skill development, and increased comfort to address the needs of MCH populations. All sessions will be recorded and posted on the MCH Workstation (see next section for more information about this tool), allowing staff to access the information if they are unable to attend. The following are the planned session for the coming year.



Join the Kansas Department of Health and Environment's Maternal and Child Health Team, along with subject matter experts from across the state, for monthly learning opportunities! These sessions will focus on providing information about initiatives and resources that can be applied to maternal and child health work in your community. Attend them all or join as your schedule allows! Register for individual sessions by clicking on the links, below. **All sessions will be held on the third Thursday of the month from noon – 1 p.m. CT.**

**Maternal Warning Signs**

August 19, 2021 - Register [here](#)

**Youth in Crisis: Adolescent Suicide Prevention**

September 16, 2021 - Register [here](#)

**Perinatal Behavioral Health Services and Resources**

October 21, 2021 - Register [here](#)

**Adolescent SBIRT: Resource Guide and Toolkit Overview**

November 18, 2021 - Register [here](#)

**Tobacco Cessation During Pregnancy and Postpartum**

December 16, 2021 - Register [here](#)

### How to Build and Sustain a Perinatal Community Collaborative

January 20, 2022 - Register [here](#)

### Supporting Kansas Families Through School-Based Health and Population-Based Approaches to Serving Children with Special Health Care Needs

February 17, 2022 - Register [here](#)

### Women's Health Resources: Addressing Barriers to Preventive Care

March 17, 2022 - Register [here](#)

### Month of the Young Child: Increasing Literacy While Reducing Screen Time

April 21, 2022 - Register [here](#)

### KSKidsMAP: A Resource for Responding to the Pediatric Mental Health Crisis

May 19, 2022 - Register [here](#)

### Consumer and Family Engagement: Essential for Maternal and Child Health

June 16, 2022 - Register [here](#)

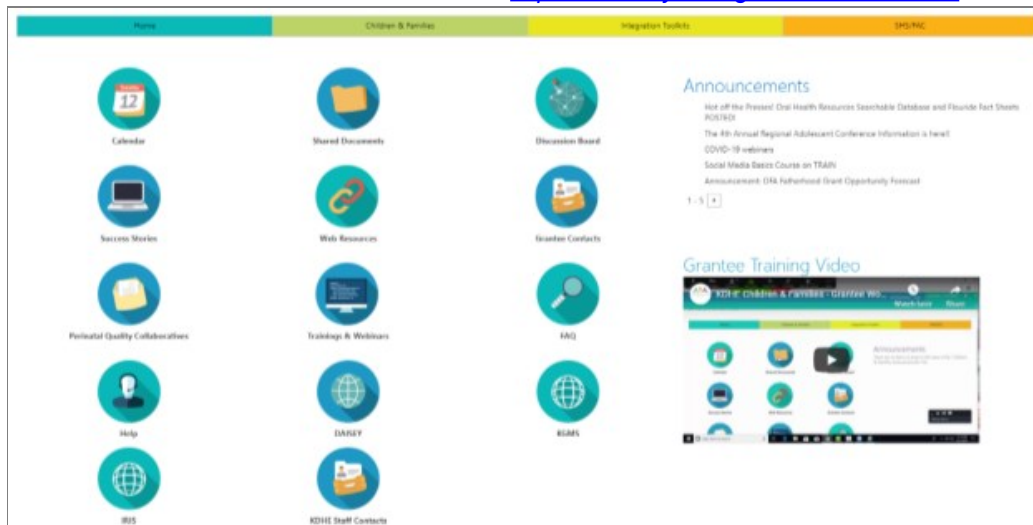
### MCH Opportunity Project: Health Equity Outcomes and Takeaways

July 21, 2022 - Register [here](#)

Regional meetings will be provided for local MCH grantees across all six regions to build stronger, supportive relationships during SFY22. If travel is not permitted, virtual trainings will be provided. 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, emerging issues, and staff concerns related to data trends and program reports.

***MCH WorkStation:*** A collaborative SharePoint application within the Community Check Box (CCB), commonly referred to as the WorkStation, continues to be utilized to enhance training and technical assistance while increasing statewide connections and collaboration among program staff and grantees. The WorkStation for MCH grantees offers 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.

Screenshot of the MCH WorkStation - <https://www.mycb.org/wst/KansasMCH/cf>



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

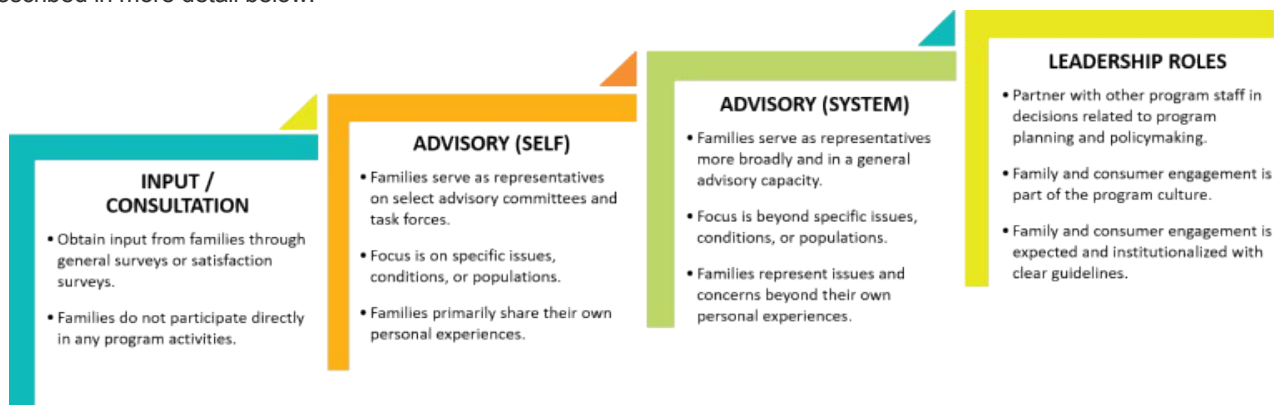
*“Kansas invests in family/consumer engagement and partnership to affirm that the family and consumer voice is a critical component to moving services in the right direction.”*

Families and consumers provide firsthand knowledge and insight to areas that state program staff may not consider; they also make suggestions on how to create 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.

#### **Kansas Family Engagement Frameworks**

The *Framework for Understanding the Elements and Developing Interventions and Policies* outlined in the MCH Block Grant Guidance describes the continuum of patient and family engagement at different levels in the health care system. This provides foundational support to the impact and effects that patient and family engagement can have on a higher quality and more efficient health care system. In addition to this, there are several other frameworks at the state and national levels that focus on engagement and partnership of families and consumers. Each offers various components that may be valuable to the work we do and supports our efforts to engage and partner in different ways. The framework components include foundational principles, quality standards, engagement strategies, and evaluation and assessment approaches. An overview of the frameworks is included below; a crosswalk can be found in the Program Purpose and Design section.

Levels of Family Engagement in Title V MCH & CYSHCN Programs: Kansas Title V strives to support family and consumer engagement at all levels, as outlined by the [Levels of Family Engagement in Title V](#) developed by the Association of Maternal and Child Health Programs (AMCHP), and released in a 2016 AMCHP brief. These levels of engagement include input or consultation (e.g., programmatic and community input surveys or focus groups); advisory opportunities (e.g., self/family level, broader systems/community-level); and leadership (e.g., staff, key partners, decision-making). These are described in more detail below.



The 2016 brief also outlined the fact that the CSHCN MCH population domain has historically engaged families and consumers at a much greater rate than other population domain areas (e.g., women/maternal, perinatal/infant, child, adolescent).

Kansas Family Engagement & Partnership Standards for Early Childhood: The [Kansas Family Engagement and Partnership Standards for Early Childhood](#) guide early childhood programs, providers, communities, and educational system on effective engagement. The standards were developed by the Kansas Parent Information Resource Center (KPIRC) in partnership with Title V. They are designed to help others view families as:

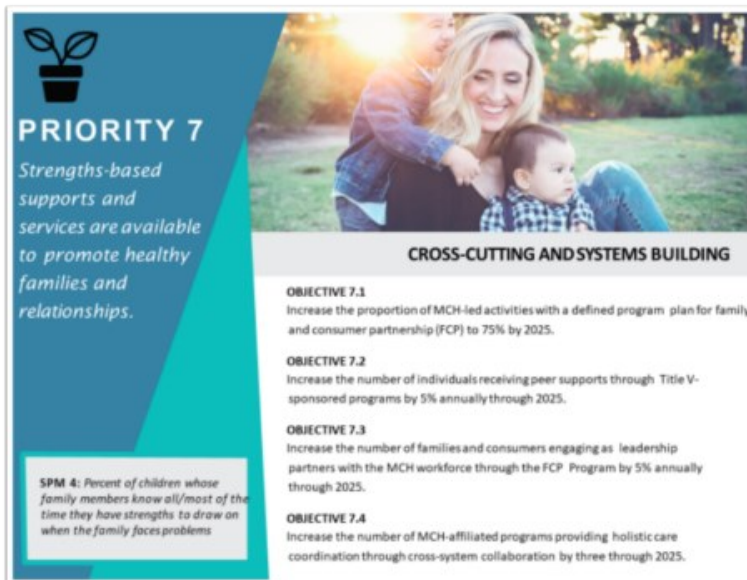
- Foundation: All families are recognized and promoted as their child's first and most influential teacher.
- Communicators: Early childhood provider and families have effective and ongoing communication.
- Advocates: Families actively engage as an advocate and decision-making for their child.
- Partners: 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.

The document references the six key factors from the National Association for the Education of Young Children (NAEYC) definition of family engagement and the School Readiness Framework, specifically, how these intersect and are supported by the Standards. In addition to outlining the Standards, there are also examples of what those may look like in practice and a full set of assessment worksheets to help programs identify how well they aid community stakeholders in assessing their current strengths and opportunities for growth within each of the five standards.

**Standards of Quality for Family Strengthening & Support:** Developed by the National Family Support Network (NFSN) Title V has begun focused work on alignment and integration of the [Standards of Quality for Family Strengthening and Support](#). This started with the inclusion of these Standards in the 2025 Needs Assessment, upon recommendation from the Title V Family Advisory Council (FAC) and was a major influencer in the development of Priority 7, *Strengths-based supports and services are available to promote healthy families and relationships*. These 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.”

**A Framework for Assessing Family Engagement in Systems Change:** Developed by Family Voices, this framework strives to assess family engagement as it relates to systems change. There are four domains for promoting and ensuring meaningful and sustainable family engagement at the systems level: Commitment (e.g., engagement as a core value); Transparency (e.g., access to information); Representation (e.g., reflecting diversity of population served); and Impact (e.g., identifying changes resulting from family engagement). Key criteria for each domain was offered to support interested organizations in program and staff assessment and program planning.

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



**PRIORITY 7**  
*Strengths-based supports and services are available to promote healthy families and relationships.*

**SPM 4:** Percent of children whose family members know all/most of the time they have strengths to draw on when the family faces problems

**CROSS-CUTTING AND SYSTEMS BUILDING**

- OBJECTIVE 7.1**  
Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP) to 75% by 2025.
- OBJECTIVE 7.2**  
Increase the number of individuals receiving peer supports through Title V-sponsored programs by 5% annually through 2025.
- OBJECTIVE 7.3**  
Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program by 5% annually through 2025.
- OBJECTIVE 7.4**  
Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration by three through 2025.

It is well known that when families are strong, connected, and healthy, the family members and the community in which they live, thrive. In 2020, Kansas selected a new cross-cutting priority specifically focused on family engagement and supporting families from a strengths-based perspective.

The Kansas Title V program prioritizes family engagement and demonstrates this commitment through time and resources, and is distinctly poised to strengthen 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. This further solidifies the long-standing priority that Kansas has had on family engagement and consumer partnership. The Title V MCH and CSHCN Directors have set clear expectations that families be engaged at all stages (design, planning, implementation, evaluation) in an ongoing, continuous way. Input from consumers is utilized in making decisions around



program implementation, program updates/revisions/improvements, and priority areas for focus in the future. Staff are asked to think critically around advancing and enhancing consumer and family engagement across programs. 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.

With the creation of the System of Supports Section in early 2020, development of a formal Family and Consumer Partnership (FCP) Program is underway. Additional capacity was added in fall 2020 when a full-time FCP Program Coordinator position was created. A website (<https://www.kdheks.gov/fcp/>) was developed to highlight the importance of this work and bring awareness to the various engagement opportunities available within the Bureau. An excerpt from the program overview is below.



### Peer Supports

- Supporting You
- Caregiver Resource Website (partnership with LEND)

**Supporting You** is a peer-to-peer support program designed by parents for parents.

The goal is to connect people who share experiences to support one another around a specific topic or need. This program is for those that want to learn from another with a similar experience.



Learn more at [www.supportingyoukansas.org/](http://www.supportingyoukansas.org/)



### Advisory

- Expanded FAC
- PDG Family Leadership Team

The **Family Advisory Council** is a group of family leaders that work to assure the needs of families and consumers are central to programming, initiatives, and special projects. In other words, making sure the needs of families are first and foremost in our minds in all we do.



Learn more at [kansasmch.org/fac](http://kansasmch.org/fac)

### Leadership

- Title V Delegate
- Family Leadership Program AMP (Alumni, Mentorship, Policy)



The **Family Delegate** advises Title V programs, policy change, and family education efforts.

The **Family Leadership Program** provides a pathway for families to build upon their lived experiences and grow as leaders in the MCH field.

Learn more at [www.kdheks.gov/fcp](http://www.kdheks.gov/fcp)

### Technical Assistance

- Family & Consumer Engagement Toolkit
- MCH Change Academy



The **Family and Consumer Engagement Toolkit** will assist interested programs and partners to create family-driven programming, actively engage families at all levels, inform partnership strategies, and evaluate family strengthening & support activities.

The **MCH Change Academy** will provide training and skills-building resources to support strong family leaders as part of the MCH workforce.

Learn more at [www.kdheks.gov/fcp](http://www.kdheks.gov/fcp)

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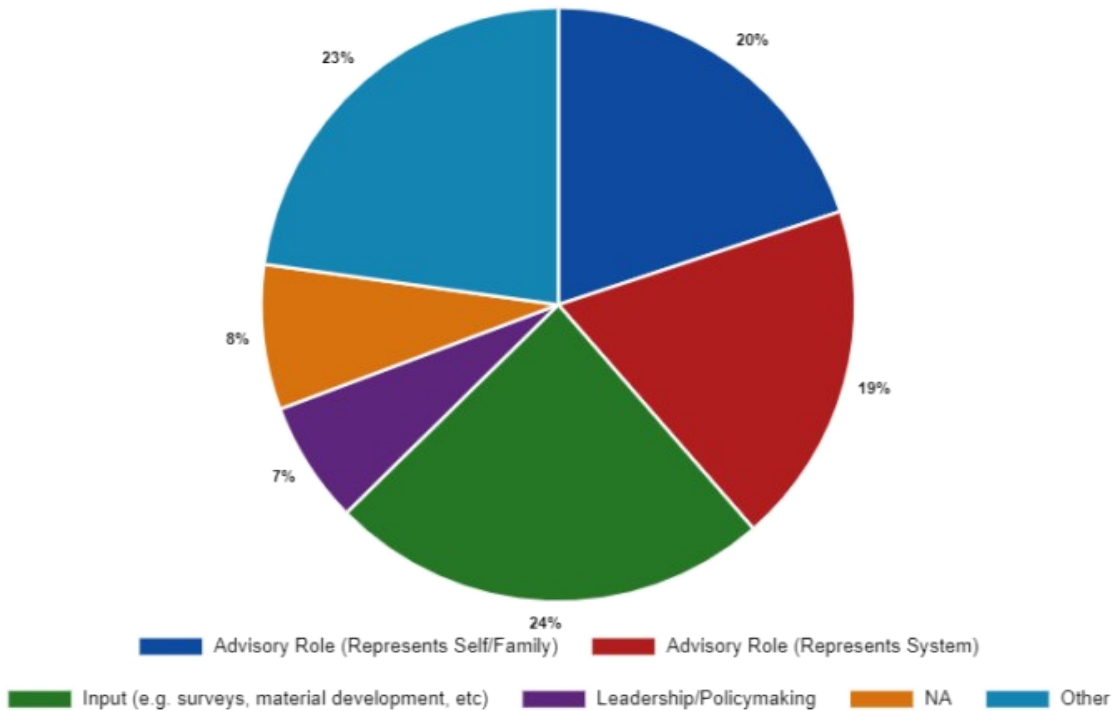
For more information, contact Heather Smith at [Heather.Smith@ks.gov](mailto:Heather.Smith@ks.gov) or 785-296-4747



**Measuring Family Engagement:** The levels of family engagement in MCH activities is tracked through the MCH Community Check Box (CCB), a web-based tool that supports evaluation of the implementation of the action plan and monitors progress towards MCH goals and outcomes. The chart below depicts the level of family engagement for activities since we began monitoring through the CCB 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.



**FFY20 Levels of Engagement of Families/Consumers in MCH Activities**  
**10/1/2016 - 9/30/2020**  
**N = 241**



*Family Engagement Strategy Guide:* In collaboration with the Kansas Children’s Cabinet and Trust Fund (KCCTF) and the University of Kansas Center for Public Partnerships and Research (KU-CPPR), Title V assisted in the development of a strategy guide to help ensure that family voices are included and elevated in decision-making for the early childhood care and education (mixed delivery) system. This a major component of the [All in for Kansas Kids Strategic Plan](#) and the Preschool Development Grant Birth to 5 (PDG B-5). There are two goals in the plan focused on supporting families through empowerment and informed decision-making. The following is an excerpt from the internal “Strategy Guide” document related to Family Engagement.

## Strategic Plan Connection

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**Goal 2: Community-Level Coordination** - *Communities are empowered and equipped to create the best environments to raise a child.*

- **Tactic 2.2.1** Identify parent or family groups that exist within the community and seek feedback on their needs and suggestions for increasing family representation in community decision-making about programs and services.
- **Tactic 2.2.2** Respond to the cultural, ethnic, racial, language, and socioeconomic characteristics and preferences of families to create equitable family engagement opportunities at the community level.
- **Tactic 2.2.3** Include family representatives from the local community on coalitions and/or advisory councils, and as program evaluators, co-trainers of pre-service or in-service training sessions, mentors for other families and professionals, grant and application reviewers, and participants in needs assessment processes.

**Goal 3: Family Knowledge and Choice** - *Families have what they need to make informed decisions and can get services where they live and work.*

- **Tactic 3.1.4** Provide unique opportunities for families to engage with providers in their communities through events such as community baby showers, health fairs, and back-to-school nights.
- **Tactic 3.2.1:** Respond to the cultural, ethnic, racial, language, and socioeconomic characteristics and preferences of families to create equitable family engagement opportunities at the state level.
- **Tactic 3.2.3** Use family engagement initiatives such as the Kansas Family Advisory Team, Parent Leadership Advisory Council, Head Start Policy Councils and Parent Committees, and the annual Parent Leadership Conference<sup>48</sup> to strengthen family voices in leadership, including but not limited to gaining insights into child development and the family's role in supporting development and learning, reviewing proposed policies, and informing programs.
- **Tactic 3.2.4** Identify and replicate effective family engagement strategies from across Kansas, including compensation for families, engaging family representatives as members of statewide task forces and advisory boards, and as participants in the planning, development, delivery, and evaluation of programs.

Additional goals of the strategy guide include: 1) approaching family engagement through an equity lens; 2) investigating and addressing disparities in diverse family representation across the state of Kansas; and 3) increasing alignment and collaboration among state agencies regarding family and consumer partnership. To accomplish these things KDHE, KCCTF, and KU-CPPR will work with the Family Leadership Team (FLT) to implement the following strategies:

- Better understand diverse family needs, challenges, and preferences
- Research and identify best practices and innovative strategies
- Explore partnerships and tools to increase representation among family engagement opportunities throughout state
- Directly engage family leaders in coordination with KDHE and other partners
- Increase alignment and commitment to family engagement among state agencies
- Develop directory of existing statewide and regional councils, coalitions and committees with family leadership focus
- Develop and disseminate family engagement tools and resources for families and professionals
- Create resource hub for family engagement resources and opportunities

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

Individual parents and/or parent groups are represented in place-based communities, serving as a conduit of information, communication, and outreach to other families. Peer to peer connections build engagement and social supports, a protective factor to support family well-being. Formally, families can serve in two advisory council roles at this time: Family Advisory Council (FAC) and the Kansas Maternal and Child Health Council (KMCHC). As the FAC has expanded beyond only the one targeted population group (i.e., CSHCN), so have leadership opportunities through serving as a Co-Chair to one of the five targeted population work groups. Collectively, the ten Co-Chairs serve as the FAC Executive Committee.

*Family & Consumer Engagement Supports:* Title V has adopted a [Consumer Reimbursement policy](#), in which family or consumer participants 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. It is evident that this has not been common practice among family engagement efforts outside of Title V and it has been integrated in as part of the Strategy Guide and will be included as a crucial part of the FCP Toolkit.

*Family Advisory Council (FAC):* Consumer engagement is a guiding principle of the Title V program. At its core this principle stems from the philosophy “nothing about us without us,” so buy-in from those directly affected by changes occurs frequently. It is an expectation of the Title V 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. Kansas is dedicated to expanding family and consumer engagement across all MCH populations, not only among CSHCN families, as has historically been the case.

The FAC serves to advise the Title V Program and the Secretary of KDHE and others on ways to improve the health of families, focusing on the MCH population. The FAC brings together family/consumer leaders with a broad range of lived experiences related to programming and supports. FAC members provide insight on personal and lived experiences; advise on the best methods to reach and communicate with families; inform engagement efforts across BFH and at all levels; inform strategies and activities to address population needs; create a network of community change agents to improve MCH health outcomes and serve as an ambassador to community service systems; and consult with the Title V programs on the development of the annual MCH Block Grant Application, five year needs assessment, and other program plans identified.



As described in the Needs Assessment Update section, the FAC experienced a transformation in the last year. Throughout 2020, former FAC members (families of CSHCN) engaged in various discussions and engagement efforts to re-think and re-design the FAC structure, including establishing mission and purpose statements aligned with Title V and the KS MCH Council (KMCHC) – establishing advisory capacity from both MCH professionals and families/consumers at an equal playing field. The new FAC website is available online at [www.kansasmch.org/fac](http://www.kansasmch.org/fac).

The FAC is comprised of five core work groups (Women/Maternal, Early Childhood, Child, Adolescence, and CSHCN) to

represent the Title V populations served. Each work group will develop an annual action plan (i.e., Work Group Charter) aligned with the scope of their group with actionable objectives and tangible outcomes to advance the Title V State Action Plan (SAP). These groups are being established in each meeting through calendar year 2021, timeline is included below.

- *Woman/Maternal*: Representing women, ages 18 to 45 years, this group will focus on addressing the strategies and objectives found under the Women/Maternal Health and Perinatal/Infant Health priorities within SAP.
- *Early Childhood (birth-5)*: Representing the views of parents/caregivers of children birth through Kindergarten entry, this group will focus on strategies and objectives under the Perinatal/Infant and Child Health priorities within the SAP. This group will also monitor the work of the All in for Kansas Kids State Plan, facilitated through the Kansas Children's Cabinet and Trust Fund.
- *Child (6-11)*: Representing the experiences of parents/caregivers of children, ages 6 to 11, this group will focus on strategies and objectives outlined in the Child Health priority in the SAP and monitor the work of the All in for Kansas Kids State Plan.
- *Adolescence (12-21)*: Representing parents/caregivers of youth and young adults, ages 12 to 21, this group will address strategies and objectives found under the Adolescent Health priority in the SAP.
- *CSHCN (birth-22)*: Representing the needs of children with special health care needs (CSHCN) and their families, birth through adulthood, this group will focus on addressing strategies and objectives under the CSHCN priority in the SAP.
- *Special Initiative Work Groups*: Comprised of existing Council members to support special projects that may need development or extra insight/care.



The following additional groups are desired to be established in the future, to address additional MCH populations.

- *Youth/Young Adults*: Comprised of youth and young adults from various backgrounds, service systems (e.g., teen parenting programs, disability services, school-based health care), and social experiences (e.g., health care access issues, bullying, mental health, transition).
- *Fatherhood*: Represents the father perspective to advance activities that support fathers across Title V programming.



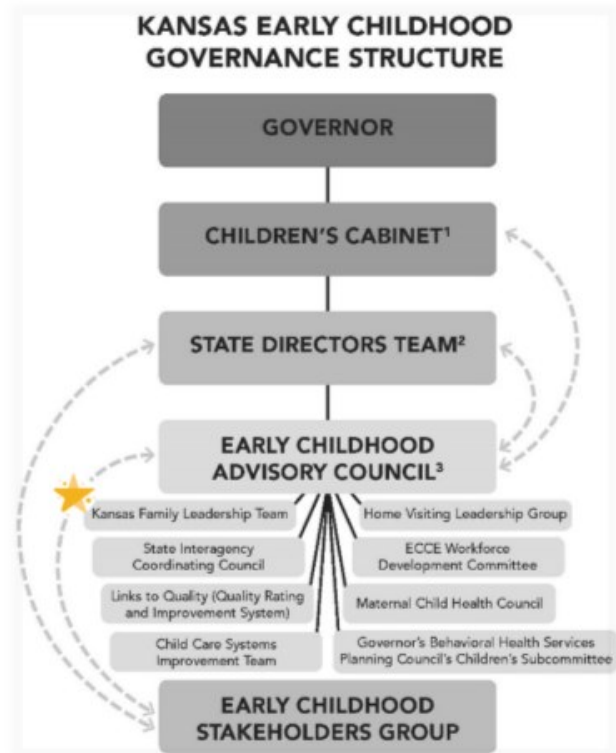
Each work group will select two members to serve as co-chairs to facilitate the discussion and assure the group is making progress towards their defined goals and objectives. These members will also make up the FAC Executive Committee. The Executive Committee serves as a proxy for the full membership in between Council meetings to support membership recruitment and orientation, review activities across Council work groups, make formal recommendations to KDHE, and periodically review/suggested revision of Council bylaws, meeting organization/structure, and input on Council agendas. The Executive Committee will also function as the Kansas Family Leadership Team, as part of the Early Childhood Governance Structure adopted as part of the cross-agency collaborative work around All In For Kansas Kids (depicted to the right).

This transition will also lay the foundation for future implementation of the FCP Toolkit (described in further detail in the Cross-Cutting domain narrative) 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.

Organizationally, the System of Supports Section Director and Family Engagement Administrative Specialist serve as Council staff, and the Executive Committee will provide oversight of FAC operations, make recommendations for bylaw revisions, and bring key issues to the table. Other Title V staff will engage with each work group as subject matter experts and support the advancement of FAC planned activities and objectives.

It is desired to maintain a diverse membership roster like that of the KMCHC (e.g., geographic regions, family experiences, racial/ethnic backgrounds, ages and medical needs of children), which is being monitored closely as the expansion takes place. It is desired to assure this diversity not only across the full Council, but also within the work groups as much as possible. To assist with recruiting members, six core membership benefits are promoted.

- **Advocacy Training:** 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:** opportunities to serve in leadership roles in the FAC structure (e.g., Executive Committee, Work Group Leaders, New Member Orientation, Alumni & Mentorship Program); training on the MCH core competencies; engagement with the StrengthsFinder Assessment
- **Peer Supports:** opportunities to learn from and get to know one another are integrated into meeting agendas throughout the day
- **Conference Opportunities:** support to attend leadership conferences (e.g., AMCHP, Family Voices, Family Support Network)
- **Program Planning/Policy:** input, feedback, guidance, and support to Title V program planning and policy development
- **Making a Difference in the Community:** support and encouragement to engage in other community initiatives to





support their interests

Individualized resources, guidance, and/or special training may be provided to support an FAC member's 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 other state agencies or systems groups, such as part of the Managed Care Organization (MCO) Consumer Groups. Several FAC Alumni now serve on the Kansas Council for Developmental Disabilities (KCDD). 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 (KMCHC):* 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. More can be found online at <https://www.kansasmch.org/aboutus>.

*Alumni & Mentorship Program (AMP):* AMP was developed in 2016 for members who leave the Council due to term limits or personal reasons but desire involvement at some level. The alumni group provides opportunities for these seasoned and motivated family leaders to remain engaged 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 AMP 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 includes 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 local 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.

Tools were first introduced to MCH partners and stakeholders as part of the Title V 2021-2025 Needs Assessment. Plans for implementation can be found in the Cross-Cutting narrative.

- *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.
- *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.

- Standards Participant Survey: A 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. MCH Data Capacity

#### III.E.2.b.iii.a. MCH Epidemiology Workforce

Within the Bureau of Family Health (BFH), there is commitment and staffing to assure the timely collection and reporting of MCH data to inform program planning and implementation. As outlined in previous sections of this application, the Kansas Title V program is focused on data-driven decision making as the foundation to improving outcomes and establishing priorities and objectives to address the needs of the MCH population. Activities are supported and made possible through strong leadership, a committed team, and epidemiology capacity.

The core Title V MCH Data Support Workforce within BFH consists of two MCH Epidemiologists and one data analyst, with additional capacity through a second data analyst focused on the data available through the screening and surveillance unit (e.g., newborn screening, birth defects). The Screening & Surveillance Unit Data Analyst position was created to offer capacity in connecting data from the newborn screening and birth defects surveillance programs with other critical MCH data sets. In addition to the staff listed, there are other Bureau of Epidemiology and Public Health Informatics (BEPHI) experts that partner with the Title V program to provide support from the Office of Vital Statistics, Maternal Mortality Review Committee, and Pregnancy Risk Assessment Monitoring System (PRAMS) data collection and/or analysis.

The existing staffing and partnership structures are designed to support interfacing with epidemiological work conducted in other Bureaus inside the agency and with other organizations and efforts across the state. All MCH data support positions are dedicated to assuring the utilization of data to drive public health programming and initiatives, evidence-based practices, and improved outcomes. These positions assist programs with assessments and evaluations, conduct assessments, and address epidemiologic needs of the BFH. One epidemiologist is focused on working with Medicaid related to alignment of shared work/goals, data sharing, review/analysis, and impact on programmatic efforts.

#### MCH Data Support Workforce

Epidemiologists: Title V works with BEPHI and co-locates two full-time Senior MCH Epidemiologists with the BFH team.

Jamie Kim, MPH - 1 FTE		Funded through State Systems Development Initiative (SSDI)
<b>MCH/Title V Experience</b>	Served as an MCH epidemiologist at KDHE since 2003; began public health career in 1995 as a KDHE infectious disease epidemiologist	
<b>Education</b>	Master of Public Health, Wichita State University / University of Kansas Bachelor of Science in Chemistry, Wichita State University	
<b>Program Expertise</b>	Serves as the SSDI Project Director. Lead epidemiologist. Provides expert epidemiologic, scientific, and technical leadership in designing and conducting epidemiologic investigation. Provides advanced professional analytical work in the surveillance, detection, research, and statewide needs assessment for the MCH population; skilled in developing and designing methods of collecting, analyzing, and disseminating data. Provides oversight of MCH monitoring and evaluation activities and performing appropriate research in MCH. Utilizes 25+ years' experience in SAS & SUDAAN programming to support high-quality and comprehensive data analyses.	
<b>Primary Work Assignments</b>	Provides epidemiological support to Title V (broadly) as well as multiple sections in the Bureau (System of Supports, Children and Families, Nutrition and WIC Services) <ul style="list-style-type: none"><li>• Pregnant women and infants (e.g., infant mortality, Perinatal Periods of Risk approach, maternal morbidity and mortality, maternal opioid-related diagnoses, neonatal abstinence syndrome, substance use, teen pregnancy, family planning)</li><li>• Birth Defects Surveillance</li><li>• Newborn Screening</li><li>• Health disparities in children due to disability status</li><li>• WIC (Women, Infants, and Children) Program</li></ul>	

Shannon Lines, MPH - 1 FTE		Funded through Title V MCH
<b>MCH/Title V Experience</b>	Joined MCH team in December 2020, transferring from Bureau of Health Promotion, Community Health Promotion Section. Professional background includes cancer, chronic disease prevention, and tobacco cessation. Selected to participate in the 2021 Training Course in MCH Epidemiology (last three weeks of July 2021).	
<b>Education</b>	Master of Public Health, Epidemiology and Biostatistics, Saint Louis University	
<b>Program Expertise</b>	Currently completing orientation and onboarding related to Title V Block Grant, data sources and data sets, etc. Completed a Title V-Title XIX priorities and measures alignment. Working on reviewing grantee data on the Edinburgh Postnatal Screening Tool: determining the number of women screened, number and percentage of women positive, number and percentage of women who receive an intervention, and number and percentage of women who receive a referral for services. Program staff planning a "Lunch and Learn" presentation to utilize data.	
<b>Primary Work Assignments</b>	Provides epidemiological support to Title V (broadly) as well as multiple sections in the Bureau (System of Supports, Children and Families, Nutrition and WIC Services) <ul style="list-style-type: none"> <li>• Newborn Screening</li> <li>• Aid-to-Local Grant Support</li> <li>• Medicaid/Title XIX</li> </ul>	

**Data Analysts:** The BFH shifted funding and staffing responsibilities to support the addition of two full-time data analyst positions in recent years. One is dedicated solely to Title V. Unfortunately, both positions were vacated in May 2021. Immediate supervisors are strategically reviewing the position descriptions to elevate these positions to provide added supports to programming and alignment across two sections – Children and Families and System of Supports Sections.

VACANT, MCH Data Analyst - 1 FTE		Funded through the Title V MCH Block Grant
<b>Primary Work Assignments</b>	Provides data management, analysis, and reporting support to Title V and programs within the Children and Families Section. Serves as the primary point of contact for data housed in multiple systems with emphasis on local-level MCH program data stored in DAISEY.	

VACANT, Screening & Surveillance Data Analyst - 1 FTE		Funded through the State Newborn Screening Fee Fund
<b>Primary Work Assignments</b>	Provides data management, analysis, and reporting support to programs within the Screening & Surveillance Unit (e.g., newborn screening birth defects surveillance). Serves as the primary point of contact for data housed in the shared Welligent/Auris database and case management system. Monitors data feeds from the Office of Vital Records (OVR), the public health laboratory (KHEL), and the KS Health Information Network (KHIN).	

## Professional Development & Ongoing Trainings

It's expected that any MCH Epidemiologist will hold a Masters-level degree (e.g., MPH, MS) and show experience as an applied epidemiologist (preferred experience is three years or more). However, it is noted that even the most skilled epidemiologists need dedicated orientation to MCH Services and the Title V Block Grant. The Title V MCH Director/Bureau Director jointly supervises MCH Epidemiologists with a BEPHI manager that reports to the State Epidemiologist.

The Title V Director has established a training plan (orientation/onboarding, initial and ongoing training) for all new MCH Epidemiologists, providing a solid foundation to support knowledge and understanding of the block grant and various data sources the MCH Epidemiologist will be expected to access, utilize, and analyze in their work.

Initial & Ongoing Training: Onboarding materials for a new MCH Epidemiologist are numerous. At the national level they include, but are not limited to: Title V Legislation, HRSA Title V Block Grant Main and Resource Pages, Title V Glossary, Title V Block Grant Federal Guidance, Title V Block Grant Appendix/Supporting Documents, Federally Available Data, State Snapshot, National Performance Measures Dashboard, AMCHP resources and toolkits, and MCH Navigator assessments and courses. At the state level they include: the state's application/annual report, needs assessment, action plan, snapshots, data trends, MCH aid-to-local program information and related documents/websites, and Kansas MCH websites. Information about the MCH Council is also provided, as the MCH Epidemiologists are active members.

The following data sources are all aligned in some way with the Title V priorities and measurement framework, therefore specific emphasis is placed on a solid understanding of how these data are utilized through the ongoing needs assessment and Block Grant reporting activities. Other community/local, state, and national datasets may be included at any time.

- Vital Statistics
- Hospital Discharge
- Medicaid Claims
- Census Bureau Data (e.g., American Community Survey [ACS] Public Use Microdata Sample [PUMS])
- Behavioral Risk Factor Surveillance System (BRFSS)
- [DAISEY](#) (Data Application and Integration Solutions for the Early Years) – KS MCH Shared Measurement System
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- National Survey of Children's Health (NSCH)
- [Data Resource Center for Child & Adolescent Health](#)
- Kansas Communities That Care (CTC) Survey

Additionally, a new MCH Epidemiologist learns about previous projects by reviewing prior epidemiologists' assignments. The Bureau Director advises new epidemiologists to participate in the Training Course in MCH Epidemiology and supports MCH epidemiologists attending conferences for professional development such as AMCHP, Council of State and Territorial Epidemiologists, among others.

Annual Training: MCH Epidemiologists are expected to engage in ongoing professional development, beyond engaging in the BFH activities (e.g., StrengthsFinder, BFH All-Staff Event) and agency activities (e.g., Quality Improvement, Accreditation, Health Equity). It is expected that MCH Epidemiologists will engage in each of these during their tenure in Kansas MCH, however it is noted that each offering will be assess relevancy and capacity at the time of the offering.

- HRSA Title V TA Meetings\*
- HRSA TVIS Trainings\*
- CityMatCH Training Course in MCH Epidemiology\* (expected in the first year, unless not offered)
- Association of Maternal & Child Health Programs (AMCHP) Conference
- CityMatCH Conference (Epi)\*
- Council of State & Territorial Epidemiologists (CSTE) offerings

*Those noted with \* above are required for all MCH Epidemiologists.*

Resources: MCH Epidemiologists are encouraged to engage with the [AMCHP Epidemiology and Evaluation](#) team to support their understanding and application of evidence-based strategies, quality data, valid and reliable measures, and effective data translation and communication.

- [AMCHP Epidemiology and Evaluation Resources](#)
- CDC Preconception Health Indicators ([CSTE Resource](#))
- Life Course Approach & Indicators/Metrics ([AMCHP Online Tool](#))
- Infant Mortality ([AMCHP Toolkit](#))
- Children Special Health Care Needs ([AMCHP CSHCN Systems of Care](#))
- Assessing Family Engagement ([Family Voices FESAT](#))

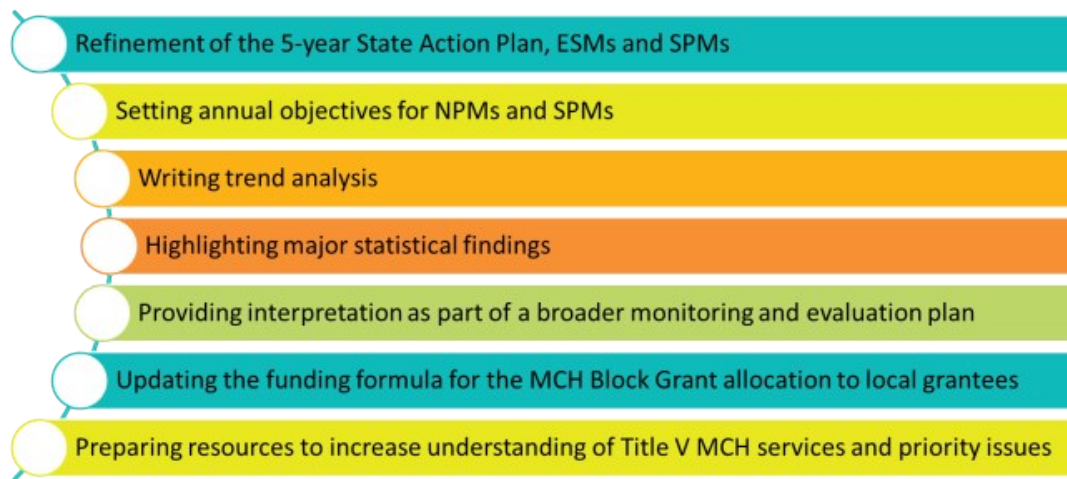


### III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

#### State Systems Development Initiative (SSDI) Overview

The SSDI Project Director, lead MCH Epidemiologist since 2003, and the other epidemiological supports (e.g., second MCH Epidemiologist, Data Analysts) provide extensive support throughout the statewide MCH needs assessment process and ongoing throughout the five-year plan period. Specifically, the SSDI Grant provides capacity and support to improve our ability to share and link MCH data to drive public health practice and programming. Cross-program data sharing provides the foundation for special projects, and data analysis allows program staff to determine the efficacy of program activities. Published products and data analyses can be found at <http://www.kdheks.gov/c-f/mch.htm>.

As part of the ongoing epidemiologic support, the SSDI grant and project director continue to assist with:



#### SSDI Contributions to Linked MCH Datasets

Kansas has the capacity to access in a timely manner and link data from multiple sources to support MCH programs (e.g., birth, death, Medicaid, WIC, hospital discharge, newborn metabolic screening, newborn hearing screening, birth defects, Behavioral Risk Factor Surveillance System [BRFSS], Youth Risk Behavioral Survey [YRBS]). There is annual linkage of birth to infant death, Medicaid (mother-infant dyads), WIC, hospital discharge (mothers only; no mother-infant dyads, due to limited identifying information for the infant), birth defects, newborn metabolic screening, and newborn hearing screening data. Newborn metabolic screening, newborn hearing screening, and birth defects information systems (including Kansas Health Information Network - KHIN) are integrated into one electronic system called Auris, which is linked with birth records and receives automated daily birth record information (selected variables). This provides an opportunity to address longitudinal research questions or track and follow children across multiple programs over time. The Kansas State Department of Education and KDHE's Bureau of Health Promotion (BHP), in partnership with local school districts, conduct the YRBS. KDHE's BHP conducts BRFSS.

As evidenced by information on Form 12, Title V has access to data from:

- Vital Records (birth and death)
- Medicaid
- WIC
- Newborn Screening (bloodspot, hearing, heart)
- Hospital Discharge
- Pregnancy Risk Assessment Monitoring System (PRAMS)

## SSDI Role in Title V Assessment, Monitoring, & Reporting

Participation in the Title V performance measurement framework provides a solid foundation for Title V assessment and monitoring and supports the annual reporting expectations. Kansas strives to implement the following expanded assessment, monitoring, reporting, and evaluation activities. Much of this work is led by the SSDI Project Director, with support from the other members of the epidemiological and MCH teams.

*Evidence-Based or -Informed Strategy Measures (ESMs):* Kansas has selected to establish ESMs for each of the state's national and state performance measures (NPMs/SPMs). The SSDI Project Director conducts a thorough review of the ESM and utilizes the ESM Evidence Checklist for each to determine the evidence base for the measure. Additionally, for each ESM, the quantifying outputs are examined, and a baseline value is identified to assure that it is feasible to adequately monitor and measure for improvement. In the coming year(s) Kansas Title V intends to continue expanding on the use of ESMs and establish internal ESMs for the majority (if not all) of the objectives outlined in the State Action Plan (SAP). This aligns with a long-term goal to establish a formal evaluation for the Title V program in Kansas.

*Monitoring Activities:* Title V utilizes the Community Check Box (CCB) Evaluation System to support efforts around monitoring and evaluation. The SSDI Project Director assures up-to-date indicator data is in the CCB to support trend analysis and our internal team "sense making" activities. The added capacity of the SSDI Grant allows for more intentional and strategic assessment of our accomplishments and programmatic activities and what impact this has on our long-term outcomes. In addition to state program staff entering into the CCB, a select group of Title V contract partners have been asked to begin entering their contract activities for monitoring. It is desired that other grantees will begin entering their activities into the CCB in the coming year(s). This will provide a more cohesive and complete picture and allow for more robust monitoring of objectives as related to grant activities. More information on this initiative can be found in the next "Other MCH Data Capacity Efforts" section of this Application.

As part of the state's monitoring efforts, the SSDI Project Director produces a "[Data Snapshot](#)" to visibly show the trends associated with all national outcome and performance measures and the alignment with measurements in the Medicaid system.

*Evaluation:* In partnership with the [University of Kansas Center for Community Health and Development](#) (KU-CCHD), who specializes in supporting community health through collaborative research and evaluation, Title V has established an agreement for the KU-CCHD to assist in implementing a MCH Monitoring & Evaluation (M&E) System, using the MCH Community Check Box (CCB) Evaluation System, which includes a formal evaluation plan and report associated with each of the objectives in the Title V State Action Plan. The SSDI Project Director and other MCH epidemiological and program staff will determine specific outcome measurements for each of the objectives.

Title V staff participated in a workshop hosted by KU-CCHD that included foundational information that focused on helping staff better understand evaluation and what it can mean for Title V and MCH programming moving forward. The overall objective was to begin framing our own formal evaluation plan. The workshop content included: evaluation design, applying evaluation principles, describing measures of success, describing improvements and change, identifying key stakeholders.

The KU-CCHD team supports Title V in establishing a formal evaluation plan utilizing the "Evaluating the Initiative" toolkit in the Community Toolbox, designed to help community programs develop an evaluation. The KU-CCHD will adapt as needed and work with our team in the coming year(s), specifically aligning with the intent and purpose of the SSDI Grant and engaging the SSDI Project Director to support long-term evaluation efforts for the Kansas Title V Block Grant.

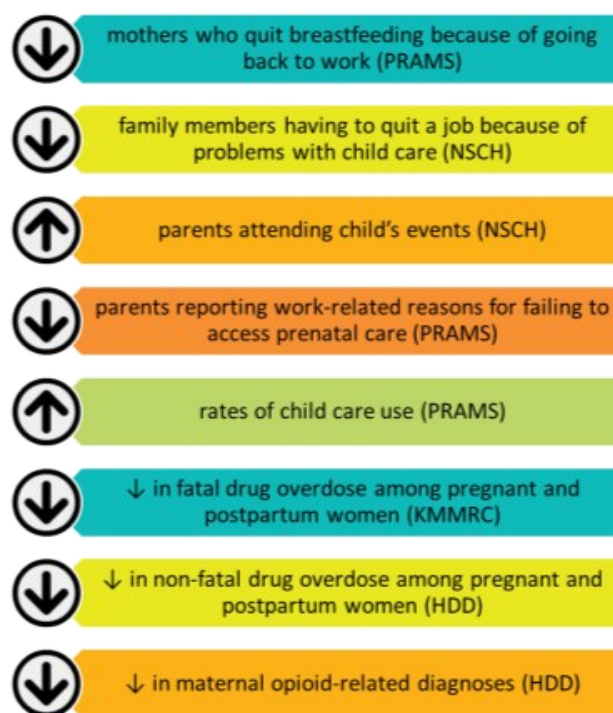
## Key SSDI & Title V Activities

The Kansas SSDI team, composed of the SSDI Project Director, MCH Epidemiologist, and Data Analyst, actively participate during MCH Leadership (monthly), MCH Coordination (monthly), and KMCHC (quarterly) meetings to provide emerging,

persisting or ongoing needs in response to staff requests and related to our own projects and local requests for data, what we learned about the measures over the course of the year related to the needs assessment, and any priorities shifting. 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.

**Block Grant & Ongoing Needs Assessment:** As part of the ongoing epidemiologic support, SSDI continues to assist with: refining the 5-year State Action Plan, ESMs and SPMs, setting annual objectives (linear forecasts) for each NPM and SPM, writing trend analysis, highlighting major statistical findings and providing interpretation, developing funding formula for the MCH Block Grant allocation to local health departments and grantees, and preparing the resources/tools to increase knowledge and understanding about the Kansas Title V MCH federal-state partnership, services, block grant, and the state's priority issues for 2016-2020. SSDI shares data and set the stage as to the current state of MCH in Kansas; using the MCH measurement framework, discusses about the trend and current status for NOMs, NPMs, ESMs and SPMs; and identifies where we need to take note/pay attention to the negative and opportunities to improve.

The SSDI Project Director and MCH Epidemiologist, as part of the Kansas Power of the Positive (KPOP) (<http://www.kansaspowerofthepositive.org/>) Data Team, involve/contribute in designing a Protective Factors Dashboard that will track population-level data capturing parent's experiences of increased protective factors and decreased risk factors. Once the questions are collected and/or data use agreements completed, the anticipated result will be a constellation of indicators that help the coalition track progress and measure the impact of family friendly work place conditions. Examples of the data points that are/will be provided via the Dashboard and trends that we hope to see (and utilize as part of the needs assessment) are provided below.



**Maternal Morbidity & Mortality:** With epidemiological support from SSDI and staff support from the CDC ERASE Maternal Mortality grant, Title V released the first [annual report for maternal mortality](#), including severe maternal morbidity (SMM). Three infographics (SMM, pregnancy-associated deaths, and pregnancy-related deaths) and an easy to read Kansas Maternal Mortality Review Committee (KMMRC) [Annual Report Summary](#) were developed. Published products can be found at <https://kmmrc.org/reports/>.

Kansas Perinatal Community Collaborative (KPCC) Annual Reports: The [2019 Becoming a Mom® State Aggregate Report](#) was completed in April 2021. The SSDI Project Director and Data Analyst continued to work with Vital Statistics to link the 2019 program data with birth record data for the 2019 evaluation report. The goals of this process were to:

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 (4.4%) than for Kansas births overall (10.1%), 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.

Medicaid-Birth Record Linkage: After several trials to link data, and a revision of the states' Medicaid Management Information System (MMIS), the birth, hospital, and Medicaid data linkage has been completed for five years and will be performed on an ongoing basis. The efforts included reprocessing calendar year 2015 linkages of the three datasets using data from the new Kansas Medicaid Management System. Record linking for calendar years 2016 through 2019 has also been completed. Linking for 2020 will start after final hospital data are received and enough time to adjudicate 2020 Medicaid claims has passed. Based on the linking efforts about 25% of resident births were covered by Medicaid. The linked files will enable SSDI and other agency staff to perform analyses to review hospital coverage as well as information from five claims table: (1) pharmacy, (2) inpatient care, (3) professional services, (4) dental, and (5) outpatient. In order to evaluate non-pregnancy related healthcare, the SSDI program has access to eligibility information for females (ages 0 to 55) and males (ages 0 to 22) as well as claims information from the five claims tables. This will enable SSDI to better assess Medicaid-covered health care between pregnancies and post pregnancy.

Minimum/Core Indicators: SSDI has advanced the use of the Minimum/Core (M/C) Dataset indicators. Whilst the Kansas Title V team continues work related to the Title V Needs Assessment and State Action Plan in partnership with many internal and external partners, KMCHC, and the Special Health Services Family Advisory Council, the primary focus involves monitoring progress and measures/trends, discussion areas of work that have been in the plan since inception but not executed, and emerging issues for Title V populations not reflected in the plan. MCH team meetings are held monthly to review the state action plan, measurement framework data/trends, and work on partnerships and alignment related to objectives and strategies within each priority. This is to ensure we are on target with priority work and relevant efforts. A system is developed by the team for ongoing assessment to track progress with measures and identify program responses based on the data (e.g. develop a TA webinar, conduct site visits, provide resources/materials, and plan a conference or skills building session). Example documents used by the program to continuously monitor the Title V measures are Performance Measure and Evidence-based or informed Strategy Measure (ESM) Tracking Snapshots, which include the majority of the M/C Dataset Indicators.

SSDI Minimum/Core (M/C) Indicators	
<b>Core/National Dataset (C/NDS) – 8 indicators</b> <ul style="list-style-type: none"> <li>• Total Preterm Birth</li> <li>• Very Preterm Birth</li> <li>• Tobacco Use During Pregnancy</li> <li>• Multivitamin/Folic Acid Use Before Pregnancy</li> <li>• Exclusive Breastfeeding at 3 Months</li> <li>• Access to Medical Home</li> <li>• C-Section Among Low Risk Women</li> <li>• WIC BMI 2-5 Years</li> </ul>	<b>Core/State Dataset (C/SDS) – 13 indicators</b> <ul style="list-style-type: none"> <li>• Pregnancy Weight Gain</li> <li>• Newborn Bloodspot Screening</li> <li>• Infant Back Sleep Position</li> <li>• Immunization by 2 Years (Medicaid Only)</li> <li>• Immunization by 13 Years (Medicaid Only)</li> <li>• Emergency Department Visits 0-19 Years (Medicaid Only)</li> <li>• Asthma Hospitalizations Under 5 Years</li> <li>• Nonfatal Injury Hospitalizations 0-9 Years</li> <li>• Nonfatal Injury Hospitalizations 10-19 Years</li> <li>• Motor Vehicle Injury Hospitalizations 0-14 Years</li> <li>• Motor Vehicle Injury Hospitalizations 15-19 Years</li> <li>• VLBW Infants born at Level III+ Centers</li> </ul>
Minimum/National Dataset (M/NDS) – 24 indicators	
<ul style="list-style-type: none"> <li>• Infant Mortality</li> <li>• Black/White Infant Mortality</li> <li>• Low Birth Weight</li> <li>• Very Low Birth Weight (VLBW)</li> <li>• Newborn Hearing Screening</li> <li>• Any Breastfeeding at 6 Months</li> <li>• Immunization of 19-35 Month Olds</li> <li>• CSHCN Medical Home Access</li> <li>• CSHCN Adequate Health Insurance</li> <li>• CSHCN Community-Based Services</li> <li>• CSHCN Transition to Adult Life</li> <li>• Child Mortality 1-9 Years</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescent Mortality 10-19 Years</li> <li>• Suicide 15-19 Years</li> <li>• Injury Mortality 15-19 Years</li> <li>• Motor Vehicle Mortality 0-14 Years</li> <li>• Motor Vehicle Mortality 15-19 Years</li> <li>• Teen Birth 15-19 Years</li> <li>• Adolescent Chlamydia 15-19 Years</li> <li>• Young Adult Chlamydia 20-24 Years</li> <li>• Access to Health Insurance</li> <li>• Medicaid Eligibility Standards</li> <li>• State-level Poverty</li> <li>• State-level Child Poverty</li> </ul>

A few specific examples of describing the use of M/C Dataset indicators to promote data-driven decision-making, linkage of state MCH databases (KPCCs pilot linkage project), and contribute to public reporting (e.g., infographics, online public facing data dashboards, fact sheets, presentations) include:

- [Maternal Child Health Domains Profiles](#)
- Data Maps
  - [Infant Mortality Maps](#)
  - [Sleep-Related Unexplained Infant Death Maps](#)
- Provider Resources
  - [Preconception Health Guide](#)
  - [Stillbirth in Kansas](#)
  - [World Preeclampsia Day](#)
  - [Preterm Birth Infographic](#)
  - [National Breastfeeding Month Action Alert](#)
  - [Baby Safety Month Action Alert](#)
  - [National Newborn Screening Month Action Alert](#)
  - [Health Disparities Data \("Did You Know" – Spotlight on Black Maternal Health\)](#)



### III.E.2.b.iii.c. Other MCH Data Capacity Efforts

The Kansas Title V program demonstrates strong commitment to coordinating and collaborating beyond mandated work and addressing the emerging and ongoing needs of all MCH populations while continuously focusing on quality improvement. Title V goals are infused in, and supported by, the entirety of the Bureau's work across programs, funding sources, resources, and shared infrastructure. This commitment drives development of integrated systems of care and assessment for community level MCH initiatives.

#### **Shared Measurement & Data Monitoring Systems**

*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/>) since 2015 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. 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. DAISEY is available free to all local grantees and is the required centralized collection system for MCH services.

A [website](#) 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.



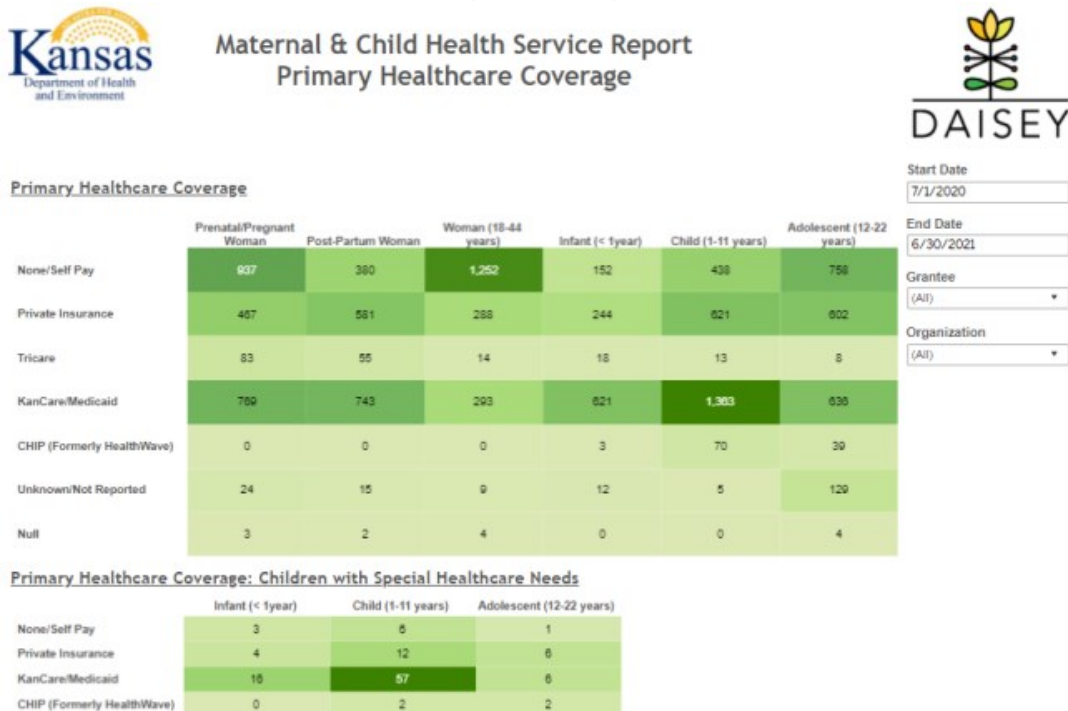
As of July 2021, there are 890 DAISEY users representing 96 grantees and 162 organizations. The DAISEY team completes

an annual User Audit to verify all DAISEY users are accurate and still in use.

Active Live User Totals		All Organization Totals	
Initiative	User Total	Grantee Total	Org Total
KDHE Title V/X	798	92	116
KDHE MIECHV	65	1	9
KPQC	6	1	30
KDHE LYFTE	6	1	5
KCC	15	1	2
<b>Total</b>	<b>890</b>	<b>96</b>	<b>162</b>

DAISEY's data and analytics infrastructure continues to be enhanced, with focus shifting 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 share the impact of their programs at the community, regional, and statewide levels.

#### Sample DAISEY Report



In addition to the extensive TA and support that is provided, a DAISEY Advisory Group was developed in 2017; however, this group did not meet in FY2021 due to the high demand of COVID-19 responsibilities (likely to resume in the coming year). The group is comprised of users representing multiple programs in both rural and urban areas – 22 members currently represent 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. Membership will be reevaluated during this next year to verify members are willing to represent their community in the advisory group.

Input from the KDHE MCH 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, 2021, the following forms were added/updated:

- MCH Service Form (added new response options to Education and Services provided)
- Pregnancy Maintenance Initiative (PM) Service Form
- Teen Pregnancy Targeted Case Management (TPTCM) Service Form
- Added six new screening forms:
  1. CRAFFT+N Interview (CAR, RELAX, ALONE, FORGET, FRIENDS, TROUBLE)
  2. GAD-7 (Generalized Anxiety Disorder scale)
  3. PHQ-9 (Patient Health Questionnaire)
  4. PHQ-A (Patient Health Questionnaire Adolescents)
  5. PSC-17 Caregiver (Pediatric Symptom Checklist)
  6. PSC-17 Child (Pediatric Symptom Checklist)

Typically, staff participate in monthly DAISEY “Deep Dives” to review and discuss data. The team strategizes around topics/focus areas and how to show impact. Due to the COVID-19 pandemic priorities, these were put on hold but will resume in the coming year. The MCH team is already discussing the data around the Edinburgh Postnatal Depression Scale and what we are seeing with the positive screens and referrals made.

The DAISEY Data Dictionary is available online at <https://kdhe.daiseysolutions.org/find-answers/>. During the pandemic, an additional question was added to the KDHE Program Visit Form for both adult and the infant/child/adolescent encounters. The new question is to determine whether or the visit occurred in person or remotely. There are multiple response options to select from: In-Person; Virtual, phone only; Virtual, video chat (Skype, Zoom, Facetime, etc.). KDHE will be able to use this to assess the client encounters during and after the pandemic.

**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.



In Kansas, there has been a concerted effort to align systems in public health, early childhood, family supports, behavioral health, and social services at the state and community level. IRIS is an important tool in this work, as the referral tool and community-based implementation model has served to bridge the technical and adaptive gap between systems to engage individuals and families and get them connected to the services to address their unique and often complex needs. Local public health is a cornerstone in communities and the value of local public health engaging in IRIS is great. Often local public health is the entry point into the system of care for our most vulnerable populations. A foundational role of local public health is to connect families to other needed resources and supports in the community. Local public health is critical in identifying goals and needs based on risk factors for families and connecting them to wrap around services. Local public health is

often the HUB of the wheel in which other community organizations, or the spokes, spread from. IRIS is an efficient, low cost way for local public health to communicate with other providers, make those connections for families, and close the feedback loop, to ensure that families truly are connected to the supports that they need. It also allows other organizations within the IRIS network to see what local public health has to offer and to refer into the public health system as well.

In many instances, we find that strong referral networks are not in place to support comprehensive needs of families. Additionally, all community members, including providers, are not aware of all the wrap around services that their community has to offer. When a system such as IRIS is in place, organizations can start to see a map of their community. They are easily able to recognize what services are available to families and make those connections. IRIS allows organizations to easily track referrals made, to ensure that families do get connected to the services they need. It is often hard or nearly impossible for a family in crisis to try to navigate their way through a complicated system, IRIS can help alleviate some of that stress from a family. A referring organization can see if and when services are available, rather than directing a family to a resource that may not be accepting new patients or has eligibility criteria that the family does not meet. That can save many fruitless phone calls and frustration for the referring organization and the family.

Kansas Title V communicates our support for local partners engaging in IRIS with both broad and targeted messaging for IRIS. When we engage in new projects, such as pilot projects, we always try to ensure that IRIS is part of the equation if the providers do not have another means of referring and connecting. We encourage all partnering organizations to be involved in a local IRIS community to support holistic care if another platform is not already in use. Our approach supports meeting communities where they are, so if a community has already engaged in a referral system that is robust, offers bi-directional referrals and closes the feedback loop, and that system is working for the community, then that is ok. But, if a system is not in place, then we will encourage the community to adopt IRIS. We have provided financial support for communities to adopt IRIS as part of a larger grant or pilot projects, but we encourage communities to work together collaboratively to develop a plan for start-up and maintenance for long-term sustainability.

The following screenshot shows IRIS implementation progress. Since last year, we had a new community launch and three more begin implementation. Total families touched through IRIS connections increased from 6,148 to 8,887 and total referrals completed increased from 8,950 to 13,489. A total of 43.1% enrolled in services, slightly up from last year (42.1%). Learn more about IRIS in the Child Health Section and online at <http://connectwithiris.org/>.



# Growing a Connected Network Around a Family

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



**8,887**  
**KANSAS FAMILIES**

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



**13,486**  
**REFERRALS**

Many families were involved in multiple referrals.



**43.1%**  
**ENROLLED IN SERVICES**

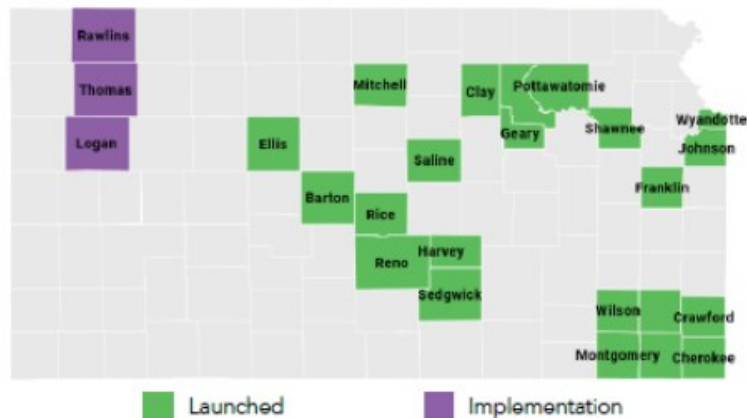
Families connected with needed services in IRIS communities.

Updated May 31, 2021

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	6/3/19	24	36	37	37.8%
Clay County	2/12/21	37	1	1	0.0%
Ellis County	9/16/19	14	53	61	36.1%
Franklin County	5/20/19	24	54	61	18.0%
Geary County	2/28/18	34	1,461	3,040	59.9%
Harvey County	7/22/19	37	27	42	33.3%
Johnson County	7/1/19	78	316	430	45.6%
Mitchell County	11/15/19	42	12	13	61.5%
Pottawatomie, Riley Counties	5/9/18	43	1,167	1,605	23.3%
Reno County	10/1/18	23	190	206	27.2%
Saline County	9/30/19	45	84	94	55.3%
Sedgwick County	3/4/19	49	908	1,773	44.8%
Shawnee County	8/27/18	10	429	440	21.4%
Southeast Kansas	12/11/17	67	2,331	3,429	38.0%
Wyandotte County	4/2/18	70	1,818	2,254	46.6%



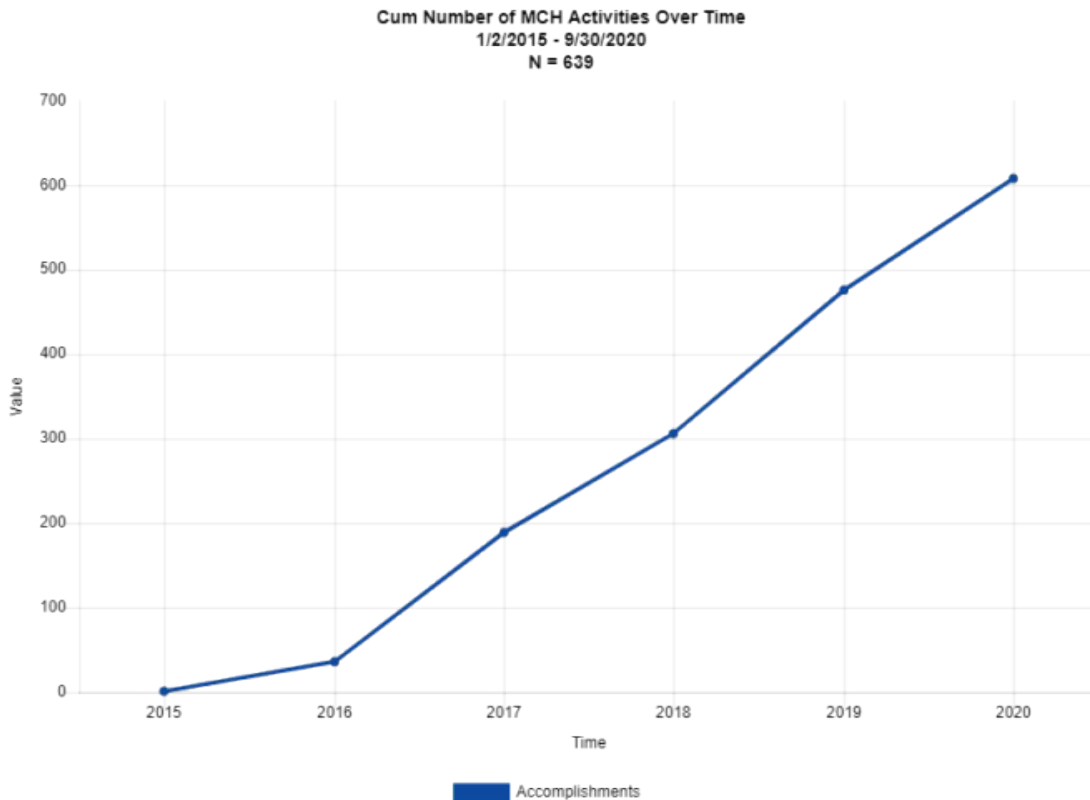
**Aid to Local Funding:** The MCH Epidemiologist and Teen Pregnancy Targeted Case Management/Pregnancy Maintenance Initiative (TPTCM/PMI) Program Manager worked to identify potential changes to the TPTCM/PMI funding formulas to better reflect the populations served within each grantee county, including 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.



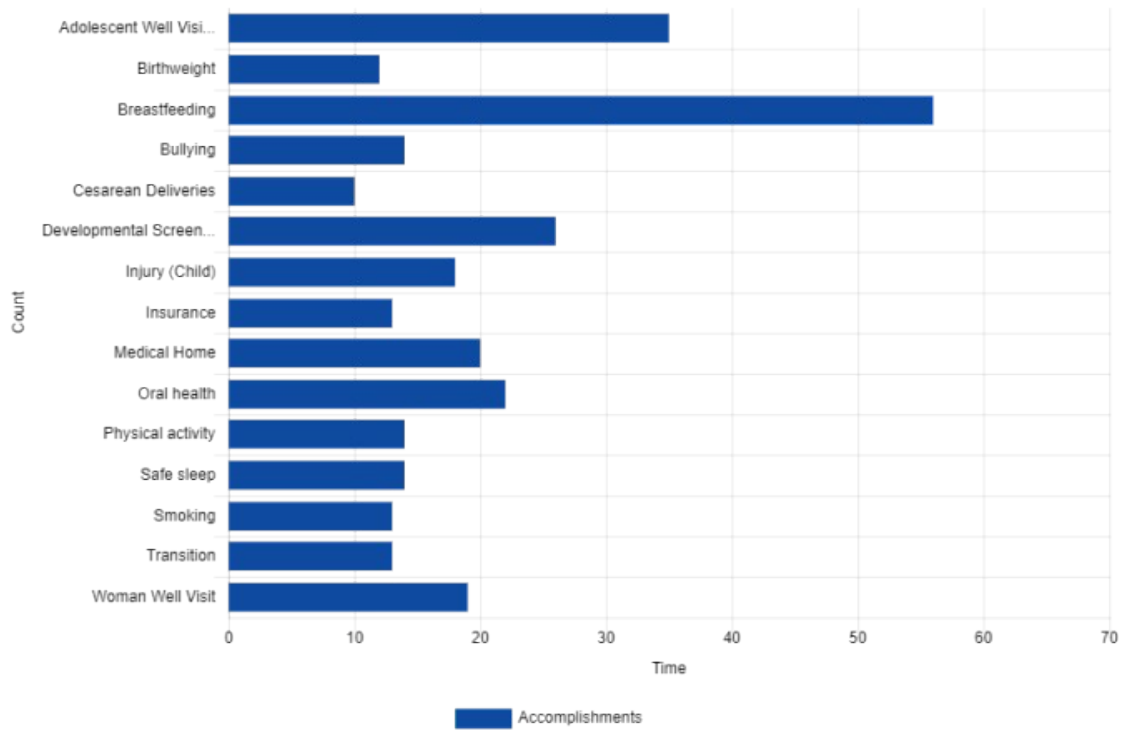
Program	Funding Formula Criteria
<b>TPTCM</b>	<ul style="list-style-type: none"> <li>• females ages 12 to 21 years on Medicaid</li> <li>• overall population of females ages 12 to 21 years</li> <li>• county teen pregnancy rates in ages 10 to 19 years</li> </ul>
<b>PMI</b>	<ul style="list-style-type: none"> <li>• overall population of females ages 15 to 44 years</li> <li>• uninsured females ages 18 to 64 years</li> <li>• county infant mortality rates</li> </ul>

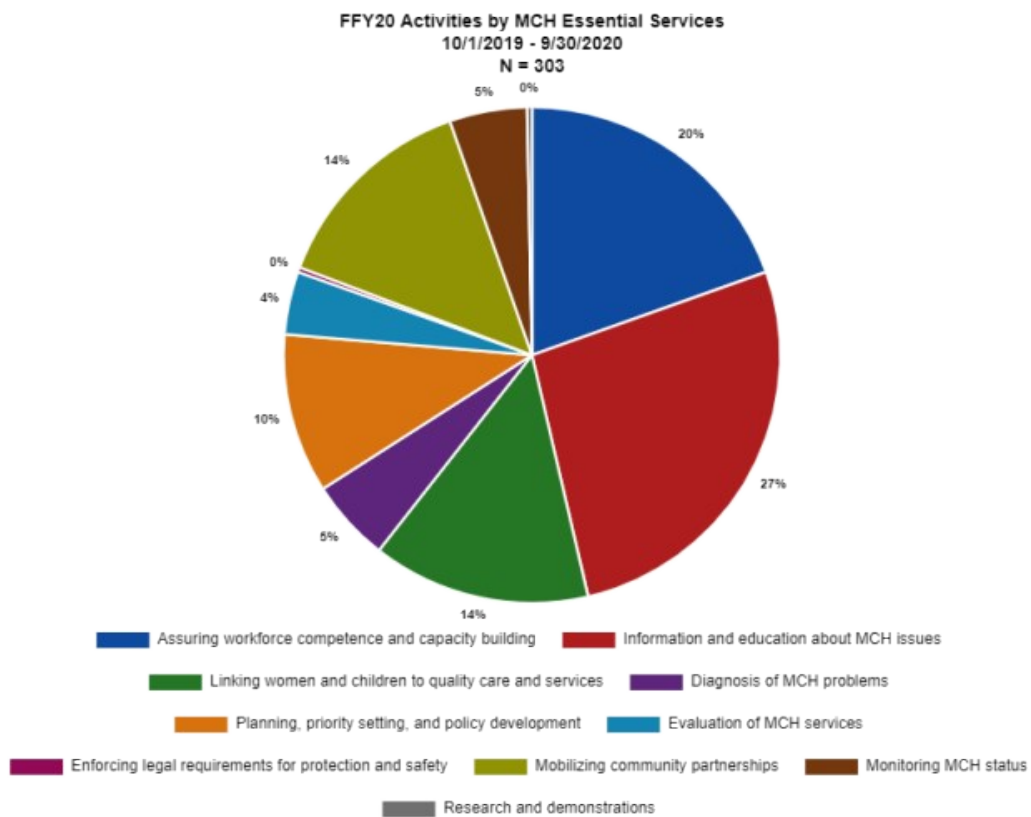
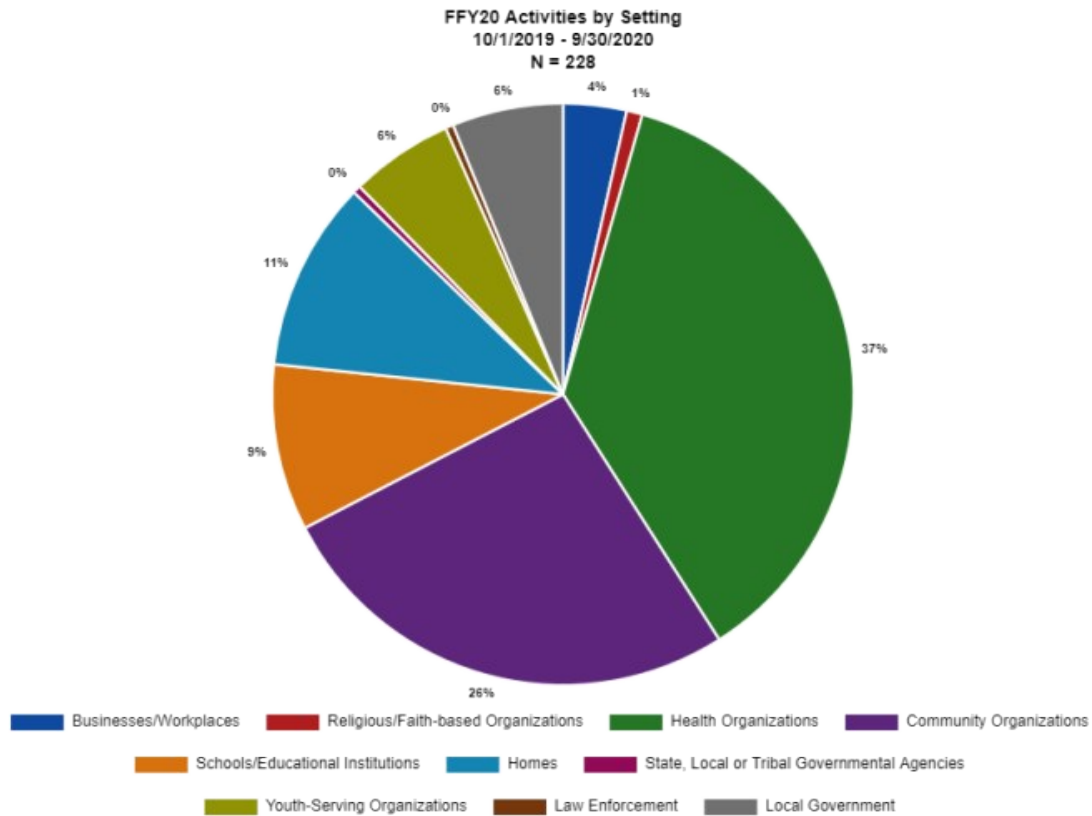
*MCH Community Check Box (CCB): Monitoring the State Action Plan:* Title V has been utilizing the [MCH Community Check Box](http://communityhealth.ku.edu) (<http://communityhealth.ku.edu>) since 2017. The monitoring tool was developed by the KU Center for Community Health and Development. CCB captures, characterizes, and communicates state action plan activities/accomplishments. The information collected is used for learning, improved collaboration, quality improvement, and monitoring the extent to which state and local partners are building capacity and acting to address the plan priorities and measures. Title V tracks how these activities may be influencing key indicators such as maternal and infant mortality. Sensemaking sessions take place quarterly with the Title V and KU teams.

The graphs below were created with CCB data and detail the extent to which efforts were focused on priority areas and performance measures as well as through what means or essential MCH service for the FFY2020 reporting period.

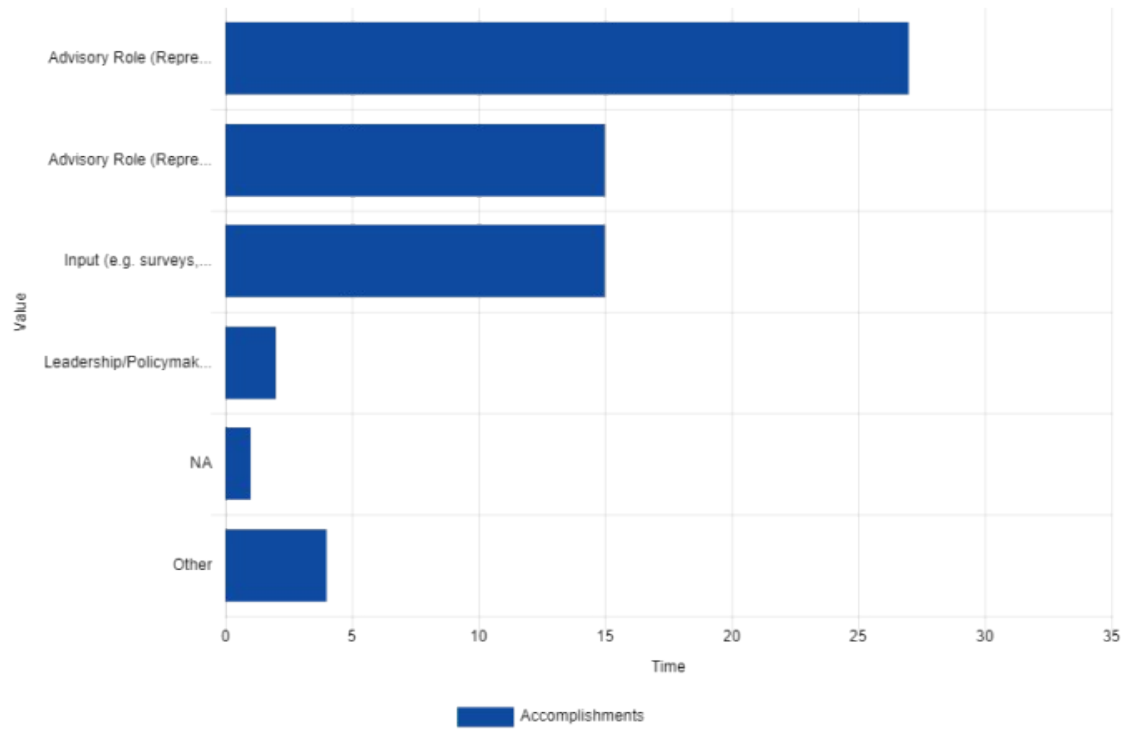


**FFY20 Activities by National Performance Measure**  
**10/1/2019 - 9/30/2020**

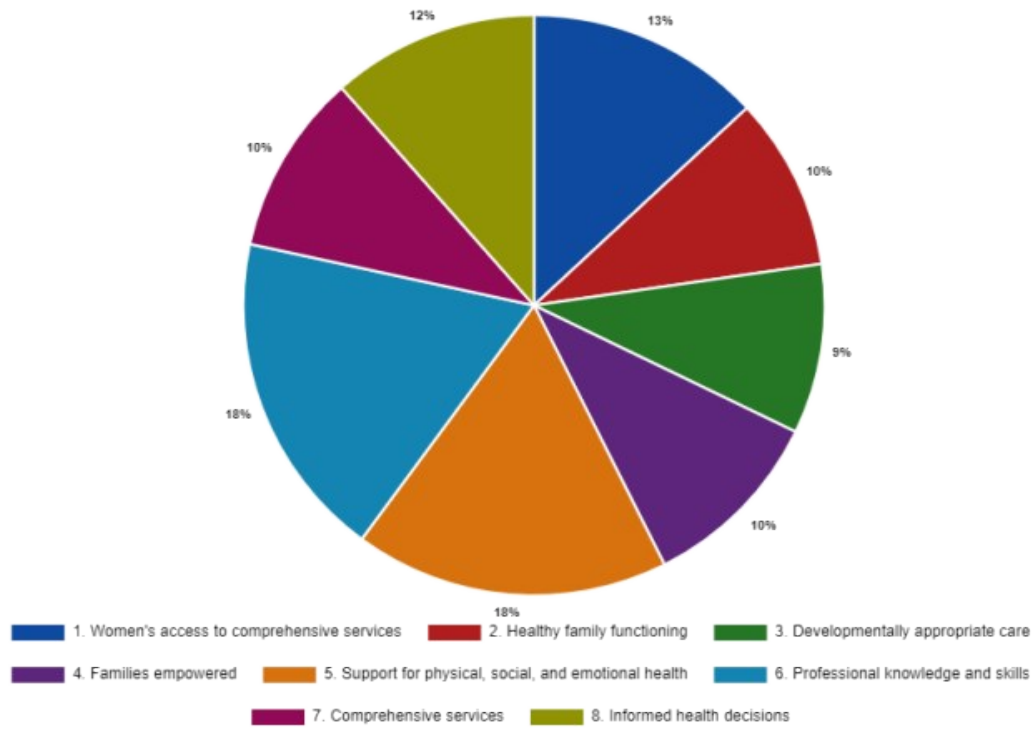




**FFY20 Levels of Engagement of Families/Consumers in MCH Activities**  
**10/1/2019 - 9/30/2020**



FFY20 Activities by State Plan Priority Area  
 10/1/2019 - 9/30/2020  
 N = 617





### **III.E.2.b.iv. MCH Emergency Planning and Preparedness**

#### **Title V Involvement in State-Level Emergency Preparedness & Response**

The emergency operations plan is referred to as the [Kansas Response Plan](#) (KRP), revised 2017. The KRP establishes a unified, cross-agency approach to incident management to support coordination, efficacy, and efficiency in the state's capacity to prevent, protect against, mitigate, respond to, and recover from terrorism, major natural disasters, and other emergencies. The KRP is designed to support county and federal emergency response plans. This document provides guidance and policy direction on interfacing with county emergency operations plans and the Federal Interagency Operational Plans and is based on the fundamentals within the National Incident Management System.

The KRP is comprised of fifteen emergency support functions (ESF), of which Public Health and Medical Services is ESF 8 and is led by the Bureau of Community Health Systems at the Kansas Department of Health and Environment (KDHE). ESF 8 provides information to support coordinated health and medical activities conducted in response to disasters or emergencies, specifically MCH-related needs such as the behavioral health needs of survivors and responders, medical needs of "at risk" populations (e.g., pediatrics, pregnant women, children with special health care needs, individuals from diverse cultures).

In addition to the statewide KRP, the KDHE Emergency Readiness Initiative Plan outlines the various roles and responsibilities of staff within the Incident Command System (ICS). Given the breadth of services, supports, and programming provided through the Bureau of Family Health, the Bureau Director, also the Title V MCH Director, serves as "Deputy KDHE Commander" and the System of Supports Section Director, also the Title V CSHCN Director, serves as a "Behavioral Health Branch Director" during ICS response activities to assist and support day-to-day responsibilities and various functions within the ICS depending on the situation. It is also not unlikely that other Title V subject matter experts could be added to the formal ICS staffing list, as was the case in the recent Zika public health emergency. BFH/Title V staff are involved in the review and revision of the state emergency operation plans, including the KDHE Emergency Operations Guide. Staff also participate in tabletop "readiness" exercises internal to the agency.

Additionally, the agency's Continuity of Operations Plan (COOP) ensures the provision of critical public health services to the MCH population during an emergency or disaster event and timely and efficient coordination of MCH personnel and resources before, during, and after an event. Within the Bureau of Family Health, the COOP outlines the specific maternal and child health emergency response needs as related to the primary functions of the Bureau (including critical public health infrastructure and programming); key personnel and required training/certification for each function; plans for accessing records and equipment; staff contacts and an order of succession; and the key stakeholders in which communication must be established.

#### **Participation in Emergency Preparedness Planning Activities**

When KDHE's ICS is activated, the KDHE Commander is the ultimate authority on anything and everything related to that incident and serves with guidance from the KDHE Secretary. Underneath the KDHE Commander are Officers (Public Information/Political Liaison Officer, Safety Officer, Department Liaison Officer) who provide subject matter expert support to the KDHE Commander at the Commanders direction. Under the KDHE Commander and taking care of functional areas are the Operations, Planning, and Logistics/Administration Sections which are led by Chiefs. These sections perform functional tasks related to the incident in the achievement of operational objectives, goals, and implementing direction from the KDHE Commander. Other supporting units like human resources and legal are typically called in for brief periods of time, usually in the Logistics/Administration Section, to provide specific subject matter activities for that Section Chief and the KDHE Commander. All agency staff participate in agency planning and preparedness in some way, more extensive at times depending on the type and duration of an emergency, to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population.

## Data Assessment & Surveillance

**Training:** All employees at the agency have the following outlined in their position descriptions: “Perform other duties as assigned including serving as a member of the KDHE Disaster Response Team as needed to assure the agency's public and environmental health response is adequately staffed during and immediately following natural and/or manmade disasters, infectious disease outbreaks, and/or acts of terrorism.” As such, all employees are required to complete the ICS trainings within the first 90 days of hire. In recent years, the agency has provided other preparedness trainings around topics such as self-defense and situational awareness, active shooter response, and CPR/First Aid.

**Communication Plans:** The COOP outlines internal and stakeholder communication plans associated with activation and response of the plan. Individual Bureaus are required to complete Annex B to the plan, which outlines five sections (1) Functions (includes key personnel and required training or certification for each function), (2) Records and Equipment, (3) Bureau Order of Succession, (4) Staff Contact Sheet, and (5) Stakeholders. Internal protocols are established to determine communication plans for each program related to staff and stakeholder contacts.

**Coordination with Other PH Programs:** Ongoing planning and coordination is necessary across public health programs. The Bureau of Family Health routinely works with the surveillance programs to identify needs and respond (dangerous exposures for pregnant women, birth defects/patterns that could be attributed to investigations, high blood lead levels in young children, etc.). The child care program has emergency disaster guidelines which go into effect during any local or state declaration of emergency and cooperation with other programs, including but not limited to Immunizations, is necessary. In the past, the KS Special Health Care Needs Program has participated in the agency's Extreme Weather Work Group to assure the needs of people with disabilities were considered during extreme heat and cold seasons in Kansas.

### **COVID-19 Pandemic Response (Jan. 2020 to present)**

The COVID-19 pandemic specifically elevated the need for agency staff to monitor and engage in emergency planning and preparedness at all levels, beyond the agency's COOP planning activities. Throughout the pandemic response, the Title V MCH Director was instrumental in emergency operations and support to the agency, the Governor's Office, and the Federal Emergency Management Agency (FEMA).

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; extending unemployment benefits to help ensure the protection of Kansas families; relief for child care facilities continuing operation; and more.

Title V staff proactively monitored all guidance provided by the Centers for Disease Control and Prevention (CDC), national experts, and epidemiologists and infectious disease subject matter experts at KDHE. Based on these sources, Title V staff developed guidance for providers and staff as well as the MCH population. Content/guidance was developed for topics including but not limited to service provision for pregnant and perinatal populations (exposure, testing, vaccines, etc.), delivering home visiting services via telehealth, crisis/behavioral health, and safe operation of child care facilities. The guidance is updated episodically based on evolving recommendations and made available on the [KDHE COVID-19 Resource Center](#). Title V stayed abreast of evolving recommendations related to maternal and child health and created resource guides for providers inclusive of these frequent updates. These efforts alleviate the burden on local providers to regularly search for updated recommendations during the pandemic and ensure best practice recommendations are being operationalized related to Title V services.

Title V worked closely with the other KDHE Bureaus and the Kansas Department of Emergency Management (KDEM) to make sure families have access to supports/benefits such as the Emergency Food Assistance Program, the Supplemental

Nutritional Assistance Program, Temporary Assistance for Needy Families, and Child Care Assistance. Resources for how to connect to crisis centers, including mental health and substance use treatment facilities, were developed. A community resilience toolkit and scripts for public health contact tracers to utilize provided suicide prevention resources. Additionally, the Title V program worked closely with our local MCH agencies to use funding in innovative ways to help support families in their communities during the pandemic, such as using MCH funds to purchase technology and 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).

### III.E.2.b.v. Health Care Delivery System

#### III.E.2.b.v.a. Public and Private Partnerships

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.

#### Collaborative Work & Relationships

Partnerships at the state and local level ensure coordination within the MCH health care delivery system. 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 contracts with local agencies to provide family centered, community based, and culturally competent services/care to MCH populations across the state. Local funding awards are based on MCH population data (census as source), plans, performance, collaboration, and potential to impact.

The Title V vision leads the way and provides direction for all we do in Kansas across the life course, from birth through adulthood. 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. Strong linkages have been identified across plans and needs assessment findings. BFH staff continue to better align and coordinate with other programs and initiatives with specific roles to address the maternal and child health population.

Title V strategically works to set priorities, goals, objectives, and identify linkages among other core programming that serves MCH populations. Specifically, progress has been made related to reproductive health and family planning with new activities, resources, and interventions in place, and shared priorities with WIC and Child Care (e.g., breastfeeding, oral health, smoking cessation).

#### INTERNAL AGENCY PARTNERSHIPS

*All overseen by the BFH/Title V MCH Director*

- Birth Defects Surveillance (BDS)
- Breastfeeding Peer Counselors
- Child Care Licensing (CCL)
- Early Childhood Comprehensive Systems (ECCS)
- Early Hearing Detection and Intervention (EHDI)
- Early Intervention/Infant Toddler Service (ITS) – Part C of IDEA
- Kansas Connecting Communities (KCC)/Maternal Depression and Other Behavioral Disorders
- Maternal Mortality Review Committee MMRC)
- Maternal, Infant and Early Childhood Home Visiting (MIECHV)
- Newborn Screening (NBS) - blood spot and heart
- Pediatric Mental Health Care Access/KSKidsMAP
- Perinatal Quality Collaborative (PQC)
- State Systems Development Initiative (SSDI)
- Supplemental Nutrition for Women, Infants, Children (WIC)
- Title X/Family Planning

#### State Health Department Programs

**Bureau of Health Promotion (BHP):** MCH programs work closely with BHP on chronic disease risk reduction, tobacco cessation, injury prevention (e.g., Safe Kids Kansas), suicide prevention, and substance/opioid use prevention/response. MCH staff have been active in the development/implementation of the state's injury prevention plan; adolescent driving safety; physical activity in early care settings; and preventing and addressing Adverse Childhood Experiences (ACEs). BHP also facilitates key activities for the agency around credentialing, training, and expansion of community health workers which Title V has been heavily involved in to align holistic care coordination activities.

**Bureau of Epidemiology & Public Health Informatics (BEPHI):** As described previously, Title V works with BEPHI related to core MCH epidemiological supports. This collaboration has resulted in implementing the Pregnancy Risk Assessment and Monitoring System (PRAMS), launching maternal mortality review, and enhancing birth defects surveillance. Epidemiologists serve lead roles with the Perinatal Periods of Risk (PPOR) Analysis, Fetal and Infant Mortality Review (FIMR) processes, local public health system assessments, and developing/monitoring the State Health Assessment and Improvement Plan.

**Bureau of Community Health Systems (BCHS):** In partnership with BCHS, Title V supports development, training, capacity building, and systems development across the public health and MCH workforce (e.g., annual Governor's Public Health Conference, MCH pre-conference). The KS Special Health Care Needs (KS-SHCN) program participates on the Emergency Medical Services for Children (EMSC) Advisory Council to support partnership and collaboration across the EMSC and Title V grants.

**Bureau of Oral Health (BoH):** Title V has partnered with BoH and other state organizations such as Oral Health Kansas to promote and support good oral health and dental care across the life course. Specifically, BoH Director, also the Medicaid Dental Director, participates in the needs assessment process and provides input on the MCH State Action Plan. Targeted work continues to focus on integrating screening and sealant services into local programs/services, expanding school-based health services beyond dental services already in place on site, and consistent messaging across all public health programming at the local level, including prenatal education.

**Bureau of Disease Control & Prevention (BDCP):** Title V and BDCP are strong partners as it relates to women's health (e.g., immunizations; reproductive health/wellness; STI prevention and intervention during adolescence, preconception, pregnancy, and postpartum periods). As shared priorities and identified needs emerge as a result of the pandemic, there are plans to partner in establishing maternal health care managers to address both general needs, as well as those associated with COVID-19 vaccinations and treatment.

### **Other Public, Private & Governmental Organizations Serving the MCH Population**

In addition to the robust partnerships outlined throughout this application with local health departments to provide technical assistance and funding support, the additional Title V partnerships are critical to the overall MCH service delivery.

**Early Childhood Systems:** Since 2019 Title V has been actively involved in the comprehensive, cross-agency early childhood systems initiative (referred to as [All In For Kansas Kids](#)). Established as a result of a robust [Needs Assessment](#) and [Strategic Plan](#), and supported by Preschool Development Grant Birth through Five (PDG B-5) funding from the Department of Health and Human Services (HHS), this unprecedented opportunity for statewide collaboration is focused on building a coordinated system to support early childhood. The BFH and Title V Director participates on the State Directors Team, with leadership from the Kansas Children's Cabinet and Trust Fund, Kansas State Department of Education, and Kansas Department for Children and Families. The approach and collaboration are based on a blueprint organized into three building blocks: Healthy Development, Strong Families, and Early Learning, consistent with the Cabinet's Blueprint and MCH State Action Plan.

**Kansas Tribes:** KDHE continues its work to build relationships with the four Kansas tribes and will build from information learned during the two focus groups focused on tribal youth health needs conducted during the Title V Needs Assessment.



Title V will include guidance for specific cultures and health services around health care transition planning and seek more conversation from youth and young adults in the tribal community as work continues in the upcoming years.

*Public Health/Health Professional Education Programs:* In support of public health education, Title V works with undergraduate programs at state Regents Institutions and the MPH program at the University of Kansas. Health professionals play an active role in development and implementation of the MCH State Action Plan and programs, including a strong presence on the KS Maternal and Child Health Council (the current chair is a pediatrician at the School of Medicine in Wichita. Title V has a strong partnership with the Kansas State University Research and Extension Office, with a specific focus on adolescent health. Recently, the CSHCN Director has expanded a partnership with the Leadership Education in Neurodevelopmental Disorders (LEND) program and are currently working on establishing a formal partnership agreement to compliment strategies under both grants.

### **Other State & Local Public & Private Organizations Serving MCH Populations**

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. 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 establish school-based health centers.

Other organizations that have not been previously mentioned include the Kansas Hospital Association, Kansas Academy of Family Physicians, philanthropies including the Kansas Health Foundation and the 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), along with many other state and community-based organizations.

### III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Title V and Title XIX (KDHE Division of Health Care Finance/Medicaid) are working to identify and address disparities among Medicaid beneficiaries. A strong focus has been on use of the Medicaid-linked birth data set and areas where measures and programming align, such as disparities in prenatal care and birth outcomes. Title V assists Medicaid to identify and address reporting and other program requirements related to childhood immunization status, live birth weight, well child visits, and chlamydia screening.

#### Title V-Title XIX Intra-Agency Agreement (IAA)

The Title V-Title XIX IAA, established in 2016, outlines the formal partnership. The partnership has evolved over the years but not grown and strengthened to the level needed. The agreement was reviewed in 2019 and amended to further define and detail the relationship between Title V and XIX as it relates to Maternal Mortality Review. The amendment resulted in direct access to data needed to conduct case reviews.

Although communication has improved and progress has been made, there have been delays with implementing and advancing aspects of the Medicaid alignment, integration, and data sharing. These very real challenges are likely due to significant and repeated changes in leadership positions (Secretary, State Health Officer, Health Care Finance Division Director, Medicaid Director, Medicaid Medical Director) since December 2017. The Medicaid Director and Secretary changed again in January 2019; the Medicaid Medical Director and Medicaid Director (again) in May 2020. A new Medicaid Director was named in July 2020 and Division Director shortly after in 2020. The Medicaid Medical Director remains vacant. Despite the past challenges and recent events (key vacancies, COVID-19 pandemic), agency leadership continue to embrace, understand, and support the need for increased collaboration and communication, including data sharing. Overall, the IAA has potential but isn't fully operationalized or institutionalized.

A crosswalk of Title V and Title XIX priorities and measures was included in the IAA to show alignment potential; the alignment was updated in June 2021. A crosswalk of the adult and children's CMS quality measures was also completed to support stronger partnerships between the two programs. (partial document screenshots below).

#### Medicaid & Maternal & Child Health (MCH) Alignment: Priorities & Measures

##### Medicaid Pay for Performance Measures

The State implemented a pay-for-performance (P4P) program to incentivize high performance. The State will withhold a portion of the payments due to KanCare health plans each month. At the end of the year, the State will assess whether or not each health plan has met the required performance target. If they have, the health plan will receive the payments back. If they do not, the State will retain the withheld payments.

KanCare <sup>1</sup>	Title V <sup>2</sup>	
Measure	Priority	Measures
Timeliness of Prenatal Care - PPC	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 1 – Percent of pregnant women who receive prenatal care beginning in the first trimester
Childhood Immunization Status – Combination 10 - CIS		
DTaP Vaccine – by age 2	Priority 2 – All infants and families have support from strong community systems to optimize infant health and well-being.	NOM 22.1 – Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1 3* 3:1 4) (DTaP, Polio, MMR, Hib, HepB, Varicella, PCV)
IPV Vaccine – by age 2		
MMR Vaccine – by age 2		
Hib Vaccine – by age 2		
Hepatitis B Vaccine – by age 2		
VZV (chicken pox) vaccine – by age 2		
Pneumococcal conjugate vaccine – by age 2		
Hepatitis A Vaccine – by age 2		
Rotavirus Vaccine – by age 2		

Influenza Vaccine - by age 2	Priority 2 – All infants and families have support from strong community systems to optimize infant health and well-being.	NCM 22.2 – Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
Immunizations for Adolescent – Combination 2 - IMA		
Meningococcal Vaccine – by age 13	Priority 4 – Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health.	NOM 22.5 – Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
Cervical Cancer Screening – CCS	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year ESM 1.1 – Percent of women program participants (18-44 years) with a preventive medical visit in the past year
Sources: 1. 2020 KanCare Evaluation Annual Report. Retrieved from: <a href="https://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/annual/kancare-annual-report-to-cms-year-end-12-31-20.pdf?sfvrsn=d894511b_4">https://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/annual/kancare-annual-report-to-cms-year-end-12-31-20.pdf?sfvrsn=d894511b_4</a> 2. National Outcome Measures and National Performance Measures: Kansas Maternal and Child Health Services Block Grant 2021 Application/2019 Annual Report. Retrieved from: <a href="https://www.kdheks.gov/bfhd/download/KS_TitleV_PrintVersion_FY21.pdf">https://www.kdheks.gov/bfhd/download/KS_TitleV_PrintVersion_FY21.pdf</a>		
NPM: National Performance Measure NOM: National Outcome Measure ESM: Evidence-based/informed Strategy Measure		

### 2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

The Affordable Care Act (Section 1139B) requires the Secretary of Health and Human Services (HHS) to identify and publish a core set of health care quality measures for adult Medicaid enrollees. The law requires that measures designated for the core set be currently in use. In January 2012, HHS published an initial core set of for voluntary use by Medicaid. The core set was last updated for 2021.

CMS <sup>1</sup>	Title V <sup>2,3</sup>	
Measure	Priority	Measure
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Priority 6 – Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.	NPM 14.1 – Smoking during Pregnancy and Household Smoking ESM 14.1.1 – Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted service
Cervical Cancer Screening (CCS-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year ESM 1.1 – Percent of women program participants (18-44 years) with a preventive medical visit in the past year
Breast Cancer Screening (BCS-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	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
PC – 01: Early Elective Delivery (PC01-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 7: Percent of non-medically indicated early elective deliveries
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 24 – Percent of women who experience postpartum depressive symptoms following a recent live birth SPM 1 – Percent of women who experience postpartum depressive symptoms following a recent live birth
Sources: 1. 2021 Core Set of Adult Health Care Quality Measures for Medicaid and CHIP (Adult Core Set). Retrieved from <a href="https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-core-set.pdf">https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-core-set.pdf</a> 2. National Outcome Measures and National Performance Measures: Kansas Maternal and Child Health Services Block Grant 2021 Application/2019 Annual Report. Retrieved from <a href="https://www.kdheks.gov/bfhd/download/KS_TitleV_PrintVersion_FY21.pdf">https://www.kdheks.gov/bfhd/download/KS_TitleV_PrintVersion_FY21.pdf</a>		
NPM: National Performance Measure NOM: National Outcome Measure SPM: State Performance Measure ESM: Evidence-based/informed Strategy Measure		

### 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided to and health outcomes of children in Medicaid and CHIP. CHIPRA required Health and Human Services (HHS) to identify and publish a core measure set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs. On December 29, 2009, the Secretary posted for public comment in the Federal Register, an initial core set of 24 children's health care quality measures for voluntary use by Medicaid and CHIP programs. The core set includes a range of children's quality measures encompassing both physical and mental health. The core set was last updated for 2021.

CMS <sup>1</sup>	Title V <sup>2</sup>	
Measure	Priority	Measure
Timeliness of Prenatal Care (PPC-CH)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 1 – Percent of pregnant women who receive prenatal care beginning in the first trimester
Live Births Weighing Less Than 2,500 Grams (LBW-CH)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 4 – Percent of low birth weight deliveries (<2,500 grams)
Developmental Screening in the First Three Years of Life (DEV-CH)	Priority 3 – Children and families have access to and utilize developmentally services and supports through collaborative and integrated communities.	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
		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
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	Priority 5 – Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	NPM 10 – Percent of adolescents, ages 12 through 17 with a preventive medical visit in the past year
		NOM 20 – Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95 <sup>th</sup> percentile) SPM 3 – Percent of children ages 6 through 11 who are physically active at least 60 minutes per day
Child and Adolescent Well-Care Visit (WCV-CH)	Priority 5 – Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
		ESM 10.2 – Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months
Immunizations for Adolescents (IMA-CH)	Priority 5 – Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	NOM 22.2 – Percent of children, ages 6 months through 17 years, who are vaccinated annual 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.
<b>Sources</b> 1. 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Retrieved from <a href="https://www.medicicaid.gov/medicaid/quality-of-care/downloads/2021-child-core-set.pdf">https://www.medicicaid.gov/medicaid/quality-of-care/downloads/2021-child-core-set.pdf</a> 2. National Outcome Measures and National Performance Measures: Kansas Maternal and Child Health Services Block Grant 2021 Application/2019 Annual Report. Retrieved from <a href="https://www.kdheks.gov/bh/download/KS_TitleV_PrintVersion_FY21.pdf">https://www.kdheks.gov/bh/download/KS_TitleV_PrintVersion_FY21.pdf</a>		
NPM: National Performance Measure NOM: National Outcome Measure SPM: State Performance Measure ESM: Evidence-based/informed Strategy Measure		

### Title V-Title XIX Partnership Impacts

Title V continues to build on activities and progress that have provided a strong foundation for the partnership. Key activities have reduced some barriers and paved the way for a new precedence of partnership, data sharing, and collaboration.

#### Title V/Title XIX Partnership Opportunities

- Appointment of a Medicaid Program Manager on the Kansas MCH Council (KMCHC)
- Ongoing engagement/discussion about maternal and child health services
- Ongoing discussions between Title V CSHCN Director and Home and Community Based Services Director related to Appendix K COVID-19 policies
- 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 working to confirm Medicaid and other benefits (e.g., KS-SHCN, maternal mortality, EHD).



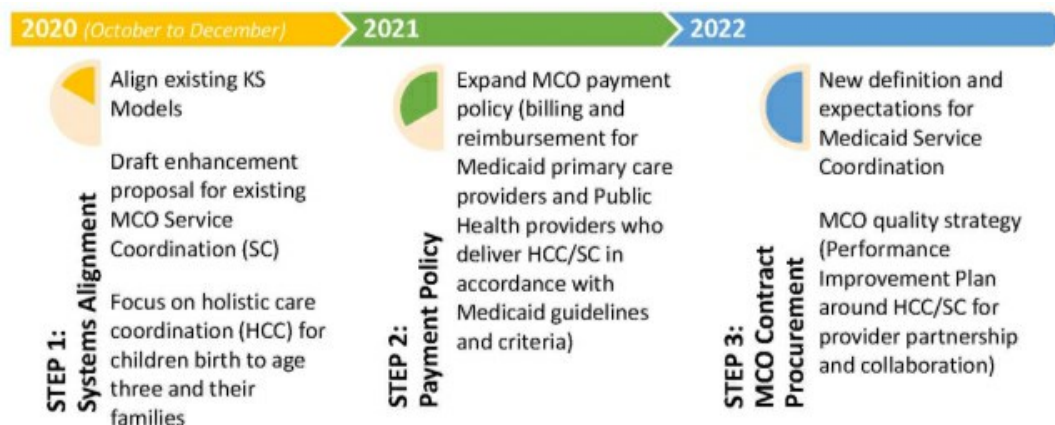
There are several initiatives that will continue to be pursued to advance systems of care for the MCH population. The slide below outlines some of the current work with status related to key policy areas.

### Medicaid & BFH/MCH Shared Work – Key Activities

- Goal: Expand Medicaid pregnancy coverage from 60 calendar days to 12 months postpartum.
  - Research from leading organizations, other states, and CMS informing KS pathway/approach
  - Impact paper drafted by BFH/MCH; Medicaid working on fiscal and program impacts
  - Discussion among Governor's Office, Secretary, Medicaid Director, KS PSP team, and national consultants; planning for policy implementation effective SFY2023
- Goal: Revisit maternal depression screening policy effective Jan. 2021 to expand provider types and settings and include treatment
- Goal: Expand MCH services covered based on public health evidence/data/findings
  - Focus has been on home visiting, care coordination/navigation, and prenatal education
  - Reviewing alternatives to cover bundled services for pregnancy and postpartum periods
- Goal: Expand telehealth reimbursement policies for virtual early intervention (Part C/tiny-k) services to
  - Focus has been on virtual services during public health emergencies
  - Ensure policies extend beyond public health emergency declaration timeframes
- Goal: MCO utilization of IRIS (platform for community referral) to seamlessly connect to services beyond those offered by the MCO
  - Meetings with United HealthCare (UHC) to exchange information about services, participant needs, and referrals
  - UHC Care Coordinators actively connecting beneficiaries to local MCH programs and using IRIS
  - Title V working to get the UHC community to join the broader community-based IRIS network

### Kansas Pediatrics Supporting Parents (PSP)

In partnership with the Phase 1 PSP team and national consultants, a new policy was implemented to cover maternal depression screenings under the child's plan. PSP Phase 2 goal is to "Improve young children's social and emotional development in pediatric primary care by strengthening care coordination practices delivered through Kansas Medicaid." There were three project focus areas: Systems Alignment, Payment Policy, and MCO Contract Procurement. Title V remains involved in discussions for each these areas, despite formal project support ending in December 2020. The team developed a timeline spanning from 2020 through 2022.





## STEP 1: Systems Alignment

**Proposed Goal:** Leverage lessons learned and momentum created through existing care coordination models. Focus on cross-system alignment, partnership, and collaboration necessary to provide quality holistic care coordination services.

### Key Alignment Opportunities:

- *Medicaid:* Existing MCO service coordination; incorporate strong elements from KanCare 2.0
- *Public Health:* Title V Maternal and Child Health (MCH) holistic care coordination programs (primary care, special health care needs); Kansas Perinatal Community Collaboratives; Community Health Workers/Navigators
- *Early Childhood Systems:* Help Me Grow; Bridges (transitions from early intervention/Part C)

## STEP 2: Payment Policy

**Proposed Goal:** Design a payment policy focused on ensuring and enhancing holistic care coordination for young children to support social and emotional development through public health, pediatric primary care, and Medicaid managed care utilizing the existing infrastructure to increase access for families and improve collaboration for providers.

## STEP 3: MCO Contract Procurement

**Proposed Goal:** Propose contract language for the next MCO re-procurement that:

- (1) Expands the definition and scope of service coordination that health plans must provide (holistic focus); and
- (2) Assures quality strategies aimed at pediatric populations to:
  - a. Increase performance on child quality measures;
  - b. Enhance rates of developmental, vision, hearing, and maternal depression screenings/evaluations; and
  - c. Improve select performance on existing perinatal and child health measures.



Drafted October 2, 2020

## Community Health Workers & Medicaid

Title V continues to support Phase 2 PSP recommendations through avenues such as the expansion of community health workers (CHWs), known to effectively address social determinants and health disparities. In partnership with United Methodist Health Ministry Fund (UMHMF), a cross-agency “steering committee” and broader “work group” has been convened to focus on credentialing and payment policies for CHWs. The Bureaus of Family Health and Health Promotion (BFH and BHP) represent KDHE on these groups.

CHWs support individuals by connecting them to the information and services needed for optimal, individualized health outcomes. Established by the Kansas CHW Coalition the following Scope of Practice (SOP) outlines roles and responsibilities of CHWs.



Mission &  
Vision

Kansas Definition of a  
Community Health  
Worker

Kansas Community Health  
Worker Coalition Core  
Competencies

**Kansas Community  
Health Worker Scope of  
Practice**

Kansas Community Health Workers (CHW) utilize core competencies that aid in connecting individuals to the information and services needed for optimal, individualized health outcomes. Core competencies support the CHW in performing appropriately within different models of practice as determined by employers. The following Scope of Practice encompasses the roles and responsibilities CHWs may have based upon existing practice models being utilized by multi-disciplinary employers:

- **Client Support:** Provide encouragement and social support to assist clients with goal setting and barrier identification within professional boundaries.
- **Care Coordination:** Assist in coordinating care by linking people to appropriate information and services.
- **Healthcare Liaison:** Serve as a culturally-informed liaison between clients, community and healthcare systems.
- **Health Education:** Provide culturally appropriate health education to individuals, organizations and/or communities, in an effort to reduce modifiable risk factors and encourage healthy behaviors.
- **Advocacy:** Recognize gaps and advocate for individual and community health needs.

This scope is distinctly aligned with the model supported through Title V public health, referred to as holistic care coordination (HCC). These initiatives (i.e., PSP, CHW credentialing/policy, HCC) share the following objectives:

- Create a system of care for all families to receive supports in navigating health, community, social, and family needs.
- Create a pathway for a high quality, trained workforce to provide these supports (e.g., training, credentialing).
- Establish policies to assure adequate reimbursement to provide these services to families across systems.

Through this work, Kansas is drafting a policy memo for short- and long-term payment strategies, credentialing, and Medicaid procurement. BFH and BHP are partnering to support a cohesive and integrated approach that show the intersection of work in the state around care coordination. As a supplement to this policy memo, a robust and collaborative Medicaid payment policy will be included that allows for payment of care coordination, as a service line, for various provider types (including CHWs, home visitors, and other care coordinators) in both public and primary care settings. It is anticipated to include existing Medicaid services under the “Care Coordination” service through OneCare Kansas (OCK), the legislatively mandated health homes initiative. Per the OCK Program Manual, Care Coordination is done through “appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and support.”

In addition to the policy recommendations outlined in the memo, the team intends to focus on the recommendations from the PSP work, to “Amend the Contract to Address Service Coordination for Preventive Care.” Title V is currently monitoring progress on re-procurement to support public health’s role in amending the RFP to reflect that MCOs must provide service coordination to all enrollees, considering national standards aimed at pediatric populations for care coordination.

### Other Title V-Title XIX Activities

*Navigating Kansas Medicaid & the Insurance System:* Local MCH agencies assist clients in navigating insurance systems (public/private/Medicaid). Many facilitate on-site enrollment of MCH clients and screen for insurance status/coverage at each encounter. If uninsured, Medicaid eligibility is reviewed and a referral is made, when appropriate. Staff assist

individuals/families to complete the application and submit to Medicaid, when needed. For those who do not qualify for Medicaid, private Marketplace information is provided along with contact information to a Navigation Specialist.

*Kansas Special Health Care Needs (KS-SHCN):* KS-SHCN works collaboratively with Medicaid/MCO to assure dually enrolled clients receive appropriate services and quality case management/care coordination (addressed in the IAA). MCOs share data monthly around authorized Medicaid services to the KS-SHCN Care Coordinator, allowing them to assist clients in getting appointments scheduled, fill prescriptions, communicate with providers, and other supports. KS-SHCN coordinates with MCO care coordinators around gaps or barriers in services. KS-SHCN routinely presents to the MCOs and Medicaid partners to discuss various challenges in meeting the needs of the SHCN population.

*MCH Opportunity Project:* The MCH Opportunity Project focuses on targeting health inequities at the local/community level. One of the participating communities has determined their project will be focused on hiring and training additional health care navigators who will focus on enrolling pregnant and postpartum women in Medicaid or other available health plans. Their strategy includes targeted outreach and education at community events and through partnerships with allied organizations – meeting pregnant or postpartum persons where they are and ensuring they have covered care during a critical and high-risk period.

*CMS Improving Postpartum Care Affinity Group:* Kansas is one of nine states/teams participating in collaborative learning with staff from the Centers for Medicare & Medicaid Services, quality improvement (QI) advisors, and subject matter experts (SMEs) in improving postpartum care. The goal of this effort is to improve postpartum care visits and the quality of visits among Medicaid and the Children's Health Insurance Program (CHIP) beneficiaries. While the Kansas team, led by Medicaid staff, is still working on defining specific goals, measurements, and outcomes, the BFH team is involved to ensure alignment with related efforts, specifically the Fourth Trimester Initiative guided by the Kansas Perinatal Quality Collaborative (KPQC) and aimed at reducing severe maternal morbidity and maternal mortality.

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

#### **Women/Maternal Health**

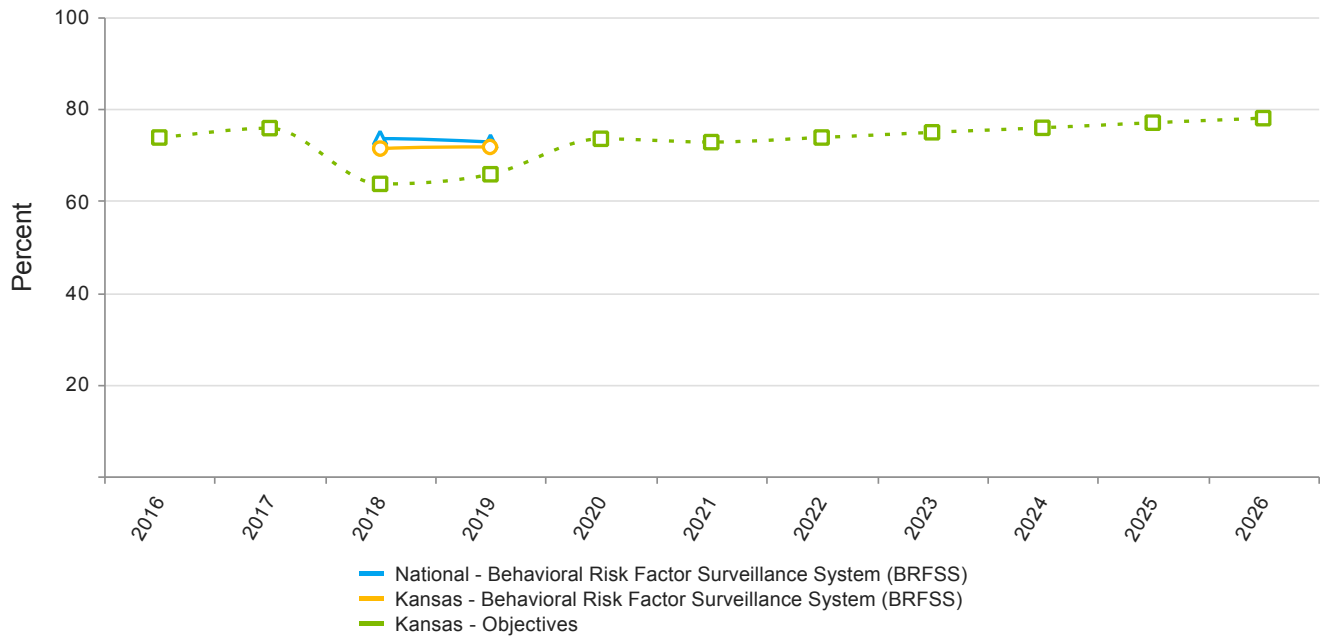
#### **Linked National Outcome Measures**

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	62.1	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	16.7	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.6 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	10.1 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	27.2 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.2	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.4	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.4	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	201.3	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	115.8	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	3.8	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.3 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	19.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	13.5 %	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	2020
Annual Objective					73.4
Annual Indicator				71.4	71.7
Numerator				351,350	351,743
Denominator				492,351	490,367
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

**i** Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

#### Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	72.7	73.7	74.8	75.8	76.9	77.9

**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**

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	78.5	
Numerator	5,412	
Denominator	6,896	
Data Source	DAISEY	
Data Source Year	2019	
Provisional or Final ?	Provisional	

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	80.5	82.5	84.5	86.6	88.8	91.0

## 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	2020
Annual Objective		
Annual Indicator	14.7	13.5
Numerator	4,930	4,466
Denominator	33,605	33,035
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.8	12.2	11.6	11.0	10.4	9.9

## 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 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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.

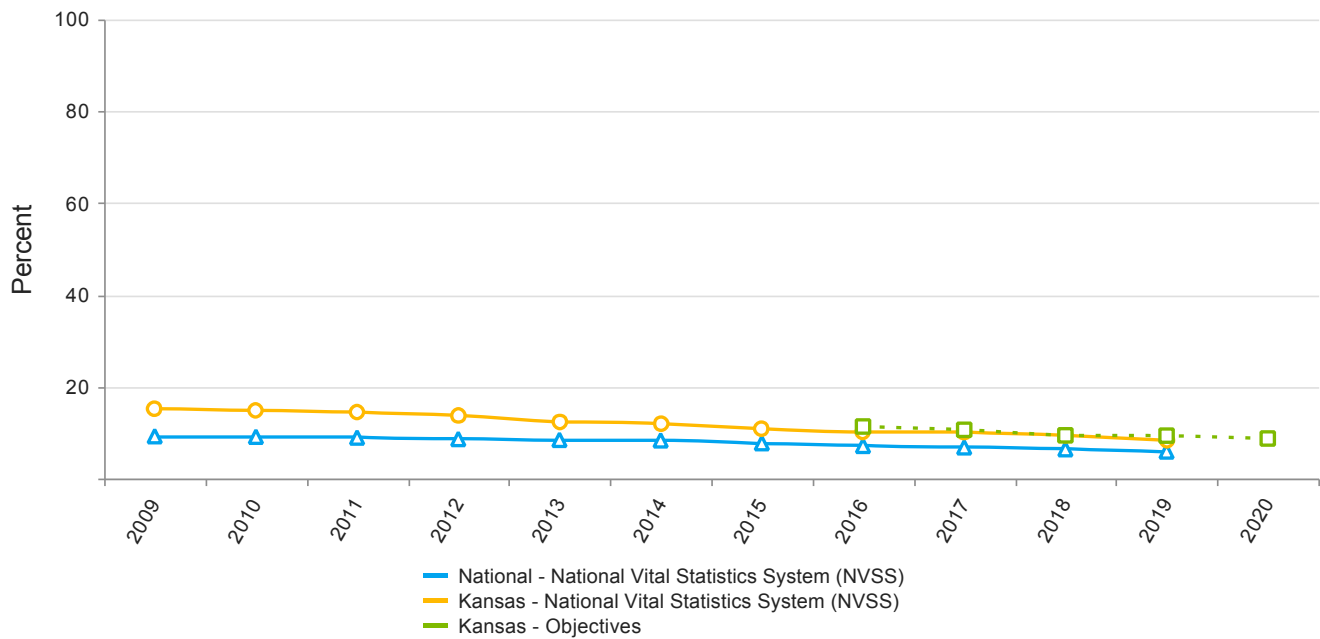
Develop regional models and innovative approaches to increase reach and support rural expansion of perinatal community collaboratives.

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

**2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy  
Indicators and Annual Objectives**



**Federally Available Data**

**Data Source: National Vital Statistics System (NVSS)**

	2016	2017	2018	2019	2020
Annual Objective	11.4	10.7	9.5	9.4	8.8
Annual Indicator	11.0	10.2	10.1	9.5	8.5
Numerator	4,298	3,877	3,683	3,440	2,994
Denominator	39,083	37,965	36,434	36,155	35,284
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019



State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	11.4	10.7	9.5	9.4	8.8
Annual Indicator	11	10.2	10.1	9.5	8.5
Numerator	4,294	3,878	3,680	3,438	2,994
Denominator	39,052	37,961	36,374	36,161	35,280
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	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	2020
Annual Objective		15	30	50	55
Annual Indicator	31.1	38.9	43.5	32	32.9
Numerator	42	96	104	89	55
Denominator	135	247	239	278	167
Data Source	DAISEY	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	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	2020
Annual Objective		8.3	8.9	9.1	8.7
Annual Indicator	8.8	9.1	9.6	9.5	10.1
Numerator	3,423	3,454	3,490	3,438	3569
Denominator	39,102	38,031	36,438	36,238	35,373
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	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)

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*Local MCH Reach:* During SFY2020, 64 of 70 grantees (91%) provided services to the Women & Maternal population.

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

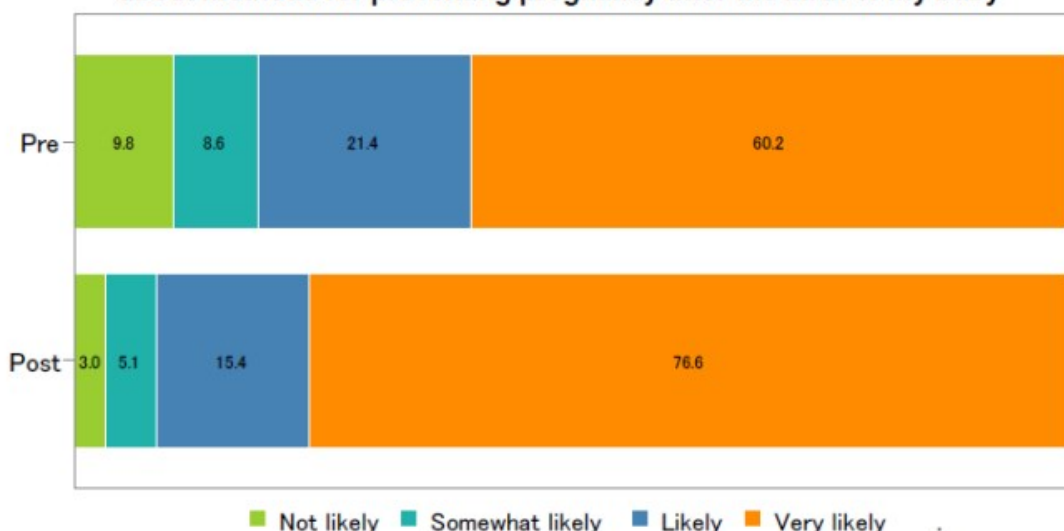
**Objective:** *Increase the proportion of women receiving a well-woman visit annually.*

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.<sup>1</sup> In 2019, an estimated 71.7% of Kansas women aged 18-44 years reported having a routine medical checkup within the past year. The prevalence of having a routine checkup within the past year increased with household income. Women living in households with an annual income \$75,000 or higher (78.1%) are most likely to report having a routine checkup. This is significantly higher than women in households earning less than \$25,000 (65.8%). Women with a college education (76.1%) were most likely to report having a routine checkup in the past year. This is significantly higher than women with a high school education (67.5%) or women with some college education (69.8%). Uninsured women (49.5%) were significantly less likely to have had a routine checkup within the past year than insured women (76.7%). There was no significant difference reporting a routine checkup within the last year for non-Hispanic black (75.2%), non-Hispanic white (71.0%) or Hispanic women (73.8%). There was no significant variation across the three age groups for women ages 18-24 (68.7%), 25-34 (72.9%) or 35-44 (73.0%). There was no significant difference in receiving a routine checkup between married women (74.1%) and unmarried women (69.6%). Place of residence was not associated with use of routine checkups (metro 70.7% vs. non-metro 74.2%).

**Data note:** *The routine checkup items changed in 2018 and data is not comparable to previous survey years. The definition of a routine checkup is a general physical exam; an exam for a specific injury, illness, or condition is no longer part of the standard question and only provided if a respondent asks for clarification: "About how long has it been since you last visited a doctor for a routine checkup?"*

**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 addressing the importance of well visits. Activities include the integration of personal health plans and the development of a reproductive life plan (RLP) for each woman completing the 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. The below figures are examples of data that demonstrates these improvements. Read more about the program, impact, and evaluation findings in the [2019 BaM State Aggregate Report](#).

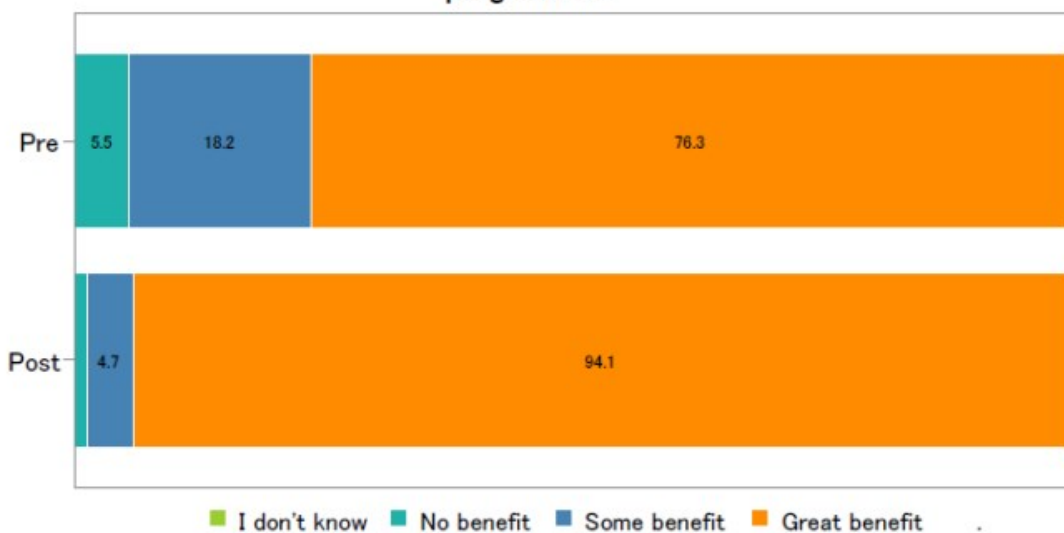
**Figure 28: I am \_\_\_ to talk to my healthcare provider during my prenatal care about methods for preventing pregnancy after the birth of my baby**



N=876

Source: BaM Program Data, 2019

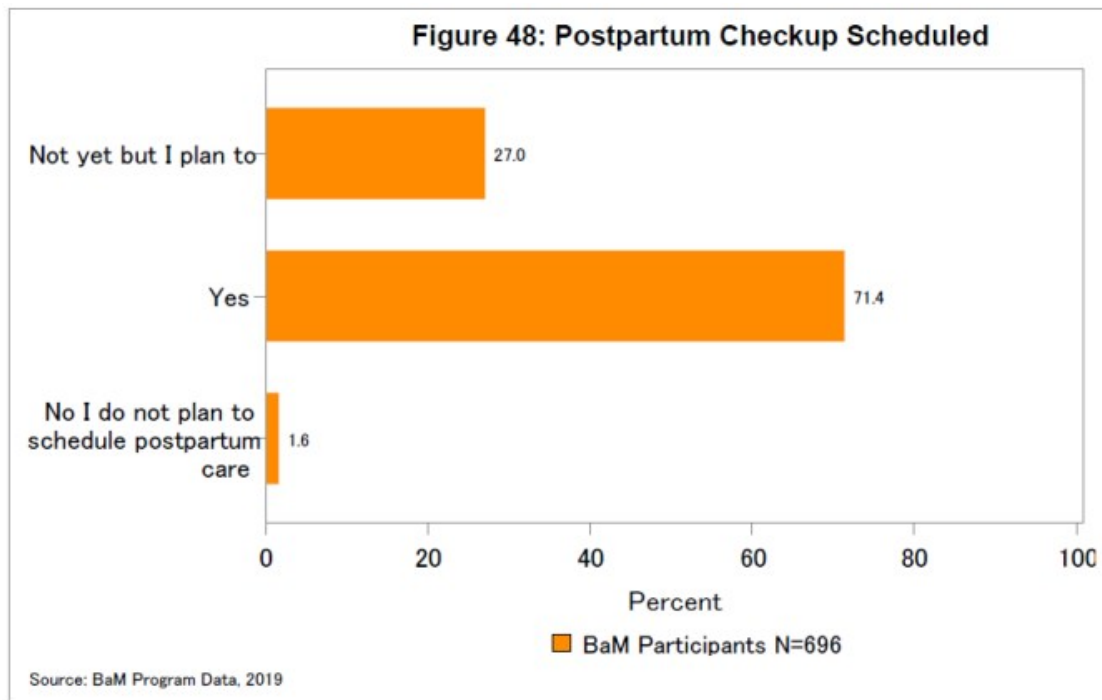
**Figure 29: I believe there is \_\_\_ benefit for waiting 18-24 months between pregnancies**



N=870

Source: BaM Program Data, 2019





The data and trends cited at the beginning of this section reveal disparities Title V is 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.

**Well-Woman Visit Toolkit:** Throughout 2020, Title V staff worked with Title X and the Bureau of Health Promotion (BHP), among others, to create two toolkits addressing the need to expand access and care for women across the lifespan through the well-woman visit. The toolkits (one for providers, one for communities) focused not only on recommended core components of the preventive visit, but how to effectively address identified barriers to receiving these services.

The content for the toolkits is based on a number of reliable and trusted sources including the American College of Obstetricians and Gynecologists (ACOG), [Women's Preventive Services Initiative \(WPSI\)](#), [CityMatCH](#), and the University of Illinois School of Public Health' (UIC-SPH) Well-Woman Project, among others. As preventive services evolve into more comprehensive, integrated, and holistic endeavors it is important to acknowledge that a single provider alone cannot address all medical and social care needs of individuals. These toolkits serve as a starting place, and for many a continuation of efforts, to ensure the provision of consistent, quality medical care while building community systems that foster long-term and sustainable improved health outcomes for women and families.

The Family Advisory Council (FAC) had an opportunity to weigh in and provide input on the toolkit contents in August 2020 before the toolkits were finalized (Fall 2020) and made available on the [KDHE Integration Toolkits](#) page. An overview webinar was provided on KS-TRAIN for home visitors and a comprehensive marketing plan began in early 2021.

**Reproductive Life Planning:** Reproductive wellness is a critical component of well-woman care. Title V staff worked closely with CRADLE KC, a community-based organization serving Kansas City and the surrounding metro areas, the March of Dimes, the Wyandotte County Health Department, and Vibrant Health (FQHC) to create [My Life, My Goals: Family Planning Life Plan](#). The resource was created with input from community members and public health experts with the intent of developing a guide that can be used in clinical and non-clinical settings. This tool walks women through the process of

assessing their reproductive goals and needs and connects them with resources to help them achieve these goals. The tool was finalized in Fall 2020 and made available on the [KDHE Integration Toolkits](#) webpage, in a fillable format, making completion easy online or in-person. An overview webinar was provided on KS-TRAIN for home visitors.

**Local MCH Agencies:** Local MCH agencies worked in collaboration with Title X Family Planning (FP) programs to educate clients 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 SFY20 show 48.2% reported “yes” (received 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. This decrease from SFY19 (56.4%) was anticipated because of the COVID-19 pandemic and women delaying annual preventive visits due to concerns over safety, additional child care and schooling responsibilities, etc. The importance of well-woman visits will continue to be addressed with MCH grantees for consistency through individual and group technical assistance. Title V will promote and encourage local agencies to utilize the resources outlined in the Well-Woman toolkit which focus on community education and addressing systemic barriers to care.

**Behavioral Health Investment & Expanded Programming:** Title V recognizes that achieving whole health without integrating behavioral health practices and services is not possible. Therefore, capacity through a HRSA grant (*Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement*) has allowed additional focus on perinatal mental health, early childhood behavioral health outcomes, and substance use. Related activities are discussed in detail in the Cross-Cutting sections.

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

**Long Acting Reversible Contraceptives (LARC):** Title V 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. ACOG advocates for increasing access to LARCs as they are the most effective contraceptive method at preventing unintended pregnancies,<sup>3</sup> as a part of a prevention solution. KDHE as the state public health agency and the State Health Officer, along with MCH, has prioritized preventing unintended pregnancy and use of LARCs.

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 question and answers and group discussion around LARC issues. In 2020, LARC Lunch and Learns were held on February 28 (Clinical Indications), July 15 (Case for Change) and October 14 (Addressing Myths and Misperceptions). While the total number of family planning clients significantly decreased in 2020 due to the pandemic the proportion of overall family planning clients that indicated LARC was their primary contraceptive method increased from 8% (CY2019) to 10% (CY2020).



## The Case for LARC

### Long-Acting Reversible Contraception

### What is a LARC?

LARC is an acronym for Long-Acting Reversible Contraception. In other words, LARC is reversible birth control that provides long-lasting pregnancy prevention. LARCs are more than 99% effective, last from three to 10 years, and require no further effort after insertion. There are two types of LARCs:

- **IUDs (intrauterine devices)** – small, T-shaped devices that are put into the uterus to prevent pregnancy.
- **Implants** – matchstick thin plastic rod that is inserted under the skin of the upper arm to prevent pregnancy.

### LARC as a Prevention Effort

Unintended pregnancy is associated with an increased risk of poor birth outcomes<sup>8</sup>. Increasing the use of LARC as a prevention effort can help:

- Reduce unintended pregnancy
- Reduce teen pregnancy
- Support adequate/safe birth spacing
  - Reduce 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)

### How can LARCs cut costs?

- In Kansas, in 2010, the federal and state governments spent \$166.1 million on unintended pregnancies. Of this, \$115.7 million was paid by the federal government and \$50.4 million was paid by the state<sup>9</sup>.
- Publicly funded family planning centers in Kansas helped avert 7,900 unintended pregnancies in 2014, which would have resulted in 3,800 unplanned births and 2,800 abortions<sup>10</sup>.
- By averting unintended pregnancies and other negative reproductive health outcomes, publicly funded family planning services provided by safety-net health centers in Kansas helped save the federal and state governments \$81.3 million in 2010<sup>11</sup>.

Unintended pregnancies contribute to significant health care costs. If the delivery is premature or results in a low birth weight infant, costs are greatly multiplied.

One Key Question® State Initiative: An annual well visit addresses a woman's existing state of health but often lacks time and opportunity to discuss pregnancy intention. It's well known that birth outcomes are 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. About 1 in 4 mothers who had a live birth in 2019 (26.7%) reported that their pregnancies were unintended.<sup>2</sup> 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 began implementing [One Key Question®](#) (OKQ®) in 2018 through a partnership with the national team, Power to Decide, with a series of three in-person trainings across the state. At the onset of the COVID-19 pandemic, as in-person trainings were no longer an option, Title V staff reached out to Power to Decide to explore online training options. Kansas was the first state to pilot the OKQ® online training curriculum and was able to engage in direct feedback on

areas of improvement and potential additions to enhance online delivery of the OKQ® curriculum prior to its national rollout. As a result of this partnership, and move to online training, 34 healthcare providers and allied professionals across the state completed the OKQ® certification training. In addition to the core training, Kansas participants were also provided access to new training modules devoted to preconception and inter-conception care and screening.

All local MCH programs ask the OKQ® at each client visit 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. This form takes a much deeper dive into the responses client's give and action that was taken. Data collected during SFY2020 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.

SFY20 – Local MCH Agencies Entering Client Level Data in DAISEY on OKQ®						
Population Served	No	Okay Either Way	Unsure	Yes	NA	Total
Post-Partum Women	4,169	60	347	34	27	4,637
Prenatal/Pregnant Women	7,406	82	556	78	78	8,200
Women (18-44 years)	1,233	36	117	34	8	1,428
<b>Total</b>	<b>12,808</b>	<b>178</b>	<b>1,020</b>	<b>146</b>	<b>113</b>	<b>14,265</b>

Program	OKQ® Response				
	No	Okay Either Way	Unsure	Yes	Total
Family Planning	1300	16	11	24	1351
MCH	335	13	9	4	361
PMI	24	0	1	0	25
TPTCM	58	1	2	0	61
<b>Total</b>	<b>1717</b>	<b>30</b>	<b>23</b>	<b>28</b>	<b>1798</b>

The OKQ® data shows that the clear majority of individuals asked between October 1, 2019, and September 30, 2020, did not want to get pregnant in the next 12 months. Of those that answered “yes,” 55% were referred for additional services, 25% of those that answered “okay either way” were referred and 20% of those that answered “unsure” were referred. This highest percentage of referrals were to OB/GYNs (57.5%) with family planning programs following at 32.5%, additional referrals went to other physicians, MCH programs and other providers.

Referred	OKQ® Response				
	No	Okay Either Way	Unsure	Yes	Total
Family Physician/Practice	0	0	0	1	1
Family Planning Program	0	2	3	8	13
MCH Program	0	0	1	0	1
OB/GYN	0	8	4	11	23
Other	0	0	0	1	1
Safety Net Clinic <i>FQHC Rural Health Clinic income-based or free clinics</i>	0	0	0	1	1
<b>Total</b>	0	10	8	22	40

Data uncovered that a higher percentage (93.8%) listed “other” as a barrier to referral. While “other” is an important category to try and capture all reasons why a woman was not referred, when the response is not accompanied by explanation, it is not helpful. In the coming year, Title V will work closely with local MCH agencies to provide technical assistance on the “other” category, helping local agencies understand the importance of elaborating on “other” responses so that Title V may work to improve barriers to referrals that have been happening at the local level.

Barrier	OKQ® Response				
	No	Okay Either Way	Unsure	Yes	Total
No Health Insurance	0	0	2	0	2
Other	1	14	10	5	30
<b>Total</b>	1	14	12	5	32

*Preconception Health Guide*: Title V and X partnered with the Bureau of Disease Control and Prevention to develop a preconception health guide as a follow up to the OKQ and to assist providers with identifying the important topics that should be covered during a preconception health visit. This guide contains recommended screening guidelines for Congenital Syphilis; Kansas, like the rest of the country, has seen significant increases in the disease, which can have a great impact on pregnancy outcomes. The preconception health guide is available online at [https://www.kdheks.gov/cf/integration\\_toolkits/Preconception\\_Health\\_Guide.pdf](https://www.kdheks.gov/cf/integration_toolkits/Preconception_Health_Guide.pdf). Hard copies of the guide were also mailed to every local Title V MCH and Title X Family Planning agency. The hard copies are laminated one-page (front and back) documents that can be stored in exam rooms for ease of use. Images of these are included below.





## Important Considerations for Screening Before Pregnancy

### Include Syphilis in Routine STI Screening

- **Widely Recommended.** CDC's treatment and screening recommendations are endorsed by American College of Obstetricians and Gynecologists (ACOG), and the United States Preventive Services Task Force (USPSTF) concluded with high certainty that the net benefit of screening for syphilis infection in nonpregnant persons at increased risk for infection was substantial ("A" Recommendation).
- **Risk Factors May Not be Disclosed.** When deciding which patients to screen for syphilis, clinicians should be aware that the risk factors of the patient's sex partners are just as important as those of the patient themselves. Factors associated with increased prevalence are described in the table below.
- **Kansas is an Area of Increased Prevalence.** Since 2013, the rates of syphilis infections among women have more than doubled. Subsequently, reported rates of Congenital Syphilis cases have also increased substantially, with Kansas ranking 15th in the nation for Congenital Syphilis cases adjusted for population in 2018, despite ranking much lower in syphilis infections among adults.

### Treatment and Follow-up Recommendations

Screen all patients at first prenatal visit, regardless of risk Non-treponemal test such as RPR or VDRL, with reflex confirmatory treponemal test such as TP-PA			
SYPHILIS DIAGNOSIS AT INITIAL PRENATAL SCREENING			RESCREENING IF FIRST TEST IS NEGATIVE
<b>Primary</b> + Chancre	<b>Late-Latent or Unknown Duration</b> NO symptoms, and infection does not meet criteria for early latent <sup>2</sup>	<b>Neurosyphilis<sup>3</sup></b> + CNS sign or symptoms + CSF findings on lumbar puncture (LP)	<b>Rescreen all patients at 28 weeks gestational age (regardless of risk).</b> Also re-screen at delivery if patient at risk: • Missed re-screen at 28 weeks • Lives in high morbidity area • HIV-positive • Other STD diagnosed the past 12 months • Illicit substance use • Reports transactional sex • Homeless/unstable housing • History of incarceration within the past 12 months • Multiple sex partners or partner with other partners
<b>Secondary</b> + Rash and/or other signs <sup>1</sup>			
<b>Early-Latent</b> NO symptoms and infection occurred within one year <sup>2</sup>			
<b>Benzathine penicillin G</b> 2.4 Million Units, Intramuscularly (IM) Once	<b>Benzathine penicillin G</b> 2.4 Million Units IM every 7 days, for 3 doses (7.2 mu total)	<b>Aqueous penicillin G</b> 3-4 Million Units Intravenously every 4 hours for 10-14 days	
<b>Repeat follow-up titers at 28 weeks. Consider monthly titers until delivery if at risk for reinfection.</b> Post-treatment serologic response during pregnancy varies widely. Many women do not experience a fourfold decline by delivery. If fourfold increase occurs after treatment completion, evaluate for reinfection and neurosyphilis.			

## Preconception Health

A Healthy Pregnancy Starts Before a Woman Gets Pregnant

A Guide for Women's Health Providers



Women Should Avoid:	Assess & Discuss:	Educate On:
<ul style="list-style-type: none"> <li>• Drinking alcohol</li> <li>• Smoking or using tobacco/nicotine products</li> <li>• Illicit drugs or taking prescription medication for uses other than what they were intended</li> <li>• Highly stressful situations</li> <li>• Exposure to toxic substances such as radiation, chemicals, cat or rodent feces</li> <li>• Unsafe sex, risk of STIs, or birth defects causing infections or illnesses (HIV, syphilis, diabetes, rubella, Zika)</li> </ul>	<ul style="list-style-type: none"> <li>• Client's overall physical and mental health</li> <li>• Screenings needed (pap smear, STI [including HIV screen], depression screening, substance use screening, social determinants of health screening)</li> <li>• Medical conditions that could cause risk to their pregnancy (diabetes, high blood pressure, obesity, asthma, dental decay)</li> <li>• Vaccinations needed</li> <li>• Prescription medicines, over-the-counter medications, or supplements that may cause risk for pregnancy</li> <li>• Sobriety support options for substance use, including alcohol, illicit drugs, and/or tobacco use</li> <li>• Family planning and birth control – deciding when and if to get pregnant is a woman's choice</li> <li>• Problems with any previous pregnancies (preterm birth or baby weighing less than 5 pounds 8 oz)</li> </ul>	<ul style="list-style-type: none"> <li>• Taking Folic Acid (400 to 800 mcg every day – based on woman's needs)</li> <li>• A nutritious diet</li> <li>• Regular physical activity that is right for the woman</li> <li>• Healthy ways to reduce stress</li> <li>• Strengthening client support system and positive relationships</li> <li>• Understanding insurance coverage and payment concerns (prenatal care, delivery services)</li> <li>• Health history of client or partner's family</li> </ul>

**Women's Health Awareness Efforts:** Title V staff worked with KDHE Communications and the Kansas Maternal and Child Health Council (KMCHC) to raise awareness around key health issues impacting women in Kansas, often in the form of social media posts on agency and council channels, including twitter and Facebook. These posts were tied to emerging health trends or needs, including heart health or Black maternal health. Examples of posts include:

1. Today, on World Heart Day, learn more about how to improve your heart health to ensure you are thriving and able to be there for those that count on you. <https://www.world-heart-federation.org/world-heart-day/better-choices/>
2. In KS 1 out of 4 Black mothers reported experiencing depression during their pregnancy as well as after the baby was born. During this stressful time if you, or a mom you know, is struggling check out Postpartum Support International for help: <https://www.postpartum.net/get-help/help-for-moms/> #BMHW2020

In partnership with the KMCHC, Title V created a Women's Health Month toolkit for local providers to use for awareness each week in May 2020 (<https://www.kansasmch.org/womenshealthmonthtoolkit.asp>). The toolkit included graphics and messages for social media.





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

**Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM):** With proven success, Kansas MCH remains committed to supporting the expansion and sustainability of the [KPCC initiative](#), providing training and technical assistance on community collaborative development and MCH program integration. Although this objective was originally focused on expansion of the model by five communities per year, a strategic decision was made in 2019 to shift focus from expansion by “number” to expansion of *strength* and *capacity*. During 2019 and 2020, focus has been centered on strengthening infrastructure to support current and future sites, 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, in southwest Kansas, 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. In SFY20, a collaboration between the Seward County Health Department, Southwest Medical Center and National Beef to jointly facilitate prenatal education sessions at the hospital for National Beef employees as a benefit of their health insurance plan. National Beef requires all pregnant employees or spouses who are enrolled in their health care plan to attend sessions and will waive the co-pay for prenatal care and delivery. 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 regional collaborative prototype will be replicated in additional communities in the coming years.

The focus on infrastructure building, rather than traditional expansion, was even more validated with the COVID-19 pandemic, where opportunities for public health, private health care providers, public service and support organizations to work together were necessary. Throughout the pandemic, Title V and BFH staff worked tirelessly to get guidance documents, FAQs and other trustworthy resources created and disseminated to local care providers, businesses and the general public. Additionally, the team facilitated listening sessions in the fall of 2020 for local Title V providers to voice the challenges and barriers they’ve faced throughout the pandemic. The focus was on continued needs, but also on opportunities and innovative solutions they’ve identified through the pandemic response. KPCC communities were well positioned as providers across sectors were already working collaboratively and meeting on a regular basis to respond to

the needs of their shared perinatal population. Technical assistance was provided by Title V to support the provision of home visiting and BaM prenatal education services virtually and telephonically, as well as creating fillable PDFs for electronic collection of service data and risk screening such as with the Edinburgh Postnatal Depression Scale (EDPS).

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 (6.4% compared to 9.47). 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 5.2 in 2015-2019. The Saline County IMR decreased from 9.0 in 2005-2009 to 5.9 in 2015-2019.

Preterm Birth Rate (<37 Weeks)	All Community Collaboratives <sup>2</sup>	Kansas/State <sup>1</sup>
2017-2019 3-year avg.	6.4%	9.7%
Infant Mortality Rate <sup>1</sup>	Geary Collaborative established* July 2012	Saline Collaborative established* Jan. 2010
2005-2009	11.9	9.0
2015-2019	5.2	5.9

Sources: <sup>1</sup>KDHE, Bureau of Epidemiology and Public Health Informatics;  
<sup>2</sup>2017-2019 KDHE, Bureau of Family Health

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

The preterm birth rate, those occurring before 37 weeks gestational age, increased significantly from 9.5% in 2018 to 10.1% in 2019. The late preterm birth rate also increased significantly from 6.9% in 2018 to 7.4% in 2019. The slight increase in the early preterm birth rate from 2.5% in 2018 to 2.7% in 2019 was not statistically significant.

The preterm birth rates for births with non-Medicaid indicated as the source of payment for the delivery increased significantly from 8.6% in 2018 to 9.3% in 2019. The slight increase in the preterm birth rate for births with Medicaid as the source of payment for the delivery increased from 11.4% in 2018 to 11.9% in 2019 was not statistically significant.

Nonsignificant increases in preterm birth rates were observed from 2018 to 2019 for births to each race and Hispanic origin group: Hispanic (10.0% in 2019 from 9.2% in 2018), non-Hispanic White (9.6% in 2019 from 9.2% in 2018), non-Hispanic Black (14.8% in 2019 from 13.3% in 2018), non-Hispanic American Indian/Alaska Native (11.6% in 2019 from 10.5% in 2018), non-Hispanic Asian/Pacific Islander (9.5% in 2019 from 8.0% in 2018), and non-Hispanic other race and ethnicity (10.8% in 2019 from 10.2% in 2018).



### Distribution of preterm births with Medicaid and non-Medicaid by racial and ethnic group

Race and ethnic group	2018		2019	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
Non-Hispanic White	11.3	8.4	11.7	8.9
Non-Hispanic Black	15.4	10.3	15.3	14.1*
Hispanic	9.7	9.0	10.7	9.6
Non-Hispanic Other	9.4	9.1	11.0	9.7
Total	11.4	8.6	11.9	9.3*

\* Indicate a statistical significance of rate difference

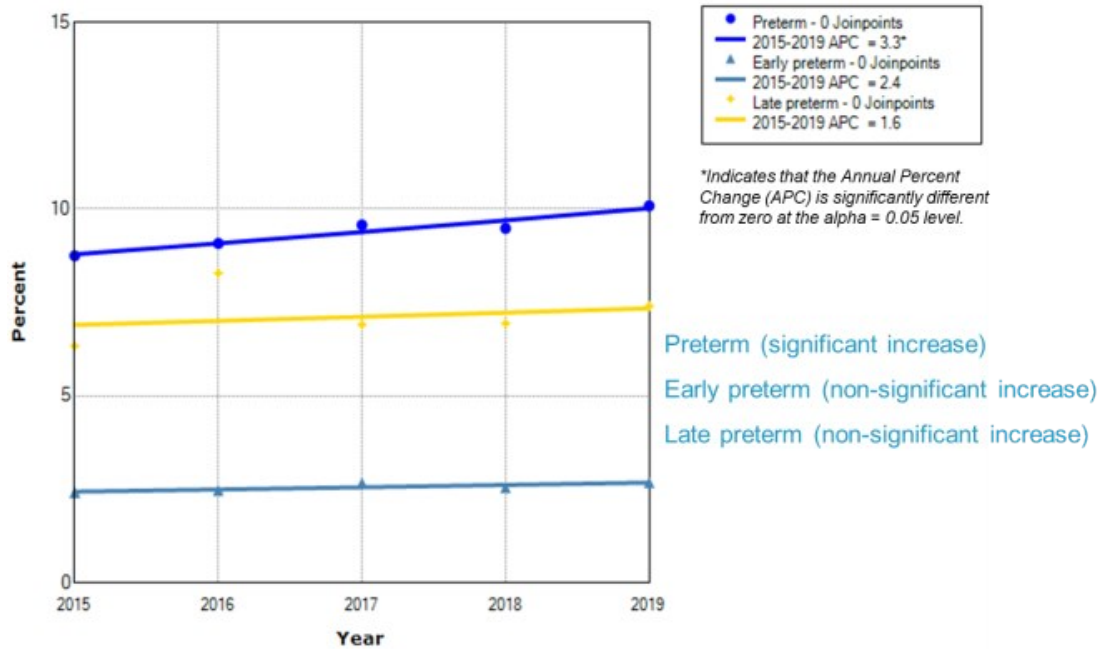
Nonsignificant increases in preterm birth rates were observed across the age groups: under 20 (11.2% in 2019 from 9.8% in 2018), 20-29 (9.5% in 2019 from 9.0% in 2018), 30-39 (10.6% in 2019 from 9.9% in 2018), and 40 and over (12.8% in 2019 from 12.3% in 2018).

In 2019, the rate for preterm births, was slightly lower in Kansas (10.1%) than the U.S. (10.2%). Despite an increase in 2019, the Kansas preterm birth rate in 2019 continued to surpass the Healthy People 2020 goal of 11.4%, though the Medicaid population did not meet this goal (11.9%). Non-Hispanic White, non-Hispanic Asian/Pacific Islander, and Hispanic preterm birth rates were lower than the State average rate. The preterm birth rate was significantly higher for births with Medicaid indicated as the source of payment for the delivery on the birth certificate (11.9%) than non-Medicaid payers (9.3%). This pattern was consistent for 2015-2019. During 2015-2019, the overall preterm birth rate for Kansas showed a significant increase.

Changes in the distribution of births by gestational age were observed from 2018 to 2019. The percentage of infants born early term (37-38 weeks) slightly increased from 26.3% in 2018 to 27.2% in 2019. Decreases were also observed in term (39-40 weeks, from 60.3% to 59.4%), late (41 weeks, from 3.7% to 3.1%), post-term (42 weeks and higher, from 0.3% to 0.2%) births. Similar patterns for 2018-2019 were observed for the three largest race and Hispanic origin groups. The 2019 preterm birth rate for singleton births was 8.3%, a significant increase from 7.7% in 2018. The late preterm birth rate for singleton births also increased significantly from 5.8% in 2018 to 6.2% in 2019. The slight increase in the early preterm birth rate for singleton births from 1.9% in 2018 to 2.1% in 2019 was not statistically significant. The 2019 preterm birth rate for multiple births was 66.3%, a non-statistically significant increase from 62.5% in 2018.

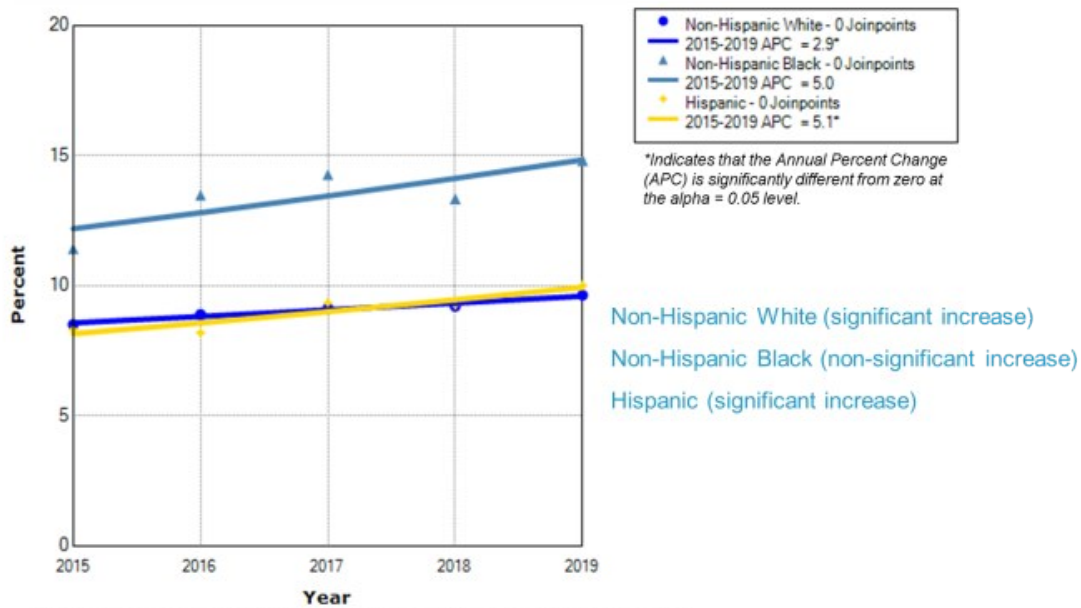


### Percentage of preterm births (preterm, early preterm vs. late preterm), Kansas, 2015-2019



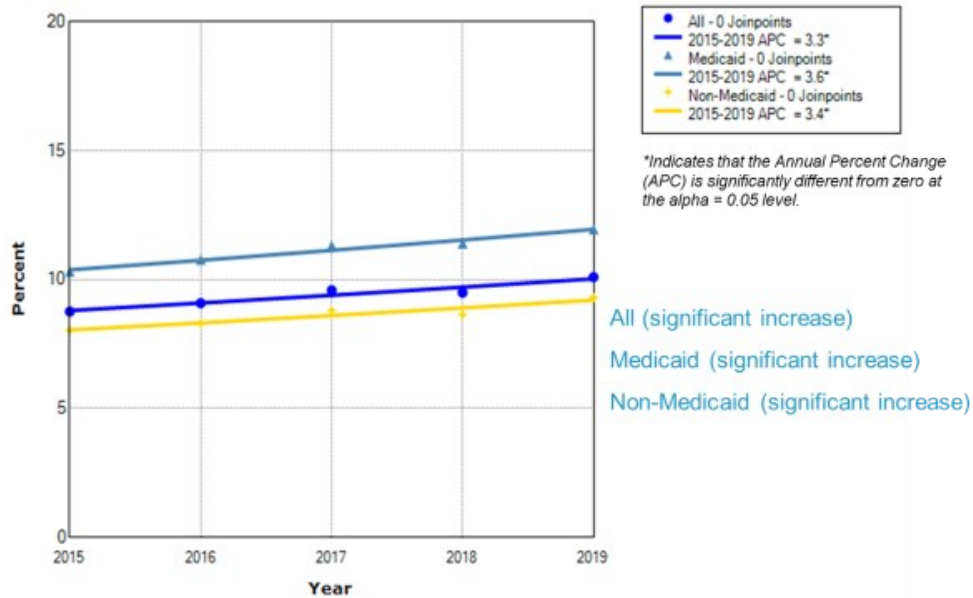
Source: Kansas Department of Health and Environment, Kansas birth data (resident)

### Percentage of preterm births (non-Hispanic White, non-Hispanic Black vs. Hispanic), Kansas, 2015-2019

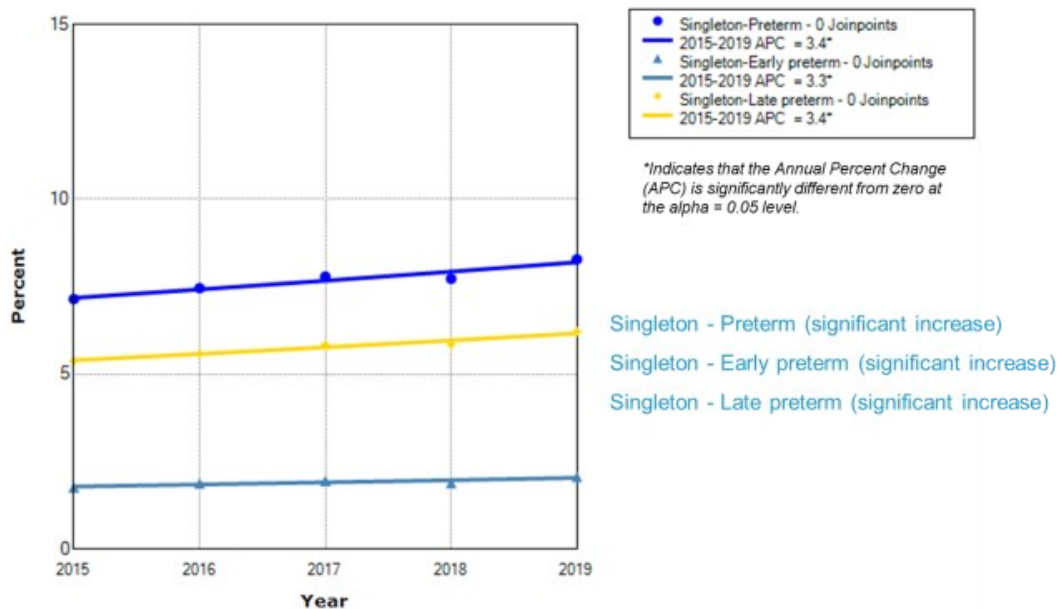


Source: Kansas Department of Health and Environment, Kansas birth data (resident)

Percentage of preterm births (Overall, Medicaid vs. non-Medicaid), Kansas, 2015-2019



Percentage of preterm births for singleton births (preterm, early preterm vs. late preterm), Kansas, 2015-2019



**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.**

**Utilization of 17P:** Title V recommends that women work closely with their prenatal care providers for all aspects of their care, including the prevention of preterm birth. Recommendations from Title V around further promotion of 17P as an intervention to reduce recurring preterm birth has ceased since the FDA Advisory Committee statement was released on October 29, 2019 to remove Makena (17P) from the market due to findings that weekly injections of the treatment were

ineffective. Upon conversation with Kansas providers Kansas Title V, in accordance with ACOG recommendations, supports the use of 17P for preterm birth in specific situations in which a woman's provider feels the therapy is necessary and impactful.

### ***Other Activities to Reduce Preterm Birth***

***Perinatal Risk Assessment:*** To easily identify participants with specific risk factors for preterm birth (e.g., smoking in pregnancy, previous spontaneous singleton preterm birth, lack of prenatal care), a form in DAISEY was established in 2017, however data indicate it has been underutilized. Title V worked with partners to develop a more comprehensive "perinatal risk assessment" tool aligned across programs and utilized by KPCC sites, home visitors, and other MCH programs.

***Preterm Labor Risk Education:*** A major focus KPCC's, supplemental resources were created, such as: handouts on preterm labor and risk reduction and educational presentation, embedding videos from MOD on signs of preterm labor and ["Is It Worth It"](#) from the National Child & Maternal Health Education Program. Each KPCC participant was also provided a "Signs of Preterm Labor" magnet, customizable with the date they reach 37 completed weeks of pregnancy and their provider's phone number. Program evaluation efforts show significant improvement in knowledge/recognition of preterm labor signs by program participants' pre to post testing.

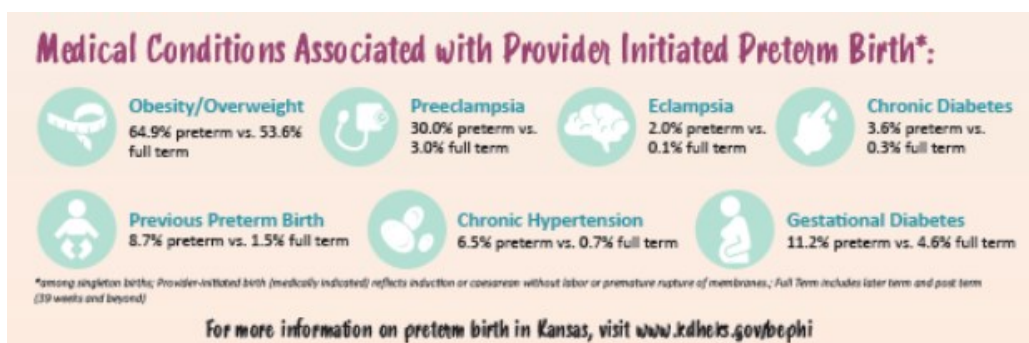
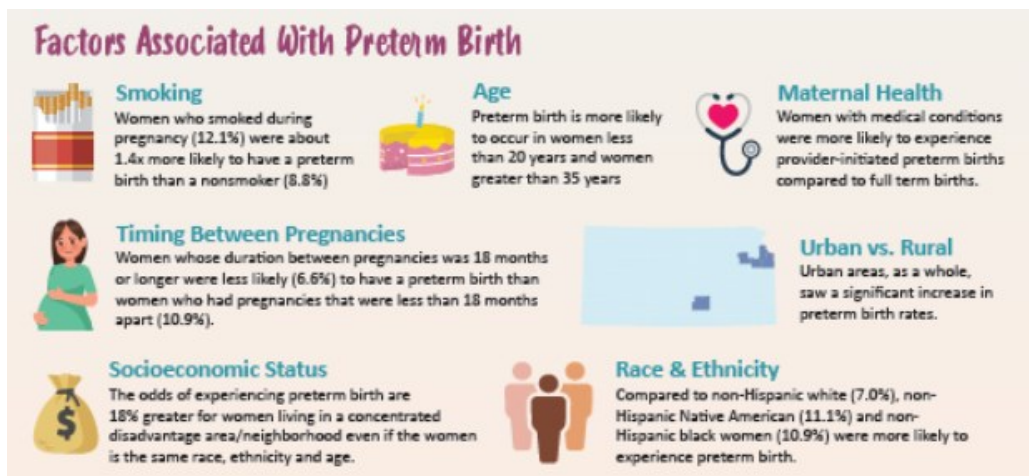
**Table 2: Pre/Post-Intervention Answers to Knowledge Questions (percentage answering correctly)**

Question	Pre-Survey (%)	Post-Survey (%)
<i>Signs of Preterm Labor</i>		
Color of discharge or bleeding	71.8	87.3*
Feeling that baby is pushing down	58.1	79.5*
Backache	53.4	75.8*
Belly cramps	45.9	70.5*
Cramps that feel like your period	64.7	76.7*

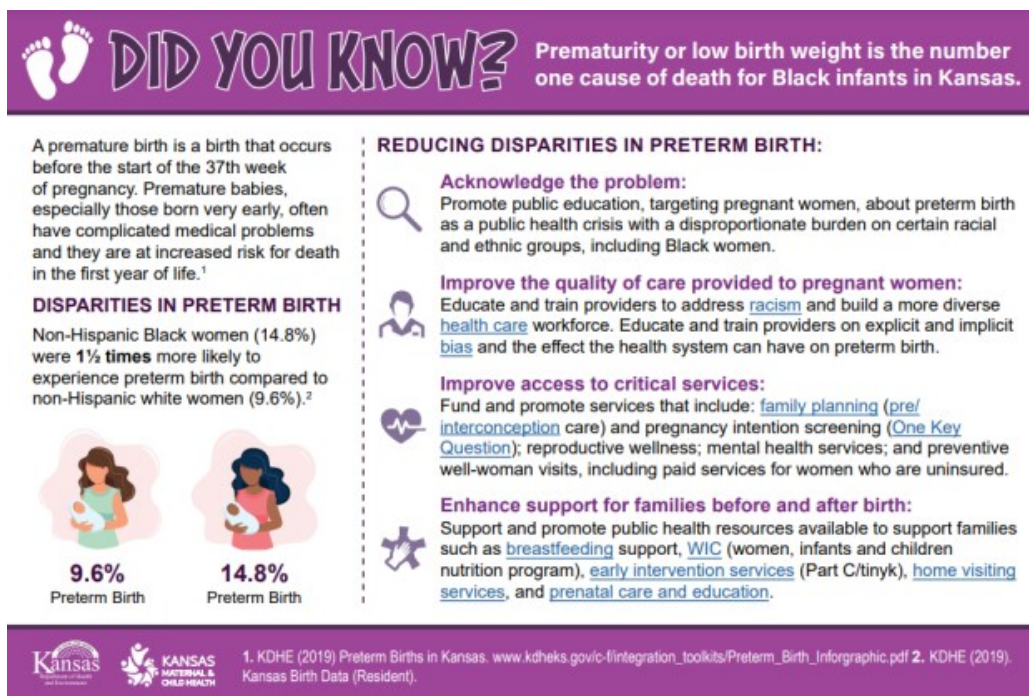
Several measures are tracked to understand birth outcomes and the general health of both the mother and baby at the time of delivery and the impact the KPCC education may have on pregnancy outcomes. For the 2019 report, linkage of BaM and vital records was completed for key outcome measures (e.g., gestational age, low birth weight, cesarean deliveries). Data indicate that BaM mothers had:

- Significantly lower preterm birth rate (4.4%) than for Kansas births in general (10.1%);
- Similar, but slightly improved low birthweight rate (6.9%) compared to Kansas births in general (7.6%); and
- Slightly lower likelihood of cesarean deliveries (28.3%) compared to Kansas births in general (29.7%).

***Preterm Birth Awareness:*** The data above revealed the need for greater preterm birth awareness, therefore Title V created a preterm birth infographic highlighting KS trends and factors (social determinants and medical conditions) associated with preterm birth. The purpose of this infographic was to raise awareness of preterm birth and prevention factors.



In partnership with the Kansas African American Affairs Commission (KAAAC), Title V created a series of Did You Know (DYK) infographics highlighting health disparities in the Black communities, featuring specific data and action steps for reducing disparities. The November 2020 DYK was focused on preterm birth.





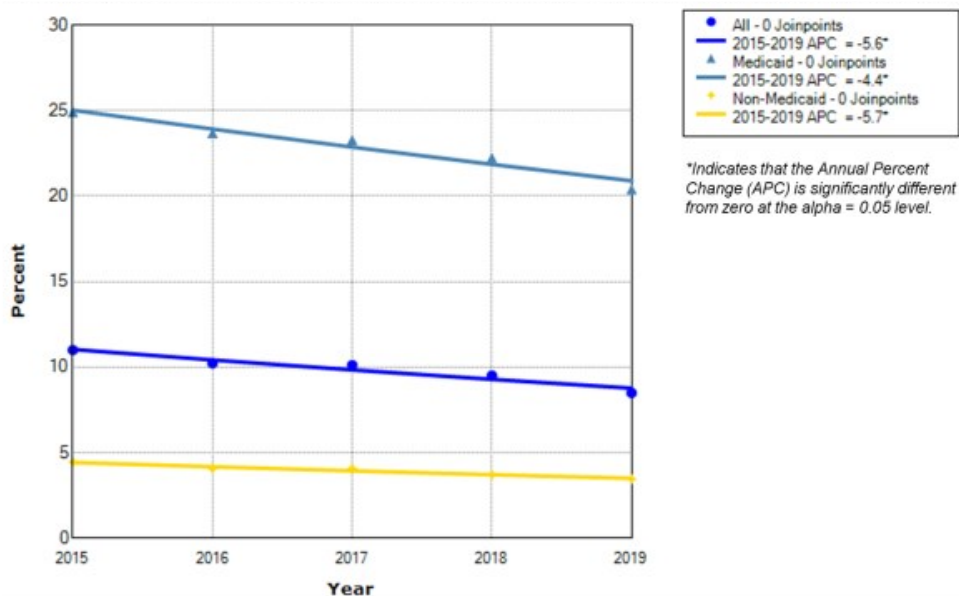
#### NPM14: Smoking (during pregnancy/household smoking)

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. During 2015-2019, there was a statistically significant decreasing trend observed in overall, Medicaid and non-Medicaid as the principal source of payment for the delivery.

In 2019, 8.5% of women reported smoking during pregnancy, a significant decrease from 2018 (9.5%). In 2019, Medicaid paid for the delivery of 10,445 (29.7%) Kansas live births. Among women who reported smoking during pregnancy, 71.5% reported Medicaid as principal source of payment for this delivery. This was a slight decrease from 2018 (73.3%).

The smoking rate was highest for non-Hispanic Native American women at 17.8%, followed by non-Hispanic Black women (10.6%) and non-Hispanic white women (9.6%). Rates for Hispanic (3.6%) and non-Hispanic Asian women (1.3%) were substantially lower. Both older teenagers (aged 18-19 years) and women in their early twenties (aged 20-24 years) had the highest smoking rates, 11.3%. Smoking rates for women in their thirties and older were sharply lower, around 7%.

Percent of smoking during pregnancy (Overall vs Medicaid vs Non-Medicaid), Kansas, 2015-2019



Source: Kansas Department of Health and Environment, Kansas birth data (resident)

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 2018-2019 National Survey for Children's Health, parents were asked whether anyone in the household used cigarettes, cigars, or pipe tobacco. Overall, 19.6% of Kansas children were reported to live in households where someone smokes. About 19.3% of non-Hispanic White children, 9.8%\* of non-Hispanic Black children, 25.1%\* of non-Hispanic other children, and 22.3%\* 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 29.1%\* lived in a household with a smoker, of children with household incomes between 100 and 199 percent of the Federal poverty level (FPL), 28.5% lived with a smoker, of children with household incomes between 200 and 399 percent of FPL, 18.9% lived with a smoker, and of children with household incomes of 400 percent or more of FPL, only 8.4% had a smoker in the household.

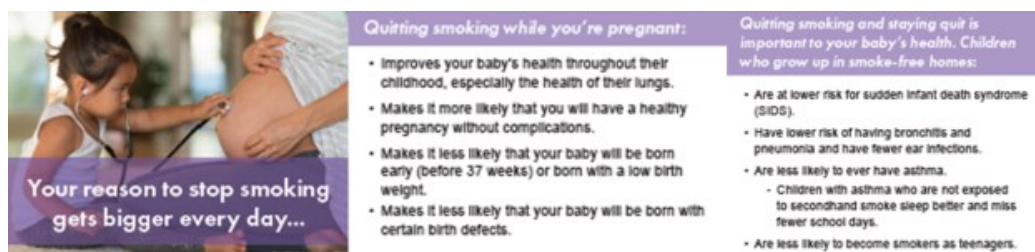


*\*Please interpret with caution: estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable.*

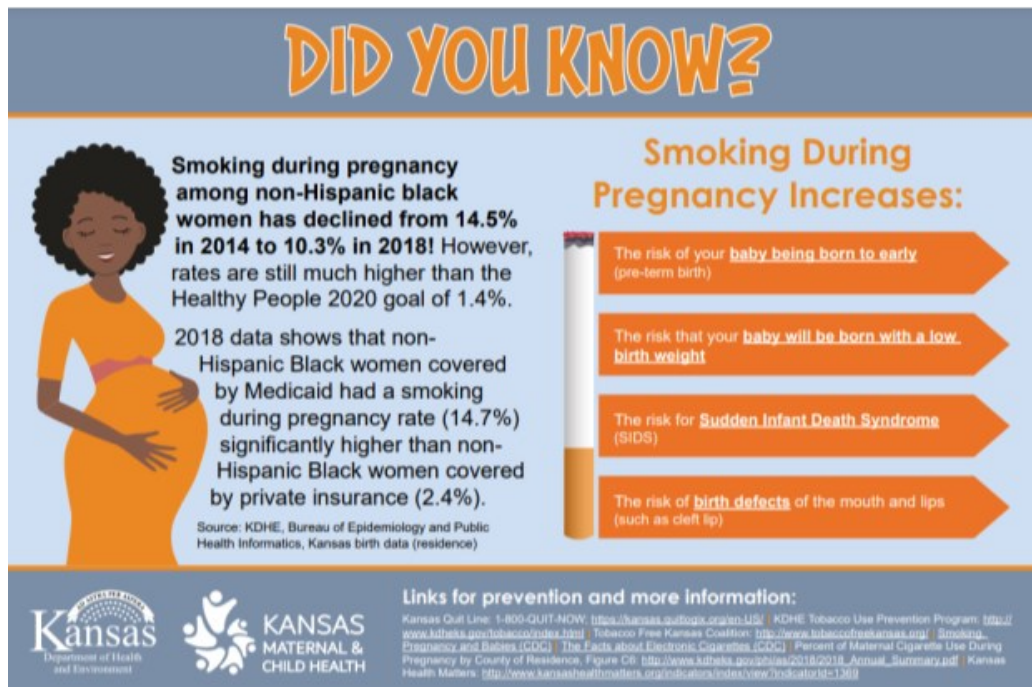
**Objective: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.**

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 includes multiple evidence-based cessation programs.

- **Smoking Cessation & Reduction in Pregnancy Treatment Program (SCRIPT):** [SCRIPT](#) is an award-winning, evidence-based intervention known to assist women with quitting smoking. The BFH continued to provide technical assistance as needed throughout the reporting period and will continue to monitor progress. Although several programs expressed interest in SCRIPT training in 2020, due to the further trainings were not provided. Title V staff are working with BHP to identify other possible trainings and interventions that currently integrate the KS Quitline.
- **Baby & Me Tobacco Free (BMTF):** [BMTF](#) is an evidence-based intervention targeted to pregnant women who smoke. It is currently implemented in four communities that have modified the delivery model to increase participation and lower attrition rates. Sites reporting success have linked the program to local prenatal education classes and added incentives to reinforce cessation during the prenatal period. Title V did not provide additional BMTF training during the reporting period.
- **KS Quitline/KanQuit:** Title V worked with the Tobacco Cessation program to disseminate social media and print messaging to educate about the dangers of smoking during pregnancy. The Tobacco Quitline Rack Cards were disseminated to local MCH providers. Samples of the images/content on these cards are depicted below.



- **Tobacco Cessation Integration Toolkit:** The tobacco cessation toolkit includes an integration guide/plan, screening tools, referral flowchart, resource/reference summary, provider education materials, Medicaid coverage guidance, and resource access (provider and patient).
- **Smoking Disparities DYK:** The below infographic was created to highlight the disparities among non-Hispanic Black women in smoking during pregnancy and was made available to the public and all MCH providers. The infographic included links for prevention tips and more information.



These approaches focus on clinical and public health provider education; a tobacco cessation toolkit; patient education resources; integration into existing programs; and Medicaid coverage for screening, counseling, and postpartum nicotine replacement therapy. MCH local agency referrals to BMTF and SCRIPT are captured in DAISEY to monitor participation related to implementation and quality improvement

**Local MCH Agencies Entering Client Level Data in DAISEY  
SFY2020 Smoking Cessation Services**

Counseling	BMTF	SCRIPTS	5As/2As & R	Other
105	98	5	40	44

**SFY2020 - Local MCH Agencies Entering Client Level Data in DAISEY**

Smoking Cessation Program	Referrals Made	Referrals Completed	% Completed
BMTF	62	31	50%
Kansas Tobacco Quitline	288	212	73.6%
SCRIPT	24	23	95.8%
Other	20	14	70.0%

**Essential State & Local Partnerships:** The BFH MCH and WIC programs along with the BHP, 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. A revised state tobacco control plan is currently in draft form and will be distributed to partners in the spring of 2021. 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.

**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)**

**KPQC Quality Initiative:** During FY20, Title V and the [Kansas Perinatal Quality Collaborative \(KPQC\)](#) continued their partnership with the Vermont Oxford Network (VON) to complete the KPQC's first quality initiative related to addressing the impact of substance use during pregnancy, in some cases resulting in infants diagnosed with Neonatal Abstinence Syndrome (NAS). In October 2020, the KPQC marked the completion of the efforts. The NAS approach involved 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). There were four Aims for the project:

1. By October 2020, 85% of all birth centers enrolled in VON NAS Universal Training Program will have achieved "Center of Excellence" designation;
2. By October 2020, less than 50% of infants at risk for NAS will be directly admitted to the NICU;
3. By October 2020, the number of infants at risk for NAS who require pharmacological treatment will decrease by 25%;
4. By October 2020, the LOS of infants with NAS treated pharmacologically will decrease by 2 days.

A total of 33 birthing centers participated in the KPQC initiative and enrolled with VON, representing more than 85% of all births in the state. All four Aims were achieved by the participating centers and 31 of the 33 became a VON *Center of Excellence* by completing the universal training for the care of NAS. By achieving a rate of over 85%, Kansas achieved the VON *State of Excellence* in Education and Training distinction.

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## Other Activities Impacting Women & Maternal Health

**Kansas Maternal Mortality Review Committee (KMMRC):** The 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 state was funded for the Preventing Maternal Deaths: Supporting Maternal Mortality Reviews CDC Cooperative Agreement in September 2019. The KMMRC membership is diverse, including 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.

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. Timing of death is depicted below.



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

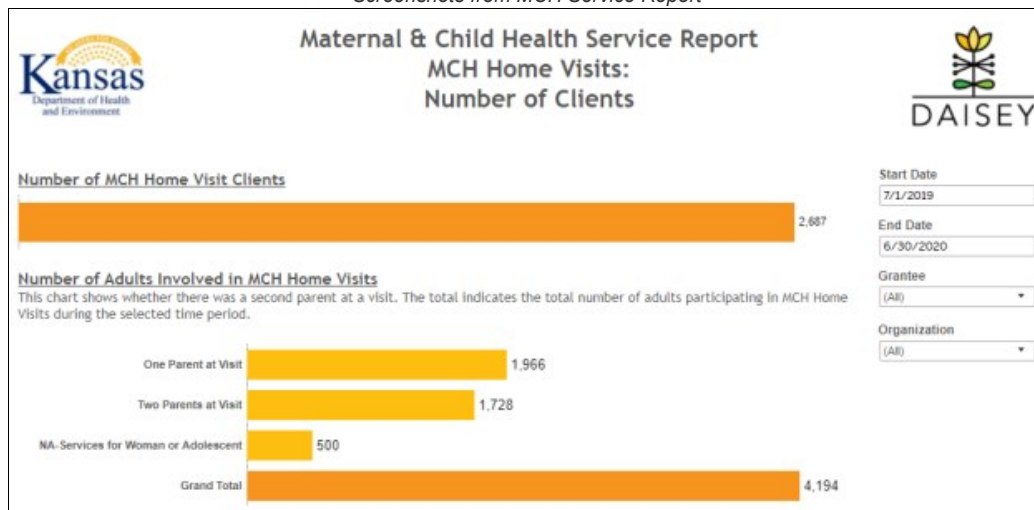
diseases, 1 (1.8%) blood disorders, 1 (1.8%) cardiomyopathy, 1 (1.8%) cerebrovascular accidents, 1 (1.8%) mental health conditions, 1 (1.8%) seizure disorders. Infographics are available on the KMMRC website: pregnancy-associate death <https://kmmrc.org/wp-content/uploads/2021/03/PA-Infographic-Handout.pdf>; pregnancy-related death <https://kmmrc.org/wp-content/uploads/2021/03/PR-Infographic-Handout-update-3-4-21.pdf>.

The first-ever [Maternal Mortality & Morbidity Report](#) was published in January 2021; it contains data, findings, and recommendations for deaths occurring in calendar years 2016 through 2018 and highlights findings related to [severe maternal morbidity](#). A report will be published each year. The [KMMRC](#) recently completed review of 2019 deaths and began review of 2020 deaths. Learn more about the KMMRC and view the committee's first report at <https://kmmrc.org/>. Read more about the KMMRC efforts and plans for action in the Perinatal/Infant Plan section.

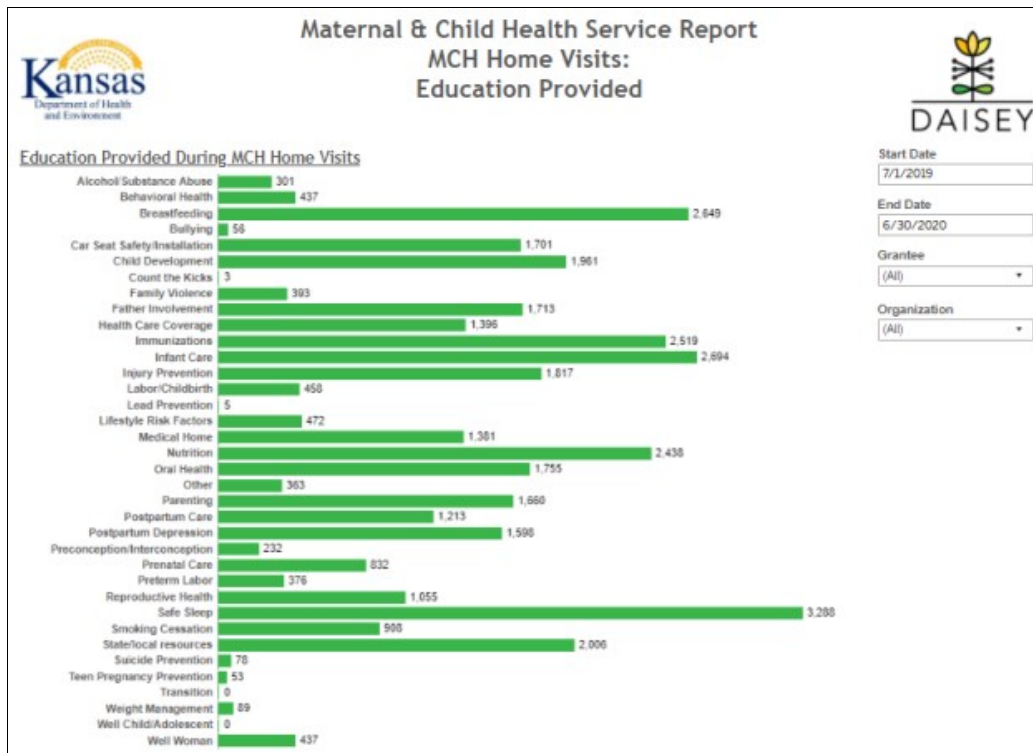
Universal Home Visiting: [MCH Universal Home Visiting](#) includes protocol and utilization of standard tools for smoking/tobacco, alcohol, substance use, and mental health, including perinatal mood and anxiety disorders. MCH Home Visitors make every effort to ensure that prenatal and postpartum mothers 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 5,500 visits, reaching 2,687 women (14% inter-conception; 32% pregnant; 54% postpartum) during SFY2020. Women are encouraged to have their partner/family attend the visit (see screenshot #1).

For SFY2020, parents were educated on a variety of topics including breastfeeding, safe sleep, infant care, immunizations, etc. (see screenshot #2). There were 364 women who received a home visit that reported they smoked (11%) and 603 reported someone else in the household smokes (18%). A total of 74% of women reported they initiated prenatal care in the 1<sup>st</sup> trimester (see screenshot #3). Of the total women served in SFY2020, 1,587 women-initiated breastfeeding (67%). NOTE: This data reflects information collected from local MCH agencies related to the individuals served and services provided. Results may not be 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*







**Mental Health Integration – Perinatal Mood & Anxiety Disorder (PMAD) Screening:** The BFH promotes use of the EPDS across MCH services in the state as a standard perinatal anxiety and depression screening measure. The EPDS has been incorporated into the [Perinatal Mental Health Integration Toolkit](#) and is included as a screening tool among forms in DAISEY.

**Medicaid Policy Improvements:** The Maternal Depression Screening (MDS) Workgroup (formed in 2018) to increase MCH local agency knowledge of screening, referral and treatment for perinatal mood and anxiety disorders, developed a maternal depression impact paper to help advocate for the Medicaid reimbursement of MDS. In 2019, KS participated in the Pediatrics Supporting Parents (PSP) initiative and an established workgroup for this project carried forward the MDS Workgroup's maternal depression impact paper. With technical assistance, the PSP impact paper was strengthened to highlight the prevalence of maternal depression, impact on child development, financial impact of untreated maternal depression, national recommendations for standards of care and practice, the role of Medicaid in screening and treatment, and identified eight policy recommendations. The MDS policy was drafted and included with the impact paper for Medicaid's consideration. In August 2020, Medicaid approved the MDS policy effective January 1, 2021. The policy supports reimbursement for up to three screenings during the prenatal period under the mother's Medicaid ID. The policy also



supports reimbursement for up to five screenings during the 12-months postpartum under the child's Medicaid ID as part of a well-infant/child visit (KANBeHealthy). Guidance was developed providers treating pregnant woman and conducting well-infant/child visits. MCH will continue to support implementation by developing guidance and offering training opportunities to providers. The Kansas PSP success story was highlighted in a national blog.

**SBIRT Workgroup:** Much like the MDS workgroup, the goal of the SBIRT Workgroup is to ensure collaboration across system partners to ensure existing resources are leveraged and consistent messaging occurs. Workgroup activities include creating a [SBIRT for Perinatal Substance Use 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. The SBIRT Workgroup is transitioning their targeted population and will explore options for implementing SBIRT during well-child/adolescent visits. Anticipated activities include the development of a resource guide and supporting materials.

**Stillbirth Prevention Initiative:** The Kansas stillbirth rate increased from 4.4 per 1,000 live births and stillbirths in 2007 to 5.4 per 1,000 live births and stillbirths in 2018. Vital Statistics reports that 196 stillbirths occurred in 2018 which was up from 184 stillbirths in 2017. In 2018, Title V launched a partnership with 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 3<sup>rd</sup> trimester of pregnancy. Thanks to this investment from Title V, providers statewide can order free educational materials at [www.countthekicks.org](http://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.

Kansas continues to promote CTK and increase awareness about stillbirth by recognizing October as Stillbirth Awareness Month each year, including webinars and social media posts. As a compliment to a stillbirth fact sheet, a webinar was held in October 2019 re-energize the campaign and recruit additional providers. A series of social media posts were also made to increase awareness and expand reach.

**KS Title V CTK Social Media Posts  
October 2019 – October 2020**

<b>Total Posts</b>	23
<b>Total People Reached</b>	17,650
<b>Total Reactions, Comments, &amp; Shares</b>	579

In October 2019, the MCH team was introduced to a mother who credits CTK for saving her baby's life. The [success story](#) with video can be found on the CTK website. During this reporting period Title V has continued to promote CTKs through social media and other avenues. A new provider letter was sent out to 573 providers in counties with the highest stillbirth rates and electronic communication was sent to midwives and doulas across the state. This letter asked providers to partner with us in reducing the number of stillbirths, reminding them of the free materials available to them. The letter also highlighted the stories of two babies saved in Kansas; one of the impactful stories is below.

*Yelly Sarah C., a resident of Overland Park, Kansas, received a Count the Kicks brochure from her provider at her 28-week prenatal appointment and started using the Count the Kicks app right away to track her daughter Eva's movements. A few days after her 36-week appointment, Yelly Sarah noticed a change in her baby's movement. Thanks to the app, she noticed her baby wasn't moving as much as normal and that it was taking a lot longer than usual for her baby to get to 10 movements. Yelly Sarah contacted her provider right away to report the change.*

*"She ordered an ultrasound and it was discovered that I had almost no amniotic fluid. I was sent to the hospital and induced the same day. My daughter [Eva] was born September 2, 2020 at 37 weeks 1 day, and although she's on the small side, she is healthy," she said. "I am grateful that Count the Kicks made me aware of the importance of paying close attention to baby's movements and also that my provider took my concerns seriously and took action."*

From the time of launch in August 2018 to October 2020, over 309 orders for free materials were placed by providers from all corners of the state, equating to 95,805 pieces of education being distributed. Over 4,800 Kansans have visited the CTK website seeking more information about kick counting, and more than 1,680 expectant parents have downloaded the free app to track their baby's movements.

In 2019, there were 192 stillbirths reported for resident mothers, a decrease of 2% from 2018. While it is impossible to tell if this decrease is related to the CTKs initiative we will continue to track stillbirth data for impact. The introduction of CTK has the potential to save 60 babies every year if the stillbirth rate decreases by 26%, which is the result of the campaign in neighboring Iowa.

**Pregnancy Maintenance Initiative (PMI):** During FY2020, 10 agencies received PMI funding and provided services to 560 women. The program provides case management services for pregnant women to enable them to carry their pregnancies to term and increase access to appropriate prenatal care. PMI Case Managers provide individualized assessment and goal development, parenting education, adoption counseling and guidance, drug and alcohol assessments and treatment, breastfeeding education and support, and more with goals to improve pregnancy outcomes for women and their babies. Local agencies agree the PMI program is of great benefit for their communities, and the results are seen in success stories shared by the grantees.

*PMI Case Worker enrolled a 38-week expecting mother into the PMI program and was able to offer her emotional support during a stressful time in her life. The client was referred to a local car seat program where she was able to obtain a car seat for her baby. The PMI program was able to provide her with necessary diapers, wipes, baby blankets, baby clothing and hygiene items. A healthy baby girl was born full-term and a goal for the client was to breastfed, but due to complications was unable to do so. The program was able to help her obtain a specialty formula. After birth, the client strived to advance her life and enrolled as a full-time student online for a Pharmacy Tech certification and has recently started a part-time weekend job to help finance her family's needs as her fiancé is on disability and a full-time student as well. The client reported that the PMI program has helped her with things that she needed for the baby and gave her extra support during tough times.*

**PMI Program Manager  
Catholic Charities of Northern KS**

**COVID-19 Positive Pregnancy Support (CPPS):** Title V staff, in partnership with the Ford County Health Department and the Western Plains Medical Complex, began offering support services for COVID-19 positive women who were pregnant in July 2020. This program was designed is to provide ongoing, weekly support, up to 12 weeks postpartum, to women in Ford County, Kansas who tested positive for COVID-19. The Woman/Maternal Health Consultant contacted women who have

been identified as pregnant and COVID-19 positive biweekly. The consultant engaged the woman in conversations around how they are feeling physically, emotionally and if they need any services or support. All data for each contact was recorded and provided to the KDHE epidemiology team to use in conjunction with work being conducted for the CDC COVID-19 Pregnancy Surveillance project.

#### References

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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)

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Local MCH Reach: Based on SFY2022 MCH Aid-to-Local applications received:

- 55 of 61 grantees (90%) plan to provide services to the Woman & Maternal population
  - 34 of 55 grantees serving Woman & Maternal population (62%) plan to provide well-woman services
  - 49 of 55 grantees serving Woman & Maternal population (89%) plan to provide post-partum depression 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 program participants 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 Kansas MCH website and social media.

Kansas Title V remains committed to the continued development and expansion of the Kansas Perinatal Community Collaboratives (KPCC) model, implementing the Becoming a Mom® (BaM) curriculum. This commitment extends to the development and implementation of additional integration components that allow for the strengthening of particular priority areas, such as the: Well-Woman Visit Integrated Toolkit; Reproductive Life Plan (RLP) Workbook; One Key Question®

approach; Fourth Trimester Initiative (FTI); and [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 Toolkits:** Published in December of 2020, the KDHE Well-Woman Visit Integration Toolkits for Providers and Communities KDHE intends for these resources to help ensure every woman in Kansas has access to, and receives, comprehensive, integrated care every year. There are three main areas covered in each toolkit: recommended components of a well woman visit; barriers faced by women that prevent them from receiving annual preventive care and recommendations to address these barriers; and resources for communities and providers. Supplemental modules will be added during FY22 that provide in-depth guidance related to:

- **Comprehensive screening:** A streamlined prescreening tool is being developed by MCH Title V staff, with a planned dissemination date of December 2021. Technical assistance will be provided to local partners on how to: administer the prescreening 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:					
<b>SUBSTANCE USE</b> Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	<b>TOBACCO USE</b> ASSIST Tobacco Use Survey	<b>MENTAL HEALTH</b> Patient Health Questionnaire-9 (PHQ-9) for depression	<b>PREGNANCY INTENTION</b> One Key Question (OKQ)	<b>SOCIAL DETERMINANTS OF HEALTH</b> KDHE Parental Health Screener	<b>INTIMATE PARTNER VIOLENCE</b> CUES: Evidence-Based Intervention Lethality Assessment Program

- **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. 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, such as the CUES: Evidence-based Intervention and the intimate partner Lethality Assessment Program.
- **Partnerships:** The toolkit's success will rely on partnerships with allied professionals and community agencies. The Community Provider Toolkit focuses on educating partner programs about the importance of the well-woman visit. Title V will provide webinars with key programs, specifically targeting MCH-serving programs (e.g., Title X, WIC, PMI, TPTCM, MIECHV, KPCC). In addition, the Well-Woman Toolkits and the Reproductive Life Plan will be a key component of the Kansas Perinatal Quality Collaborative (KPQC) Fourth Trimester Initiative.

MCH-led promotional efforts around awareness months and weeks (e.g., National Women's Health Week, Minority Health Month, Black Maternal Health Week) will incorporate messaging related to the importance of the well-woman visit. Promotional materials and social media kits developed will be shared with all Title V and Title X partners as well as other key partners such as the Kansas Maternal and Child Health and Family Advisory Councils.

**Behavioral Health Integration:** In support of best practice recommendations, Title V strives to assure women are screened for anxiety, depression, and substance use annually, along with the well-woman visit. Title V will add behavioral health screening forms to our shared data management system, DAISEY, to increase availability of evidence-based screenings to local MCH agencies. Currently, only the Edinburgh Postnatal Depression Scale (EPDS) for perinatal depression and anxiety and ASSIST for substance use in adults is available in DAISEY. Three questions will be added to the DAISEY Services Form: *Was an <anxiety / depression / substance use> screening administered?* Question responses, as well as screening results and plan of action form responses, will be reviewed and used to identify any training or technical assistance needs. The following forms will be added July 2021:

- CRAFFT – Substance Use, Ages 11-21
- Generalized Anxiety Disorder (GAD-7) - Anxiety, Ages 12+
- Patient Health Questionnaire (PHQ-9) - Depression, Ages 11+
- PHQ Modified for Adolescents (PHQ-A) - Depression, Ages 11-17



- Pediatric Symptom Checklist (PSC-17) - General Mental Health Screening, Ages 4-16

Guidance will be made available to local programs when the screening forms go live in DAISEY. The guidance will include a 1-page overview of each of the screening tools and scripts for introducing the tool to a client, administering the screening, and details on scoring the screen, determining risk-level and appropriate interventions. Additionally, a Plan of Action form will be populated in DAISEY for moderate or high-risk screening results. This form allows for local MCH staff to document that a brief intervention was conducted, the type of brief intervention provided, indicate referral(s) made, and summarize any emergency or support services initiated for a client experiencing a crisis.

**Medicaid Policy Improvements:** The Medicaid Maternal Depression Screening (MDS) policy became effective January 1, 2021 to reimburse for up to three screenings during the prenatal period under the mother's Medicaid ID and for up to five screenings during the 12-month postpartum period under the child's Medicaid ID. The policy also allows for reimbursement to occur when non-licensed professionals, like home visitors and community health workers, to administer screenings under supervision of a licensed professional. MCH developed [MDS Medicaid Policy Guidance](#) to aid in these efforts. The guidance was added to the [Perinatal Mental Health Integration Toolkit](#), which is available to all Kansas perinatal providers on the [KDHE Integration Toolkits](#) website.

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. Through the BFH's [Kansas Connecting Communities \(KCC\)](#) initiative, BFH contracted with the AAP-KS Chapter to develop guidance for pediatric primary care physicians. The [Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well-Child Checks](#) is also published in the Perinatal Mental Health Integration Toolkit and is promoted for use by BFH and AAP-KS Chapter. MCH will continue to support implementation, awareness, and utilization of MDS as a billable service.

**Integration Toolkits Website Redesign:** In an effort to make Title V resources more accessible to partners, Title V consultants will work closely with KDHE communications staff to redesign and expand the content and format of the [Integration Toolkits](#) website. Resources will be searchable by domain and topic as well as type of resource e.g. toolkits, awareness materials, trainings, etc. The redesign's anticipated completion date is January 2021.

**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:

- *Barton County* will increase the number of times well woman education is given to women. They will utilize written information in English and Spanish, about the benefits of well-woman visits to support verbal recommendations at first pregnancy visit and again at postpartum visit. The agency will work with women to refer them to their local physician or clinic of choice to schedule a well-woman exam.
- *Community Health Center of Southeast Kansas* will provide access to the full spectrum of women's health services regardless of ability to pay. CHC/SEK provides comprehensive women's health services including obstetrics and annual well woman exams in its clinics in Crawford, Bourbon and Cherokee County. Additionally, CHC/SEK provides dental and behavioral health/substance use disorder services, which are important components of a comprehensive well woman visit.
- *Kearny County Hospital* will continue to provide well-women services to their community on a regular basis. They are encouraging postpartum moms to come in for 2-week and 6-week postpartum checks. By following up with these mothers twice after they have delivered, rather than just once, staff is able to check on the mothers' mental status as well as their breastfeeding and postpartum recovery journey. They also will provide education to patients even at sick visits, explaining the importance of having well-women exams done on a yearly basis.

**Objective: Increase the proportion of women receiving pregnancy intention screening as part of preconception and interconception 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 interconception 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 interconception 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, including preconception and interconception 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 SFY22 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.

- *Barton County:* One Key Question® is used to screen for pregnancy intention. The agency provides Family Planning Services and routinely make referrals to that program or to primary medical provider for birth control services.
- *Wichita Children's Home:* The TPTCM case manager will work with clients to promote the importance of completing their basic education or vocational goals and will work to help clients understand the benefits of delaying subsequent pregnancies. The TPTCM case manager will utilize OKQ® during the second case manager session with clients to facilitate conversations. It will be discussed throughout the program for any changes that may be deemed necessary. The TPTCM case manager will refer clients to family planning services in the community, if not already established with one.
- *KU School of Medicine:* TPTCM program participants who attended at least three visits will receive education on a reproductive life plan, with focus on supporting their goals (e.g., delaying subsequent births until after basic education or vocational goals are attained). Staff have been trained in OKQ® and will utilize this to facilitate conversations. Referral to Family Planning services will be made for participants who do not have access to family planning services which may be needed to meet their reproductive goals.

**Reproductive Life Plan (RLP) Workbook:** Officially released in December 2020, the RLP Workbook was developed for use across agencies and sectors of the health care system in our state in both clinical and non-clinical settings. The workbook was 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. The workbook is available in English and Spanish and as both a printable document and a fillable PDF form. In the coming year, the workbook, along with the Well-Woman Visit Toolkit, Preconception Guide (*Prenatal Syphilis Screening, Staging, Treatment, and Monitoring for Congenital Syphilis*) will be key components for training related to the

well-woman visit. Materials will be integrated into promotional efforts for National Women's Health Month, Black Maternal Health Week, the KPQC Fourth Trimester Initiative (FTI) as well as applicable webinars and trainings for MCH and Title X providers.

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 the Women/Maternal Report narrative. Upcoming plans include:

- *LARC Preceptor Network*: A peer to peer learning model to allow trained physicians to serve as preceptors for newly trained providers that need experience.
- *Lunch and Learn Webinars*: Title V plans to continue the 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, Intimate Partner Violence Considerations, LARC Service Delivery) followed by a Q&A session where participants can discuss LARC cases and get expert and peer advice.

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### **SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)**

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

Local MCH Agencies: Many of the local MCH agencies will continue to provide PMAD screenings during visits with pregnant and/or postpartum women using the EPDS. Case managers from the Pregnancy Maintenance Initiative (PMI) and the Teen Pregnancy Targeted Case Management (TPTCM) programs 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. Some additional examples among local MCH agencies are as follows:

- *Baby Talk*: Using the EPDS, the University of Kansas School of Medicine plans to increase the number of pregnant women who are knowledgeable about PMADS and have access to screening, diagnosis and treatment. All staff are trained and authorized to administer the EPDS, which is intended to be administered to every woman upon program enrollment (or more frequently as indicated); however, completion is optional. For those who participate in the birth outcome survey (~6 weeks postpartum), the EPDS is also administered postpartum. Referral and follow-up on a positive screen is conducted as outlined through KDHE guidance. If possible, all referrals are made through the Integrated Referral and Intake System (IRIS) to ensure continuity regarding referral outcomes.
- *Delivering Change*: Participants of Delivering Change receive postpartum depression education, along with Maternal Depression Screenings. This helps assure prenatal and postpartum women are aware of signs and symptoms of postpartum depression, and the services available to them. Each client is also offered enrollment into the BaM prenatal education series, in which at least screening through the EPDS occurs during the classes. This provides an assessment of the woman's mental/emotional health, along with receiving targeted education around postpartum depression and mood disorders.
- *Catholic Charities of Northern Kansas*: Ensuring participants complete the EPDS at pre/postnatal visit with their PMI case manager, they partner with local OB-GYN offices, prenatal/postnatal depression and mental health support groups, local community mental centers and/or other mental health clinicians/providers. They also utilize a Social Determinants of Health (SDOH) intake to assist in improving client outcomes by addressing their at-risk/low income status. Their goal is to assist women, especially those at-risk to socioeconomic factors, in carrying out a healthy, full-term pregnancy.
- *Wichita Children's Home*: With the goal to assess 100% of their TPTCM participants for PMADs, the Case Manager will educate clients on symptoms of these disorders and assess clients at intake (and as needed) through

pregnancy and the postpartum period utilizing the EPDS assessment. The TPTCM case manager will refer for mental health services in the area as needed.

[Kansas Connecting Communities \(KCC\)](#): Managed by the Title V Behavioral Health Consultant as funded by the HRSA *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement* (awarded in October 2018), KCC strives to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders. KCC will continue to increase statewide access to screening, assessment, and treatment for maternal depression, anxiety, and substance use disorders. Grant activities were focused in the SE KS region for the first 2 years of the award (10/2018 – 09/2020), however KCC has started expansion efforts and is promoting all resources and capacity building opportunities statewide.

To bring awareness and utilization of KCC capacity-building trainings, a Perinatal Behavioral Health Survey was developed with goals to pilot with KPCCs, PMI, TPTCM, and MCH ATL grantees. The survey was designed to support the KCC team in tailoring resources to meet program needs. The survey will be conducted across these programs in a phased approach, beginning with the KPCC sites in May 2021 to support the implementation of a KCC/KPCC training plan focusing on enhancing perinatal mood and anxiety disorder screenings and interventions and implementing perinatal substance use screening and interventions.

For MCH programs, this is a continuation of the 2020-2021 Perinatal Behavioral Health Community Collaborative. By aligning with KCC, there is an increase in trainer capacity to assist more local programs. The components that were developed as a guide to Perinatal Behavioral Health Community Collaborative participants will be incorporated into KCC's training plans and will serve as guidance for local agencies to enhance their programs. These components include establishing an agency screening policy, executing a MOA/MOU with a mental health or substance use treatment professional/organization to increase access to timely care, and starting a support group. Additionally, several training opportunities will also be made available in the coming year:

- *PMAD Components of Care Training*: This virtual, [2-day training](#) follows an evidence-based curriculum designed for nurses, physicians, social workers, mental health providers, childbirth professionals, social support providers, or anyone interested in learning skills and knowledge for assessment and treatment of PMADs.
- *PSI Advanced Psychotherapy Training*: With the onset of the MDS Medicaid policy and increase in screening practices, an increased demand in perinatal mental health treatment services is anticipated. This evidence-based, advanced, curriculum (6-hour virtual [training](#)) is designed for mental health and psychotherapy providers and covers differential diagnosis, evidence-based psychotherapeutic approaches, and advanced therapeutic issues. It combines expert presentation with case studies, group discussion, and practical examples of treatment approaches. KCC is collaborating with the Association of Community Mental Health Centers of Kansas (ACMHCK) to ensure mental health clinicians employed by Community Mental Health Centers, Kansas' community-based public mental health services safety net, can participate.
- *Kansas Moms in Mind (KMIM)*: Family physicians and OB practitioners play a critical role in the identification and treatment of PMADs. The KMIM project will allow for up to 5 Kansas family practice and/or OB clinics to receive assistance (rapid five-month project) in improving their clinic's PMADs screening practices during pregnancy. Participating clinics will receive implementation technical assistance and case consultations to support effective screening and treatment practices during pregnancy. KCC will evaluate the KMIM project and make any necessary changes before launching a second KMIM focused on perinatal substance use.

[Maternal Mental Health Treatment Pilot Project](#): To further increase the identification of postpartum women experiencing perinatal mood and anxiety disorders (PMADs) and improve access to mental health treatment (counseling/therapy), Title V is partnering with Russell Child Development Center (RCDC) on a *Maternal Mental Health Treatment Pilot Project*. RCDC is a Part C, Infant Toddler Services program, that provides early childhood services in 19 rural/frontier counties in Southwest Kansas. All 19 counties are designated Mental Health Provider Shortage Areas, and timely access to quality perinatal mental health treatment is limited. The aim of the pilot is to increase the availability, accessibility, and affordability of evidence-based

maternal mental health treatment services by:

- Increasing timely detection, assessment, and treatment of PMADs in postpartum women using evidence-based practices;
- Increasing RCDC staff capacity to provide maternal mental health specialty treatment services to caregivers of children participating in RCDC services; and
- Supporting infrastructure development and create a replicable and sustainable model for addressing maternal mental health conditions through early childhood systems.

RCDC will employ a licensed master's social worker (LMSW) who will accept referrals for treatment from RCDC staff, local healthcare, social services, and other providers screening for risk of PMADs. Self-referrals will also be accepted. Maternal mental health therapy services will be made available in-person and by telehealth and in collaboration the individuals' healthcare providers to coordinate comprehensive care for the caregiver and the family. The pilot will allow infants and toddlers (0-3) and their caregivers to receive therapeutic services from one organization. While reducing barriers in accessing care, the pilot also increases local capacity by expanding the mental health professional network and subject-matter expertise in a mental health professional shortage area. Title V will provide instruction and technical assistance to RCDC, including coordination with Kansas Medicaid, to ensure services will be sustained beyond the pilot project period and can be replicated by other early child development centers.

*Peer & Social Networks*: Title V staff will continue to support pregnant and new mothers through the KPCC model, which 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).

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. CEI is also developing a *Perinatal Support Group Guidebook* which will serve as a resource for local communities wanting to start or revamp a perinatal support group. The Guidebook will include information on recruitment and promotion, establishing a support group agreement, group structure and environment, choosing a group's location (e.g., in-person and virtual meeting place considerations), facilitator roles and responsibilities, and how to keep a support group going. Content will be reviewed by subject matter experts, including MCH Perinatal/Infant Health Consultants and the Postpartum Support International Kansas Chapter's executive board, before being published (target is October 2021).

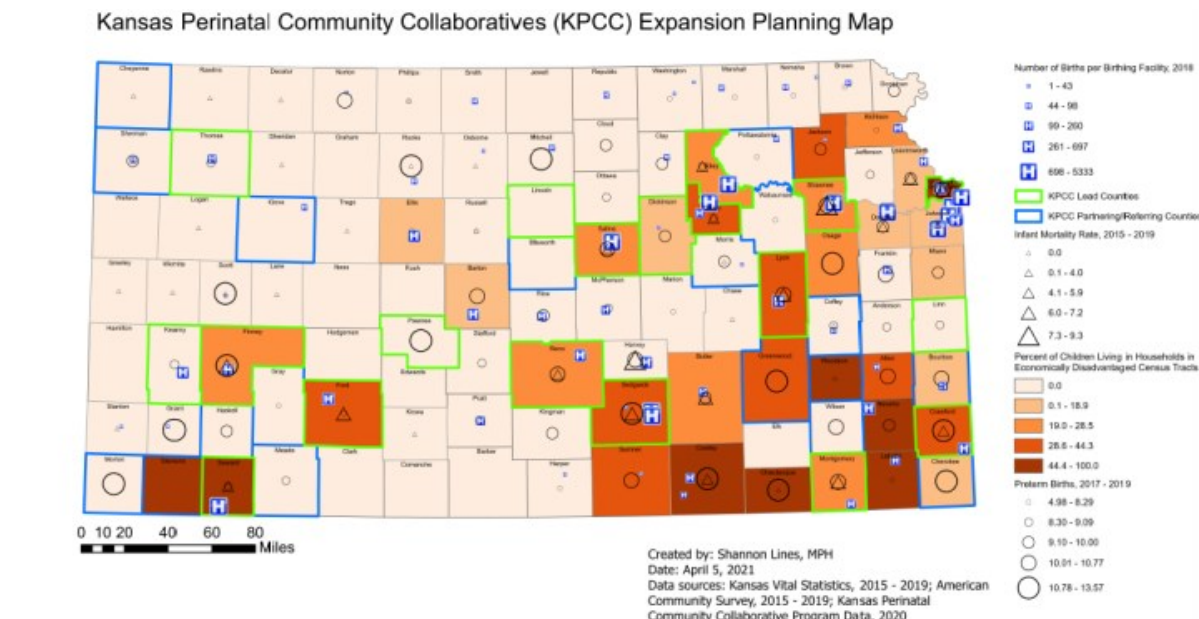
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***Objective: Increase the proportion of high-risk pregnant women receiving prenatal education and support services through perinatal community collaboratives.***

KDHE's Title V commitment to this model is greater than just increasing the number of KPCCs across the state, or programs who implement the BaM program. Rather 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 are in early stages but will focus on targeted outreach and potential funding opportunities for sites who develop specific marketing and implementation plans that will engage these high-risk populations to a greater degree than have historically been reached. The below "Expansion Planning Map" identifies hot spots in the state related to economic risk factors and rates of preterm birth and infant mortality, while also identifying existing KPCC and birth facilities, assisting in planning for



targeted outreach and recruitment based on areas of greatest need, while pulling from existing resources.



An additional session is being developed for the existing BaM prenatal education series with a focus on the postpartum period, 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/interconception self-care activities).

**KPCC/BaM Website:** Resources for regional and statewide implementation of KPCCs have been under development over the past several years to ensure both growth and sustainability of the initiative. The [Perinatal Community Collaborative](#) website is an access point to introductory information about the initiative has been completed, however a website redesign and expansion is under development. 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. These enhancements will include the incorporation of infrastructure support components, such as links to the March of Dimes 5P's approach; KDHE's MCH Integration Toolkits; resources on health equity; and much more.

Revisions are also being made to the existing KPCC partner-only website to provide additional trainings and implementation resources for program coordinators and group facilitators, especially once they are ready to begin implementation. Additional training webinars will also be developed as new integration toolkits are made available and new initiatives are implemented, such as the Maternal Warning Signs and Fourth Trimester Initiative. 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 KPCC/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. The COVID-19 pandemic

heightened the need for a virtual prenatal education option across all sites. Resources and guidance documents for virtual implementation, including online data collection and screening for PMAD, were developed and disseminated. This infrastructure component will continue to be improved and supported.

KPCC and BaM infographics were developed to aid communication and recruitment for new communities and to showcase the impact of the KPCC model and BaM programming in existing communities. A listening session was hosted in the fall of 2020 to determine technical assistance needs of local programs and their community partners as they strived to meet the needs of their MCH population during the quickly changing and ever challenging conditions of the pandemic. Continued conversations with local stakeholders are planned for FY22.

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## 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 3<sup>rd</sup> 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. The following are examples of planned initiatives:

- *Stillbirth Awareness Month*: Encourage local MCH agencies to spread awareness in their communities and encourage moms to count kicks. (October 2021)
- *Kansas CTK Mobile App*: A KS-specific version of the app with four follow-up questions that will connect mothers directly with resources in Kansas based on expressed needs and concerns.
- *CTK Toolkit*: including low literacy materials and kick counting wrist bands that will be distributed to home visitors across the state.

*Black Maternal Health Statewide Virtual Focus Groups*: Title V has awarded a contract to Wichita State University to conduct virtual focus groups with Black mothers to better identify barriers to care and gaps in services to better inform policies and programs. The goal of these groups is to facilitate conversations and record the perspectives of Non-Hispanic Black mothers in Kansas regarding the following:

- Views on importance of overall health and the functionality of the current health care system
- Health priorities and biggest needs
- Availability of health care services for them and their children
- Services and supports they feel were lacking during the perinatal period III and neonatal periods related to physical health, emotional wellbeing, and mental health
- Barriers faced when seeking whole health services, including prenatal and postpartum care
- Tools they find helpful, or would find helpful, when navigating the health care system

The focus groups will begin in early summer of 2021 and the final report and subsequent presentation of the findings will be concluded by December 2021.

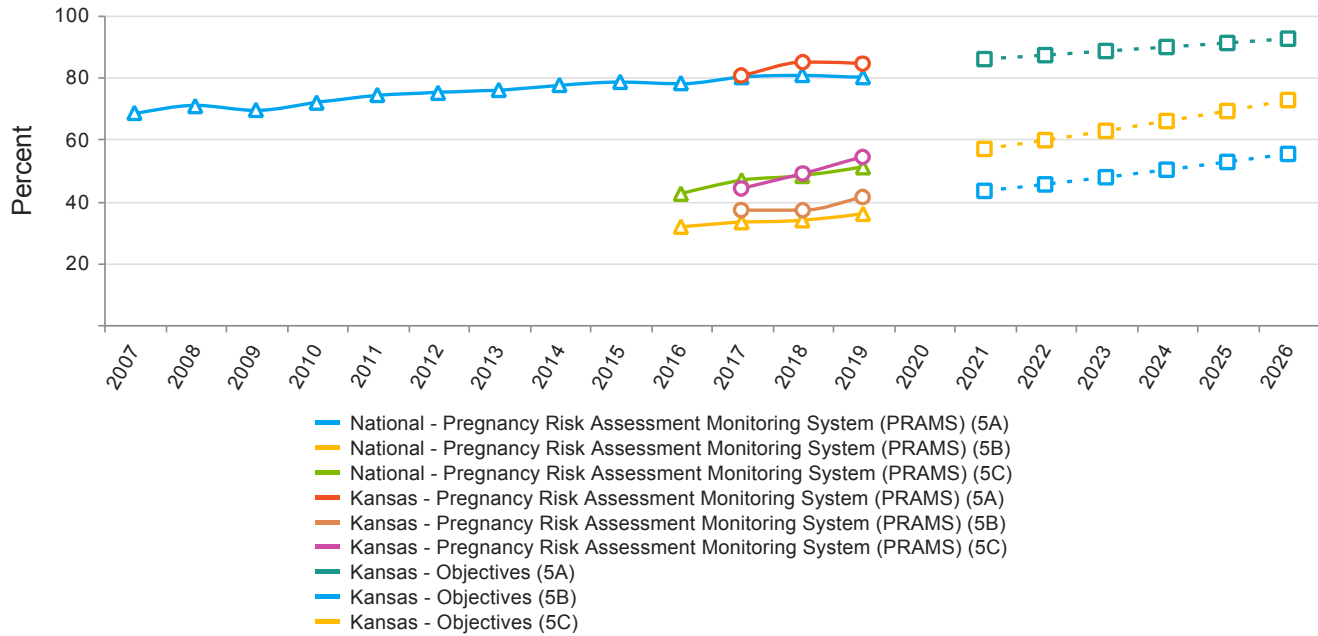
## Perinatal/Infant Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.4	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	115.8	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	2020
Annual Objective		
Annual Indicator	84.8	84.4
Numerator	28,021	27,690
Denominator	33,030	32,822
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.7	87.0	88.3	89.6	90.9	92.3

**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	2020
Annual Objective		
Annual Indicator	37.0	41.2
Numerator	11,666	13,034
Denominator	31,547	31,644
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.3	45.4	47.7	50.1	52.6	55.2



**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	2020
Annual Objective		
Annual Indicator	49.1	54.1
Numerator	15,627	17,106
Denominator	31,810	31,621
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.8	59.6	62.6	65.8	69.0	72.5

## 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	2020
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	2026
Annual Objective	94.2	95.2	96.1	97.1	98.1	99.0

**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	2020
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	2026
Annual Objective	91.3	92.2	93.1	94.1	95.0	96.0

## State Performance Measures

### SPM 2 - Percent of infants breastfed exclusively through 6 months

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	31.4	31.6
Numerator	10,404	9,812
Denominator	33,125	31,016
Data Source	NIS	NIS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.4	33.2	34.0	34.9	35.8	36.6

## 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 - 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

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

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NOM 9.5 - 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.

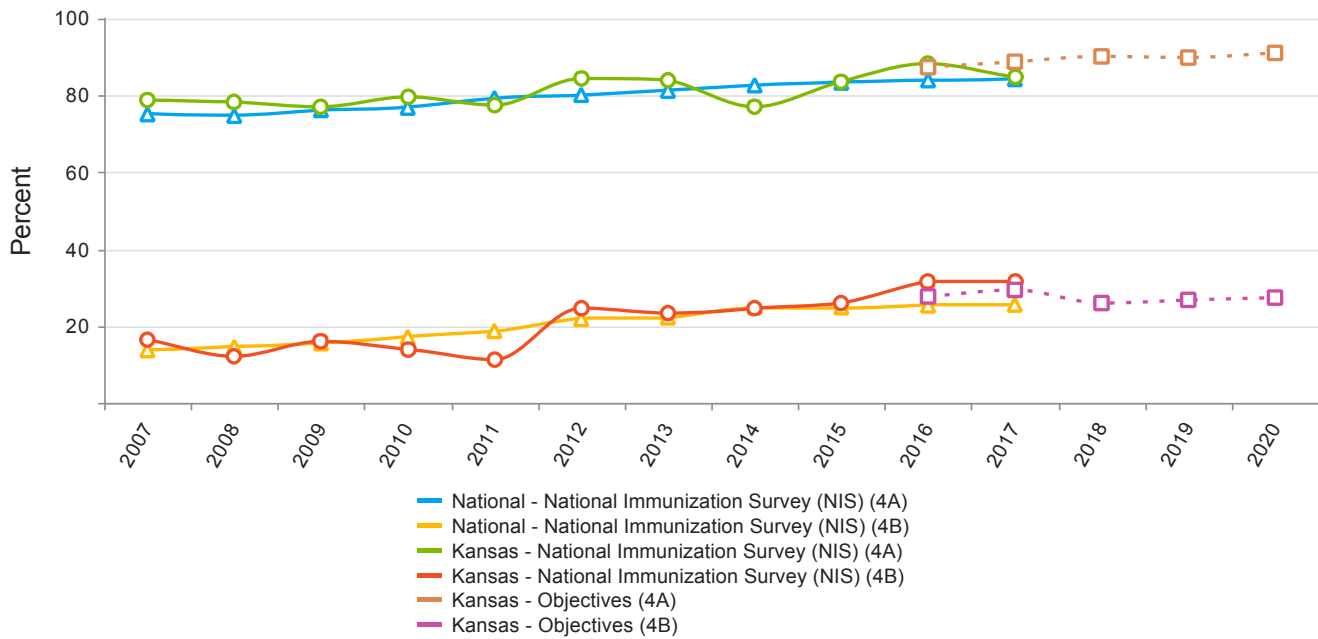
Establish and increase consumer/family and provider awareness about the importance of home visitation supports and impact on family and infant outcomes to increase referrals and number of families receiving support through MCH Universal Home Visiting programs.

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	2020
Annual Objective	87.2	88.6	90	89.7	90.9
Annual Indicator	83.8	77.1	83.6	88.0	84.6
Numerator	32,783	29,183	30,314	29,928	26,783
Denominator	39,126	37,866	36,276	34,017	31,642
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017



State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	87.2	88.6	90	89.7	90.9
Annual Indicator	87.4	88.1	88.5	88.7	88.9
Numerator	34,078	33,429	32,162	31,987	31,339
Denominator	38,998	37,937	36,331	36,066	35,234
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	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	2020
Annual Objective	27.7	29.4	26	26.8	27.4
Annual Indicator	23.4	24.5	26.1	31.4	31.6
Numerator	9,025	9,095	9,159	10,404	9,812
Denominator	38,643	37,166	35,100	33,125	31,016
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

**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	2020
Annual Objective		22.5	15	17.5	20
Annual Indicator	14.1	13.9	13.7	13.1	12.7
Numerator	943	990	966	1,319	1,185
Denominator	6,671	7,121	7,075	10,035	9,314
Data Source	KWIC	KWIC	KWIC	KWIC	KWIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**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	2020
Annual Objective			55	100	105
Annual Indicator	36	50	93	177	279
Numerator					
Denominator					
Data Source	KIDS Network	KIDS Network	KIDS Network	KIDS Network	KIDS Network
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	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

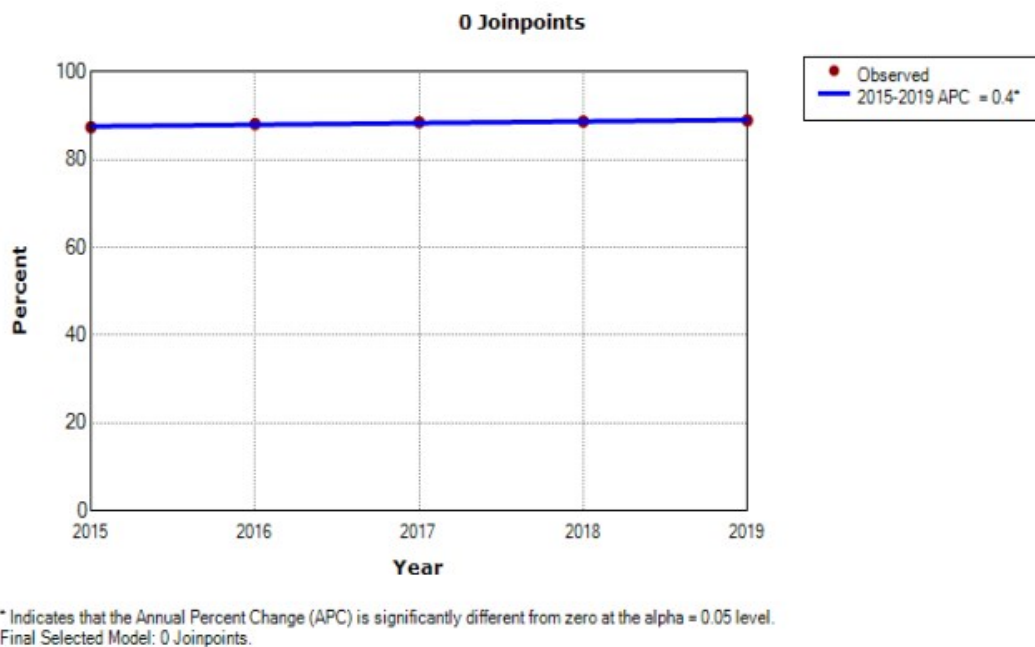
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*Local MCH Reach:* During SFY2020, 62 of 70 grantees (89%) provided services to the Perinatal/Infant population.

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### NPM4: Breastfeeding [ever, exclusively through 6 months] and breastfeeding at 6 months

In 2019, **Kansas birth certificate data** showed that mothers initiated breastfeeding in 88.9% of resident live births. This was a small increase from the 88.7% reported in 2018 and surpassed the Healthy People 2020 target of an 81.9% breastfeeding initiation rate. Non-Hispanic Asian mothers had the highest breastfeeding initiation rate (92.7%), followed by non-Hispanic White (90.1%) and Hispanic (87.0%) mothers. Non-Hispanic Black mothers had the lowest breastfeeding initiation rate (81.8%) among the three largest race and Hispanic-origin groups. The overall breastfeeding initiation rate has been significantly increasing by 0.4% per year (95% Confidence Interval: 0.2%, 0.6%) for the past five-year period (2015-2019).



According to the most recent National Immunization Survey (NIS), for infants born in 2017, 84.6% of mothers reported ever breastfeeding, 58.7% reported breastfeeding at 6 months, and 31.6% 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.<sup>1,2</sup>

Based on the most recent 2018 Maternity Practices in Infant Nutrition and Care Survey, known as the mPINC\*, 53 of 63 eligible Kansas hospitals (84%) that deliver babies participated in the survey. Kansas scored 79/100, which is the same as the national average.<sup>3</sup> Kansas scored higher than 3 out of 4 neighboring states - Nebraska 71%, Oklahoma and Missouri 75%, Colorado 85%. Kansas hospitals are doing well in teaching prenatally about breastfeeding and teaching breastfeeding techniques which results in early initiation. However, there are few policies to support these measures to assure that all staff is trained in assisting breastfeeding families. This may be reflected in the flattening rates of exclusive breastfeeding at six months in Kansas.

\*The mPINC survey was redesigned in 2018. Results from the 2018 mPINC survey cannot be compared with results from previous mPINC surveys.

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**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): The [Kansas Breastfeeding Coalition](#) (KBC), in partnership with Title V, continued to launch and sustain CSB communities. The Kansas CSB program has received state and national attention and was selected as an Emerging Practice for [AMCHP's Innovation Station](#) (2016) and was featured in AMCHP's NPM 4 toolkit (2019). The CSB is also included in the [Kansas Health Matters database of promising practices](#). 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 2020, 28 communities had achieved the CSB designation with support from Title V, KBC, Kansas Health Foundation (KHF), United Methodist Health Ministry Fund (UMHMF), and Prime Health Foundation. Read more about CSB here: <http://ksbreastfeeding.org/>.

Local Breastfeeding Coalitions: Having a local breastfeeding coalition is one of the six required CSB criteria. Over the past 10 years, the number of local breastfeeding coalitions has increased 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/>.

The KBC "Local Breastfeeding Coalition (LBC) Section" supports local coalitions by providing networking and learning opportunities and fostering the formation of new coalitions. During FY20, the LBC coordinated a panel of four local coalitions for the October 2019 KBC Conference. This group met bi-monthly throughout FY20 to share ideas and find solutions to common challenges (agenda items/discussions highlighted below).

- Panel of mothers sharing their experiences and work with local coalitions;
- Working with local food pantries to support breastfeeding families;
- Outreach ideas and tools for swimming pools, faith-based organizations, and emergency preparedness;
- Recruitment of additional establishments into the KBC's "Breastfeeding Welcome Here" program; and
- Leadership & coalition development (the Kansas Leadership Center presented twice).

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.

- Conducted bi-monthly breastfeeding coalition meetings and Local Coalition Section meetings.
- Facilitated the Saline County Breastfeeding Coalition re-forming meeting (August 2020).
- Connected to the 53 local MCH agencies who selected breastfeeding as a priority in FY20 and FY21, to facilitate the implementation of breastfeeding strategies.

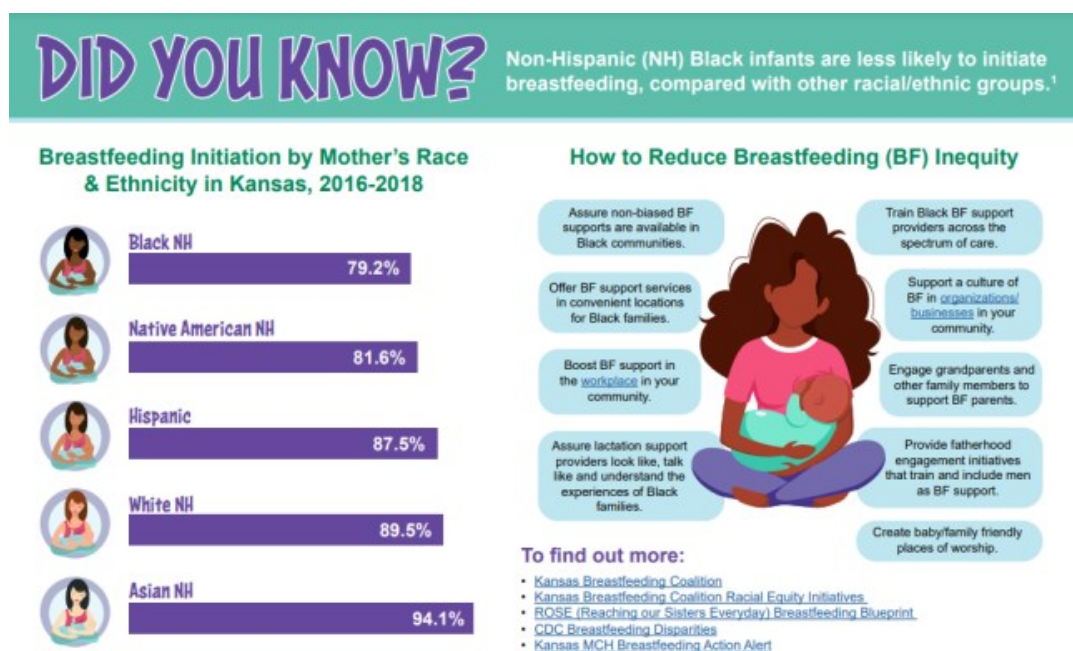


- Held annual “Kansas Breastfeeding Coalitions Conference”
  - October 2019: 195 attendees; 65 communities
  - October 2020: VIRTUAL, 263 attendees
- Provided resources such as sample coalition documents, project ideas for local coalitions, community engagement ideas, and tools for local coalitions on the KBC “Tools for Coalitions” webpage.

Local breastfeeding coalitions have demonstrated resilience and resourcefulness during the COVID pandemic. The below story illustrates the support KBC provides to local breastfeeding coalitions across the state.

- **Kaw Area Breastfeeding Coalition & Northeast Kansas Breastfeeding Coalition:** Both coalitions moved their meetings online during the COVID pandemic. KBC provided technical support and hosted the meetings their business platform. The new online format had two unanticipated positive outcomes: 1) More local members were able to participate in the local coalition meetings. Busy work schedules that didn’t allow for driving to meeting locations across town or even counties away, were no longer an obstacle to attendance; and 2) KBC Executive Director was able to actively participate in meetings on a regular basis since they were hosting the meeting. This resulted in greater collaboration and “cross-pollinating” with other local breastfeeding coalitions and state programs.

**Addressing Breastfeeding Disparities:** 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. During the reporting period, the KBC provided 10 scholarships (5 funded by Title V, 5 by the KHF) to persons of color to become an International Board-Certified Lactation Consultant or a Certified Lactation Counselor. The scholarships were provided to 5 Black, 4 Latina and 1 Indigenous/Latina. In August of 2020, Title V created a Did You Know to highlight the disparities seen in breastfeeding in Kansas and give tips for reducing those inequities (see below). In the upcoming year, Title V plans to dig into disparities in breastfeeding even more. See the Perinatal and Infant Plan section for more details.



**Child Care Provider Training:** To support breastfeeding families using evidenced-based practices, partnerships between Title V, KBC, Child Care Licensing and Kansas Child Care Training Opportunities (KCCTO) provide this online course for child care providers at no cost each month. KDHE Child Care Licensing also collaborated with the KBC to support breastfeeding friendly online training. During the reporting period, the KBC Child Care Section met bi-monthly and includes 40 members. A Breastfeeding Friendly Child Care Provider toolkit was created and disseminated. This toolkit was presented

to stakeholders during the August 2020 Early Childhood Systems Building webinar, local licensing surveyors (with COVID information, 63 attendees) and to Child Care Health Consultants with Child Care Aware of KS. During the reporting period, 235 child care providers completed the online 2-hour course “How to Support the Breastfeeding Mother & Family.” Over 4,500 child care providers have completed the training since its launch in June 2013 (up from 3,951 in FY19), most through an online course hosted by KCCTO.

**Other CSB Related Efforts – Businesses & Employers:** Other CSB breastfeeding initiatives are supported by a key MCH partner, 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 was 1,003 establishments in FY20. 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, 357 (up from 350 in FY19) 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. In this reporting period the K-State Center for Child Development and Bloom Pediatrics & Lactation Center in Kansas City received the Gold award; Cargill in Dodge City received the Silver award and the City of Dodge City received the Bronze award.

**COVID-19 Breastfeeding Guidance:** Throughout the pandemic the Title V Perinatal/Infant Clinical Consultant created and published public guidance on breastfeeding for providers and mothers. This guidance can be found on the [KDHE COVID-19 Resource Center](#). The guidance is updated regularly based on the latest recommendations from the American College of Obstetricians and Gynecologists, the Centers for Disease Control and Prevention among others.

**Local MCH Agencies:** Fifty-three local MCH agencies selected breastfeeding as a priority in FY20. 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:

- **Thomas County:** Provided breastfeeding information/education at each clinic visit for pregnant/breastfeeding women and infants for the MCH and WIC programs. Their Breastfeeding Peer Counselor (BPC) is also their MCH Home Visitor and makes hospital visits to provide breastfeeding resources and enroll women in home visiting. They display Collective posters and encourage clients to come to prenatal breastfeeding classes. All women in WIC initially receive a Central Kansas Breastfeeding resource list, this list is provided again at the hospital and available from home visitors. Using KWIC breastfeeding data for a 6-month cohort, they saw 89.2% of their clients initiated breastfeeding. During FY20 breastfeeding initiation went up from 83% to 87.7%.
- **Shawnee County:** Educates all pregnant women and their families about the benefits of breastfeeding. The MCH staff and WIC BPC work closely together to make cross referrals. Local MCH staff attended the Breastfeeding Basics and Breastfeeding Beyond the Basics courses offered by KBC, which helped staff feel more confident when educating pregnant women and new mothers about breastfeeding. Of the participants enrolled in their Baby Basics prenatal education class, 91% of participants reported that they initiated breastfeeding.
- **Riley County:** Provided education on breastfeeding, nutrition and safe sleep to 196 clients in FY20. Three out of five of their MCH staff are Certified Lactation Counselors (CLC). This reporting period 113 clients were counseled specifically on breastfeeding and 47 breastfeeding assessments were done. Clients can receive one-on-one breastfeeding help from MCH CLC staff, WIC dietitians or Via Christi Hospital (walk-in breastfeeding support clinic offered twice weekly). During this reporting period, 100% of Riley County KPCC participants initiated breastfeeding and 86% breastfed exclusively through 6 months.

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

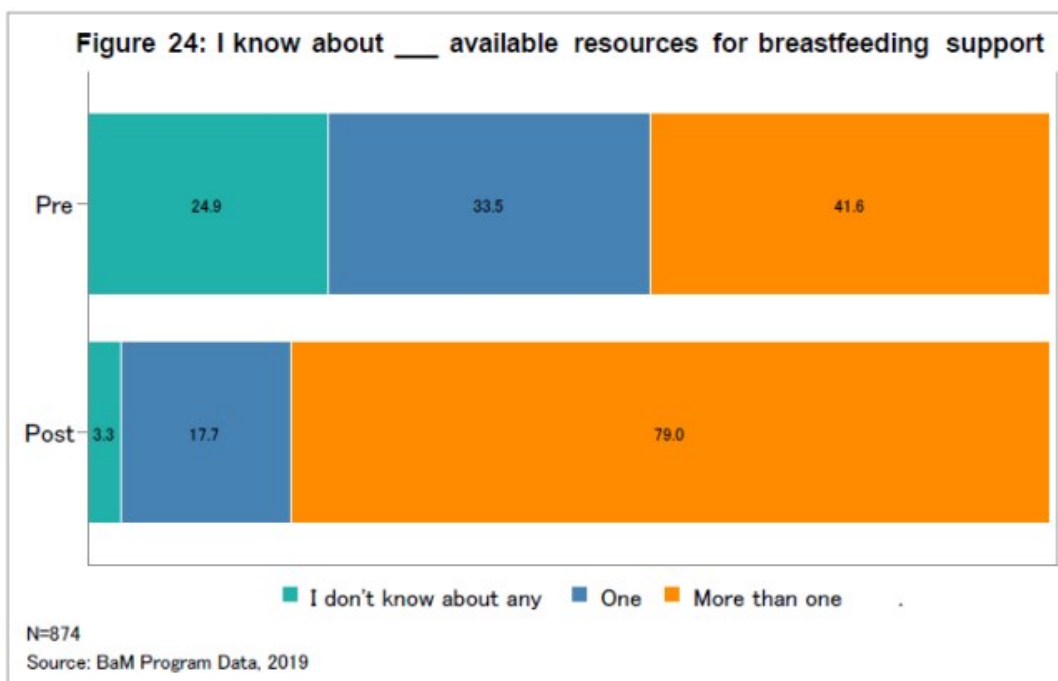
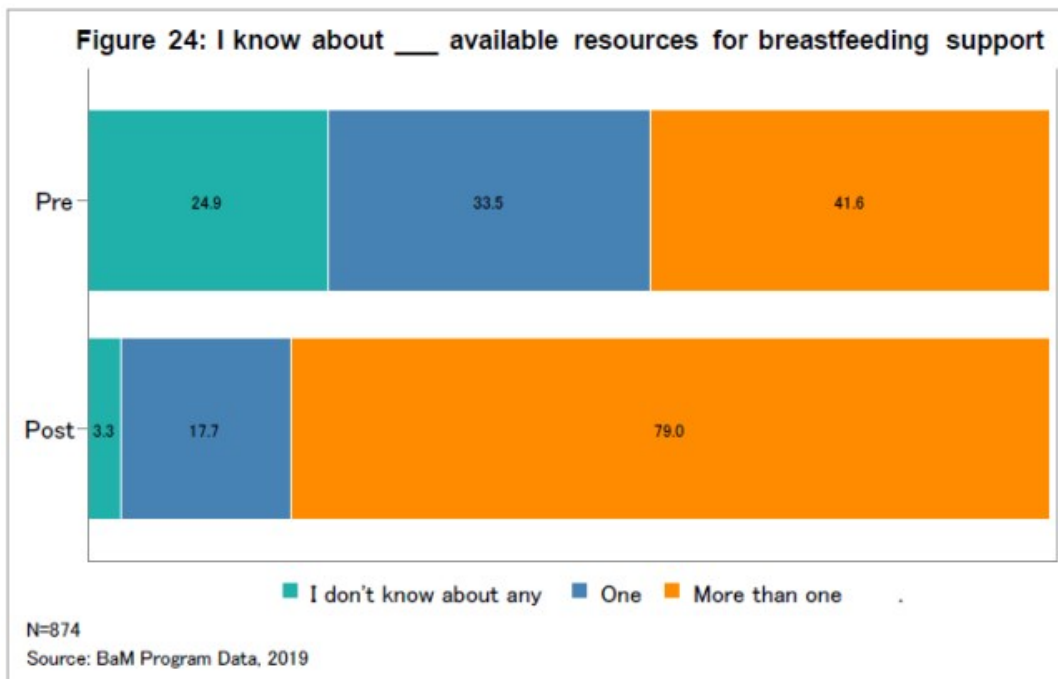
Kansas Breastfeeding Coalition (KBC) Partnership Activities: Title V collaborated with the KBC, UMHMF, and WIC to expand the [High 5 for Mom and Baby](#) program (funded and administered by the UMHMF) by increasing the number of hospitals trained and number implementing the program. As of the end of the reporting period, 36 Kansas hospitals and 1 birthing center demonstrated their commitment to supporting breastfeeding success by participating in High 5 activities. A total of 30 hospitals have achieved High 5 program recognition. High 5 for Mom and Baby is no longer training new hospitals, so the number of participating hospitals will not increase in the future. High 5 for Mom and Baby has created the NEW [High 5 for Mom & Baby Premier](#) designation for 2020. Ten (10) Kansas hospitals have achieved the High 5 for Mom and Baby PREMIER 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. All the above-mentioned entities are also working collaboratively to implement [Cofective](#) materials, promoting familiarity with the tools and repeat messaging of the same guidance across different access points in the community.

KBC reviews and updates the BaM curriculum annually, and 2020 revisions included updates on breastfeeding guidance related to the COVID-19 pandemic. Revisions have been made to align with the latest edition of "[Your Guide to Breastfeeding](#)" by the Office on Women's Health. Alignment with the Kansas Baby-Friendly Hospital efforts has occurred, assuring the curriculum meets Baby-Friendly Hospital requirements. Work was completed in early 2019 to produce a recorded training webinar for the Breastfeeding Integration Toolkit (on the BaM private website with content specific for BaM sites) that is provided as part of the online resources on the BaM private website. This addition reduced reliance on in-person training, thereby promoting greater long-term sustainability of efforts. BaM resources continue to be made available to WIC and MCH programs in counties across the state where KPCC/BaM sites are not in place. The BaM Integration tool kits (including the Breastfeeding Integration tool kit) are currently being adapted for use by the broader public health field. As tool kits are adapted, they will be housed on the public Bureau of Family provider resources page, which can be found here: [https://www.kdheks.gov/c-f/integration\\_toolkits.htm](https://www.kdheks.gov/c-f/integration_toolkits.htm).

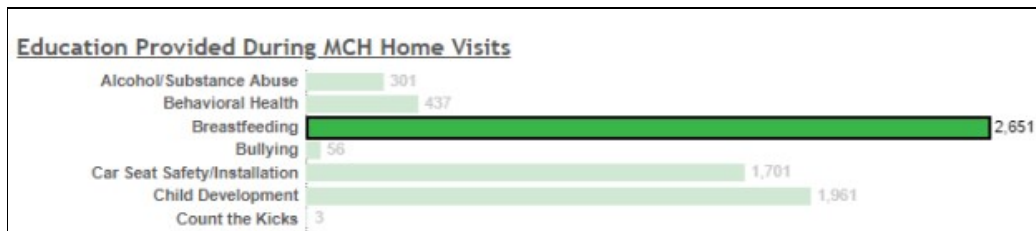
According to the 2019 BaM Aggregate Report for KPCC, initiation rates were 90.4% (slightly higher than the 88.9% state rate, according to Kansas Birth Certificate data, 2019), which we feel is reflective of efforts by KPCC to provide extensive education and support around this priority. See data to the 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.



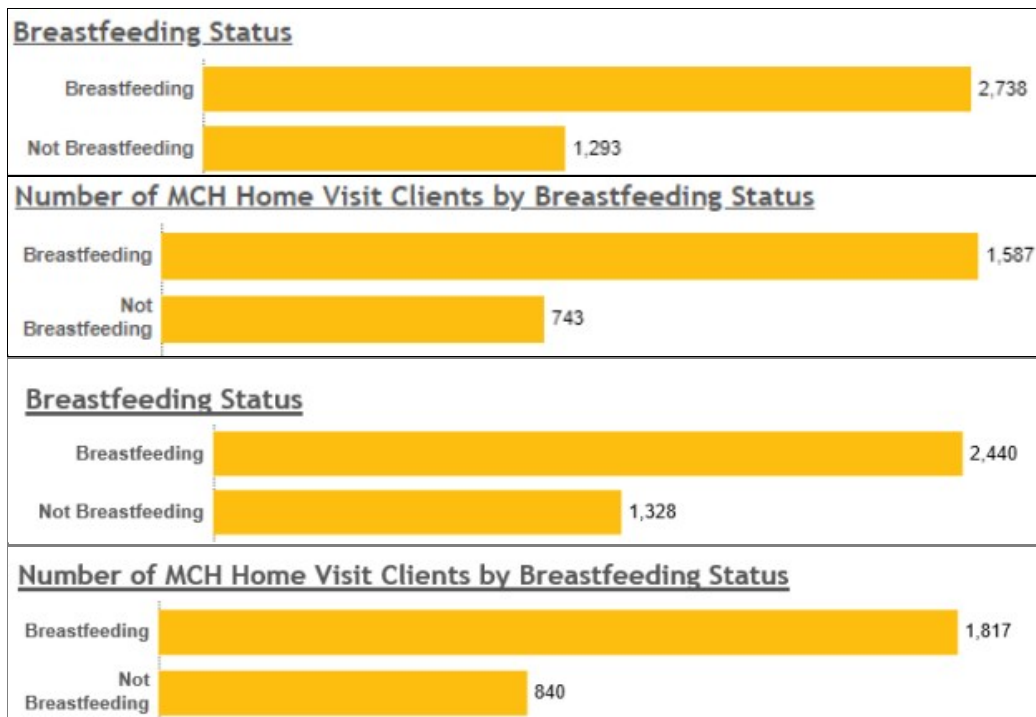
Additionally, data consistently show the BaM session focused on infant feeding as the highest ranking related to “helpfulness of the session”, with 92% rating it between very (40%) and extremely (52%) helpful. Although breastfeeding initiation rates across the state have improved steadily in recent years, 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.

Local MCH Agencies: Local MCH agencies provided education to ,193 prenatal and postpartum clients. A total of 2,651

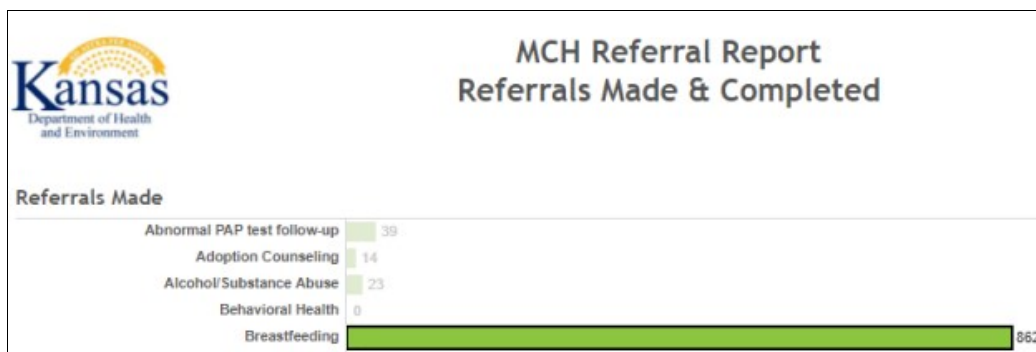
received the education as part of an MCH Home Visit.



During SFY2020, 65% of all clients who gave birth in the past year reported breastfeeding. In addition, 67% 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 SFY2020, of the 862 referrals made for breastfeeding, 834 clients (over 95%) accepted the referral. Many MCH staff and home visitors are Certified Lactation Counselors (CLC), 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, childcare providers, and local physicians to provide consistent messaging about breastfeeding. The work of two local breastfeeding coalitions is highlighted below.

- *Mitchell County Breastfeeding Coalition:* In the spring of 2020, the Mitchell County Breastfeeding Coalition (MCBC) recognized a gap in services to families after the Mitchell County Hospital discontinued their quarterly in-person prenatal class due to COVID-19 concerns. MCBC addressed the lack of prenatal breastfeeding education in the area by providing a 2-hour “Feeding Your Baby” class online and free to area families. This class was created by the Kansas Breastfeeding Coalition (KBC) with support from KDHE Title V, as part of the Becoming a Mom series of classes. MCBC received a grant through the Solomon Valley Community Foundation to provide printing, mailing materials to participants, and a few visual props. MCBC collaborated with the Mitchell County Regional Medical Foundation (MCRMF) for use of their GoToMeeting platform and needed technology. The first live online class was held in October 2020. Five participants attended. Stephanie Simmons, MCRMF Director, and Tracey Palen, La Leche League Leader and Certified Lactation Counselor, presented the class. They received positive feedback regarding the information and materials. The intention was to offer a live class on a quarterly basis, but it quickly became apparent that due to the increased professional demands on volunteers to teach, continuing a quarterly Saturday presentation was not feasible. MCBC is currently working to reformat the KBC class to pre-recorded segments accessible via a private link, accompanied by a live Q&A platform offered either by Zoom, GTM, or possibly a private Facebook group. The new format should be available to families in March 2021.
- *Ford County Breastfeeding Coalition:* To celebrate World Breastfeeding Week in August 2020, Ford County Breastfeeding Coalition hosted their 4<sup>th</sup> annual Baby Expo. Due to the pandemic, the Baby Expo was held virtually through a Facebook Live event. Virtual Baby Expo was held over 7 days with an informational Facebook Live and give-away for each day. The event was attended by 259 individuals. All members of the Ford County Breastfeeding Coalition participated in putting on the event, responding to messages online and engaging with attendees during the event. Coalition members and local businesses donated items for a gift basket of giveaways. Many coalition members who supported the Baby Expos are Ford County WIC staff whose time is supported by KDHE, including the Ford County WIC Breastfeeding Peer Counselor.



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 (more information below in the safe sleep report) to promote breastfeeding, safe sleep, and to connect pregnant women and their support persons with community resources.

*MCH Workforce Initiatives with KBC:* The KBC provides ongoing education to communities, including the MCH workforce. An overview of key presentations offered throughout the reporting period are depicted below.



Presentation	Audience
<b>Perinatal Maternal Mental Health</b> <i>Supporting Breastfeeding and Maternal Mental Health</i>	Maternal and Child Health lead agencies and enrolled KCC Providers
<b>Breastfeeding Makes All the Difference</b> <i>Maternal Mental Health</i>	Various
<b>Community Health Workers: Support of Families Prenatally and Postpartum</b>	Community Health Workers Coalition members
<b>Reducing the rates in infant mortality</b> <i>Breastfeeding is an Evidence-based Strategy</i>	Various community groups
<b>Breastfeeding 101: Role of the Home Visitor</b>	Kansas Home Visitors
<b>The Intersection of Breastfeeding &amp; Safe Infant Sleep</b>	Kansas WIC agencies
<b>The COVID-19 Pandemic: Infant Outcomes and Feeding in this Emergency</b>	Various
<b>Advanced Topics in Lactation</b>	Various

The following are other activities supported through expanded capacity funded by MCH.

- Issued the 2020 State of Breastfeeding in Kansas report
- Exhibited at Celebrate Day 366 (Black infant mortality awareness event)
- Exhibited at the virtual Community Care Network of Kansas Conference
- Presented a staff lunch and learn to Pediatric Care Specialists of Overland Park, KS
- Presented the Kansas mPINC report to High 5 for Mom and Baby
- Held Breastfeeding Basics courses August 20-21 and August 27 (52 attendees)
- Held Breastfeeding Beyond the Basics course August 27-28 (20 attendees)
- Presented Webinar titled *Synergy in Kansas: The Story of a Relationship between a State WIC Agency & a State Breastfeeding Coalition at the National WIC Association*
- Created Blueprint for Continuity of Care for Breastfeeding (CDC funded project) with Committee of National Association of City and County Health Officials
- Facilitated workgroups to advance breastfeeding in child care, local breastfeeding coalitions, hospitals, and public health (see schedule below)

#### KBC Sections & Workgroups:

Section	Meeting Dates	Current Work
Child Care	Bi-monthly (odd months), 2 <sup>nd</sup> Wed., 12-1	Integration of 2-hour KCCTO course into community college ECE courses (requiring students to complete the KCCTO course)
Local Breastfeeding Coalitions	Bi-monthly (odd months) 2 <sup>nd</sup> Thurs. 12-1	Sharing and networking between local breastfeeding coalitions, using <a href="#">Toolkit</a> and <a href="#">Tools for Coalitions</a> resources, guest speakers
Hospitals	Bi-monthly, 4 <sup>th</sup> Tuesday, 12-1	Support and staff education; implementing evidence-based maternity care practices, review of CDC's <a href="#">Kansas mPINC survey</a> results
Public Health	Bi-Monthly (even mos.) 2 <sup>nd</sup> Thurs. 10-11	Data visualization and "mini-reports" from " <a href="#">Breastfeeding Support by Kansas County</a> "
<i>Breastfeeding Education Advisory Committee</i>	As-needed	Scholarship selection committee, breastfeeding course curriculum review & KBC conference planning
<i>CSB: Next Steps Workgroup</i>	Monthly, 3 <sup>rd</sup> Wed. 8:30 – 10:00	Began Aug. 2020; convened to determine next steps for CSB communities to build on what they started

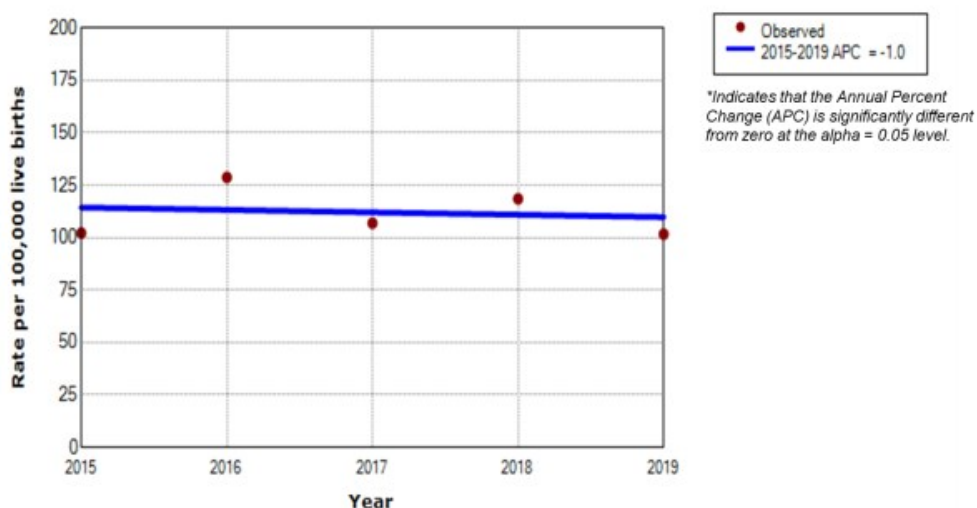
KBC also maintained a statewide "[Local Resources Directory](#)" to allow families and health care providers to find local breastfeeding support by entering their zip code. A Google map is populated with breastfeeding resources from a wide variety of sources to include health departments, hospitals, private practice, lactation consultants, peer breastfeeding support groups and walk-in clinics. The range 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 have been distributed to hospitals and local health departments.

#### 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).<sup>1</sup> The Sudden Unexpected Infant Death (SUID) rate is the combination of SIDS, ASSB, and unknown cause deaths.

During the five-year period (2015-2019), overall SUID rates in Kansas slightly decreased by -1.0 per year (95% CI: -12.6, 12.1), from 102.2 deaths per 100,000 live births in 2015 to 101.7 deaths per 100,000 live births in 2019. This decrease was not statistically significant.

Rate of sudden unexpected infant death, Kansas, 2015-2019



Source: KDHE, Bureau of Epidemiology and Public Health Informatics

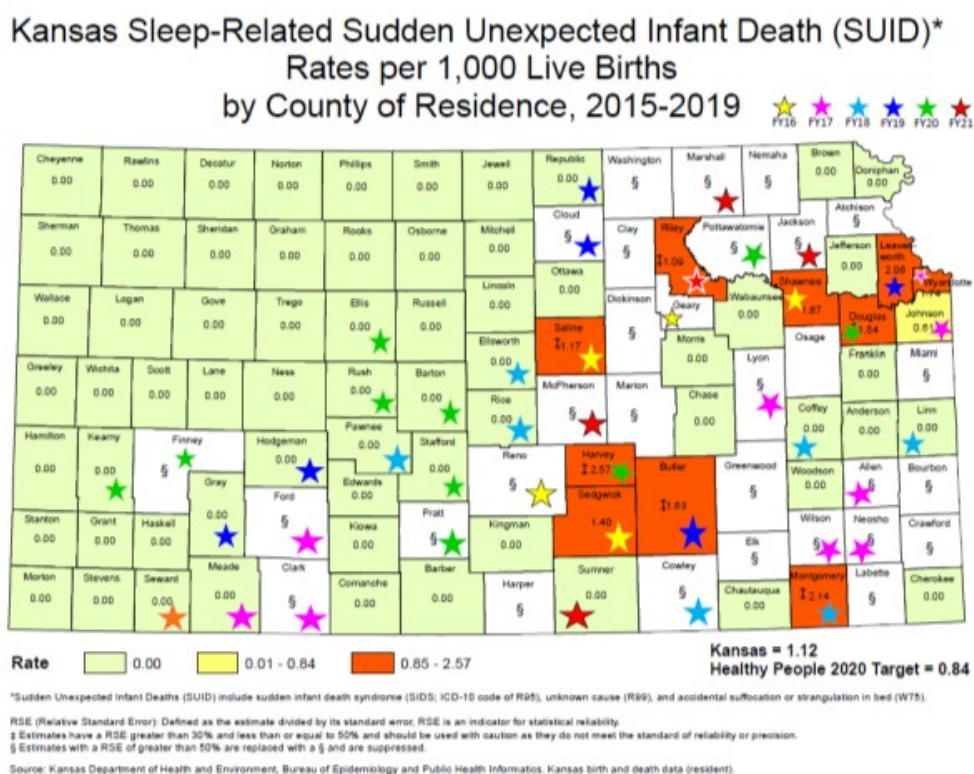
During 2015-2019, 207 Kansas infants died due to SUID. SUIDs are the second leading cause of infant death in Kansas (19.0%). SUID was the leading cause of death in infants who had reached at least 28 days of age (52.7%). Non-Hispanic Black infants (34 cases, 272.9 deaths per 100,000 live births; 95% CI, 189.0-381.3) died at a significantly greater rate than non-Hispanic White (116 cases, 89.6 deaths per 100,000 live births; 95% CI, 73.3-105.9), and Hispanic infants (36 cases, 117.7 deaths per 100,000 live births; 95% CI, 82.5-163.0) where the cause of death was SUID.

According to the 2020 [Kansas State Child Death Review Board Annual Report](#) (2018 Data), there were 43 sleep-related deaths. Of those, 13 were classified in a SIDS category, 18 as unclassified sudden infant death (USID), and 12 as an unintentional suffocation or strangulation.

- Based on the 43 sleep-related deaths reviewed, 35 deaths (81%) occurred in the child's home followed by four deaths (9%) in a relative's home. The remaining four deaths (10%) occurred in other locations such as unlicensed child care facilities, non-relative homes, or shelters.
- Of the 33 deaths that occurred while sleeping on an adult bed or couch, 28 infants (85%) were sharing the sleeping surface with another person(s) at the time of the incident.
- While 32 of 43 families (74%) were known to have a crib or bassinet in the home, only six (14%) occurred when the infant was in a crib or bassinet as recommended. In other words, 86% were not sleeping in a crib or bassinet.
- In 10 deaths (23%), the mother/caregiver reportedly fell asleep while breast (7) or bottle (3) feeding the infant. In

those 10 deaths, one was classified as SIDS, two were classified as USID, and seven were classified as unintentional injury. Mothers should be encouraged and supported to breastfeed safely. Education about how to safely breastfeed in bed and counseling about risk factors and prevention is critical. Parents should be reminded that if infants are brought to an adult bed for a feeding (breast or bottle), they should be returned to a separate safe surface (crib or bassinet) when the parent is ready to return to sleep.

- In 12 deaths (28%), the caregiver had consumed alcohol or drugs at the time of the incident (including two whom had consumed drugs or alcohol and were breastfeeding at the time of the incident) or had previous concerns regarding substance use.
- In 19 deaths (44%), nearly half, there was current or past history with Kansas Department for Children and Families. In five deaths (12%), 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.
- All 13 SIDS cases were classified as SIDS II, indicating the presence of one or more elements of unsafe sleep; four (31%) were documented as not being placed supine (on the back) to sleep (recommended position).



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

The KIDS Network reaches across the entire state of Kansas 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 Safe Sleep Community Baby Showers, Cribs for Kids, Dissemination of Safe Sleep Education, Healthcare Provider Education, Childcare Provider Education. In FY2020, 50 Kansas counties were impacted by the KIDS Network through outreach and education. 43 health care professionals were trained by the KIDS Network as Safe Sleep Instructors. The Safe Sleep Instructors provided safe sleep training to 2,939 professionals statewide. 1,189 pregnant women were educated about safe sleep through demonstrations at KIDS Network Safe Sleep Community Baby Showers. A total of 26,015 community members were trained on safe sleep and bereavement through presentations at hospitals, universities, KSTrain online education system, conferences, and outreach activities including professional meetings, community events, social media and KIDS Network events (e.g., Susan E. Bredehoft Candle Lighting, Haley's SIDS Scramble, Step Up for KIDS).

*Kansas Infant Death & SIDS (KIDS) Network – Safe Sleep Expansion Initiative:* Title V maintained a contractual partnership with the KIDS Network of Kansas during the reporting period to reduce infant mortality, specifically with focus 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, the 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.



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*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. A memorandum of understanding was established by the BFH, KIDS Network, KBC, and the Bureau of Health Promotion/KS Quitline 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 three or more ways to avoid 2<sup>nd</sup> hand smoke; identify at least one local tobacco







cessation resource






- Breastfeeding: confidence in ability to breastfeed at least 6 months; identify at least one local resource for breastfeeding support

As mentioned above, 1,189 pregnant women were educated about safe sleep through demonstrations at KIDS Network Safe Sleep Community Baby Showers. Kansas PRAMS data shows improvement of infants being placed to sleep “mostly on the back” from 80.2% in 2017 to 84.0% in 2019. This data reveals that 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. Due to COVID-19, outpatient clinics in the process of KIDS Network Safe Sleep Star Outpatient Toolkit implementation have been halted until non-mandatory trainings are resumed in the clinic setting.

National Safe Sleep Hospital Certification Program		
*Represents the number of hospitals who have reached this level of Safe Sleep Designation/Certification (as of October 2020).	Bronze	Develop and maintain a safe sleep policy consistent with the AAP recommendations.
	 in progress	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
	 in progress	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
	 Reached	Hospitals must conduct at least two community outreach activities (e.g. health fair, public service announcement regarding safe sleep) per year.
	 in progress	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.

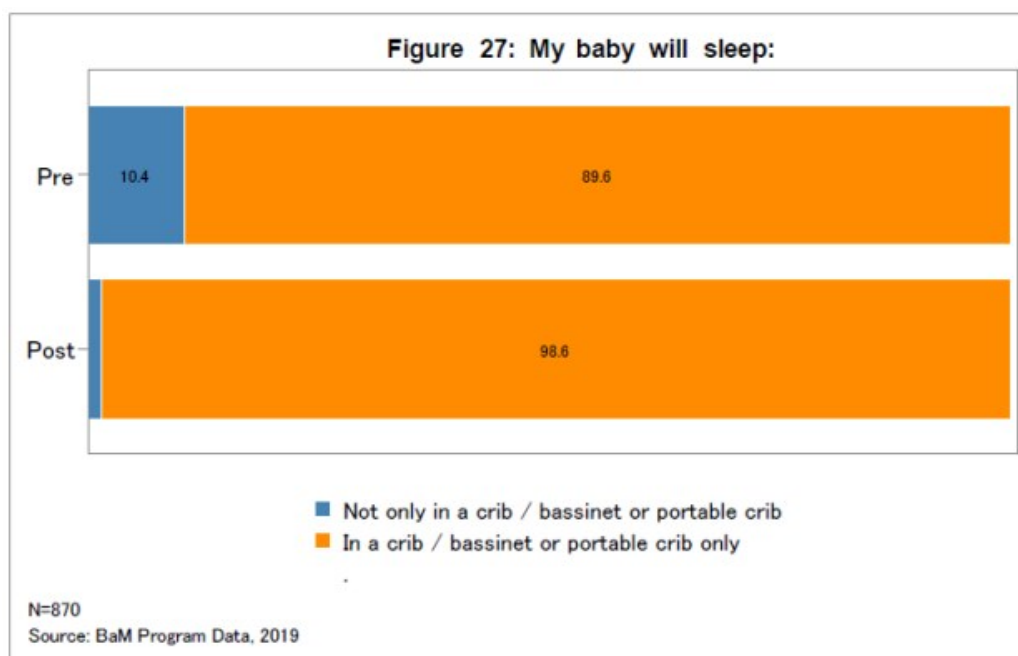
**Provider Safe Sleep Star Program + Outpatient Toolkit:** The Safe Sleep Star Outpatient toolkit was launched in FY18 to address infant mortality by providing tools to help outpatient maternal and infant healthcare providers improve safe sleep promotion utilizing evidence-based or evidence informed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

Provider Safe Sleep Star Program + Outpatient Toolkit		
*Represents the number of hospitals who have reached this level of Safe Sleep Designation/Certification (as of October 2020).	Bronze	Provides annual safe sleep training to employees
	 Reached	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
	 in progress	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
	 Reached	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
	 Reached	Engages in safe sleep education at the community level through health fairs, community baby showers, or other community outreach at least twice a year
	 in progress	

Due to COVID-19, outpatient clinics in the process of KIDS Network Safe Sleep Star Outpatient Toolkit implementation have been halted until non-mandatory trainings are resumed in the clinic setting.

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 2016 supporting 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 are made on an annual basis through the existing KIDS Network – KDHE partnership. In addition to curriculum content having a SIDS/Safe Sleep focus, program incentives across every site include the pack-n-play crib distribution which provides a safety approved crib for expectant mothers with limited resources. The 2019 BaM outcome data (figures below) show significant improvement in knowledge and intentions for safe sleep position and location, following provided education (based on pre and post-tests).





In January 2020, updates to BaM program evaluation efforts included questions being added to the Birth Outcome form which assesses the baby's actual sleep location and position. These fields were added to determine if parents/caregivers were following through with intentions expressed during their pregnancy.

Training on the SIDS/Safe Sleep integration component, along with the other comprehensive integration components, is provided to new KPCCs preparing to implement the BaM curriculum, via recorded TA webinars housed on the BaM website. The training webinar for the safe sleep component was recorded in partnership with the KIDS Network in February 2020. This allows new BaM facilitators to receive comprehensive training on all integration components in a timely manner that fits their local timeline rather than waiting on the schedules of partners to allow for group travel to the location to provide in-person training. This transition has supported long-term expansion and sustainability efforts. Recent experiences during the pandemic have validated the need for online training opportunities more than in any previous year.

**Local MCH Agencies:** According to DAISEY data for SFY2020, safe sleep education was provided more than 4,919 times during clinic visits and roughly 3,200 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 the provision of a sleep sack for the infant.

- **Barton County:** The MCH Home Visitor has been trained as a safe sleep instructor and are working to include safe sleep info in their fatherhood initiative. They are utilizing the Back to Sleep materials at the hospital visits and home visits. Home visit info includes general home safety info as well as poison safety and the poison control hotline info magnets are given. The documented number of times safe sleep education was provided more than doubled, increasing from 206 in SFY19 to 509 in SFY20 according to the Daisey MCH report for education provided.
- **Hodgeman County:** The Hodgeman Community Baby Shower was held on January 11, 2020 with 8 pregnant women and 4 caregivers trained on safe sleep practices. A total of 6 pack and plays were given to those in need of a safe sleep surface for their infants. Additional handouts, books, wearable swaddle/blankets were given. Parents and caregivers were given a demonstration on the difference between safe and unsafe sleep surfaces. Safe sleep information continues to be shared on the Department's Facebook page and on the website.

- *Sedgwick County Healthy Babies*: Providers discuss safe sleep strategies during pregnancy visits and inspect the sleep environment at every home visit. During this reporting period, 132 out of 132 clients received safe sleep education and 125 out of 132 of those clients practiced safe sleep during their last home check.
- *Shawnee County*: The SCHD has a Certified Safe Sleep Instructor who serves as a resource for all staff. Staff are encouraged to attend the Baby Basics Perinatal Education Class in which Safe Sleep practices are taught to participants. All MCH clients that are seen are educated and given hand-outs about safe sleep practices for infants. At the SCHD annual Community Baby Shower, held in November of 2019, 71 pregnant women and their support person were educated on safe sleep.

*Child Care Licensing (CCL) Safe Sleep Efforts*: KDHE CCL collaborated with Kansas Infant Death & SIDS Network to offer online Safe Slumber training in English and Spanish. The training is available on KS-TRAIN and at no cost to providers (made possible with MCH funds). The number of participants completing the training between October 1, 2019 through September 30, 2020 went up dramatically from FY19 (408 participants) to FY20 at 1,035 participants (986 English and 49 Spanish).

### Other Perinatal/Infant Health Activities

*Pregnancy Risk Assessment Monitoring System (PRAMS)*: Since October 2019, Kansas PRAMS has continued to collect information on the health and experiences of Kansas mothers. PRAMS finished its third year of data collection, achieving a 63.3% 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 BFH to increase screening for perinatal mood and anxiety disorders and were used to pass a new Medicaid policy allowing for screening to be covered under the infant's Medicaid plan.
- PRAMS staff worked with KDHE's Tobacco Use Prevention Program to illuminate gaps in referral to the Kansas Tobacco Quitline.
- PRAMS implemented a new Workplace Leave Supplement, to help gather statewide data for the first time on maternal leave.
- PRAMS 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.
- PRAMS team begun carrying out data collection for a PRAMS follow-up study of moms with a live birth in 2020, which is funded by Columbia University.

Below is a timeline of key activities within PRAMS during the reporting year.

#### October 2019

- Data collection (third year); received 2018 data from CDC (achieved 60.8% weighted response rate)
- Infographic on breastfeeding continuation disparities at KBC's annual meeting; networked with meeting attendees
- Presented PRAMS findings to local health departments, at the 3rd Quarter Public Health Regional Meetings

#### November 2019

- Presented data on maternal depression at KDHE's monthly IDEA presentation, to an audience of epidemiologists, data analysts, and local health department staff.
- Published the Kansas PRAMS 2018 Surveillance Report

#### January 2020

- Presented data on maternal tobacco use at the 2020 Community Health Promotion Summit

## March 2020

- Created a fact sheet about Black maternal health using PRAMS data

## April 2020

- Incorporated the Workplace Leave Supplement, which asks questions about maternal leave
- Began offering an opt-out option, for mothers to opt-out of the PAWS follow-up study

## July-August 2020

- Produced two infographics using PRAMS data, which focused on prevalence of maternal tobacco use, and the intersection between maternal tobacco use and mental health
- Contributed data on prenatal care to the Kansas Prenatal Care Report
- Presented a poster about screening for perinatal depression and access to treatment at the Association of Maternal and Child Health Programs (AMCHP) annual meeting

### References:

1. U.S. Department of Health and Human Services. Healthy People 2020. [www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf](http://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/](http://www.cdc.gov/breastfeeding/data/NIS_data/)
3. Centers for Disease Control and Prevention. Kansas 2018 Report, CDC. Survey of Maternity Practices in Infant Nutrition and Care. Atlanta, GA. April 2020. [https://www.cdc.gov/breastfeeding/data/mpinc/state\\_reports.html](https://www.cdc.gov/breastfeeding/data/mpinc/state_reports.html)

## 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)

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*Local MCH Reach:* Based on SFY2022 MCH Aid-to-Local applications received:

- 54 of 61 grantees (91%) plan to provide services to the Perinatal & Infant population
  - 50 of 54 grantees (93%) plan to provide breastfeeding services
  - 41 of 51 grantees (76%) plan to provide safe sleep services
- 

**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, childcare facilities, and other providers to support safe sleep practices and accurate, consistent safe sleep messages across all sectors in a community. Consistent and current safe sleep education and messaging is critical as we strive to eradicate unsafe sleep practices.

Title V will continue to partner with local coalitions and community organizations leading efforts to support safe sleep, mental well-being, breastfeeding, and tobacco use prevention by providing direct education and referrals to families at high risk for adverse outcomes through Community Baby Showers (CBS). During the COVID pandemic, many communities began offering local CBS events virtually. Review of evaluation results from this format will be completed to determine its effectiveness and practicality for continuation beyond the pandemic. 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 continued 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 system to assist childcare 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 the KIDS Network Safe Sleep Instructor Certification program by providing technical assistance, advanced training opportunities, and annual reporting requirements for Certified Safe Sleep Instructors.
- Enhance the CBS model by incorporating mental health supports and providing technical assistance to communities.
- Support consistent safe sleep education and messaging through updates to the safe sleep integration component of

the March of Dimes Becoming a Mom prenatal education curriculum.

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 will be recorded and available on the private website, along with the other integration components for new facilitators to receive comprehensive training on their own timeline and support long-term expansion and sustainability efforts. KDHE plans 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. In addition, KDHE will work in partnership with the KIDS Network to grow “Advanced Training” opportunities with SSIs to increase the number of Cribs for KIDS Safe Sleep Hospital Certifications and KIDS Network Safe Sleep Star Outpatient toolkit settings statewide by ten per year through targeting existing SSI communities and KPCCs.

As described in the Women/Maternal Plan, the BaM curriculum is being enhanced with the addition of a seventh session, which will include a safe sleep component to provide follow-up on education received prenatally, after delivery. This provides an opportunity to engage with caregivers who are struggling with the reality of life with a newborn and provide support for engaging in best practice behaviors and stimulate real conversations about the struggle’s caregivers are facing and insight into how they can be approached and overcome.

Local MCH Agencies (including affiliate programs PMI & TPTCM): 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:

- *Barton County*: Plans to host two CBS events, with one being a large community event in collaboration with the Healthy Families Program and inviting other partners to participate. The other will be offered to existing MCH/TPTCM/PMI clients. They would also like to increase the number of times safe sleep education is discussed and will hand out the "Sleep Baby Safe and Snug" book in English or Spanish to promote reading to baby and hear the repeated safe sleep message. The child care licensing surveyor is also a safe sleep instructor and will provide safe sleep info to child care providers at annual surveys and through her newsletter.
- *Butler County*: Plans to train 15 professionals (e.g., childcare workers, DCF personnel) in the community on safe sleep with the goal to build relationships with community partners. The Safe Sleep Instructor will attend webinars and training to ensure the most up-to-date information is being provided.
- *Community Health Center of Southeast Kansas (CHC/SEK)*: Plans to deliver Safe Sleep education to 100% of parents with newborns in Crawford, Cherokee, Labette and Bourbon counties. All MCH/TPTCM Case Managers will be trained in Safe Sleep guidelines and all expectant MCH clients will participate in one or more educational sessions on Safe Sleep. Halo Sleep Sacks (which replace blankets in the crib) will be provided to all CHC/SEK newborns just prior to delivery.
- *Catholic Charities of Northeast Kansas*: They will provide translate the Safe Sleep educational materials (printed guides and verbal training) to their large population of clients that speak Burmese or Swahili, so all clients receive educational materials in their spoken language.
- *University of Kansas School of Medicine*: TPTCM clients will receive safe sleep education based on various research-based curriculums (e.g., Partners for a Healthy Baby, Before Baby Arrives, Baby's First Year). They will provide handouts about safe infant sleep and receive referrals to the Baby Talk program, which includes a 45-minute portion on infant safe sleep, and referral to Safe Sleep CBS or Virtual Safe Sleep Crib Clinics in Sedgwick County where families can participate in a crib demonstration and receive free materials to create a safe sleep environment for their infant. Staff will maintain certification from the American Academy of Pediatrics Safe Sleep Recommendations and can provide additional information on how to overcome barriers to following the guidelines.
- *Delivering Change*: TPTCM clients will receive safe sleep education (ABC's of Safe Sleep) and the TPTCM

Navigator will talk with each client during their pregnancy about practicing the ABC's of Safe Sleep, encouraging clients to keep their baby alone, on their back and in a crib/pack n play/bassinet, reducing the risk of SIDS. The Navigator will help clients ensure that they have a safe sleep area for baby prior to delivery or help them secure a safe sleep area for the baby. During a client's postpartum period, the TPTCM Navigator meets with each client while they are still in the hospital, before discharge, to discuss education and answer questions the client may have before going home with their baby. TPTCM clients must also watch a video while inpatient in the hospital about the ABC's of Safe Sleep and practicing safe sleep. Safe sleep education is also taught during BaM and Infant Care classes.

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## **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.

- Increase access to lactation support by African American providers such as breastfeeding peer counselors, doulas, International Board-Certified Lactation Consultants, and Certified Lactation Counselors representing high-risk populations to increase the culturally relevant support women of color need to initiate and continue breastfeeding.
- 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) to build capacity in the community to support mothers of color in breastfeeding.
- Broaden 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) to 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 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 will continue in FY22 with annual updates to the BaM Infant Feeding curriculum component. KBC has provided 10 additional toolkits for new sites implementing in FY22 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 (located on the BaM private website with content specific for BaM sites) will continue as an online resource to support new BaM staff in their role as facilitators of this comprehensive prenatal breastfeeding education curriculum.

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) as this tool kit is adapted for all public health professionals, and 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 2021/early 2022.

Technical assistance will be provided to KPCC sites to develop plans for targeted outreach to disparate populations. The BaM DAISEY Dashboard allows sites to compare participant demographic data to identified high-risk groups in their 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 2021 or early 2022. 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.

**Local MCH Agencies:** The majority of MCH grantees that chose the Perinatal/Infant Health domain in their FY22 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.

- *Barton County*: Plans to increase DAISEY breastfeeding rates among home visit clients, as well as to increase attendance at group breastfeeding classes. They will provide breastfeeding education and support at each visit and utilize their breastfeeding Facebook page to provide information, announce classes and support groups, and to educate the public about critical topics, such as how to support the breastfeeding mom. For those needing a breast pump, they can loan or rent one (depends on WIC status).
- *Butler County*: Plans to increase the breastfeeding initiation rate through increasing workforce capacity (e.g., attending BF101 training through KBC, WIC Loving Support training, Coffective trainings). The Family and Pregnancy Resource Center offers breastfeeding support and has certified lactation specialists on staff.
- *Hays Area Children's Center*: Plans to increase the numbers of infants being exclusively breastfed for at least six months through education during home visits. The Lactation Educator can provide assistance when she visits with breastfeeding mothers.
- *Delivering Change*: TPTCM Navigator, who is also a Certified Lactation Counselor, will provide education and information about breastfeeding to all clients during the prenatal period, including education on the health, financial and overall benefits of initiating and continuing breastfeeding practices. TPTCM Navigator will follow the recommendation of exclusive breastfeeding for 6 months and answer any questions or concerns a client may have regarding breastfeeding, including helping them access a breast pump. The TPTCM Navigator will work with the client post-delivery, while still in the hospital, on breastfeeding, assessing feeds, answering questions/concerns the client may be having and providing support and education surrounding breastfeeding and the clients breastfeeding goal. Delivering Change holds a Breastfeeding Clinic for all breastfeeding women in the area, free of charge to get support, education and assistance and TPTCM clients are scheduled in the breastfeeding clinic 24-48 hours post discharge, with continual support through the breastfeeding clinic offered to clients.

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## 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).***

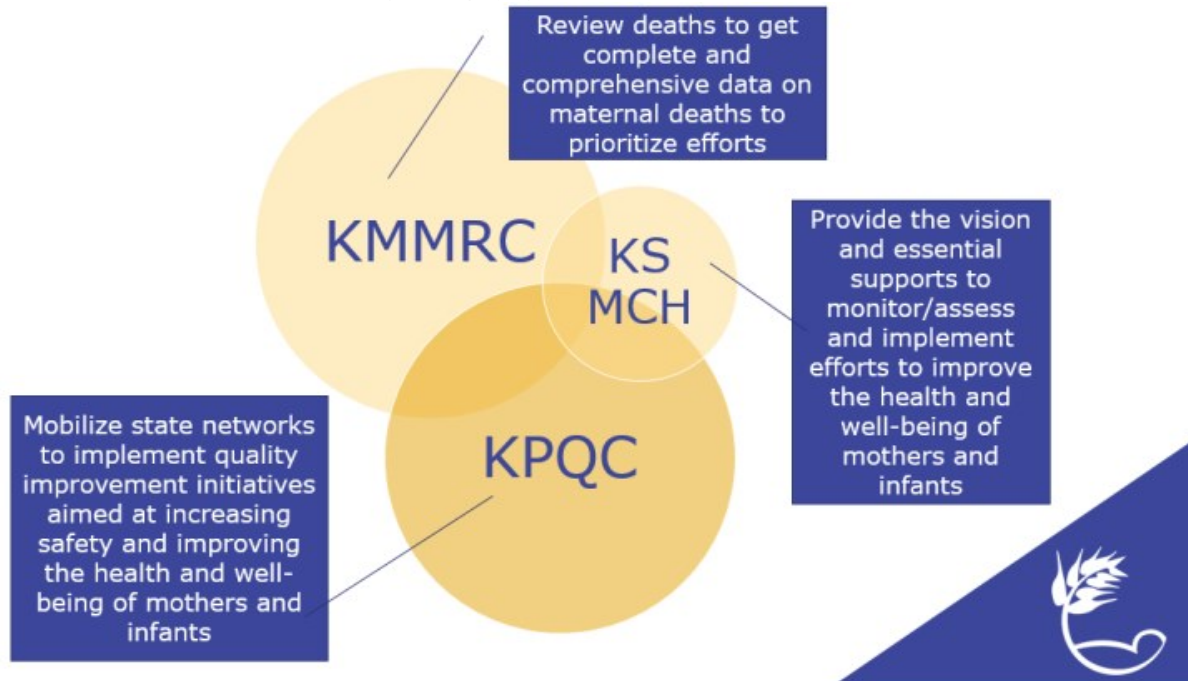
The Title V State Action Plan aligns with collaborative efforts underway for the [Kansas Perinatal Quality Collaborative \(KPQC\)](#). The KPQC is a panel of experts working to improve the quality of care for mothers and infants, affecting measurable improvements in statewide health care and health outcomes. The first initiative was focused on developing a comprehensive approach to Neonatal Abstinence Syndrome (NAS). The initiative, a lifespan approach crossing several critical periods, involved establishing 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. Learn more about the impact of the KPQC NAS initiative in the Women/Maternal Report section.

The KPQC kicked off implementation of a second initiative, the Fourth Trimester Initiative (FTI), in FY21 and will continue efforts during FY22. FTI is a maternal health quality initiative aimed at decreasing maternal morbidity and mortality. Data from KDHE Vital Statistics and the [Kansas Maternal Mortality Review Committee \(KMMRC\)](#) reveal that targeted assessment and intentional intervention in the postpartum period should be the primary care team activities to improve maternal health outcomes. FTI was designed to be a cutting-edge approach to study and improve the experience of mothers and families in Kansas. FTI focuses on chronic disease, behavioral health (including mental health and substance use disorder), breastfeeding, health equity, and access to care. The KMMRC's work and recommendations will continuously guide the KPQC and MCH activities and initiatives.

Role of State MMRCs & PQCs: 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 Displaying the Roles of the KMMRC & KPQC*



As convener of the Kansas PQC and MMRC, KDHE Title V brings together the 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), March of Dimes, Kansas Hospital Association (KHA), and more. 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.

KPQC & MMRC Collaborative Efforts – Data to Action: The KMMRC will work more collaboratively with the KPQC in FY22 to disseminate action alerts, practice recommendations, and implement the maternal health quality initiative (FTI). In addition, Kansas plans to officially enroll in the [Alliance for Innovation on Maternal Health \(AIM\)](#) (tentatively October 2021). 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:

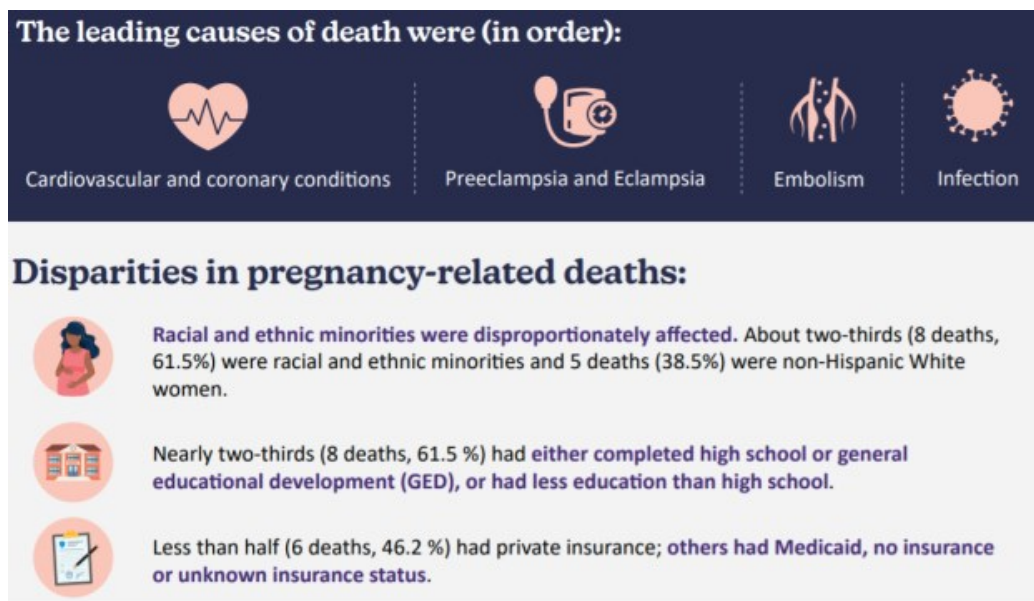
- Access to 12 “safety bundles”;
- Access to Patient Safety Tools; and
- Access to the AIM Community of States.

Kansas has identified the Postpartum Care Transition AIM bundle, identified by data gleaned from completed maternal mortality reviews as well as other MCH priority data for implementation. This bundle also positions Kansas to leverage all existing MCH investments around the Perinatal Community Collaboratives which has been improving and expanding over the last seven years.

### 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

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: 2016-2018 findings indicate the majority of “pregnancy-related deaths” are related to chronic pre-existing conditions exacerbated by the pregnancy, or conditions of pregnancy that worsen in the postpartum period (e.g., cardiovascular/coronary; preeclampsia/eclampsia; embolism; infection), where symptoms are not recognized as emergent or life threatening and appropriate treatment is not sought/provided quickly enough – 92.3% were found to be preventable.



In response, the *Maternal Warning Signs* (MWS) initiative is now formally underway with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) to implement their *Post-Birth Warning Signs* (PBWS) Education Program statewide. Adaptations to resources will support a comprehensive public health approach. Training seats have been purchased and are available for local Title V grantees, KPCC sites and partnering birthing facilities, and facilities enrolled in the FTI. Title V is including resources from multiple other national campaigns such as CDC's Hear Her Campaign



and NIH's Mom's Mental Health Matters, as well as state-developed and modified tools and resources targeting families and support persons, as well as racially and ethnically disparate and low-literacy populations. This intent and purpose of this comprehensive *Maternal Warning Signs* (MWS) statewide initiative is to provide consistent and repeat messaging across all health care sectors in all communities. MWS will include the fore-mentioned online training seats, as well as an online toolkit, TA webinars, and other resources to assist with implementation. The MWS and resources will be important components of the KPQC's FTI.

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). KPQC/KMMRC will promote and incorporate 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 and mental health. Promotional efforts will also include integration of screening and education on IPV, utilizing resources from the [Futures Without Violence](#) Initiative. Read more about SBIRT process implementation and addressing health risk behaviors in the Woman/Maternal Plan.

*Birth Defects Surveillance (BDS)*: Many states are beginning to implement Neonatal Abstinence Syndrome (NAS) as a mandated reportable birth defect. Kansas is no different and the program is beginning to review statutes and regulations to begin the arduous amendment process. The first step will include amending the Kansas Administrative Regulations (K.A.R. 28-4-520, 28-4-521) to include NAS as a reportable condition. Once amended, letters will be dispersed to all Kansas physicians notifying them of the new mandate. Reporting of NAS will allow for both mothers and infants to get the adequate follow-up care, intervention and referrals they need. In addition to adding NAS as a reportable birth defect, a foundation of referral services will be established within the BDS Program. At a minimum, all verified core disorders as described by the National Birth Defects Prevention Network, will be referred to internal and external partner groups such as the Kansas Special Health Care Needs, Infant-Toddler Services, Supporting You, March of Dimes, Ronald McDonald House Charities and other specialty healthcare clinics as related/needed for the reported birth defect. These partners will work with engaging the families and children affected by birth defects and ensure they have the proper education and outreach to effectively care for themselves and their children.

***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 University of Kansas Center for Public Partnerships (KU-CPPR) and 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 topics 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.

Home Visiting Workforce Training: The Institute for the Advancement of Family Support Professionals is a national home visiting competency training platform with existing content for use by anyone at no cost. Kansas does not have an existing platform or training module tracking system to ensure that KS home visitors receive sufficient training and professional development of the core competencies that support the quality and consistency of good practice for all home visiting models. In the upcoming year, KU-CPPR will create a custom seamless access point for Kansas Title V and MIECHV program staff and Early Childhood stakeholders to securely review data and coordinate all professional development modules completed by KS home visitors and supervisors in the Institute. This customized access requires technical linkages and secure tokens to accurately identify and pass data from the Institute into the customized Kansas Learning Management System. Another important aspect of ensuring a strong home visiting system of care 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 through 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 (May 2019). The grant was awarded and 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 is partnering with the University of Kansas Medical Center (KUMC) in Wichita to launch this pilot. 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. The project will continue to grow and evolve over the coming grant year.

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## **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 or other 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): In 2021-2022, [KS PRAMS](#) will continue data collection, including questions from supplements. The Opioid Supplement and Workplace Leave Supplement will continue through at least 2021 births. Supplements for 2022 births have not yet been finalized. PRAMS will also continue to integrate 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 actively 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. Perinatal/Infant Health Consultants will continue to work closely with the PRAMS/MCH Epidemiologist to incorporate PRAMS data into Action Alerts related to applicable Awareness Month and Health Equity topics that are shared with local MCH grantees and partner networks for promotion widely across the state.



## Child Health

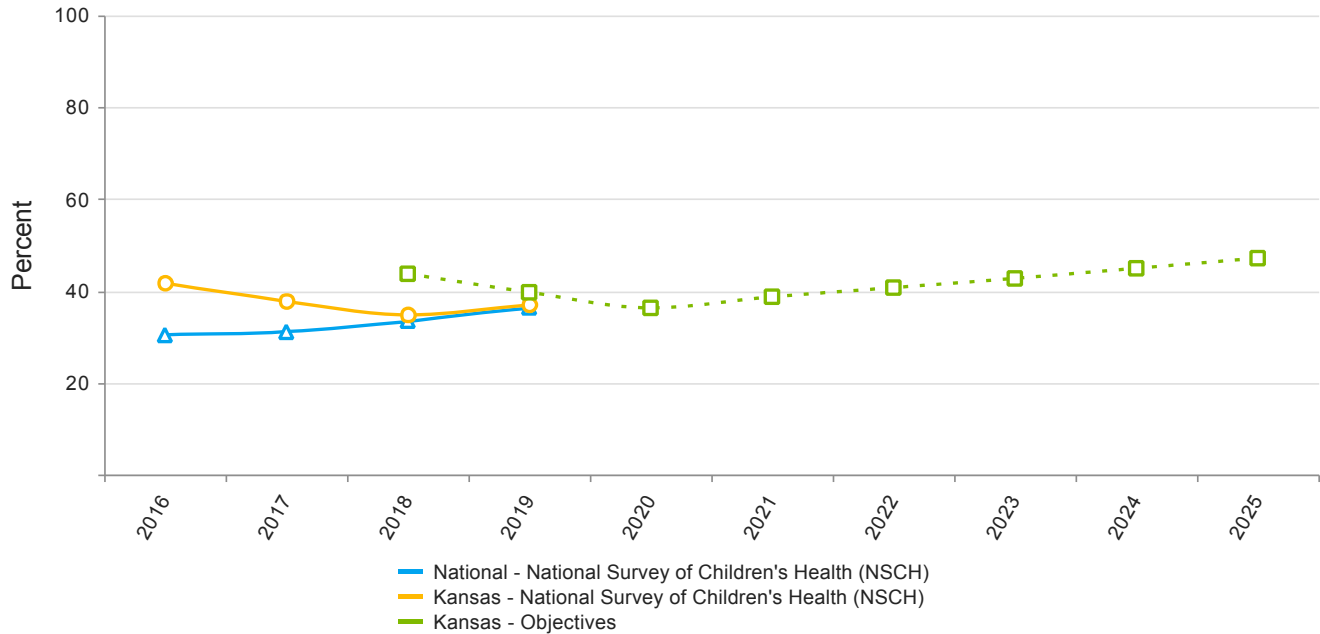
### Linked National Outcome Measures

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-2019	17.3	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	37.7	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	14.8	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	19.6	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.3 %	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	2020
Annual Objective			43.7	39.7	36.3
Annual Indicator		41.6	37.8	34.6	36.9
Numerator		33,290	30,554	27,890	31,330
Denominator		79,958	80,931	80,611	84,875
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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

	2021	2022	2023	2024	2025	2026
Annual Objective	38.7	40.7	42.7	44.9	47.1	49.4

**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	2020
Annual Objective		90	72.7	25	27.5
Annual Indicator	12.7	21.4	22.3	15	15
Numerator	243	347	340	256	256
Denominator	1,907	1,621	1,524	1,707	1,707
Data Source	DAISEY	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.5	35.0	37.5	40.0	42.5

## 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 Futures™ 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

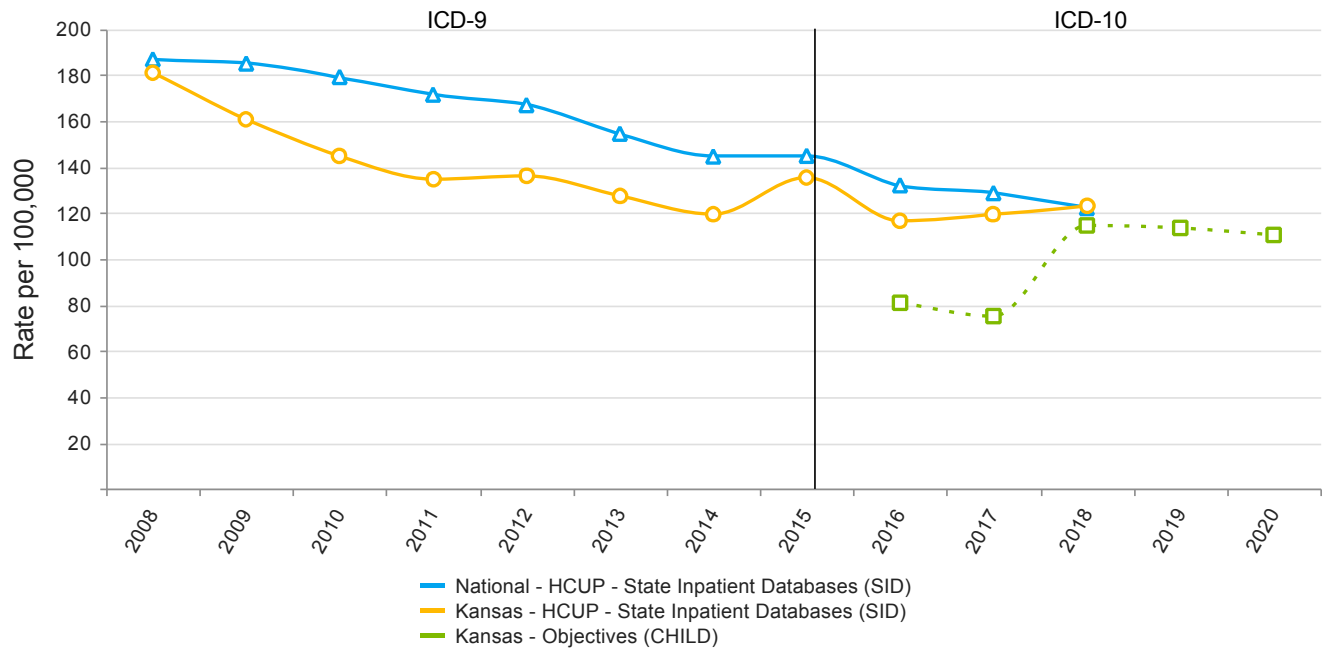
### NOMs

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	2020
Annual Objective	80.9	75.1	114.5	113.4	110.4
Annual Indicator	80.8	135.5	116.4	119.1	123.0
Numerator	325	406	461	468	476
Denominator	402,420	299,709	395,930	392,943	386,956
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	80.9	75.1	114.5	113.4	110.4
Annual Indicator		111.9	112	109.1	131.7
Numerator		443	440	422	456
Denominator		395,930	392,943	386,956	346,369
Data Source		Kansas Vital Statistics and U.S. Census Bureau	Kansas Vital Statistics and U.S. Census Bureau	Kansas Vital Statistics and U.S. Census Bureau	Kansas Vital Statistics and U.S. Census Bureau
Data Source Year		2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

**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	2020
Annual Objective		1,050	1,100	1,000	1,050
Annual Indicator	969	1,094	961	1,019	1,002
Numerator					
Denominator					
Data Source	Kansas Traffic Safety Resource Office	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	2019
Provisional or Final ?	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	2020
Annual Objective		29.6	35.4	28	29.4
Annual Indicator	28.2	32	26.7	26.8	32.7
Numerator	133,276	77,678	60,041	63,077	84,794
Denominator	473,426	242,379	224,657	234,934	258,969
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2016	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final	Final	Final

## Child Health - Annual Report

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

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

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

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

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*Local MCH Reach:* During SFY2020, 57 of 70 grantees (81%) provided services to the Child population.

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Kansas Title V has remained dedicated to assuring the 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. As such, Title V led the initiative to become a national affiliate of Help Me Grow state in 2019. 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. 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.

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." The Kansas [Help Me Grow website](https://www.helpmegrowks.org) was established in 2019 to share information about the HMG Framework, resources for families and providers on developmental health, and promotion of the statewide centralized access point, 1-800-CHILDREN.



[www.helpmegrowks.org](https://www.helpmegrowks.org)

Family Provider 1-800-CHILDREN About 

### Who

#### Families

Learning about developmental health and how to monitor a child's development helps ensure the best possible start for school and supports lifelong learning.

#### Providers

Providers are uniquely positioned to help nurture healthy development through daily interaction and to help parents understand the importance of developmental monitoring.

#### Communities

Communities benefit from healthy child development by raising the next strong generation of citizens, parents, teachers, volunteers, and employees.

The Kansas HMG 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. Additionally, this became the foundational framework for much of the early childhood systems building work and has been integrated into the [All in for Kansas Kids Strategic Plan](#).



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 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.

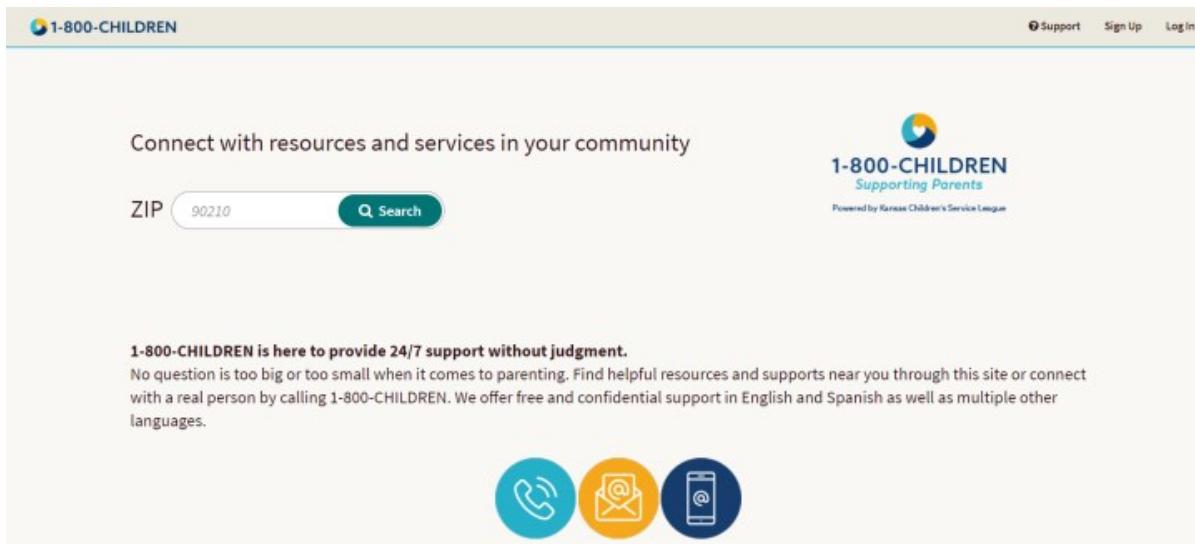
The state applied and received additional PDG funds in 2020 to be able to carry out strategies that would strengthen access to services and supports for families. Outlined in the Strategic Plan, KDHE was assigned five key initiatives:

- *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.
- *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).
- *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.
- *Supporting You Expansion, Promotion, and Marketing*: Peer to peer network expansion to 2 new programs/target populations (e.g., child care workers, foster parents).
- *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.

Each of these initiatives are aligned with the Title V State Action Plan. Additional information about Bridges can be found in the CSHCN narratives. The Holistic Care Coordination, Family Engagement and Leadership, and Peer to Peer Supports are located in Cross-Cutting narratives.

Statewide Resources through 1-800-CHILDREN: Also in 2019, Kansas merged the former state Title V toll-free "hotline" (the Kansas Resource Guide) to the "Parent Helpline." This provided an ability to expand and support a broader resource directory for families across Kansas. Significant work has happened over the last several years to strengthen this resource such as identifying and developing a robust and reliable statewide resource directory, increasing capacity to continuously maintain listed resources, increasing call line staff capacity, upgrading the mobile app, and rebranding following market research.

[1-800-CHILDREN](#) is led by the Kansas Children's Service League (KCSL) and serves as the statewide call line and resource directory. 1-800-CHILDREN provides anonymous, judgment-free support for parents. Families and helpers can easily connect with the information, local resources, and support they need 24/7, even if all they need is a listening ear. No question is off limits! 1-800-CHILDREN is available in English, Spanish, and 200 additional languages. In addition to calling, families can reach 1-800-CHILDREN by sending a text or email to: [1800children@kcsli.org](mailto:1800children@kcsli.org). Additional resources are available online at [1800CHILDRENKS.org](http://1800CHILDRENKS.org), and the mobile app can be downloaded by searching 1800ChildrenKS in iOS or Android app stores.



## 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)

The American Academy of Pediatrics recommends that all children should be screened for developmental delays during their regular well-check visits at 9, 18, and 24 or 30 months. According to the 2018-2019 National Survey of Children's Health (2 years combined), 36.9% (95% confidence interval [CI], 26.7%-48.5%) of Kansas children, ages 9 through 35 months, received standardized developmental, behavioral and social screening using a parent-reported, standardized screening tool or instrument, compared to 36.4% (95% CI, 34.0%-38.9%) 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 Early and Periodic Screening, Diagnostic and Treatment (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.

### OUR DAUGHTER'S SPEECH DELAY

*"I noticed by the time my daughter was 12 months of age that she was not speaking at the level she should have been for her age. We were in the process of moving at the time so I just kept working with her like I normally would. Once we relocated to [town] I got her into a free screening offered to the community. Got her diagnosed and given the extra support she needed to be successful. We had speech services at our home twice a month. We were given LOADS of resources to try with our daughter to ensure her success with her speech development. The speech teacher cares for her deeply and it shows. Our daughter is still behind on speech, but has flourished since getting set-up with services to help her. My husband and I are incredibly grateful to the [tiny-k program] for all the work they put into our daughter and her wellbeing. It takes a village, and I'm grateful for those who have worked to help my daughter."*

**Kansas Parent**  
story submitted in 2019 during  
the Title V Needs Assessment

**Objective: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-**

***completed developmental screening annually.***

*Aligning Developmental Screening Efforts:* KIDOS 2.0 continued to align with [Delivering Change](#) and Lifting Young Families Towards Excellence (LYFTE) project (a grant administered by the BFH, which ended June 30, 2020) in Geary County and with the MIECHV, LYFTE and [Kansas Connecting Communities \(KCC\)](#) 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 resulting in adding an additional 50 programs and 21 organizations to this referral network. KIDOS 2.0 project staff provide updates at the *Montgomery County Coalition for Children, Families, and Communities* monthly meetings, which includes all local 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 Southeast Kansas focused on improving 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 worked with LYFTE navigators to ensure that information about children's development is provided to parents participating in the program. The four LYFTE partners in Kansas are also Teen Pregnancy Targeted Case Management (TPTCM) sites so even though the funding for the LYFTE program has ended, these communities still continue providing case management and supports to the population that would have qualified for the LYFTE program.

In October 2018, the BFH was awarded HRSA's *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement* funding. Through this grant, BFH created the Kansas Connecting Communities (KCC) program and began implementation in Montgomery, Labette, and Crawford Counties. 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 perinatal mood, anxiety, and substance use disorders. KIDOS 2.0 staff worked with KCC staff to integrate perinatal mental health and substance use screening into the care coordination of SEK families.

*MCH/ECCS Partnership:* Kansas is one of 12 states that received an Early Childhood Comprehensive Systems (ECCS) Impact grant and is in year four of a five-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 advancing comprehensive systems for early childhood, and critical systems improvements have been realized (e.g., HMG framework, integrated referral and intake system (IRIS), state early childhood systems building).

The ECCS Impact project, also known as the Kansas Initiative to Develop and Optimize Systems for Early Childhood (i.e., 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 three that are achieving age appropriate developmental health in all five developmental domains by July 31, 2021. This grant aligns perfectly with the related Title V performance measurement framework (e.g., NPM 6 and Kansas ESM 6.1).

The ECCS/KIDOS work is focused in two place-based communities: Montgomery and Geary counties. In these communities, efforts include building, piloting, and strengthening systems and coordination for developmental screenings and referrals across sectors in ways that meet the needs of both families and programs. Partners drive the Collaborative Improvement and Innovation Network (CollIN), the quality improvement project central to ECCS Impact, in which community partners carry out rapid-cycle, small-scales tests of change ideas (e.g., Plan-Do-Study-Act cycles) to learn if changes will bring about improvement. The 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 2020 increased from 2019 in the areas where ECCS work takes place (1,075 in 2019 to 1,275 in 2020). Highlights of the reporting period activities in the communities, and across the state, are listed, below.

The distribution of best practice resources including [the Developmental Milestone Passport](#), [Developmental Screening Postcards](#), and [Implementation Tips for Developmental Activity Cards and Passports](#) (new this year) has been a main focus of this past year.



## Developmental Screening Passports

The developmental screening passport is modeled after the Immunization Record. Following a developmental screening, such as the ASQ®-3, the provider fills out the results of the screening on the passport.

This passport was created to empower parents/guardians to advocate for their child's health and development. The passport is also intended to help facilitate conversations between parents and a child's health care provider. If there is a concern with the results of a developmental screening, parents can bring the passport to their next appointment to share these results and talk through next steps.

Download these materials for free at: [screenearlystartstrong.org/community-resources](https://screenearlystartstrong.org/community-resources)

## Developmental Milestone & Activity Postcards

Twenty-one postcards that correspond to every Ages & Stages Questionnaire®, Third Edition (ASQ®-3) are available.

These postcards contain developmental milestones provided by the Center for Disease Control, [bit.ly/HealthyDevelopment](https://bit.ly/HealthyDevelopment), and age-appropriate activities promoted by Vroom, [bit.ly/ForProfessionals](https://bit.ly/ForProfessionals). Cards can be shared with families to start a conversation about a child's development and to encourage a fun learning experience at home.





### Creative uses for the Postcard

- ★ Families can paste a picture of their child on each card as they grow.
- ★ Write any upcoming appointments for the child as a reminder. This can be placed on the refrigerator for daily viewing.

- ★ Note the child's achievements observed during the visit on the postcard.
- ★ Write the contact name, address, and phone number of an organization or agency if a referral needs to be made.

- ★ Share websites, upcoming local events or other services that might be of interest to the family on the card.

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). As part of the 2019 KS Parent Leadership Conference, 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 was positive, indicating they would use the passports and loved the activities listed on the postcards which indicated what to look for in their child's development. The Developmental Screening Passports and Developmental Milestone Activity Cards were translated into Spanish to increase access for our Spanish-speaking population.

Title V is building on the success of the ECCS work to increase the impact of already existing MCH work related to developmental screening. 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.



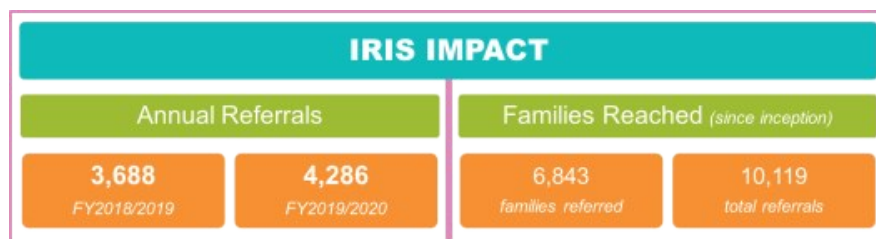
**ASQ Trainings & ASQ Screening Data:** ASQ Screening data shows that through the KIDOS 2.0 project 1,275 screening assessments were completed during this project year. Of these screenings, 76 were conducted on infants (< 1 year) and 1,199 were children between the ages of one year through five years old. A total of 65.2% were Caucasian, 13.7% were more than one race, 12.0% were Black or African American, 1.4% were Asian, and 1.2% were American Indian or Alaska Native. KIDOS 2.0, with support from the United Methodist Health Ministry Fund and partnership with the University of Kansas Center for Public Partnerships and Research (KU-CPPR), provided ongoing ASQ trainings for any professional from a community agency that works with parents and young children under age six, 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.

ECCS strives to build relationships with medical professionals through trainings on the ASQ-3 and ASQ:SE tools. ECCS staff historically have provided on-site technical assistance on incorporating development screening into these practices/facilities. While COVID-19 significantly reduced the ability to reach providers due to the reduction of in-person/on-site technical assistance, ECCS was still able to connect to 29 health care professionals and 10 community members through ASQ trainings between August 1, 2019 and July 31, 2020.

Through partnership with the Kansas Children's Cabinet and Trust Fund (KCCTF) and other state agencies, with backbone support from KU-CPPR, Title V has been involved in the discussions with Brooke's Publishing regarding using the ASQ Enterprise to bring existing 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 simply continue to 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 widespread screening for all kids and earlier interventions. More information about the Statewide ASQ Enterprise can be found in the Child Plan narrative.

**Resource and Referral System:** 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 referrals, 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 has helped align systems and increase coordination between public health and social services – 14 multi-sector IRIS networks currently span 20 rural and urban counties; local public health programs have been early and enthusiastic adopters in nearly all of them, accounting for 22% of all partners in Kansas communities. Public health organizations have initiated implementation in half of all IRIS networks, identifying and engaging multi-sector referral partners and providing ongoing leadership to sustain and expand their local network. The total number of IRIS partners in Kansas communities has risen from 350 to 479 between October 2019 and September 2020. Within these communities, 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 a critical access point 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. Below is an example of how IRIS was integrated into a local community:

- **Sedgwick County IRIS Network:** Local MCH leaders in Sedgwick county envisioned using IRIS to connect all families to a variety of needed services through a broader network of IRIS partners. Through targeted expansion efforts, as of September 2020, more than 25 programs engaged in the Sedgwick County IRIS network and have collectively made over 1,000 referrals on behalf of 660 families. This cross-sector group of partners continues to convene quarterly to increase service knowledge, problem solve, and improve practice. Survey data collected in September 2020 indicated that 92% of service providers believe IRIS has positively impacted communication among partners, closed referral communication loops, improved efficiency and tracking of the referral process, and fostered new connections among partners within the community. In comments, partners mentioned increased accountability between agencies, teamwork and relationship building, and "providing services needed for clients without letting them get lost in the system" as key successes of the network.

Learn more about IRIS at: <http://connectwithiris.org/what-is-iris/>. Read more about the future IRIS work in the Child Plan. Ongoing training and technical assistance are provided to organizations to ensure that IRIS is successfully incorporated into staff workflow. 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. 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. Below is the most current map of communities.



**Local MCH Agencies:** Local agencies provided developmental screenings to children served, birth to age six. Many agencies use the Ages and Stages Questionnaire (ASQ-3; ASQ-SE/ASQ-SE2) for developmental screenings for ages 2-60 months old. For ages above 60 months, agencies use the Bright Futures Pediatric Symptoms Checklist (PSC). Local MCH agencies provided health screenings in accordance with the 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. Some of the MCH local agencies using the ASQ are highlighted below.

- *Shawnee County*: Each child served, over the age of 2 months, is screened using the ASQ-3 and ASQ:SE2. MCH staff have received training to score the screens and talk to parents about necessary referrals when needed. Data shows that 93% of all MCH infants/eligible for a developmental screening received one (the remaining had not received their initial home visit yet or were facing a family crisis).
- *Sedgwick County*: Provides developmental screenings to infants at 2, 4, 6, 9, and 12 months, making referrals as needed to the Healthy Babies program. *Healthy Babies* home visitors conduct ASQ and ASQ-SE screenings with parents at 2, 4, 6, 9, and 12 months, making referrals to Rainbows and/or Screen for Success for cognitive developmental screening concerns and primary care providers for other physical/developmental concerns. In 2019, 117 children received the ASQ screening.
- *Saline County*: The local KPCC refers into the “Incredible Babies” program and screened for smoking status, perinatal mood and anxiety disorders and infants receive the ASQ/ASQ-SE screens.
- *Riley County*: The ASQ screening was administered to 44 clients during the reporting period – from these, 16 IRIS referrals were made to the Eugene Field Early Learning Center (USD/Parents as Teachers) and 3 IRIS referrals were made to Infant and Toddler Early Intervention Services. MCH staff completed an age appropriate ASQ on 90% of children enrolled in MCH services.
- *Coffey County*: Integrating the ASQ screening into immunization appointments, they completed 20 ASQ screens.

Local agencies use multiple screening assessment tools to determine the child’s needs and make appropriate referrals. Data is captured in DAISEY related to child development education (provided during an MCH visit) and referrals for developmental screening and/or early childhood intervention services. Child development education and referrals are also provided to clients receiving MCH home visiting services.

Child Development Education and Referrals During a MCH Visits FFY2020	
Services	1,166
Education <i>(includes Home Visits)</i>	5,258
Referrals Made	84/99
Referral Completion Rate	85%

Source: DAISEY, Client Level & Aggregate Data Report

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.

Universal MCH home visitors provide developmental screening for participants who have continued to receive services and are not eligible for other community-based home visiting programs. Technical assistance and training 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 at <http://kshomevisiting.org/>.

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

**Child Care Aware Partnership:** During this grant reporting period, Title V continued an agreement with the statewide child care resource and referral agency, Child Care Aware of Kansas (CCA), to provide new professional development opportunities to child care providers based on the results of a July 2019 Child Care Provider Training Needs Assessment survey. Three trainings packages (e.g., social-emotional, special health care needs, postpartum depression) were created and approved by KDHE Child Care Licensing.

A train-the-trainer event was held in November 2019 for 17 CCA trainers across the state. Between December 2019 through June 2020 a total of 35 professional development events were offered to child care providers and were attended by 420 participants. Two in-person events were able to be held prior to the onset of the COVID-19 pandemic with the remaining conducted virtually.

In addition, CCA hosted a Virtual School-Age Conference in October 2019. The Conference offered five, two-hour trainings, covering a variety of topics. The topics included math, growth mindset, nutrition, family engagement, literacy, behavior management, program management, and activity planning. A total of 71 providers registered for the five trainings with 44 providers from 13 different counties completing the series. According to the post evaluation, most of the participants felt that the information helped them better understand school-age care and that the concepts presented could be used in their current child care setting.

Evaluation	Above Average	Average	Below Average
Written materials, video or other media were useful and relevant to the content	79%	18%	3%
Information presented helped me better understand the topic	87%	13%	
Was an effective learning experience	82%	18%	3%
Information can be used in my child care setting	95%	5%	
My level of satisfaction with this training	79%	18%	3%

## 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.

*Data note: Data for 2016 and onward are based on ICD-10-CM/PCS and may not be comparable to previous ICD-9-CM estimates. With data provided in 2020 for 2021 Applications and 2019 Annual Reports, population denominators were revised for 2010-2016 and produced slight estimate changes. The Urban-Rural residence stratifier also changed from 2013 USDA Urban Influence Codes to 2013 NCHS Rural-Urban Classification Scheme for Counties.*

**Objective: Increase by 10% the number of children through age eight 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. Title V staff participates on the Safe Kids Kansas Board to help facilitate additional collaboration between Safe Kids and Title V programs. 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, Dickinson, Doniphan, Elk, Geary, Johnson, Marshall, Mitchell, Montgomery, Morris, Pottawatomie, Republic, and Riley counties) 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. KS Title V continues to work with Safe Kids to uncover where there are gaps in coverage of Safe Kids Coalitions.

**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, 447 car seat safety/installations were

provided to families served through MCH local agencies. Please see local examples below:

- *Barton County*: Hosted car seat safety event in collaboration with a local car dealership. Nine families attended the event and received car seat checks/installations. Provides car seat safety checks on an individual basis and have plans to train another staff member as a car seat safety technician, bringing the total trained staff members to three.
- *Cloud County*: As the founding member of the Cloud County Safe KIDS Coalition, they continue to promote child passenger safety with signage for future car seat safety check events and bike helmets for their annual bike rodeo.
- *Dickinson County*: Partners with Safe Kids Kansas to ensure that families receive a needed car seat and/or crib – and appropriate education. In this reporting period 4 car seats were distributed to families in need.
- *Gray County*: Two staff members are trained as car seat safety technicians. They held two car seat safety events in the reporting period and care seat/seat belt and general safety information was provided during all children's physical assessments and WIC appointments.
- *Hays Area Children's Center*: Provided car seats/proper installation to 26 families during the reporting period, including the provision of car seats to five families in need, as well as two safe car beds for CSHCN. Car seat installation is evaluation by technicians for every infant that is discharging from the local hospital.

***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 presentations to students regarding injury prevention.

*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 with unique special needs. 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. In SFY20 there were only 3 families who did not have smoke/CO detectors in their home. Through the SHCN and Safe Kids collaboration, these families received needed smoke and/or CO detectors. Many of the SHCN families already have these needed items due to this long-time partnership.

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)

### SPM 2: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

The 2008 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 2018-2019 combined National Survey of Children's Health, based on parent-reported data, was that 32.7% of Kansas children ages 6-11 were physically active for at least 60 minutes seven days a week. There appears to be no disparities by gender, race/ethnicity, special health care needs, parental educational attainment, household income-poverty ratio, family structure, or nativity.

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**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.**

National Childhood Obesity Awareness Month: The Child and Adolescent Health Consultant created a [social media toolkit](#) package to bring awareness to ways children and their families can easily incorporate physical activity into their everyday lives. A set of four pre-made graphics and sample captions (one for each week in September), that were based on the CDC's Move Your Way campaign, were made available to local health agencies and approximately 200 physical education and health teachers representing 106 school districts. The toolkit was also shared with Child Care Licensing and WIC staff and programs. Social media posts were placed on the KDHE and Maternal and Child Health Facebook pages throughout the month of September. The Child and Adolescent Health Consultant and the SHCN Program Manager partnered to develop a campaign dedicated to fun and applicable activities geared to children with special health care needs, below are the social media graphics utilized for this campaign.



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.

- *Finney County:* They check BMI during well-child visits and discuss results with parents. The importance of physical activity is spread through awareness and outreach events and on social media. Parents are educated about the importance of physical activity and nutrition at every well child check.
- *Morris County:* Hosts a Walk to School Day for elementary school children Pre-5<sup>th</sup> grade, with 250 children participating this reporting period.
- *Wilson County:* Held “Every Child Deserves a Bike” bike-a-thon to raise awareness of the importance of physical activity. This year, 22 2<sup>nd</sup> graders applied for new bicycles and helmets. The department continues to partner with community partners to make this event happen.

*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. This reporting period two trainings were offered based on the type of provider (center-based or home care). Both trainings were well attended with 150 center-based participants and 65 home- based participants.

***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 continue to be encouraged to bring a partnering dental hygienist from their local community to serve as a guest presenter of the session content when possible.

*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. 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. Participants are provided with resources to assist them in promoting oral health in the child care and home settings for families. Six training sessions were offered during the reporting period with a total of 105 participants completing.
- *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. During this reporting period, 6 trainings were held, serving 152 participants.

*Oral Health Kansas (OHK) Partnership:* Title V continued the partnership with OHK to conduct professional development opportunities and create resources specifically to be used with local MCH partners, Medicaid Navigators, WIC staff, early

childhood professionals and home visitors. More information can be found in the Cross-Cutting Report.

Based on feedback and follow up requests made by WIC personnel and home visitors that attended webinars given by OHK, three new parent education materials were created to assist in facilitating conversations with families regarding oral health best practices and frequently asked questions:

- For parents on basic oral health knowledge and adopting optimal oral health practices during their baby's first year.
- For pregnant women with information regarding morning sickness, daily mouth care during pregnancy, eating habits, and recommendations from dental health professionals.
- For home visitors to assist in discussion with clients and help them to prepare for an oral health appointment. This included suggested activities with families, background information, and access to sources for additional supplies/handouts to support informative and helpful conversations.

A training webinar that included fluoride facts, how to find the perfect oral health handouts and free online [oral health training](#) was also created and posted on the Title V provider webpage.

During this reporting period, Title V created an Oral Health Education Resources searchable database under the Integration Toolkit section of the website (<https://khap.kdhe.state.ks.us/c-f/oralhealthresources.html>). This database includes over 100 materials that are available to the public that have been vetted for quality and accuracy.

### **Other Activities Impacting Child Health**

***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 across programs. As a result, BFH has made behavioral health interventions, healthy social-emotional development, and cross-systems collaboration a priority for funding and programming. In July 2019, the BFH was awarded HRSA's *Pediatric Mental Health Care Access Program* Cooperative Agreement funding. Read more on Kansas MCH's behavioral health activities in the Cross-Cutting Plan.



## 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)

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*Local MCH Reach:* Based on SFY2022 MCH Aid-to-Local applications received: 43 of 61 grantees (70%) plan to provide developmental screening services to the Child population

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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 by 5% annually through 2025.***

According to the Kansas Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) report, 45,101 (91.3%) of eligible children received at least one initial or periodic screen in FFY2019. However, the NPM shows a downward trend of parents reporting the completion of a parent-completed child developmental screen in the past year (37.8% in 2017; 35.3% in 2018 NSCH). Title V staff will continue to 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, 3<sup>rd</sup> Edition (ASQ-3) and ASQ Social-Emotional, 2<sup>nd</sup> Edition (ASQ:SE-2). Utilizing knowledge and resources acquired from the ASQ-3 and ASQ:SE-2 Training of Trainers Institute hosted by Brookes Publishing, the Child/Adolescent Health Consultant will continue to join others around the state to conduct trainings for organizations, their staff members, and communities. Training participants will represent public health, family physicians, pediatricians, home visitors, childcare providers, and school personnel. The goal is to spread the awareness and use of these evidence-based screening tools, how/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-2 starter kits if they do not already utilize the screening tool at their location and register all 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 that the questionnaires they complete are tied to a developmental screening tool. For that reason, Title V will supply partners with a one-page fact sheet and social media messaging in English and Spanish to increase caregiver/parent knowledge. The fact sheet 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 electronic documents will be disseminated to local MCH agencies, childcare providers, libraries, healthcare workers, and home visitors to use with families. Documents will be made available on state and local health websites for public use and at state/local community events.

In the coming year, developmental screening will be incorporated into the Becoming a Mom (BAM) curriculum for the Kansas Perinatal Community Collaboratives (KPCCs) across the state. The Child and Perinatal/Infant Health Consultants will work together to introduce an overview on developmental screening into Session 5 – Newborn and Infant Care. Families

located in the 20 BAM/KPCC communities that enroll and attend this session will receive the one-page fact sheet and their own full set of developmental milestone activity cards and a developmental screening passport. All of these resources will be available in both English and Spanish. Ongoing discussions and planning to include more detailed information about developmental screening, recommended screening tools used, screening results, and the referral process for possible early intervention in a future session of the BAM curriculum are currently taking place.

**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. Local MCH staff including home visitors, early childhood educators, and healthcare providers will be reminded that these resources can be downloaded from the [Kansas Help Me Grow website](#). Title V staff currently have 30,000 English Passports; 15,000 Spanish Passports; 2,000 English Milestone Card Packages; and 1,000 Spanish Milestone Card Packages. These printed copies will be supplied and made available upon request as long as supplies are available.

As part of the pilot implementation for the Bridges Program, a new initiative within the Kansas Special Health Care Needs (KS-SHCN) Program, Care Coordinators received an overview on developmental screening that discussed the differences between monitoring, screening, and evaluation; benefits of screening, AAP's recommendation on developmental screening, types of screening tools and resources (including Help Me Grow Kansas and 1-800-CHILDREN); screening data in Kansas; and their role as a Bridges Care Coordinator in helping families navigate the early childhood system. Developmental Screening Passports (400 English/100 Spanish) and Development Milestone Card Sets (60 English/10 Spanish) will be provided to the five locations selected as the Bridges project sites. The KS-SHCN care coordinators will use these resources with up to 50 families across the state. Additionally, KS-SHCN will provide the overview training for those satellite offices who are not participating in the Bridges pilot. Read more about the Bridges Program in the Cross-Cutting Plan narrative.

**Coordination and Referrals:** In addition to providing ASQ-3 and ASQ:SE-2 trainings and increasing awareness and knowledge about developmental screening to families, Title V will build MCH capacity to support coordination and two-way referrals with other providers offering community-based services through the 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. The 1-800-CHILDREN resource directory includes early childhood programs and early intervention services, as well as numerous resources that address social determinants of health (e.g., food, housing, parenting, employment, education, safety, legal services).

Title V will continue to encourage MCH agencies to place the 1-800-CHILDREN logo/weblink on their agency website, show clients how to [download](#) the 1-800-CHILDREN app to their phones, update their agency information in the statewide resource directory as needed, and promote the 1-800-CHILDREN helpline on their social media platforms and at community events. As the resource becomes more widely known, Title V anticipates an increase in the amount of calls and service connections in their counties. For communities that utilize IRIS an uptick in referrals and linking families and children to needed resources is expected.

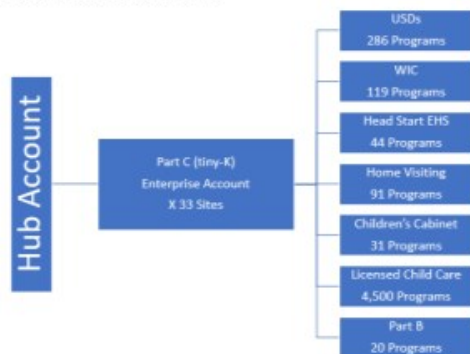
**Local MCH Agencies:** Local agencies will continue to provide developmental screening at least once a year to children they serve. Many local agencies use the [ASQ-3 and ASQ:SE-2](#) for developmental screenings for ages 2 to 60 months (5 years) and use the [Bright Futures Pediatric Symptoms Checklist \(PSC\)](#) 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.

- *Barton County*: Plans to increase the number of times "child development" is chosen as an education topic. They will collaborate with WIC to provide education about well-child visits and developmental screenings and milestones and provide this same information during lead screenings. They will provide education about developmental milestones for parents during home visits (for the infant, and for older children) and support use of the Developmental screening passport and milestone cards.
- *Shawnee County*: All children receiving MCH services will receive a developmental screening using the ASQ-3 and ASQ:SE-2. They will refer all screens that are not within the normal range, or if a parent has concerns about their child's development, for further evaluation through their local infant toddler network. The Bright Futures Toolkit will be used as a resource for all MCH staff providing home visits.
- *Lawrence-Douglas County*: All child development screens that indicate potential for delay will be referred to local infant toddler services and results sent to the child's primary care provider. Additionally, Growing Great Kids curriculum, Healthy Children (AAP website for families) handouts and ASQ child activities will be shared with parents to educate and promote techniques they can use with their children to strengthen the developmental area of concern.

**Healthy Child Development Programs:** Title V staff will recognize MCH agencies, home visiting programs, and healthcare providers that currently promote early literacy programs such as AAP's *Turn a Page*, *Touch a Mind*, the *Dolly Parton Imagination Library*, and other interactive activities recommended by *Learn the Signs. Act Early.* Campaign. Through promotion of local practices and the impact these programs have had in Kansas, Title V will encourage other partners across the state to incorporate more early literacy and age-appropriate activities that help children develop healthy habits into their services.

ASQ Online Network



**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 interventions, 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. In December 2020, the state agencies contracted with a marketing consultant to review the brand

framework around the HMG core components (provider, family, community outreach) after hearing from communities that the HMG brand was not resonating. Overwhelmingly, informant Interviews with key stakeholders and communities revealed the need for increased access to supports and services, including community-based technical assistance (adaptive Technical Assistance). In April 2021 the work was completed, and the *Navigate EC* branding was adopted. The plan is to provide a website, landing page, and coordination for all early childhood efforts across agencies.



- *1-800-CHILDREN/Hotline*. 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. 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.

More information about the history of HMG, the Helpline, and IRIS can be found in the Child Report.

## 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 by 10% by 2025.***

Title V investments in a Clinical School Health Consultant who will work closely with Title V, KSDE, local school districts, and communities on health screenings, referrals, and other school health initiatives, such as school-based health centers (SBHCs). A new school nurse website will also be established so that national and state guidance documents, upcoming trainings, information regarding continued COVID precautions, and other helpful resources and toolkits will be available to school districts as needed. Title V plans to continue partnering 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.

Another focus is the safety and inclusiveness of school and community playgrounds. 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 special health care needs (CSHCN) are children first and foremost,” our focus will be on assisting communities and schools with understanding how they can make playgrounds accessible for all children. Title V will engage communities and partners to conduct an assessment/review of safe school routes and inclusive playgrounds across the state to identify best practices and support expansion of communities with limited/no safe and inclusive play spaces. Title V will identify key partners who can provide technical assistance and establish guidance on adapting play equipment for children with mobility and sensory needs to communities and schools. Additionally, mini-grants will be made available for communities interested in building inclusive public spaces, such as school and community playgrounds. MCH local agencies will be prioritized to receive these resources and supports as they become active in ensuring that ALL children are able to enjoy community spaces.

The Family Advisory Council work group focusing on the child domain (specifically ages 6 to 11 years), has preliminary chosen to focus on assessing statewide activities around the social-emotional health of children ages six-eleven years in school settings. While this vision is only just beginning, the group members have identified they’d like to review KSDE data on school wellness policies and measurements, as well as the Social Emotional Literacy (SEL) requirements which have been identified for the school districts. Members also expressed interest in researching and providing information on incorporating mindfulness with physical activities, such as yoga, into the school day to local PTO/PTA groups, PE/Health Instructors, principals, and superintendents. The work group will establish a “charter” to guide their work and keep them focused in January 2022.

The BFH has developed *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 is 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 offers 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 plans to 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.

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

KanBeHealthy Trainings & Bright Futures<sup>TM</sup>: 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<sup>TM</sup> 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. The Kansas KBH training, including the Orientation Manual, has been updated and trainings will be provided by request. Correspondence with the regional Bright Futures representative continues and is beneficial in identifying free resources, trainings, or membership opportunities for state and local MCH agencies.



The KS-SCHN program will continue to address the need for annual preventative care for their uninsured program participants by covering an annual well child visit, vision and dental exam, which mirrors the EPSDT benefit, through the Medical Services direct assistance program (DAP-MS). Additionally, the importance of this yearly visit is reiterated to all families on the program, as this can be lost amongst the specialist and therapy visits their child requires. Some families have shared that they use their child's specialist, for example the pediatric pulmonologist, for their child's primary care in lieu of a pediatrician or family practice physician. These families are encouraged by care coordination staff to find a primary care physician in their area and assist them in this search, upon request.

Title V facilitated the acquisition of a statewide license for the online Bright Futures Tool and Resource Kit, 2<sup>nd</sup> 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 are given access to the site and resources at no cost upon completion of an online course with a demonstration of navigating the toolkit. The Child/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. Along with general inquiries about the toolkit and utilization strategies and best practices, the consultant will focus on promoting mental health conversations during well visits. In October 2020, Bright Futures published an updated Implementation Tip Sheet on this topic. By the age of 11 years, children can show onset symptoms of anxiety and impulse control disorder. The AAP Periodicity Table recommends screening for depression beginning at age 12 years. Title V staff will encourage and promote the Patient Health Questionnaire (PHQ) suggested by AAP. The KSKidsMap project created an algorithm that supports primary care providers with behavioral health screening during well visits and how to respond appropriately based on the results.

Targeted and intentional technical assistance will be provided to communities that show low well visit participation rates, immunization completion rates and uninsured children ages 5-10 years of age. Communities that show gaps in services will be invited to meet with Title V staff to review available data, brainstorm solutions and collaboration between partners with shared goals, create an action plan and marketing strategy.

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.

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## **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 Kansas 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.

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.

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.

- *Bridges*: Helping families navigate systems after early intervention and bridging transition gaps identified by the needs assessment
- *Holistic Care Coordination*: Establishing models of holistic, coordinated care in primary care settings across the state to support child development and growth
- *Family Engagement and Leadership*: Strengthening family voices in leadership through development and learning, program and policy advisory roles, and engagement.
- *Peer to Peer Supports*: Expanding peer to peer support and information sharing opportunities for families in Kansas.
- *Child Care Systems Improvement*: Increasing capacity of the child care system and assuring equitable access to high-quality early childhood care and education programs.

Each of these initiatives are aligned with the Title V State Action Plan. Plans for the coming year for Bridges can be found in the CSHCN Plan narrative and for the Holistic Care Coordination, Family Engagement and Leadership, and Peer to Peer Supports in the Cross-Cutting Plan.

*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 were developed for the BFH screening and surveillance programs along with a shared referral tracking sheet that ensures the loop has been closed on referrals. KS-SHCN will continue to promote and use the “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.

The realignment of the BFH in Fall 2019 continues to create new alignment opportunities across programs 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.

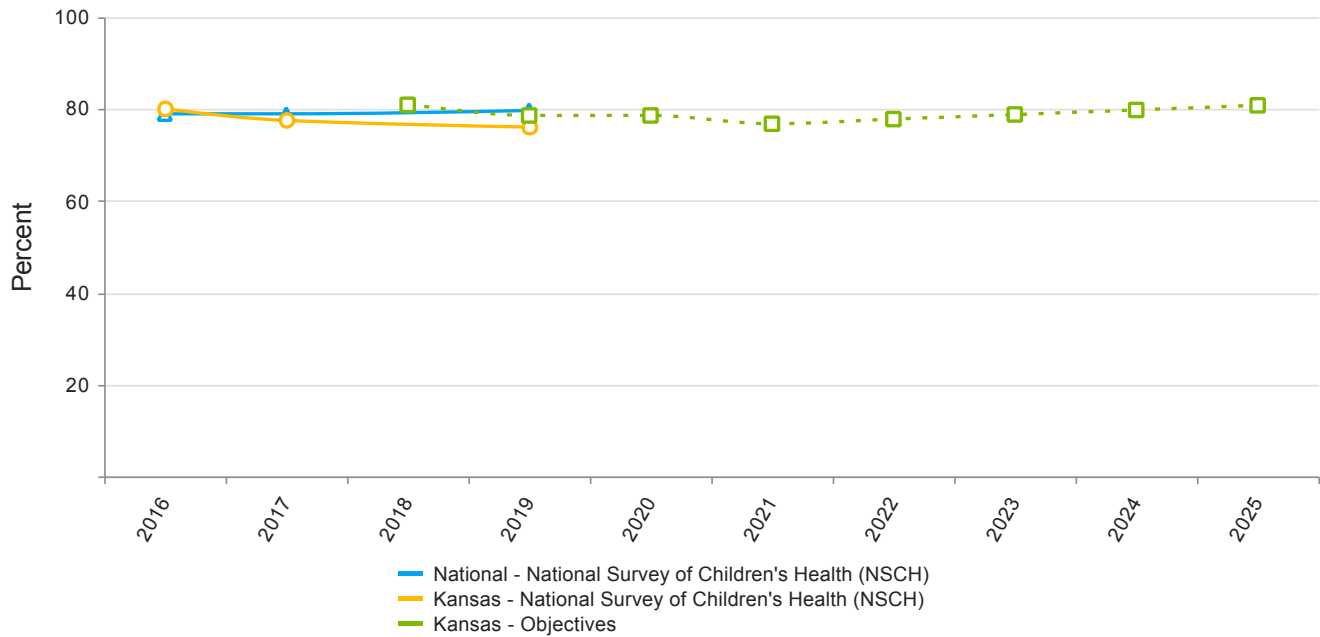
## Adolescent Health

### 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-2019	37.7	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	14.8	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	19.6	NPM 10
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-2018_2019	20.8 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	55.9 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.3 %	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-2018_2019	10.6 %	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-2018	13.7 %	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-2019	15.1 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	66.1 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	65.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	91.9 %	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-2019	80.7 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	19.2	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	2020
Annual Objective			80.8	78.5	78.5
Annual Indicator		79.8	77.5	77.5	75.8
Numerator		185,414	184,888	184,888	186,069
Denominator		232,249	238,418	238,418	245,601
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

**i** 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

	2021	2022	2023	2024	2025	2026
Annual Objective	76.7	77.7	78.7	79.7	80.7	81.7

**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	2020
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	2026
Annual Objective	38.3	40.2	42.3	44.4	46.6	48.9

## 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 Futures™ guidelines.	
Conduct annual provider educational efforts to support provider knowledge acquisition regarding the importance of comprehensive, quality adolescent well visits and the Bright Futures™ 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

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

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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)

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NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

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NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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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) - 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

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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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)

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NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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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

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NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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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) - 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

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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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)

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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

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NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## 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)

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*Local MCH Reach:* During SFY2020, 44 of 70 grantees (63%) provided services to the Adolescent population.

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The focus and activity around the Kansas Title V adolescent population has increased over the last several years. A greater emphasis on adolescent health in the past five years has helped Title V spread and scale work in the adolescent domain. As a result of the 2016 Adolescent Health Needs Assessment, Title V has addressed the disparities in the adolescent well visit through a variety of means including technical assistance focused on the components of a high-quality, comprehensive visit. Additionally, elevating the youth voice and intentionally providing opportunities for Kansas youth to play a role in activities within our objectives continues to be a Title V priority. As part of the most recent Needs Assessment, Title V partnered with Developing Caring Communities Committed to Action, Inc. (DCCCA), to host focus groups across the six public health regions of Kansas. Title V heard from over 180 middle-school, high-school, and college aged individuals through these focus groups, learning how adolescents get information, who they turn to when they have questions related to their health, and how they view a “comprehensive healthy lifestyle” and the barriers that prevent them from achieving that lifestyle. These youth/young adults spoke about their lack of trust in adults, feelings of being judged when seeking help, unwelcome cues from providers, and feeling dismissed by adults when they try to discuss issues that are important to them. The following quotes came from participants of these November/December 2019 focus groups.



*“Teens need a support system with someone that actually cares for them. Adults could talk with the youth to find out what’s going on and offer support.”*

Youth Focus Group Attendee  
Juvenile Justice System  
Title V 2021-25 Needs Assessment

*“Some people think it’s weird going to a [counselor] or don’t feel comfortable, but it would be helpful to continue to raise awareness, normalize it...make it more welcoming and positive.”*

Youth Focus Group Attendee  
College Student  
Title V 2021-25 Needs Assessment

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.*

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

Bright Futures<sub>TM</sub> Online Toolkit Demonstration: In December 2019, Title V offered local MCH partners the opportunity to attend an online, live demonstration of the American Academy of Pediatrics Bright Futures<sub>TM</sub> (AAP-BF) Online Toolkit facilitated by the AAP subject matter experts. With a total of 45 participants, who were able to submit questions to the AAP team, the training was recorded and made available via the state learning management system, KS-TRAIN. An additional 83 individuals from 66 local agencies have completed the online course, with nearly 75% (62/83) participants rating the course an overall 4/5 stars. Feedback from the course participants was overwhelmingly positive.

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 AAP-BF guidelines. With partners such as schools, medical providers, and community providers, this initiative was launched in 2017 to:

- Evaluate the capacity and infrastructure to provide school-based services
- Identify/develop best practices, existing policies, and effective procedures
- Develop a model or structure to provide well visits for youths in school settings
- Reduce barriers in obtaining preventative services
- Provide opportunities for adolescents to obtain routine yearly exams
- Increase youth/family understanding on the importance of the routine/annual well visit

The guide was developed to increase 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 unique needs of a community. The guide defines the phases in the process of establishing a school-based health center including:

- types of services;
- key partners;
- overview of target population (adolescents);
- 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.



Kansas School-Based  
Health Center Guide  
2019

During this reporting period a comprehensive [SBHC Guide](#) was added to the new [Adolescent Health website](#), which launched in September 2020.

The first pilot began development with Valley Center (USD 262), utilizing the SBHC Guide throughout their process. This district serves around 3,000 students in south central KS (Valley Center, Park City, Kechi, Wichita), across 6 schools [one Pre-K-3 building, two K-3 schools, one intermediate (4<sup>th</sup>/5<sup>th</sup>) school, one middle (7<sup>th</sup>/8<sup>th</sup>) school, and a 5A high school]. The

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.

Upon experiencing challenges in finding a medical sponsor to commit to the project, the team reviewed census data and noted that a full service SBHC may not be the greatest need in the community, as a high percentage of their population is covered with private insurance and receives services from community providers. However, data from the Kansas Communities That Care (KCTC) survey 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 in 2019 and applied for a Mental Health Intervention Team grant through the Kansas State Department of Education (KSDE), which was successful. The grant (\$60K) was used to establish a contractual MOU between the school district and the local community mental health center (CMHC) to work collaboratively in the provision of certain behavioral, emotional, and academic services to the students in the 2019-2020 school year.

The COVID-19 pandemic shed light on the need to have additional access to medical healthcare for the students of Valley Center. The school board and administrators were once again interested and open to hearing about how to establish a school-based health center in their district. When school returned in January 2021, Valley Center opened their SBHC. A Wichita television news station reported the pilot program. See the KWCH news story here:

<https://www.kwch.com/2020/12/21/bringing-healthcare-access-to-students/>

*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 identify training needs to health departments serving all 105 Kansas counties. 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 AAP-BF resources.

A team consisting of representatives from KDHE (Bureau of Community Health Systems, BFH, Medicaid), KAAP, and four health departments are currently working on developing an online EPSDT training. This training was initially to be held in-person but is being created in an online format to accommodate programs during the pandemic.

Kansas Title V purchased a AAP-BF License on October 31, 2019 which allowed local agencies access to all the tools and resources offered in the AAP-BF toolkit. Local agencies now have unlimited access to AAP-BF forms, educational handouts, presentations, and technical assistance. During this reporting period, a total of 83 individuals representing 49 health organizations across Kansas completed the mandatory demonstration webinar. These individuals have also received the AAP-BF online toolkit login and provided technical assistance from the Title V Child and Adolescent Health Consultant.

*Local MCH Agencies:* Local MCH agencies provided 417 adolescent well-visits utilizing the EPSDT screening form (which includes behavioral health screening) during this report period. AAP-BF 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:

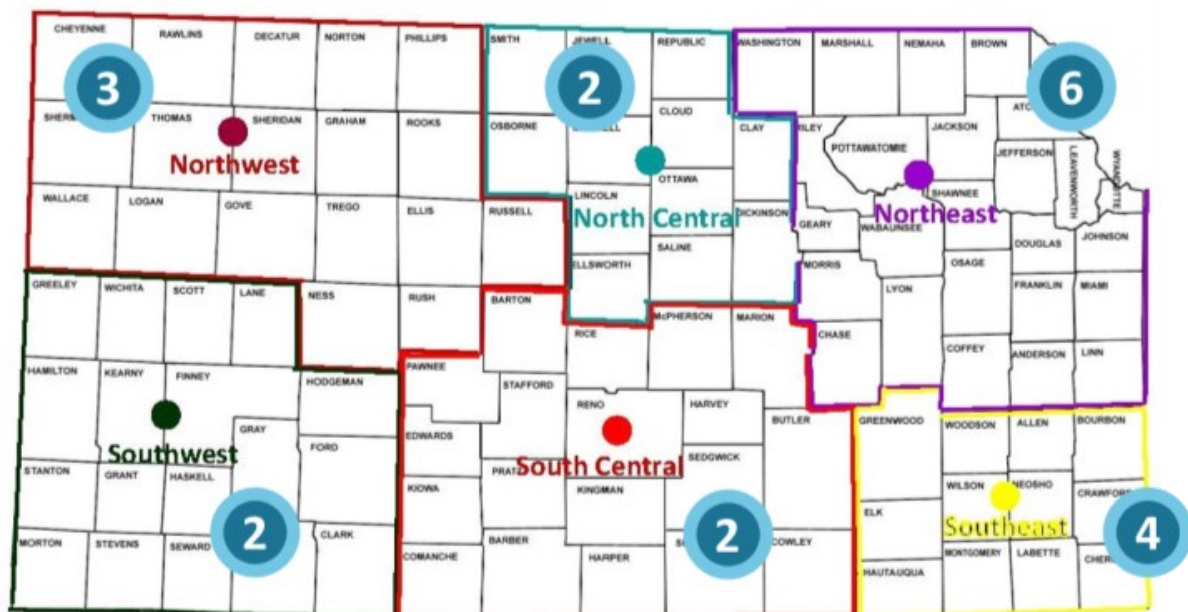
- *Wilson County:* Partnered with schools to address 5<sup>th</sup> and 6<sup>th</sup> graders on the dangers of vaping (during Red Ribbon Week and in partnership with the local Resist chapters). Additionally, MCH staff developed a survey administered to junior/seniors to ascertain the numbers of students who report vaping or smoking. They partner with local schools to offer adolescent vaccinations during school enrollment and are planning to incorporate a vaccination clinic into a free sports physicals event.

- *Wyandotte County:* Home visitors received training on One Key Question® (OKQ). They partner with the Wyandotte County school district to educate teens who utilize the SBHC. Specifically, during the reporting period, 125 teens were educated on OKQ with most teens answering that they do not want to become pregnant in the next 12 months and are provided birth control education and empowered to use these contraception options. In partnership with the school, Youth Health Days is held to provide height, weight, and blood pressure checks on all youth and healthy eating habits (by their Registered Dietitian). During this reporting period they attended 6 Youth Health Fair Days and reached approximately 1775 youth.
- *Thomas County:* Provides immunization clinics at all 3 public schools in the county, providing 102 immunizations this past year, despite staffing reductions and capacity due to COVID-19.
- *Sedgwick County:* Provided 442 episodes of counseling for adolescents during the reporting period, this includes psychosocial screenings and preconception education and counseling.
- *Saline County:* All adolescents are screened for tobacco, alcohol and drug use at their first appointment. They provide screenings for STI's (Gonorrhea, Chlamydia, HIV, Syphilis) for all clients (unless the client opts out). Blood pressure, weight and BMI are also checked at every client visit and education (verbal/printed) is given to adolescents that are under or overweight that encompasses health nutrition and physical activity habits.

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

During the focus groups held as part of the 5-Year Needs Assessment, youth shared that when they have questions about their health they most often go to their peers and friends first, with the internet a close second. These insights led to the creation of an interactive youth health guide, driven by the focus group discussions. The guide was modified and approved by youth prior to finalization. Title V chose a youth-focused marketing company based in Topeka, KS to create a social media campaign to promote the guide. During the campaign creative process youth provided input on the slogan, design, and participated in the creation of short video clips.

*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, a community organization that offers preventative programs and services for youth and adults to conduct 19 youth focus groups across the state (see map below for regional breakdown).



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. A breakdown of the number of sessions with participants from these various groups is included below.

# of Sessions by Youth Populations	
Middle/Junior High Students	3
High School Students	15
College Students	4
Tribal Communities	2
Spanish-Speaking (or marginalized households)	1
LGBTQ+ or allies	1
Youth with Special Health care Needs	1
Juvenile Justice Youth	2
Youth Engaged in Substance Use	1

**Youth Health Guide:** DCCCA utilized the information gathered through the in-person focus groups and online survey submissions to highlight the top 10 themes that were discussed: healthy eating, fitness and physical activity, mental health, stress, helping a friend, suicide prevention, substance use, social media use, health relationships, and well visits. To support youth-serving organizations in empowering young adults to take charge of their healthcare needs, the [Youth Health Guide](#) was created, and reviewed by some of the original focus group members plus some new youth and young adults. Staff asked questions and solicited feedback to ensure their interests and desires were captured and they saw the guide as a tool that would be helpful to them when taking charge of their own personal health and as a guide to help their peers when asked for guidance. The final guide is located on the Adolescent Health and MCH Council websites and was disseminated to other bureaus (e.g., BHP) and other state agencies (e.g., KSDE, Kansas Department for Aging and Disability Services/KDADS, Attorney General/AG Office). Approximately 200 health and physical education instructors from 106 school districts received the guide and have been using it for classroom discussions.

**Healthcare Provider Webinar:** Title V funded the Kansas Chapter of the American Academy of Pediatrics (KAAP) to provide a free, online webinar focused on how to create a youth-friendly environment, and gain better understanding of adolescent consent and confidentiality laws. This free CME event included the following subject matter experts in adolescent medicine and healthcare law.

- Dr. Tasneem Alaqzam MD, Assistant Professor of Pediatrics and Family Medicine, Medical Director of the Adolescent Clinic - University of KS School of Medicine – Wichita
- Denise Bloch, JD, Attorney with the firm of Lathrop GPM and has a strong background in healthcare law

The live webinar, “Engaging Adolescents in Healthcare Decisions,” was recorded and made available on the KAAP website for an additional three months (June through September 2020). Of the 17 healthcare providers who completed course evaluations, 100% of them reported that they know more about how to create a youth-friendly medical environment than they did prior to completing the course. Many participants stated a renewed understanding of how important one-on-one time with adolescents is during a well visit and expressed interest in having additional trainings or demonstrations on how to approach parents when confidentiality or mandatory reporting becomes necessary. In addition, participants suggested a quick reference guide of the Kansas consent and confidentiality laws would be helpful. This feedback was provided to KAAP and further discussions are taking place to create the recommended guide.

**WHY - Whole Healthy You Campaign:** DCCCA was tasked to work with youth 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. Youth voice was integral to the creation of a new marketing slogan and campaign during this

reporting period. A comprehensive marketing plan is being developed to launch “WHY – Whole Healthy You” in Spring 2021. This marketing package includes eye-popping graphics, posters with attention-grabbing questions and a QR Code to the Youth Health Guide, and 2 short video segments that include local youth actors.

**Teen Pregnancy Targeted Case Management (TPTCM):** TPTCM provides comprehensive case management services to pregnant and/or parenting adolescents in Kansas communities, prioritizing communities with greater numbers of adolescent Medicaid recipients. The goal is to reduce the negative consequences of teenage pregnancy, increase levels of self-sufficiency, and delay subsequent childbearing until completion of goals related to basic education/training (or 21 years). During FY2020, ten (10) grantee agencies, including seven (7) health departments, a community-based organization that provides 24/7 services to pregnant women experiencing homelessness, a federally qualified health center (FQHC), and one pregnancy/family program received TPTCM funding. Local agencies provided services to 363 pregnant and/or parenting teens across Kansas. 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, and thereby reduce negative consequences of teenage pregnancy. In addition to ensuring adolescents receive prenatal medical care, TPTCM case managers assist adolescents by providing linkages to healthcare resources for uninsured or underinsured teens and referring them to community resources and needed supports.

**Lifting Young Families Toward Excellence (LYFTE):** KDHE concluded the LYFTE project, funded by the Office of Adolescent Health (OAH) Pregnancy Assistance Fund. One of the outcomes of this project was the development of the Supporting Young Parents in Kansas, a guide for service providers across all sectors to support the unique considerations when working with expectant and parenting teens and young adults in Kansas. This guide utilized LYFTE data, feedback, and guidance from those providing direct services as supporting material for the content. A series of video links are also embedded in this guide addressing Title V's approach to [holistic care coordination](#). The video series consists of four key topic areas that are important when providing holistic care coordination, they are: A Holistic Care Coordination Overview, Relationships, Action Planning, and Referral and Collaboration.

Unfortunately, the final year work plan was affected by the pandemic; however, LYFTE navigators adapted to new tools and reported being comfortable using social media, which served as an asset across all sites in March 2020 when state-wide stay-at-home orders were implemented due to COVID-19. Many organizations were able to update their clients on current protocols for visits (in-person or virtual) and could also utilize Facebook Messenger Video as needed as a method of communication if clients preferred. Sites were encouraged to apply for the TPTCM program to continue providing services to teens in their communities.

Although LYFTE funding has ended, many aspects of the program are being continued with TPTCM grantees. Prior to the discontinuation of the funding, the Special Health Care Needs (SHCN) Program Manager shared information, data and tools around the SHCN Care Coordination model with LYFTE staff. TPTCM staff, with support from SHCN staff, will modify the SHCN tools, protocols and trainings, as needed, to meet the needs of their clients. 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.

**Bullying Prevention:** The [Kansas School Mental Health Advisory Council](#), with participation from the Title V Behavioral Health Consultant, was tasked with the execution of the Blue Ribbon Task Force on Bullying's [recommendations](#). An implementation guidance report is currently pending final approval by the Kansas State Board of Education. A *Bullying Prevention Plan and Resource Toolkit* was developed and included as an appendix within the report. This toolkit outlines resources schools and other local child-serving organizations can utilize to 1) develop a plan to address bullying; 2) build adult capacity to change climate and culture; 3) further develop or enhance competencies through evidence-based instructional guides and curriculum; and 4) measure social-emotional learning at a local level.

***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 ages 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, several state agencies convened to create a coordinated approach to youth mental health and suicide prevention strategies that address social-emotional development and mental well-being.

State level collaboration is necessary to effectively address the prevention of suicide related deaths and injuries. As a result, the Kansas State Agencies Collaborating to Empower Youth and Prevent Suicide Workgroup was established. The workgroup includes representatives from KDHE, KDADS, Department for Children and Families (DCF), KSDE, AG's Office, and Kansas Suicide Prevention Resource Center (KSPRC). 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 in Fall 2019.

The workgroup was tasked with increasing awareness of suicide prevention strategies. A tip sheet and resource listing were created (see example below).

— Preventing Youth Suicide —  
**DO YOU KNOW WHAT TO DO?**  
National Suicide Prevention Lifeline: 1-800-273-8255

**If I am a teen, I can...**

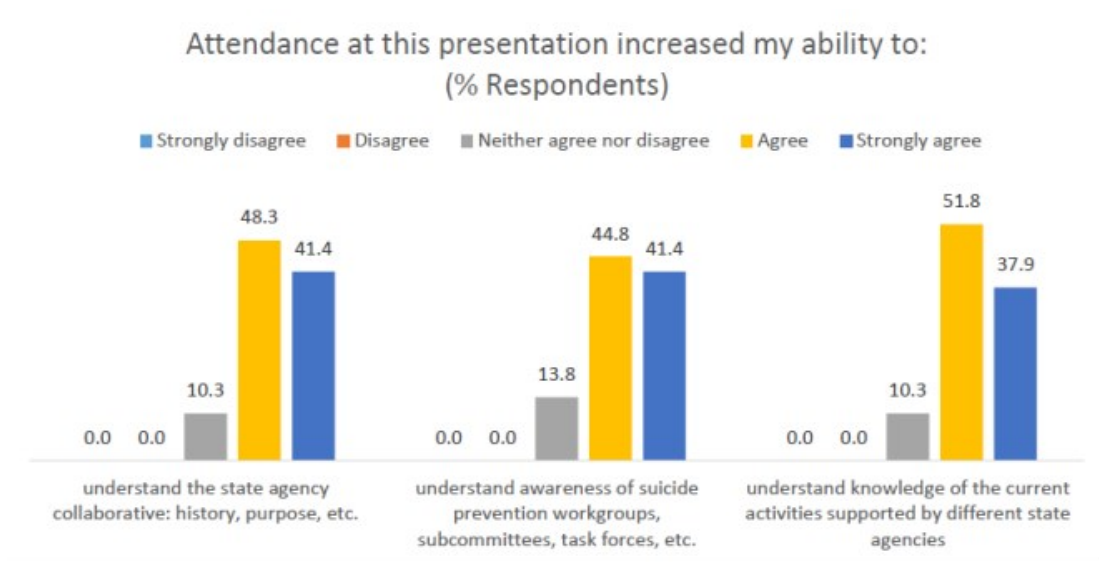
- **Encourage my friends** that getting help for life's ups and downs is the ok thing to do.
- **Ask my friends** the Columbia Suicide Severity Rating Scale questions: <http://cssrs.columbia.edu/wp-content/uploads/Community-Card-Teens-2018c.pdf>.
- **Share stories** about times getting help has worked.
- **Talk to my doctor** during my annual well-visit.
- **Break the stigma** by encouraging discussion of mental wellness.
- **Call the National Suicide Prevention Lifeline** at 1-800-273-8255 when I am worried about myself or a friend.
- **Host a National Alliance on Mental Illness (NAMI) Ending the Silence for Students** presentation: <https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Ending-the-Silence>.
- **Be an example of kindness** and connection to those around me.

Logos at the bottom: Kansas Department of Health and Senior Services, Kansas Department of Children and Families, Kansas Department of Education, Kansas Department of Aging and Disability Services, Kansas Suicide Prevention Resource Center.

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. Additionally, the workgroup submitted a breakout session proposal and was approved to speak at the 2<sup>nd</sup> Annual Kansas Prevention Conference on state collaborations for preventing suicide in October. One hundred and forty-six people attended the two-day conference. According to the final evaluation report for the event the top five audience classifications reported showed that 23.3% were from state, local, or tribal agencies; 13.7% were healthcare professionals; 13.6% were social workers; 12.4% were from youth serving organizations; and 9.6% were youth. Among the impressive list of presenters from the workgroup, the Title V Child/Adolescent and Behavioral Health Consultants joined leadership from KDADS, KSDE, and the AG's Office. Below is the evaluation from



those that participated in this presentation.



**Kansas MCH Council (KMCHC) Mental Health and Suicide Prevention Awareness Action Alert:** The KMCHC Adolescent Workgroup designed a series of social media posts based on the [#BeThe1To's](#) Five Action Steps for Helping Someone in Crisis. Everyone has a role to play in adolescent suicide prevention: parents, family members, school employees, coaches, health care professionals, community members, and friends. Therefore, two versions of the social media materials were designed. While the content is the same for both versions with the tag line "Be the one to help save a life." The different images were used that would best resonate with each targeted population group (adults/parents or adolescents/peers). During Mental Health Awareness Month (May) and Suicide Prevention Awareness Month (September), KMCHC shared the [Action Alert](#) with the Kansas MCH network. KMCHC encourages partners to post the graphics on social media platforms throughout the year.

Message #1, Adult Version



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](http://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



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](http://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



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](http://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



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](http://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/>

**Local MCH Agencies:** Local MCH agencies provided AAP-BF 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.

- **Wyandotte County:** Provides the "Futures Without Violence" pocket card which includes information about healthy relationships. This card is given to every adolescent seen in family planning or STI clinics, or the SBHC. The card is designed for adolescents who do not disclose violence in their relationships at home or outside of the home during a visit. The card is a nonjudgmental tool to give to adolescents who may not feel comfortable disclosing or may have not identified that they are in an unhealthy relationship, the card provides resources in a safe manner.
- **Barton County:** Supported the Suicide Prevention Task Force to put on the "Glow Run" suicide prevention event. Visits to schools provide vaping education and supports and collaboration with community partners for education on youth topics (e.g., healthy relationships, human trafficking, substance use).

## 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)

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*Local MCH Reach:* Based on SFY2022 MCH Aid-to-Local applications received:

- 34 of 61 grantees (56%) plan to provide adolescent well visit services to the Adolescent population.
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***Objective: Increase the proportion of MCH Program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services by 5% annually through 2025.***

*Bright Futures<sup>TM</sup>*: Often, a quality comprehensive annual preventive visit is not delivered, and insurance doesn't require documentation of all components reflected in the claim data for reimbursement. This results in care gaps for young adults. To address this issue, Title V continues to recommend that local MCH grantees adhere to the Bright Futures guidelines for preventive care/well visits for adolescents. Title V will continue state-level partnerships and will engage the Kansas American Academy of Pediatrics (KAAP), Kansas Academy of Family Physicians (KAFFP), Immunize Kansas Coalition, and Medicaid to promote shared recommendations for health care professionals to utilize the guidelines, tools/resources, and anticipatory guidance.

Title V will reach out to state partners to assess the current messaging and screening policy to promote a stronger cross-sector recommendation. The goal of the policy and subsequent messaging is to ensure adolescents receive a comprehensive annual well visit that utilizes 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 is the point of contact for this training for the state and is available for any and all questions or requests for technical assistance related to the use of the Bright Futures toolkit and materials. Additional targeted technical assistance will be offered to MCH grantees that have identified adolescent well visits as an area for improvement. Guidance will be provided on the following: marketing strategies for preventative well visits; providing simple low-cost ideas to create youth-friendly environments through tools created by the Adolescent Health Initiative; and supplying resources on how to incorporate appropriate procedures on transitioning youth, with and without special health care needs to adult care, starting at the age of 12. Evidence-based tools and resources through Got Transition, Bright Futures, and best practices from other states will be reviewed and included as part of the technical assistance service. Read more about Title V's health care transition plans in the CSHCN Plan narrative.

*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 MCH agencies that are targeting adolescents. Technical assistance will be offered to agencies individually, and as a cohort to support them in recognizing their goals to improve adolescent health measures; identify their status in meeting those goals; and identify steps to enhance, or improve, current policies and practices. 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 guidance, 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, or lost amongst the specialist and therapy visits, however KS-SHCN is working with youth and families to increase understanding through education around how these visits can help maintain optimal health and well-being. If the youth does not have a primary care provider, the care coordinator will help identify one in the area who accepts new clients and is in-network with their insurance provider.

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 and family 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 assist the adolescent with include: developing a list of questions and concerns to share during medical visits; developing and updating medication list; scheduling appointments and ensuring they work within the adolescent's schedule; 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 with appropriate screening recommendations from AAP and Bright Futures guidance. 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. KanBeHealthy (KBH) in-person trainings were not able to occur due to the COVID-19 pandemic. In response, KBH training materials have been updated and organized so that when trainings can be conducted in an in-person setting safely, the Bureau of Community Health Services staff and Title V will schedule and provide regional professional development on all of the components of a quality well-visit utilizing Bright Futures guidance.

*Local MCH Agencies:* 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 to receive feedback and address technical assistance needs.

- *Barton County:* Plans to present about adolescent well-visits to the Boys and Girls Home and increase awareness to the public through social media. TPTCM will promote well-visits after delivery and present about health/wellness at the TPTCM support group. Collaboration with other programs (immunization, family planning) will also support increased awareness on the importance of well-visits.
- *Kearny County Hospital:* Plans to increase the number of adolescent well-visits by partnering with the medical staff at their local community clinic to provide more thorough adolescent well-visits in addition to a sport's physical exam.

*Peer to Peer Awareness Campaign:* Kansas has made youth across the state equal partners in deciding what health topics are important to address. Youth driven efforts have resulted in a set of best practice marketing strategies that get critical health information and resources into the hands, phones, and minds of adolescents. The end product was the [WHY \(Whole Healthy You\)](#) campaign. The launch in the spring of 2021 was a success and Title V and the 60 partnering agencies will continue to utilize the WHY campaign to bring attention to health awareness events and highlight portions of the Youth Health Guide throughout the year. Plans for a fall WHY campaign is being planned for the back to school period in fall of 2021. Wallet-sized cards with a QR Code directing to the WHY website will be made available for dissemination to participating schools, community mental health centers, health departments, pediatricians, and local youth clubs.

*Behavioral Health Integration:* Title V will continue to promote the KSKidsMAP modified AAP algorithm for integrating pediatric mental health into well-adolescent visits. This algorithm demonstrates how the Bright Futures behavioral health screening recommendations can be integrated into well-visits, and highlights decision points in which the KSKidsMAP



Pediatric Mental Health Care Team could be contacted via provider consultation line to support the practitioner in identifying next steps for appropriate care and treatment. More information about this effort can be found in the Cross-Cutting narrative.

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### **Other Adolescent Health Activities**

***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 by 10% by 2025.***

Youth Health Guide: During FY21, adolescent focus groups (see more in the Report section) 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: healthy eating, fitness, mental wellness, substance use prevention, managing stress, technology and social media use, healthy relationships, and well visits and transitioning to adult care. The [Youth Health Guide](#) provides vetted information on these topics and will be an integral part of the back to school 2021 WHY campaign efforts.

Awareness of 2-1-1 and 1-800-CHILDREN: Kansas youth indicated during the Needs Assessment process that they are not always aware of all the community resources that are available. Title V will work to learn the extent youth and young adults in the state are aware of resources that can link them to community service organizations such as 2-1-1 and 1-800-CHILDREN. The Adolescent Health Consultant will convene youth from across the state with staff from Kansas Children's Service League, the 1-800-CHILDREN helpline, and 2-1-1 representatives to begin brainstorming ideas on how to build awareness about the statewide resource directory for the adolescent population.

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 include 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. The KS-SHCN program will request FAC assistance in reviewing these transition booklets to determine if updates or additions are needed, or if they could be more appealing to end consumers.

Title V will continue partnering with school professionals such as school nurses and special education directors in supplying materials to disseminate transition booklets to families at events such as school enrollment, orientation, and IEP meetings. Other statewide programs such as Part C/tiny-k, the Early Childhood State Directors Team, KAAP, KAFP, Kansas MCOs, and the Community Care Network of Kansas (CCN) who provide training, technical assistance, and guidance to federally qualified health centers will receive a sample of the transition booklets with an order form and return envelope to express interest in receiving this resource for their clients. 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 is desired to convene a group of adolescents and families to revise these booklets to be inclusive for all youth and prepare them for adulthood.

Feedback and suggestions for improving the transition booklets will be solicited through the SHCN FAC work group, the Adolescent FAC workgroup, and the partners listed above through an evaluation survey. Modifications and updates will be made as indicated by the evaluation and revised transition booklets will be made available when the product is finalized.

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 adolescents 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 committed 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:

- *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. Program goals are to: reduce negative consequences of teen pregnancy for KanCare-enrolled teens and their children, 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.](#)

***Objective: 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 of experiencing behavioral health conditions by 5% by 2025.***

Title V will continue their efforts to increase provider education and utilization of the evidence-based process *screening, brief intervention, and referral to treatment (SBIRT)*. To further support the integration of behavioral health SBIRT into pediatric primary care settings and well-adolescent visits, Title V will continue to promote the modified AAP algorithm developed by KSKidsMAP (Kansas' pediatric mental health care access program for primary care physicians and clinicians; more details found in the Cross-Cutting Plan). KSKidsMAP is also developing a Pediatric Mental Health Toolkit for providers that will cover the SBIRT process for several mental health conditions. Each section of the Toolkit will be focused on a different diagnosis, but all sections will include the same core components: using screening tools; first line treatment and interventions; monitoring, follow-up, referrals; and, brief interventions. The anticipated release of Toolkit sections is as follows: Anxiety- June 2021, Depression- October 2021, and ADHD- January 2022. Additional diagnosis will continue to be added to the Toolkit based on types of inquiries received through the KSKidsMAP provider consultation line and in the TeleECHO Clinic.

Title V will also add behavioral health screening forms to DAISEY, Title V's data collection system, to increase availability of evidence-based screenings to local MCH agencies. Currently, only the Edinburgh Postnatal Depression Scale (EPDS) for perinatal depression and anxiety and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) for substance use in adults is available in DAISEY. The following forms will be added July 2021:

- CRAFFT – Substance Use, Ages 11-21
- Generalized Anxiety Disorder (GAD-7) - Anxiety, Ages 12+
- Patient Health Questionnaire (PHQ-9) - Depression, Ages 11+
- PHQ Modified for Adolescents (PHQ-A) - Depression, Ages 11-17
- Pediatric Symptom Checklist (PSC-17) - General Mental Health Screening, Ages 4-16



A Plan of Action form will be populated in DAISEY for moderate or high-risk screening results. This form allows for local MCH staff to document that a brief intervention was conducted, the type of brief intervention provided, indicate referral(s) made, and summarize any emergency or support services initiated for a client experiencing a crisis.

Title V Health Consultants are developing guidance to be made available to local programs when the screening forms go live in DAISEY. The guidance will include a 1-page overview of each of the screening tools and scripts for introducing the tool to a client, administering the screening, details on scoring the screen, and determining risk-level and appropriate interventions. While this information will be made available as a packet, each 1-pager will be designed to serve as a standalone document allowing local agencies to select which screening tools they want to integrate into their program workflow. Further, three questions will be added to the DAISEY Services Form: *Was an anxiety/depression/substance use screening administered?* Question responses, as well as screening results and plan of action form responses, will be reviewed and used to identify any training or technical assistance needs.

Title V Consultants are partnering with Wichita State University's Community Engagement Institute (WSU-CEI) to create additional SBIRT resources focusing on adolescent behavioral health. During this reporting period, WSU-CEI will: a) customize a SBIRT 101 Resource Guide and Toolkit for the adolescent population based on nationally recognized evidence-based resources, AAP/Bright Futures™ recommendations, Kansas-approved SBIRT trainings, organizational policies and procedure development and implementation guidance among other items; b) WSU-CEI will present the new adolescent SBIRT resources to the MCH grantees during a lunch and learn webinar in November; and c) recruit up to five grantees to participate in an Adolescent SBIRT Implementation Learning Collaborative and provide virtual learning events along with monthly technical assistance check-in meetings. WSU-CEI staff and the learning collaborative participants will present the ongoing work and lessons learned regarding this project at the Governor's Public Health Conference in Spring 2022.

**Youth-Driven/Centered Approaches:** Increasing youth voice related to planning to address youth mental health across the state is a top priority. A statewide youth suicide prevention art contest was conducted Spring 2021. KDHE created a press release and posted social media messaging to encourage youth in grades 6-12 to use any creative medium that resonates with how they express themselves and communicates a message of hope and healing. Each of the 29 participants received a swag bag and sunglasses with the hashtag #WeAretheHopeful! WHY campaign frisbees and electronic decal stickers, a certificate signed by KDHE Secretary Dr. Lee Norman and Department for Children and Families/Department of Aging and Disability Services Secretary Laura Howard. A letter of thanks was also included and signed by Governor Laura Kelly (see picture at right with items). All submissions are available for viewing on the [Kansas Suicide Prevention Headquarters](#) and can be used by any state or local organization for youth suicide prevention awareness purposes.



**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. The KS-SHCN Program Manager and Supporting You Peer Support Administrator will begin planning discussions on first

steps for the proposed expansion.

*Cross-agency Collaboration for Improved Adolescent Health & Well-being:* 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.

### *Key Partners in Adolescent Health & Well-Being*

#### **State Agency Partners**

- 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

*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.

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.)

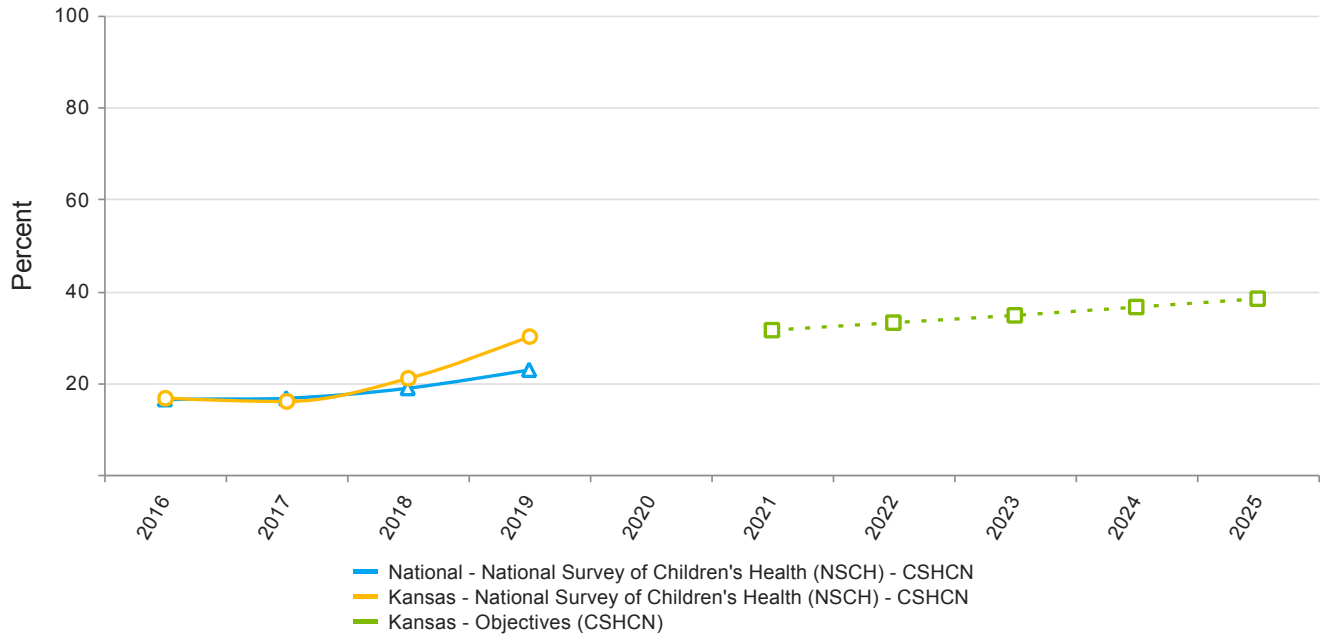
## Children with Special Health Care Needs

### 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-2018_2019	20.8 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	55.9 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.3 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.8 %	NPM 11

## National Performance Measures

### NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition 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	2020
Annual Objective		
Annual Indicator	20.9	30.0
Numerator	13,192	19,882
Denominator	63,103	66,317
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.5	33.1	34.7	36.5	38.3	40.2

**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	2020
Annual Objective		
Annual Indicator	50	16.7
Numerator	2	1
Denominator	4	6
Data Source	Welligent	Welligent
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	52.5	55.1	57.9	60.8	63.8	67.0

## 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 to prepare for the transition 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 to prepare for the transition 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 to prepare for the transition 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

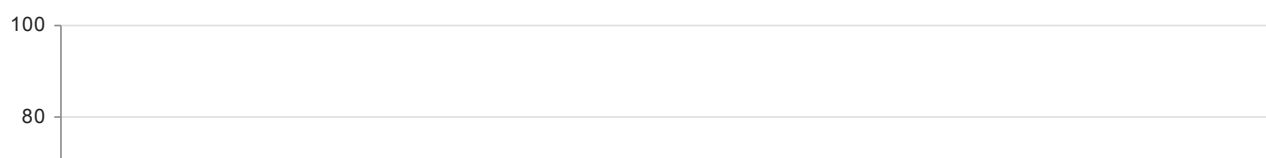
### NOMs

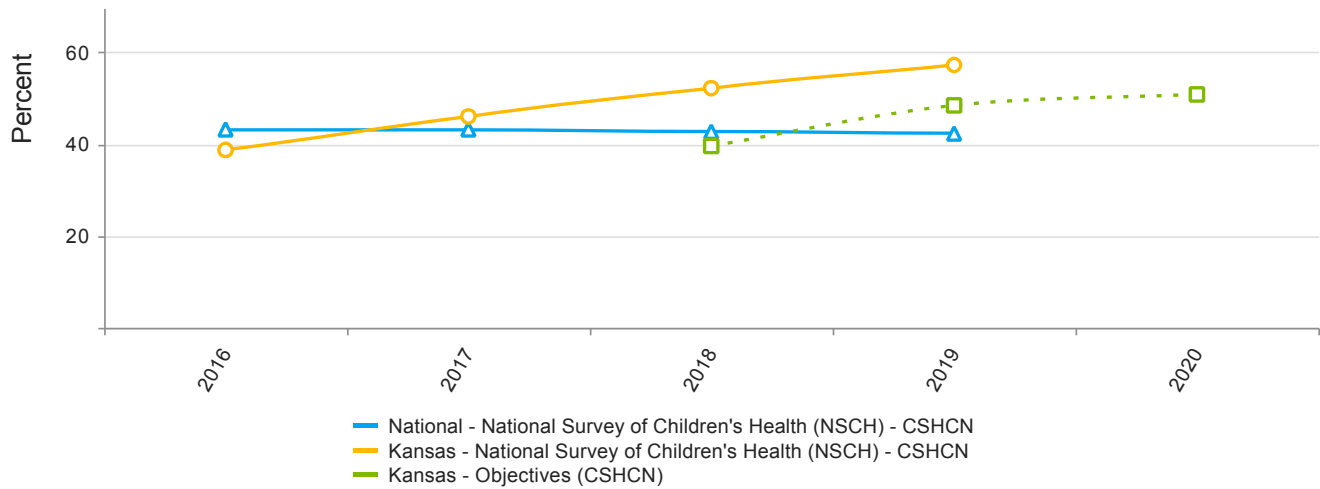
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## 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	2020
Annual Objective			39.6	48.4	50.8
Annual Indicator		38.6	46.1	52.3	57.1
Numerator		56,808	68,059	75,646	82,683
Denominator		147,272	147,776	144,559	144,750
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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	2020
Annual Objective		5	5	70	75
Annual Indicator	0	0	66.7	62.9	85
Numerator			18	22	17
Denominator			27	35	20
Data Source	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	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)

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*MCH Local Reach:* During SFY2020, 12 of 70 grantees (17%) provided services to the children with special health care needs population; 8 agencies served as Satellite Offices for the Kansas Special Health Care Needs Program.

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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 Kansas Special Health Care Needs (KS-SHCN) 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 KS-SHCN program provides services to children and youth birth to age 21 with eligible medical conditions. The program provides care coordination and financial assistance and support to approximately 1,304 individuals with special health care needs and their families. Numbers decreased in the third and fourth quarters of 2020, due to the COVID-19 pandemic, as families were fearful of taking their child into clinical settings, unless absolutely necessary. Additionally, the program assures that medical specialty services are accessible through external partnerships and contracts to provide diagnostic evaluations and treatment services. Additional information about the program, including the eligible medical conditions (per KS Statute), is available on the [website](#). 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 has just concluded implementation of year 5. However, the KS-SHCN Action Plan will remain active as some tasks have not fully been completed and others such as Holistic Care Coordination, will be undergoing expansion in the next few years. This report reflects accomplishments during year 5. 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 both medical and 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. One such change in the past year includes coverage for those with metabolic or genetic conditions screened through the newborn screen. While historically the program has covered persons of all ages with these conditions, the program made the difficult decision to change the eligibility criteria for these conditions to match the same age eligibility as others on the program. This means that as of October 1, 2020 the program no longer accepts new applications for those past their 21<sup>st</sup> birthday for individuals with these conditions, with the exception of applicants who are requesting metabolic formula assistance only for Phenylketonuria or Maple Syrup Urine Disease (per Kansas Statute K.S.A. 65-180). This provides the capacity for the program to focus on the child population, first and foremost, and will allow for the expanded care coordination and service delivery the program desires. As the program strives to focus on the overall system of care for CSHCN, rather than direct service delivery, and expand the ability to better understand the needs of the CSHCN from a population health perspective, difficult (albeit necessary) decisions are anticipated.

## 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 continued to be a central focus through this year, a recognition that the needs of the child and their family have shifted, especially after the COVID-19 pandemic, and the continued focus on stronger collaboration and integration across systems of care is essential. 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 area. While the number of SO's did not change from SFY19 to SFY20 (8), the catchment area for the SO's shifted.



The KS-SHCN workforce consisted of a total of 21 individuals, with 5 full-time positions with the remaining staff (SO) working an average of 10 hours or less per week. Staffing needs are assessed annually to ensure adequate coverage to provide holistic care coordination. A decreased in completed applications created a need to reduce the number of hours and make adjustments to the SO regions. These changes will be assessed carefully to determine how to reach more families and grow the program, rather than the continued decline we are experiencing.

### Workforce Credentials SFY2019 SFY2020

Registered Nurses	14	7
Social Workers	4	5
Other	14	9
Total	32	21

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 can 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.

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 held annually in July (although this event was cancelled in 2020 due to the COVID-19 pandemic).

*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 SFY20, a change to the Metabolic Products DAP policy resulted in allowing clients up to \$1,200 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) and the Medication DAP (DAP-Rx), 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. The guidelines for this assistance program were also simplified, as the prior directives were found to be confusing to families.

Since the inception of the DAPs, the program has become 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*: The KS-SHCN care coordination and data management system (Welligent) continues to be reviewed for efficiencies and enhancements recommended. The focus for 2020 was to ensure all components of the system work efficiently, following the full launch in 2018, but the challenges brought on by COVID has delayed this. The program is still working to assure they can track all care coordination activities and report 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.

*Aid-To-Local (ATL) Funding Process*: KS-SHCN continued to provide an opportunity for community partners to apply for funding for special projects through an online survey. 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 and 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, Unit Director, KS-SHCN Program Manager, 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 FY2020, the KS-SHCN program awarded six grants. A summary is provided below.

### Specialty and Outreach Clinical Services

- Kanas City Clinics: Cystic Fibrosis and Cleft Lip/Palate
- Wichita Clinics: Cleft Lip/Palate, Medically Complex\*, and Wheelchair Seating (\*This clinic provides 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 full-time Care Coordinator in the FQHC in SE Kansas to provide services for 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 fosters attitudes of civic engagement and services through the development of leadership skills

The first half of the reporting year, the KS-SHCN Program Manager and Lead Care Coordinator met with partners to monitor progress on funded projects and to build stronger collaborative relationships. During these in-person meetings, program updates, grantee project progress, technical assistance needs, and next steps were discussed. The program also worked with grantees to identify additional collaboration opportunities to meet the needs of the CSHCN population. Due to the pandemic these in-person meetings did not occur in the second half of the reporting year, but the KS-SHCN Program Manager kept in close contact with each partner to see how the pandemic was affecting their work and their clients. Many of the partners moved to a telehealth format while others like Kansas Youth Empowerment Academy (KYEA) FACES of Change had to adjust their scope of work to focus on the development of a virtual curriculum.

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 SFY2020 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.

**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.

<i>"Pre-" and "Post-" test completed by Occupational Therapists (Ots) and Physical Therapists (PTs)</i>								
Data	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Goal #1	2.30	4.26	2.39	4.36	2.47	4.18	2.68	4.22
Goal #2	2.46	4.43	2.55	4.64	2.45	4.46	2.68	4.59
Goal #3	2.95	4.74	2.93	4.71	3.04	4.76	3.8	4.92
Goal #4	2.42	4.59	2.55	4.75	2.42	4.67	2.7	4.73

CPRF Seating Clinics			
Quarter	# Patients Served	# Unduplicated	# SHCN Served
First	212	157	22
Second	229	171	38
Third	186	152	22
Fourth	95	81	12
Total	722	561	94

CPRF Outreach Seating Clinics				
Quarter	# of Clinics	# Patients Served	# Unduplicated	# SHCN Served
First	2	14	14	0
Second	3	16	16	0
Third	2	7	7	0
Fourth	4	4	4	1
Total	11	41	41	1

**KS-SHCN and Cerebral Palsy Research Foundation Partnership:** This year, Cerebral Palsy Research Foundation (CPRF) developed a contract with a Durable Medical Equipment (DME) provider, which resulted in significant discounts on Convaaid equipment. CPRF has passed these discounts on to the KS-SHCN program. CPRF also partners with the KS-SHCN program to cost share on more costly equipment, if their funding allows. By doing so, clients have been provided needed DME that our program was unable to previously provide, due to cost exceeding our funding capacity.

**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' in order for the MCO Case Managers/Service Coordinators and KS-SHCN Care Coordinators to 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/Service Coordinators and the KS-SHCN Care Coordinators has helped maximize resources and provide quality services for CSHCN.

During SFY2020, the KS-SHCN Program Manager presented an overview to MCO staff about the program to the MCO Case Managers/Services Coordinators to further improve collaboration and strengthen 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 for orthodontic providers serving cleft lip/cleft palate patients.

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#### **NPM 11: Medical Home (Percent of children with special health care needs having a medical home)**

The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective care. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional who is familiar with the child and family and the child's health history.

In the 2018 and 2019 National Survey of Children's Health (NSCH), the presence of a medical home was measured by a composite measure based on five components constructed from a total of 16 survey items. These components are:

- Personal doctor or nurse
- Usual source for sick care
- Family-centered care
- Problems getting needed referrals
- Effective Care Coordination when needed.

To qualify as having a Medical Home, children must meet the criteria for adequate care on the first three components: personal doctor or nurse, usual source for care, and family-centered care. Additionally, any children who needed referrals or care coordination must also meet criteria for those components in order to qualify as having a medical home.

In 2018-2019 (2 years combined), 57.1% (95% confidence interval (CI), 49.0%-64.9%) of children with special health care needs (CSHCN) and 52.1% (95% CI, 47.6%-56.5%) of children without special health care needs (Non-CSHCN) were reported to have access to a medical home.

CSHCN aged 6-11 years (57.7%) and 12-17 years (57.2%) were more likely to have a medical home than CSHCN aged 0-5 years (55.3%). CSHCN living in a household with two parents (currently married) were significantly more likely to have a medical home than those with a single parent (mother or father: currently married (living apart), formerly married or never married), 66.1% compared to 37.3%, respectively. Medical home access also varied by socioeconomic status. Receipt of care in a medical home also increased with household income: 57.5% of CSHCN living in households with incomes less than 200 % of poverty had a medical home compared to 60.9% of CSHCN living in households with incomes of 400 % or more of poverty.

Non-CSHCN aged 0-5 years (56.6%) were more likely to have a medical home than Non-CSHCN aged 6-11 years (52.9%) and 12-17 years (45.9%). Hispanic Non-CSHCN (39.4%) were significantly less likely to have a medical home than non-Hispanic White Non-CSHCN (57.3%). Non-CSHCN living in a household with English as the primary language were more likely to have a medical home than Non-CSHCN living in a household with a primary language other than English (54.4% versus 35.2%, respectively). Non-CSHCN living in a household with two parents (currently married) were significantly more likely to have a medical home than those with a single parent (mother or father: currently married (living apart), formerly married or never married), 58.2% compared to 34.4%, respectively). Medical home access also varied by socioeconomic status. Receipt of care in a medical home also increased with household income: 40.6% of Non-CSHCN living in households with incomes less than 200 % of poverty had a medical home compared to 66.9% of Non-CSHCN living in households with incomes of 400 % or more of poverty. The difference was significant.

*\*Data Note: Subgroup analyses should be interpreted with caution due to small numbers in some subgroups.*

To assist in increasing children with special health care needs ability to access a medical home, the KS-SHCN program continued to partner with a developmental pediatrician to provide technical assistance and support to others physicians



across the state who participated in the 2019 Project ECHO titled “Beyond the Developmental Screen” that was held in FY 19. He was available for assistance, upon request, to provide support via telemedicine.

**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:

*As a care coordinator for the SHCN program, I work with a single father of two teenage daughters with special needs. The mother had passed away a few years earlier, and the father has medical issues of his own he struggles with. The father reached out to me to discuss his inability to pay for school enrollment for his two daughters. He had talked with the school district about assistance, to no avail. He also tried to research other assistance options but could not find any available. I reached out to a county resource to discuss if they could help in any way. They could not, however they were able to provide me with a contact within the school system they felt that could. A conference call was arranged with this contact and the father, with the end result being the school system covered full tuition for both girls, along with other necessities needed for the new school year. This was a huge relief to the father, and he has expressed many times how grateful he was for the assistance and support I gave him.*

**Christina, KS-SHCN Care Coordinator  
Nemaha County Satellite Office**

System Navigation Training For Families: The Systems Navigation Training for Families (SNTF), formally the Family Care Coordination Training, is designed to assist parents/caregivers in increasing their knowledge of medical homes, shared plans 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. SNTF Trainers have lived experience as a parent of a CSHCN. The trainings begin with the trainer sharing their personal story to help families feel comfortable – they will share their hopes, dreams, and daily struggles of being a parent of a CSHCN. Participant response to the program has been favorable. Participants complete a pre/post-test and one-year evaluation, providing information that can be used to improve the training experience. Adolescent clients are encouraged to attend these training to assist them in preparing for their transition to adulthood. The SNTF is offered at no cost to any family in Kansas who has a loved one with any type of special health care need. This training was renamed by the FAC this past year, in hopes of increasing interest and understanding of what this training is designed to accomplish, so more families participate.

Understanding the importance of these trainings, a focus was placed on developing a “train-the trainer” model. A KS-SHCN staff member, who has a CSHCN, and a Family Advisory Council member received this training. Numerous training meetings were held to review the structure, tools and materials used for these trainings. The KS-SHCN staff person began learning the internal process to setting up and conducting these trainings, while the FAC member learned various supporting tasks to strengthen the training experience for families. Both trainers participated in their first in-person SNTF in January of 2020. Additional trainings were to be held later in the year, but due to the pandemic were unable to be held. In lieu of holding the trainings, the work to translate the training in Spanish continued. All materials, presentation and activities are being developed for Spanish speaking families. Training on this will continue with the final training requirement completed by the current trainees and the acceptance of applications for those who would like to become trainers, after the pandemic.

***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.

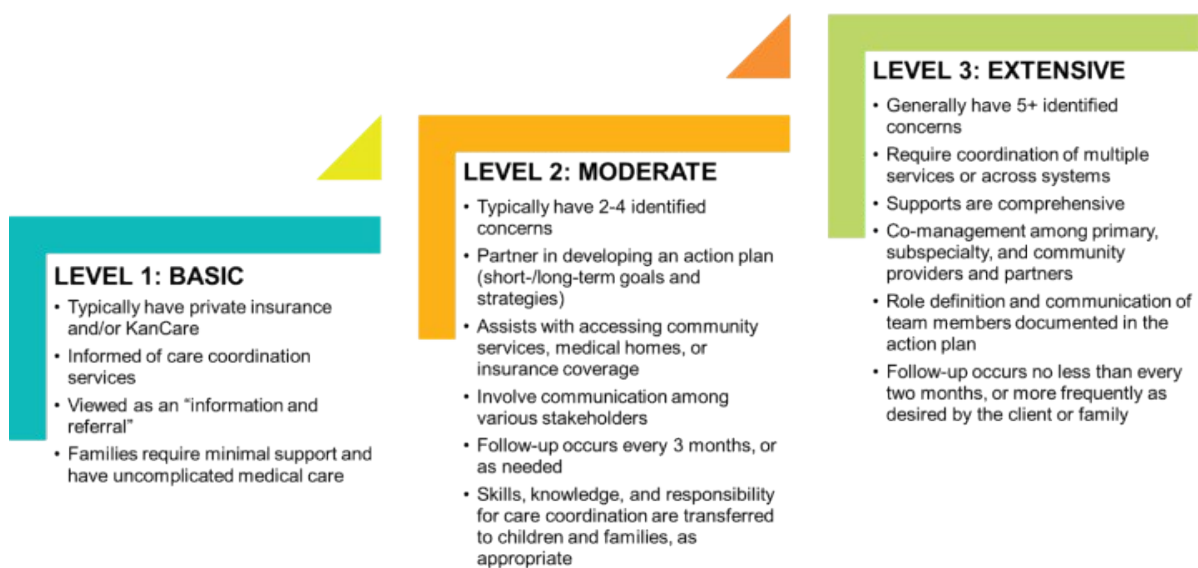
Clients and families have individual needs and require services and supports tailored to meet those needs. Care Coordinators work with families to identify needs and wants and develop an action plan when applicable to help them achieve positive goals while providing the desired level of support. Care 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 providers 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, though this will change in SFY21 to age 12 and older. 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/families have the option of opting out or back in at any time. The informational flyer for the approach is below. Individuals/families who choose to opt out of care coordination services are considered a Level 0 and fall under the parameters of a Level 1 client.

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 SFY20, 108 clients received care coordination services (a decrease from 110 in SFY19). Even though there was a slight decrease in the number of clients receiving care coordination services, indicators still support the HCC model is successful. Of the 108 clients served, 74% were at level 1 (lowest level of coordination needed). The remaining were at a Level 2 or 3, of which 85% showed improvements and moved from a more intensive level of HCC to a less intensive level. Less than 1% of clients moved to a higher need level.

Approximately 50% of SHCN clients opt out of HCC services. Upon review and discussion with families, program staff feels this is due to family's minimal needs, length on program so extra support is not needed, or they have been successful with HCC and no longer need the additional support. Any clients who opted out of care coordination services are considered level 0 clients and receive services comparable to a level 1 client per SHCN protocols and procedures.

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 SFY2020, 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.

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 144 families during the SFY2020 contract to connect them with resources and assure children are connected to a primary medical, dental and, if needed, behavioral health home. Care Coordinators assisted families in

navigating access to services and resources based on eligibility. A total of 150 office visits, 204 telephone encounters, 14 school visits, and 9 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.

The Cerebral Palsy/Medically Complex (CP/MC) Clinic in Wichita provides care coordination services, per the KS-SHCN model. Collaboration occurs frequently, leading to better service outcomes for those clients who attend clinic. In this 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. The program authorizes services and provides ongoing technical assistance support to the CP/MC clinic staff, as needed. The clinic Care Coordinator participates in Satellite Office trainings.

*Bridges Care Coordination Pilot:* Infant-Toddler Services (ITS) and KS-SHCN identified a service gap for children and their families who are moving out of ITS and into 619 Part B or community services. This can be a very difficult and stressful time for both the child and family, with many finding it difficult to navigate the various systems of care (e.g., medical, educational, social, legal, financial).

All children involved with the ITS program will have been identified as children with some type of disability or developmental delay in order to have qualified to receive ITS. Many will transition into 619 Part B services within their local school district, which are child focused services and look very different from IT tiny-k services which are family focused. Other children will not meet the criteria for Part B services and will be looking for services within their communities.

In an attempt to fill this gap, the IT and KS-SHCN programs have partnered to pilot a modified version of the SHCN holistic care coordination program. Families exiting IT tiny-k services whether moving into Part B services or not will be offered the opportunity to participate. This is strictly voluntary, and families can opt out at any time. This will be piloted in six selected communities that have an established SHCN Satellite office and a local IT tiny-k program who would like to participate. One pilot group will be for Spanish speaking families.

Participating sites have been determined, a training format developed that will be done virtually, due to the pandemic, care coordination tools and letters modified, and promotional materials developed. Data will be captured and monitored so changes can be made if necessary, to refine the program to provide the maximum benefit to the children and their families. This pilot is expected to serve a minimum of 60 families. Bridges is part of the All in For Kansas Kids work and funded through the Preschool Development Grant.

**Bridges Mission:** In collaboration with the IT tiny-k program the KS-SHCN program will provide holistic care coordination to transitioning children and their families to assist them in navigating the complex systems of care for a smooth and stress-free transition experience.

*COVID Health Care Fund:* Not only did the KS-SHCN staff in the Topeka office provide care coordination services to SHCN clients, but they also stepped up and took on additional duties to help provide care coordination/case management supports for essential workers who contracted COVID. Many in Kansas have been impacted by COVID and the KS-SHCN staff was asked to develop a program to provide assistance to those who were diagnosed with COVID. Since the program was perfectly aligned for this type of work the team was able to put together all aspects of the program in a couple of weeks. All program components were based off of the KS-SHCN Holistic Care Coordination model and provided services to over 700 individuals across the state. Kansans had the opportunity to receive financial help with COVID-related medical bills and

treatments, lost wages, and a stipend to cover additional over-the-counter COVID supplies.

**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 children 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 was to complete the System Navigation Training for Families (SNTF) train the trainer course in 2020 and begin assisting with the facilitation of these trainings with families by the fall of 2020. However, she was unable to complete her training due to the pandemic, but will complete this training and begin co-facilitating these training in 2021. This individual will also be part of the new Bridges program.

**Pediatrics Supporting Parents (PSP) Phase 2:** In June 2020, KDHE began working with partners within the United Methodist Health Ministry Funds (UMHMF) to engage in discussions around researching existing care coordination models, alignment with Medicaid service coordination, and focusing on improving young children's social and emotional development in pediatric primary care by strengthening care coordination practices delivered by Kansas' Medicaid managed care organizations (MCOs). More of this narrative is outlined in the Child Health Domain Report.

***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.

Due to the COVID crisis, work to strengthen these partnerships has been delayed, however these are still a primary focus, along with establishing partnerships with FQHCs and pediatric offices throughout the state.

**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 was aligned to add this diagnosis to the list of conditions covered by the program for services and supports upon the "go-live" date in the fall of 2020. A new subcommittee focusing on Pompe Disease and Hurler Syndrome was also established, with the intent to add these two conditions to the NBS core panel in early January 2021. Under the direction of a new NBS Program Manager, the KS-SHCN program has now become a continuous participant in new sub-committees as they are formed.

**Supporting You:** The KS-SHCN program continued to participate in the Supporting You Network as a participating program. Historically, SHCN Care Coordinators have promoted peer support groups to the families they work with as the valuable resource they are. Promotion of Supporting You is imbedded not only in our client work, but also in SHCN program

presentations. When clients are referred to Supporting You, their Care Coordinator will follow-up to ensure a supporting peer match has been made. Since the KS-SHCN program works with many parents who have become experts in navigating the various systems of care, SHCN staff work to recruit these individuals as supporting peers for the network. 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.

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Local MCH Reach: Based on SFY2022 MCH Aid-to-Local applications received:

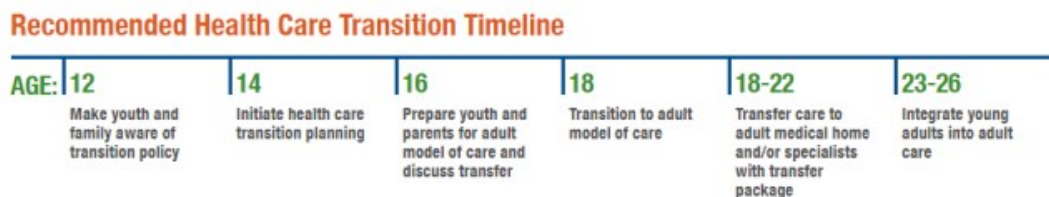
- 8 of 67 grantees (12%) plan to provide services to the Children with Special Health Care Needs (CSHCN) population
  - 7 agencies plan to serve as a KS-SHCN Satellite Office
- 

**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 by 5% by 2025.**

The partnerships and supports developed through the KS-SHCN Holistic Care Coordination (HCC) model provide a strong foundation and infrastructure to maintain the focus of assuring CSHCN have access to medical homes. Program evaluation and the needs assessment process identified the need for an increased focus around transitions for the CSHCN population in the future. Transition to adulthood for youth with SHCN is one of the many components of a comprehensive and coordinated medical home. The focus on transitions will integrate and align well with the existing HCC model, supporting and strengthening the overall system of care.

Throughout the Title V Needs Assessment and implementation of the HCC model, transition planning for youth and adolescents ages 12 and older has been an identified service gap. Youth with special health care needs (YSHCN) and their families generally do not receive guidance on transition planning from their health care providers or other support systems. During this reporting year, Title V will work to gather Kansas high school (juniors/seniors) and college student voices and stories about their experiences transitioning from pediatric to adult care. These stories will be the basis for a white paper focused on recommendations to better assist families with the transition process. Additionally, health professionals continue to note the importance of health care transition (HCT), but many struggle to incorporate transition planning into their practices. Providers state that they lack the capacity and resources to effectively plan for transition with their adolescent patients, despite an interest in doing so.

The KS-SHCN program policy requires the development of at least one transition goal for any client with an action plan 12 to 21 years. To help ensure a successful transition for all clients on the KS-SHCN program, age and developmentally appropriate transition materials and tools will be disseminated to families, regardless of their participation in care coordination services or client's level of care. The program will adopt the GotTransition recommended HCT timeline (below).



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 with YSHCN and family to develop goals that meet

their needs and help them grow and become proficient in self-care and advocacy when possible.

**Health Care Transition (HCT) Planning:** To develop a comprehensive transition plan, providers must engage 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. Some of the identified challenges include:

- 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) or lack experience in providing care to YSCHN or their specific medical needs.
- YSCHN may struggle to find flexibility in employment schedules and/or concerns about missing school.
- YSHCN transition planning takes additional time and resources for busy provider practices, where reimbursement for transition is not widely available.
- Pediatric and adult providers may need several consultation visits to support the YSHCN and their family.

KS-SHCN will be recommending evidence-based models, such as the Six Core Elements of Health Care Transition 2.0 through [GotTransition.org](http://GotTransition.org) (depicted to the right). These elements provide practical guidelines and recommendations to providers when developing their own transition planning protocols or curriculum. In addition, American Academy of Pediatrics (AAP)/Bright Futures has recently collaborated on new evidence-based resources to help healthcare providers implement transition practices and policies. This resource will be included in transition provider training and patient education efforts.

KS-SHCN will conduct a review of existing transition materials and tools, such as [The Future Is Now, Think Big](#) resources, utilized by Care Coordinators to streamline transition practices across Satellite Offices (SOs). KS-SHCN Care Coordinators and staff will be available to offer technical support to providers of mutual clients, assisting them to problem solve challenges and barriers to creating transition plans for their YSHCN patients. Lunch & Learn presentations, short webinar presentations that allow busy providers to partake in educational opportunities over their lunchtime, are a great way of providing guidance they can access and revisit as needed. These presentations will provide valuable information on all ages and stages of transition, with a special focus on transitioning into adulthood.

Title V staff will create and implement strategies to incorporate transition information to YSHCN educational tools using the WHY (Whole Healthy You) campaign that was created and designed by Kansas youth. The team will reach out to Washburn University's Student Health Services and Diversity & Inclusion department to begin conversations regarding an interest in piloting monthly WHY conversations (using the Zoom platform with small group discussions) so youth and young adults can have conversations on topics related to transitioning from pediatric to adult health care. Additional topics might include insurance coverage, how to make doctor appointments, preparing for an appointment, medications/therapies prescribed, what to look for in a “good fit” patient-doctor relationship, confidentiality/consent laws, youth-friendly environments and practices (both positive and negative experiences).

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. Telemedicine can also be utilized by a client's care provider to easily consult with others, such as medical specialists and therapists, who are part of the care team. Additionally, the COVID pandemic



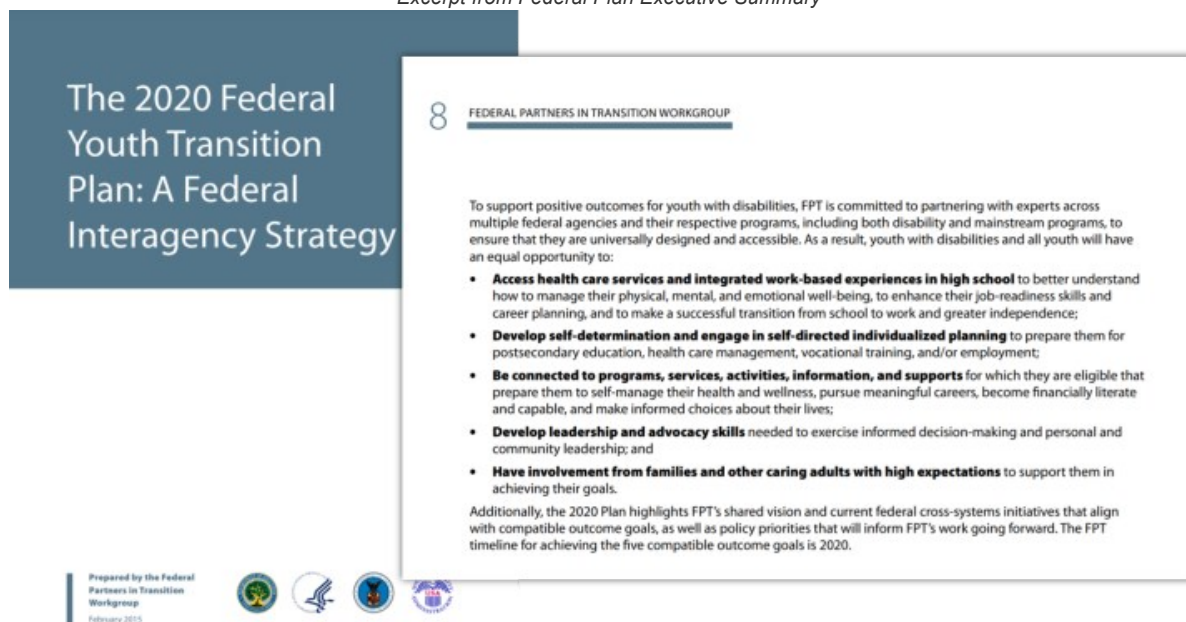


spotlighted the need for effective telemedicine options, especially for those who are medically fragile or live in rural areas of Kansas. KS-SHCN will pursue technology advancements within the program, considering integrated telemedicine possibilities within the KS-SHCN electronic records system, Welligent.

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. Recognizing effective transition planning must look holistically at the youth's needs (e.g., family needs, education, social, housing, employment), KS-SHCN will work with YSHCN and their families to discuss the importance of transition and 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*



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. For clients with special health care needs, there may be multiple specialists on the care team, making consistent and frequent communication between all providers a critical part of the care team's service delivery. The HCC provided through KS-SHCN can support these communication efforts by utilizing strategies and tools identified through [GotTransition.org](#). KS-SHCN and the HCC project staff will continue to review evidence-based transition tools and resources to be shared with providers, health agencies, families and especially adolescents.

The more a youth can assess where they are in the transition journey and have resources to help guide them as they move through this process, the higher their success rate. Program staff feel the addition of a transition portfolio would be a

valuable tool to help guide youth and their families to transition readiness and success. The portfolio would include a transition checklist, a list of members on the care team with contact information, medications, the patient's challenges and strengths, and their dreams and hopes for their future. The portfolio will also have a resource section that lists SSI or disability contact information, legal resources, career options and training, support groups, housing, and other items of need for the youth. A question/concern form will be included that can be completed prior to medical appointments to share with providers and facilitate open dialog during visits. Training webinars will be developed for care coordinators, providers and families, that focus on all stages of transition and will be tailored to all levels of abilities, with the focus to support all youth in becoming their best adult self and to reach their maximum potential.

**Local MCH Agencies:** Local agencies will provide guidance to children with special health care needs and their families/support people in navigating through transition from adolescence into adulthood. A few examples include:

- *Barton County:* Plans to offer transition services – assisting youth in finding an adult doctor, insurance, or affordable housing and assisting with managing medical appointments and needs. Youth will be provided assistance in applying for WIC services, family planning, SHCN, and TPTCM, (among others).
- *Community Health Center of Southeast Kansas:* As the primary provider of medical, dental and behavioral health services to the SHCN population, they plan to expand services to those transitioning from any aspect of their care and/or personal living situation. Assist families to access resources, so they will continue to prioritize the needs of those families/children in transition and make whatever resources needed are available at no additional out-of-pocket cost to the families.
- *Miami County:* To assist with a smooth transition into adult services, staff will provide screenings and services to CSHCN to ensure that they are enrolled in the services they need to transition easily into adult living.

**Objective: Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2025.**

**Holistic Care Coordination:** The KS-SHCN program will continue to provide HCC services as described in the CSHCN Report. These services continue to evolve based on input from clients and families and other members of their care team. The COVID-19 pandemic emphasized the continued need for flexibility and out-of-the-box strategizing to maintain a high level of care. 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 Care Coordination Pilot:** As outlined in the CSHCN Report, KS-SHCN will implement the Bridges Program to provide HCC to transitioning children exiting early intervention services (Part C of IDEA) and their families to assist them in navigating the complex systems of care for a smooth and stress-free transition experience. Any child served through Infant Toddler Services (ITS) exiting services will be eligible to receive care coordination through the KS-SHCN program until 8 years of age, regardless of movement to school-based early childhood special education program (Part B/619) or community services. These services are voluntary, and families can opt out at any time, however we are optimistic as ITS providers and families have indicated this is something that has been needed for a long time and they are happy to see a program to assist with the transition process. This was also identified as a need within the recent needs assessment conducted by the Kansas Council on Developmental Disabilities.

At this time, the program has identified five pilot communities, comprised of KS-SHCN Satellite Offices and the local ITS program partners. Bridges care coordination tools (e.g. application, initial assessment, follow-up contact, letters, action plan) and the Bridges Care Coordinator Manual have been developed and implemented. Updates and changes were made to the KS-SHCN data system to accommodate the needs of the Bridges program. A Bridges brochure was developed and disseminated to partners. Training for the Bridges Care Coordinators (BCC) occurred in March/April 2021 that included the following curriculum:

- Infant-Toddler tiny-k presentation
- Families Together, Inc. (PTI) presentation

- Bridges Overview
- LifeCourse
- Step Ahead Workshop
- FAPE and Evaluation section of the Law
- IEP Components & IEP Development
- The Infant-Toddler Partnership Structure
- Understanding the Impact of Toxic Stress and the Hope of resilience Building
- Strategies for Dealing with Challenging Behaviors
- Bridges: The Step-by-Step Process (included role playing)
- Developmental Screening (ASQ)

The pilot started in April 2021 and support will be provided by KS-SHCN through scheduled TA calls to chart progress and monitor changes that may need to occur. PDSA cycles will be implemented as needed. Monthly surveys will be developed to gather data and program change recommendations. A data tracking sheet will be developed to monitor progress and show improvement to be able to support future funding streams. Program leadership (including KS-SHCN and ITS) 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. Through careful monitoring, data collection, use of quality improvements measures, and listening to the families it is hoped that within the next year, the program can be refined and will be integrated as a service offering from KS-SHCN, rather than a pilot project.

*CSHCN Systems Alignment and Integration:* Title V CSHCN Leadership, including the Title V CSHCN Director, Community Partnerships 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. During SFY21 KS-SHCN and the Newborn Screening programs (blood, hearing, and heart screening) collaborated to restructure a referral process to increase referrals between the programs and streamline services and supports for families. Data will be reviewed regularly to identify gaps and barriers and adjustments made as needed for improvement

The CSHCN population is widely recognized as 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 approach, there are additional risk factors such as adverse childhood experiences, food insufficiency, unsafe housing, foster care and lack of access to behavioral health services. Additionally, as Kansas is a state with large rural areas, the lack of medical specialists (or, in some cases, any medical provider) necessitates families travel hundreds of miles, several times throughout the year, for the services and supports their child requires. As a result, working parents miss work, often without pay, which further impacts the financial struggles they already face. Some families do not have a reliable mode of transportation, which impacts their ability to get their child to scheduled appointments. Care coordinators will continue to determine transportation assistance and other risk factors and assist families in locating resources and supports in their area that are needed. Care Coordinators will also collaborate with MCO case managers to assist covered families in obtaining travel assistance supports through their provider, ensuring requests are completed and submitted in the required timeframe prior to an appointment, as well as partnering with the MCO to assist with other identified family needs.

According to the National Survey for Children's Health (NSCH) 2018-2019 combined data indicate that CSHCN experience two or more ACEs at a much greater rate (38.3%), as compared to non-CSHCN (15.2%). Additionally, only 42.4% of families of CSHCN reported no ACEs, as compared to 65.8% of non-CSHCN families. Families of CSHCN experience food insufficiency/insecurity at higher rates than non-CSHCN families with nearly half (46.5%) of CSHCN families reporting they

had trouble eating good, nutritious meals in some way. Access to mental health treatment or counseling is also more challenging for the CSHCN population, age 3-17 years old, with 8.5% reporting that the child had not seen a mental health specialist but needed to compared with 1.1% of non-CSHCN population – eight times as many as the non-CSHCN population.

Furthermore, some CSHCN populations experience challenges with interpersonal communication that can make it more difficult to effectively express feelings of sadness and depression to their families and providers. The KS-SHCN program will continue to work with families and provide educational supports for non-verbal children and youth, including potential technology solutions that can help bridge these communication barriers.

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 will continue to work on building stronger partnerships with foster agencies to support their understanding of the program's services and supports. Additionally, efforts are being made to develop shared protocols and 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.

The Medically Complex Clinic in Wichita, a grantee of the KS-SHCN program that provides HCC to mutual clients, has reported an upsurge of children and youth who are in the foster care system attending their clinic. Per an agreement with the state, foster families will be offered a program application and provided assistance to complete the application. This process will not only increase clients from the foster care system enrolling in the program but will also increase requests for program presentations from foster care and family preservations entities.

*Family Systems Navigation Trainings:* 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 plans to offer quarterly trainings across the state once families of CSHCN are comfortable returning to in-person events, as this intensive in-person training does not lend itself to a virtual model. KS-SHCN will work with community partners, grantees, and SO staff to plan and implement these trainings at different locations across that state.

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## Other CSHCN Health Objectives

***Objective: Increase the proportion of families 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](#). The Bureau realignment described in the Workforce Development and Capacity section has created new capacity for the Title V CSHCN Director and Community Partnerships Unit Director to engage in higher system 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 FFY22, the focus will be on identifying gaps in the plan, specifically those noted 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.

Educating families on the definition of a “well-functioning system” will be key to accurate reporting from families on the services and supports they receive. The KS-SHCN program will work to educate families on what they can and should expect from their care team and monitor their responses to questions such as “Do you feel your provider actively listens to your child?”, “Are you given the time to ask questions and express concerns?” and “Are you and your child an active participant in the care planning?” Questions like these are an integral part of initial and update assessments conducted with our care coordination families. Additionally, staff will continue to conduct post-appointment follow-up to help ensure family’s needs, questions and concerns are being met by their provider.

There is a distinct need for Kansas to establish a local, state-level set of data to inform about the CSHCN population and support the work of KDHE in building strong, well-functioning systems of care. This past year, an intern through the [Leadership Education in Neurodevelopmental and Related Disabilities](#) (LEND) assisted in a systems of care project that was designed as the first steps to:

- Creating a shared dataset (list of measures, metrics, or information shared across public and private health systems to determine if systems of care are “well-functioning”);
- Telling the story of what systems look like for the CSHCN population – in Kansas;
- Establishing a model of partnership to support cross-system data sharing practices to enhance systems of care; and
- Providing a pathway for patient-level data sharing among public and private health systems to improve access to continuous, comprehensive, and coordinated care.

The National Survey for Children’s Health (NSCH) utilizes over 50 questions within the survey, related to family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition. Data indicate that only 20.8% of families of CSHCN receive care in a well-functioning system. An internal Title V team was formed to begin looking at the questions from this survey and considering the possibility of establishing a Kansas-specific “Systems of Care” Survey. After connecting with MCHB, we learned that Illinois had conducted a similar survey in their state for their most recent needs assessment. They shared the data dictionary and survey tools and we established a Task Order with the University of Kansas to create this survey in REDCap, a HIPAA-compliant tool to collect survey responses. The team is still working through design and dissemination of this survey to pause for a discussion with the MCH Epidemiologists regarding oversampling of the National Survey for Children’s Health to capture state specific CSHCN data. However, there is still a desire to launch a convenience-sampling survey to learn more from Kansas CSHCN families.

***KS-SHCN and Medicaid Partnership:*** The general partnership between KS-SHCN and Medicaid is outlined in the Title V and Medicaid Partnership narrative. However, 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.

Division of Health Care Finance (DHCF) and KS-SHCN staff have begun discussions around improving support services for clients with cleft lip/cleft palate. Lack of in-network orthodontic providers is the largest barrier in putting timely orthodontic services in place. Through discussion with multiple orthodontic providers, low reimbursement rates, extremely slow



payment turn around and burdensome application processes are deterrents to becoming a Medicaid provider. Prior to COVID, Medicaid partners stated that they would do a fiscal review to determine if the current reimbursement rate is enough to cover the services provided by dental and orthodontic providers. Due to Medicaid staff turnover and COVID-19 this did not occur; KS-SHCN will pursue this again in the coming year. KS-SHCN also hope to begin 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, especially as the managed care contracts will be up for procurement in 2023.

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*



**OneCare Kansas Helps You:**

- Develop a plan to guide you and your doctors and other providers
- Make sure you get the right services at the right time
- Learn about your conditions and how you can help yourself be healthier
- When you are discharged from a hospital or care facility
- Reach your health goals with the help of your family or other helpers and caregivers
- Make sure you get other services and supports you need to stay in your home

**OneCare Kansas**  
a program of KanCare, Kansas Medicaid

**For more information, please contact your KanCare health plan or visit**  
[www.kancare.ks.gov](http://www.kancare.ks.gov)

**aetna**  
855-221-5656  
711 (TTY)


**sunflower health plan.**  
877-644-4623  
711 (TTY)

**UnitedHealthcare**  
877-642-9238  
711 (TTY)

**KanCare**  
a program of KanCare, Kansas Medicaid

**OneCare Kansas**  
a program of KanCare, Kansas Medicaid






**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.

**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



**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

**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.

**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.

**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)



**OneCare Kansas**  
a program of KanCare, Kansas Medicaid

**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; limited approval for necessary medical supplies; 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 consumers to determine priorities for the CSHCN population and actions to be taken. Though care coordination staff continue to identify gaps in both public and private insurance, there has not been a dedicated method that pulls the information together. A tracking sheet will be created to input data, such as type of insurance, identified gap, and whether the gap is a non-covered service or a covered service that has insufficient dollar amounts or quantity limitations.

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## Other KS-SHCN Program Activities

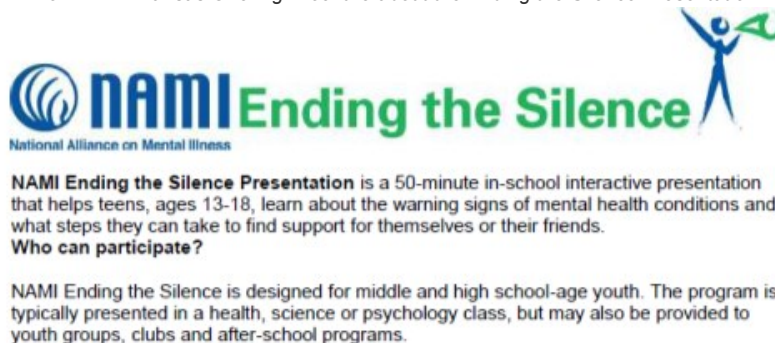
The KS-SHCN program will continue to: provide HCC services to those with medically eligible conditions; financial assistance through the Direct Assistance Programs (DAPs) and Special Bequest, meeting eligibility requirements; program strategic planning; staff workforce development; data system enhancements; quality improvement activities; peer supports; and family and consumer engagement efforts. DAPs are reviewed annually for necessary revisions – no changes were identified in SFY21, however the team recognizes the COVID-19 pandemic may have impacted the review, as there was a clear reduction in requests for services. The team plans to closely monitor the need and will determine if changes are needed mid-year. An additional diagnosis was added to the medical eligibility list (under the craniofacial anomalies umbrella) as the treatment for plagiocephaly has been a long-identified service gap, with treatment not routinely covered by either

public or private insurance. Treatment can be expensive, and if left untreated can lead to serious complications including head deformities and possible severe and permanent pressure inside the head.

**Peer Supports for CSHCN:** KS-SHCN will continue to engage as a Supporting You Network Program within Supporting You. The program will continue to promote these services to families who may benefit from additional peer support. The KS-SHCN program continues to identify parents who have become experts in navigating the various systems of care for recruitment as a Support Peer. The KS-SHCN Program Manager will work with the Peer Support Administrator to determine other recruitment strategies and conduct ongoing monitoring of support matches. 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*



**Care Coordinator Training and Workforce Development:** The annual SO training for SFY22 will be a series of webinars/zoom meetings, rather than a two-day in-person meeting. One topic of interest is Kansas Waivers. The program will reach out to Medicaid to request a training webinar on Waiver services offered in Kansas. 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. All SO staff will also have the opportunity to participate in future Bridges training over the next year.

**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 will continue to offer 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. The number of SOs will be decreased by one, Saline County, in SFY22, which will require, what is hoped to be a temporary, shift to the regional boundaries. Two SO's (Ellis and Neosho) agreed to add additional counties to their region, with the Topeka office absorbing the remaining counties, to ensure the continuation of care and promotional efforts for that region. In the upcoming year, efforts will be made to identify a new satellite office partner for this region. The newest satellite office, located in Neosho County began providing services July 1, 2020 and quickly became a much-valued partner of the KS-SHCN program team. Their true dedication to serving those in their community has not only led them to becoming part of our team, but has also led to an exploration of additional MCH initiatives and trainings to incorporate these services into their health department. Upon assessment of the population served, including geographical location and language(s) spoken, Neosho county is providing an additional bi-lingual staff to serve the roughly 20% Spanish-speaking clientele, improving service delivery and reducing burden for state bilingual Care Coordinators.

- *Enhanced Data Capacity.* KS-SHCN will work with the data vendor to enhance 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
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Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	75.0	80.0	85.0	90.0	95.0

**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	2020
Annual Objective		
Annual Indicator	55.9	55.9
Numerator	389,023	387,759
Denominator	695,564	694,108
Data Source	NSCH	NSCH
Data Source Year	2017-2018	2018-2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	58.7	51.6	64.7	67.9	71.3	74.9

## 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	2020
Annual Objective		44.7	7	6.8	6.6
Annual Indicator	47	7.2	7.9	7.9	7.9
Numerator	987,775				
Denominator	2,101,649				
Data Source	Kaiser Family Foundation	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2008	2016	2018	2018	2018
Provisional or Final ?	Provisional	Final	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	2020
Annual Objective			1,000	1,500
Annual Indicator			1,126	2,009
Numerator				
Denominator				
Data Source			State sponsored workforce development events	State sponsored workforce development events
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional



## Cross-Cutting/Systems Building - Annual Report

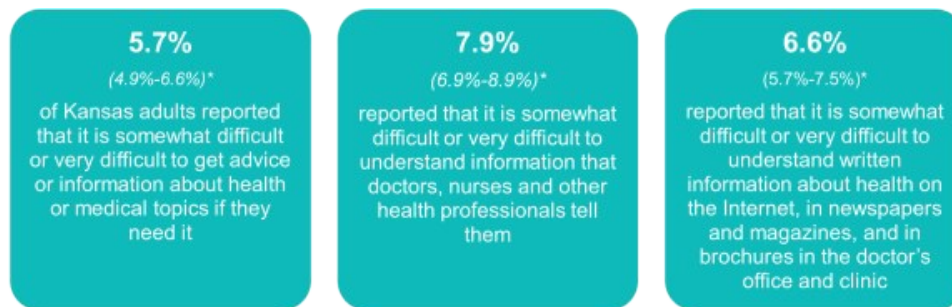
**PRIORITY:** Information is available to support informed health decisions and choices

**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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Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate decisions regarding their health.<sup>[1]</sup>

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?” and 3) **Understand written information:** “You can find written information about health on the Internet, in newspapers and magazines, and in brochures in the doctor’s office and clinic. In general, how difficult is it for you to understand written health information?”



\*The estimate is followed by the 95% confidence interval (CI) in parentheses.

<sup>1</sup> Institute of Medicine, Health Literacy: A Prescription to End Confusion. Editors, Lynn Nielsen-Bohlman, et al., Committee on Health Literacy, Board on Neuroscience and Behavioral Health. <https://www.nap.edu/catalog/10883/health-literacy-a-prescription-to-end-confusion>

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

**Local MCH Agencies:** 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.

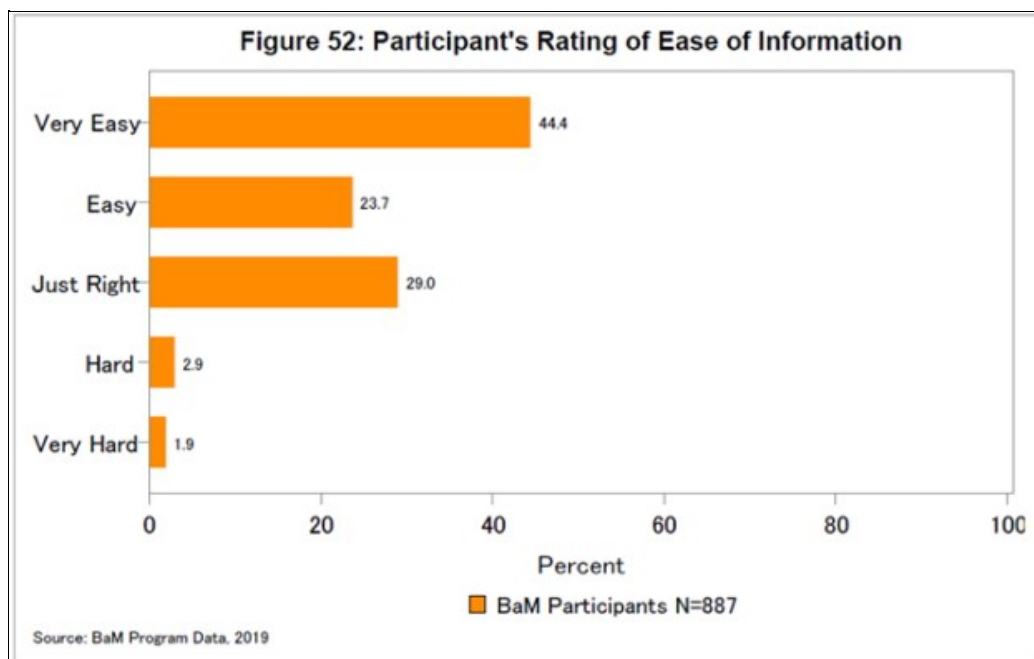
Additionally, staff acknowledge that health literacy is a primary factor behind health disparities. Local MCH agencies routinely assess written materials for widespread use regardless of reading/health literacy level and attempt to simplify information and illustrations, encourage a client’s questions, 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.

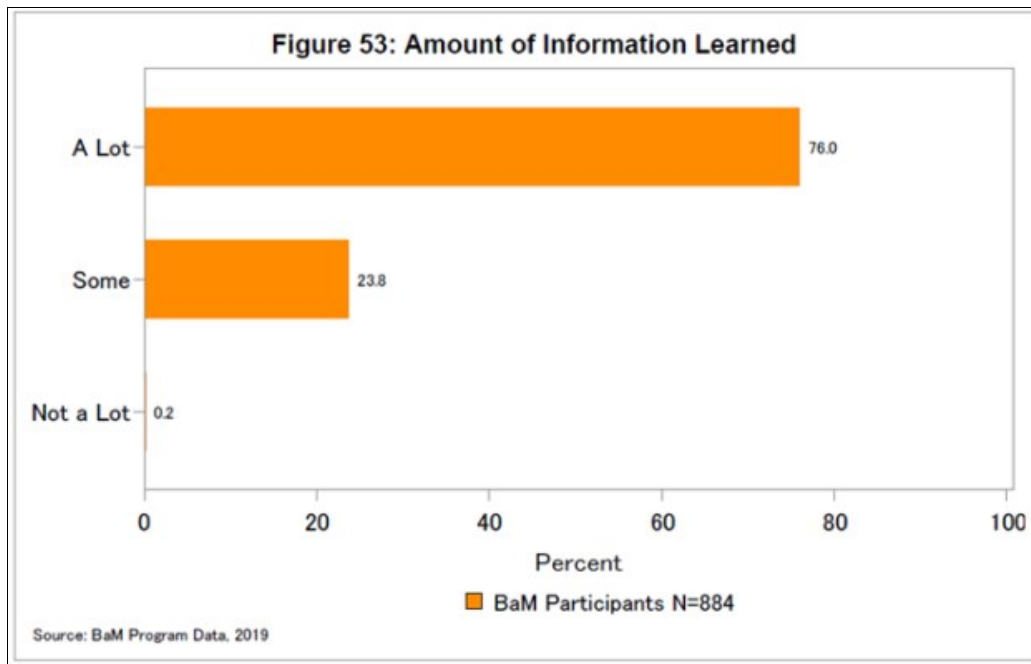
Throughout the pandemic Title V staff have developed resources related to COVID-19 which are available for download via the Kansas COVID-19 Resource Center, <https://www.coronavirus.kdheks.gov/>. These resources are available in both English and Spanish and are updated regularly based on guidance from the Centers for Disease Control, American College of Obstetricians and Gynecologists, etc. and are aimed at helping consumers and providers navigate their healthcare, including pregnancy, during these difficult times.

**KS-SHCN Holistic Care Coordination:** The KS-SHCN Holistic Care Coordination (HCC) program assists clients and families in making informed 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 client's and family's literacy abilities and modify their assistance, so needs are properly being addressed.

**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. Because 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 2019 evaluation results, demonstrate success with this. While the population served is largely undereducated (about 31.7% reported having a college degree, 47.1% 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 was committed to continuing support for the Kansas Youth Empowerment Academy (KYE) [Faces of Change](#) program. This seven (7) month program is focused on youth leadership development through civic engagement for both youth with and without disabilities. The 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. Examples of the topics discussed during the 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. Since the program's inception in 2016, 34 youth have graduated from the four cohorts.

The program traditionally concludes in November each year, and recruitment was just finishing up when the COVID-19 pandemic hit and the kick-off meeting, slated for March 2020 was canceled. KYE did not feel they could maintain the integrity of the program and leadership curriculum in a virtual environment at that time. The work did not stop, however. KDHE and KYE worked closely to enhance the curriculum and develop a marketing plan so KYE could promote the program/curriculum outside of Kansas.

**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 (typical on-site visits were postponed due to COVID-19). These will resume when state travel is allowable and the local MCH agencies are able to fully engage and their COVID-19 response needs stabilize.

**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 FY20 (see table below).

Date	Title/Topic	Attendees
10/26/2020	BaM Quarterly Webinar - Impacts of COVID on BAM	23
7/10/2020	New KDHE Forms in DAISEY	1
6/23/2020	DAISEY Learning Collaborative Webinars	10
6/17/2020	Empowering Youth and Suicide Prevention - State Agency Meeting	9
5/20/2020	State Agencies Collaborating to Empower Youth and Prevent Suicide	9
4/28/2020	Meeting with Kearny County Hospital Discussing MCH Grant	6
4/27/2020	BaM Quarterly Webinar - Overcoming COVID Obstacles	17
2/28/2020	LARC Lunch and Learn - Clinical Indications	20
2/27/2020	Expansion Strategies - Wyandotte and Sedgwick	2
2/21/2020	HACC MCH Technical Assistance	3
2/4/2020	MCH TA Webinar	113
1/30/2020	SFY2021 MCH Application Webinar	50
1/22/2020	SFY2021 MCH Application Webinar	55
12/19/2019	SFY2020 MCH Progress Report Webinar	27
12/10/2019	SFY2020 MCH Progress Report Webinar	35
11/26/2019	LARC Lunch and Learn - Billing and Coding Session	20

***MCH Local Agency Support During the COVID-19 Pandemic:*** Food insecurity was identified as an emerging trend in the summer of 2020. To address this issue, Title V staff partnered with local food access organizations to provide information and potential programming ideas to MCH staff to address these needs. Recommendations focused on integrated service solutions including fresh produce giveaways during vaccine and testing clinics. Below are excerpts from some of the promotional materials.




## HELP COMBAT FOOD INSECURITY IN YOUR COMMUNITY

More than 1 in 10 adults in Kansas reported not having enough to eat in the past seven days.



### Action Step: Harvesters and Local Agency Pop-up Produce Distributions

Harvesters will work with local agencies to provide fresh produce to distribute to patients and the public.

### Why pop-up produce distribution?

These types of food access events are considered a 'nudge'. Feeding America® defines a "nudge" as: a subtle environment change in a food distribution setting, designed to make a healthy choice the easy choice.

### Those who are food insecure:

-  **Are at increased risk for chronic diseases** like diabetes and high blood pressure.
-  **Face increased stress**, impacting ability to care for self.
-  **Increased risk of low performance** at work and at school.

In addition, resources were created to support MCH and local health department staff as they faced stressful and traumatic work and life environments, including the development of the flyer, [Maintaining Positive Mental Health](#) (portion of the flyer below).

## Maintaining Positive Mental Health During COVID-19



### Take care of yourself!

Find stress-reducing activities that help keep your body, mind, and spirit well. Take deep breaths, stretch or meditate, eat well-balanced meals, get plenty of sleep, and avoid alcohol and drugs. Pace yourself between stressful activities by doing a stress-reducing or fun activity! A few activity ideas are: watch a funny movie; video chat with a friend; explore local parks, recreational areas, or walk or bike trails.



### Understand the risks of COVID-19.

There is an overwhelming amount of information available in the news and on social media. To stay informed, use reliable sources of information, such as the [KDHE COVID-19 Resource Center](#) or the [Centers for Disease Control and Prevention \(CDC\)](#). Understanding and sharing accurate information about COVID-19 help reduce stress associated with the outbreak.



### Take breaks from hearing or reading information about COVID-19.

Try establishing specific times to check for updates – it is important to balance your time spent focusing on updates and on other activities.



### Stay connected with others!

Talk with friends, family, neighbors, and co-workers about how you are feeling. Maintain healthy relationships and build a strong support system. You are not in this alone!



### It is okay to ask for help!

Everyone reacts differently to stressful situations. If your stress impacts your daily activities for several days in a row or if you would like to talk with a professional about how you are feeling and need help finding a provider, visit [SAMHSA's Treatment Services Locator](#). Additional support services are listed below.

Multiple opportunities for engagement of local grantees in conversation around the stressors they were facing and their needs for technical assistance and resources were provided through KDHE BFH hosted COVID Listening Sessions. Through these sessions, the need for electronically fillable data collection and screening forms were identified and responded to. Data collection forms were created as fillable PDFs that can be sent to program participants electronically for their completion while receiving virtual services. Screening forms, such as the EPDS, were also created, as well as guidance documents and TA webinars were provided to assist locals with implementation of this sensitive screening in a virtual setting. [Guidance documents](#) were also created for the provision of MCH and Becoming a Mom® services throughout the pandemic, as well as FAQs for the Pregnant, Postpartum and Infant Populations. All guidance is updated regularly to keep up with the quickly changing literature and guidance from leading organizations such as CDC and ACOG. Additionally, TA and case management services were provided to local MCH service providers and perinatal persons infected with COVID-19 by KDHE BFH staff, offering services to those counties with highest caseloads and lowest resources based on rural/frontier location, identified through data tracking and trending.

**Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.**

#### Family Empowerment 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 for themselves and their families health and well-being by employing a strengths-based approach to home visiting, which helps families focus on their strengths and build goals around those strengths.
- **TPTCM and PMI:** Case 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. An example of this at work is seen in the following story.
  - Catholic Charities of Northeast Kansas enrolled a refugee woman in the PMI program. A client we will name



Clara was diagnosed with gestational diabetes, while this is a fairly common diagnosis during pregnancy, it is always scary, and it is even harder to navigate when you cannot speak English, do not possess a working knowledge of diabetes, and have never been taught how to advocate for yourself in a health care environment. During a monthly visit with the case manager, the client shared this diagnosis, revealing her feelings of confusion and powerlessness regarding it. Together, along with an interpreter, they called the client's doctor and connected with a nurse practitioner who thoroughly explained the diagnosis. The interpreter translated so that the client had a full understanding of the medical condition and her treatment protocol. After the phone call with the nurse, Clara felt much more confident in her abilities to confidently navigate the rest of her pregnancy with gestational diabetes. Having the supports emotional, practical, and linguistical to get her questions answered was just the beginning of Clara's journey. One of the tasks associated with a diagnosis of gestational diabetes is to test your glucose level using a special machine available only at specific pharmacies. Because Clara has Medicaid, the case manager needed to locate a pharmacy that a) had the machine in stock, b) would accept Medicaid, and c) was accessible by public transportation. After several phone calls and some research, Clara and her case manager located a pharmacy that met all their criteria. Now, Clara feels much more positive about this diagnosis and confident in her ability to advocate for herself and her growing family. Because of the PMI program, this client had the support she needed to get her questions answered and make the best choices she can for her baby.

- *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. An example of this includes a young, single mother and her special needs child that the program worked with. In speaking with the mother, it became apparent that she had become overwhelmed with all those that were working with her daughter and was hesitant to bring in another party. She did agree to try the care coordination services. The regional care coordinator worked with the mother to set up times to talk that would fit in her work schedule, or to take place before or after. After the first few contacts with this mother, the care coordinator had already began building a relationship of trust and mutual respect. Within the first year of care coordination services, the barriers to attending appointments had been resolved. This mother became a wonderful promoter of the KS-SHCN Program with other parents she met in service provider's waiting rooms. In her second year of care coordination she began a Facebook group for other parents with special needs 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. Providers in both the clinical and inpatient settings, in KPCC communities, have indicated that there is a clear difference between patients that have participated in the Becoming a Mom Prenatal Education classes and those who have not. Participants (as reported by their providers) are more engaged in their healthcare – by asking thoughtful, informed questions and following up on content discussed in the class setting.
- *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. A great example of this work in action is a Kansas Mom who saved her baby with CTK, Sarah Yelly, participated with the Title V Director in a media interview about the impact of CTK. Sarah encouraged other moms to speak up when they notice changes in their baby's movements.

*Alumni & Mentorship Program (AMP) Activities:* Described in the Family Partnership narrative, AMP provides opportunity for family leaders to engage beyond their formal Council membership roles, either through extended engagement with Title V or as a mentor for others. There are currently ten Family Advisory Council (FAC) Alumni members. The AMP members did not meet formally during the reporting period, however two members did participate in FAC meetings. All of these members remain connected to Title V in some fashion and are kept informed of Title V and BFH initiatives with opportunity to engage at

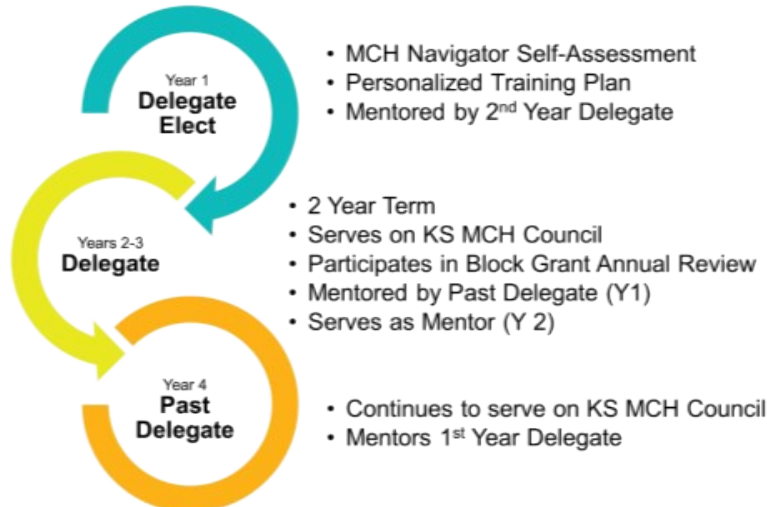


any time. Two of the Alumni members are now serving as family representatives on the Kansas Council for Developmental Disabilities and are partnering to support alignment and bring more focus to early intervention, health, and systems navigation for families of children with medical complexities and intellectual/developmental disabilities.

**Title V Family Delegate Program:** During the July 2020 FAC meeting, Council members were engaged in some planning/discussion about the Family Delegate Program and began to formalize a structure for this program. Under discussion included: the application process, eligibility or qualifications of the family delegate, training and leadership development needs, and annual expectations of the Delegate. From this discussion, a new program was formed and a progressive succession and transition plan for incoming and outgoing Delegates was established, shifting from a single-family leader involved at any given time, to three (e.g., Past-Delegate, Delegate, Delegate-Elect).

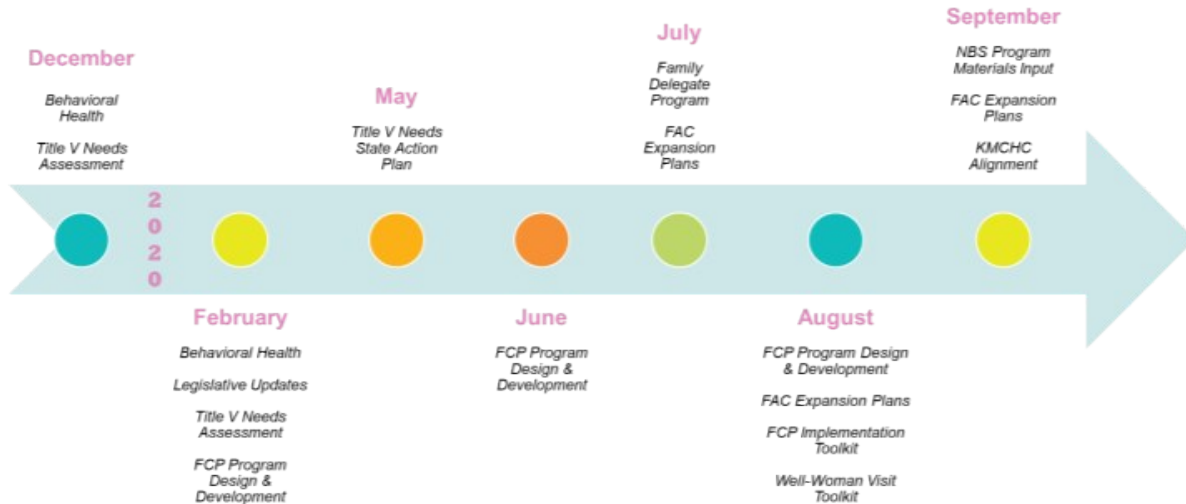
The Family Delegate now serves a four-year term which allows for progressive and more intensive training and mentorship opportunities. This also supports continuity among the family leader representing Title V. Formal supports continue to be available to family leaders engaged in this program, including stipends for meetings, travel supports and assistance, trainings, and professional coaching models. The Delegate program is open to any or all family leaders, regardless of Title V affiliation at the time of application, however it is a competitive application process with recruitment occurring every two years (next recruitment period will be in 2022).

- **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):** The FAC structure, purpose, and intent is outlined in detail in the Family Partnership narrative. 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. When in-person meetings were cancelled due to the COVID-19 pandemic, the group voted to meet virtually monthly, beginning in May 2020. During the reporting period, the FAC met seven times with a focus on the following topical discussions:

## October 2019 through September 2020 FAC Meetings



*Meeting overviews are outlined in the Supporting Documents attached to this narrative.*

**Supporting You:** Since peer-to-peer support is identified as one of the strongest measures of individual/family support, the Title V goal is to assure that every individual/family 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. In a collaborative partnership, BFH programs (KS-SHCN and the Early Hearing Detection and Intervention) worked together with the FAC to develop a family support network called [Supporting You: A Peer to Peer Support Network](#). The Network began recruiting Support Peers in October 2018 and officially launched with the ability to connect peers in January 2020. 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.

There are currently two “Network Programs,” KS-SHCN and the KS School for the Deaf. Since Network Programs serve targeted populations, Title V contracts with one FAC member to serve as a Peer Support Administrator (PSA) to catch anyone that might sign up that wouldn’t be filtered to one of the existing Network Programs. The Network was developed with the opportunity for expansion and inclusion of other community or state programs, with the intent and desire to expand beyond the CSHCN population. 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. Read more about this in the Cross-Cutting Plan narrative.

Connected peers are matched to support peers (parents, caregivers, individuals, or siblings) who have similar experiences or needs. A web-based questionnaire supports matching peers about their experiences and desired supports. The system can match on any criteria asked on the questionnaire. Since the program began, extensive work has been done to develop the data system, trainings, promotion, protocols, policies and onboarding criteria, providing a framework and recognizing the supports needed for broader utilization across MCH populations, such as the creating of peer-support programs for pregnant women, adolescents, foster children/parents, etc.

In September 2020 the part-time staff serving as the Network Administrator was reallocated to a full-time position as the Family and Consumer Partnership Coordinator, responsible for the Supporting You and FAC expanded efforts. This Coordinator will 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. Ultimately, there will be three key responsibilities: Network 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. These materials can be found in the Supporting Documents as part of this application. A promotional [video](https://www.supportingyoukansas.org) was developed and can be found online at [www.supportingyoukansas.org](https://www.supportingyoukansas.org).

**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 and cultures. A number of activities were completed by MCH in partnership with OKH during FY20 in an effort to improve awareness of the importance of good oral health to overall health and wellbeing. The following chart outlines professional development opportunities OHK provided during this reporting period.

Date	Collaborators	Activity	Topics Discussed
October 8, 2019	WIC partners	1-hour webinar	<ul style="list-style-type: none"> <li>*Impact of pregnancy on oral health</li> <li>*Importance and safety of oral health services during pregnancy</li> <li>*How to prevent oral disease</li> <li>*Answer FAQs.</li> </ul>
October 12, 2019	Child Care Providers (Geary Co.)	2-hour workshop	<ul style="list-style-type: none"> <li>*Why good oral health is important to a child's overall health and development</li> <li>*What parents can do to prevent oral disease</li> <li>*How childcare providers can integrate good oral health practices into the childcare setting.</li> </ul>
October 31, 2019 <i>Partnership with Children's Dental Health Project and Cover Kansas</i>	Marketplace Navigators and Certified Application Counselors	Recorded webinar and FAQ document	<ul style="list-style-type: none"> <li>*How dental coverage is offered on the Marketplace</li> <li>*Whether families are required to buy dental coverage, what services are covered, how dental coverage differs between Qualified Health Plans and stand-alone dental plans</li> <li>*Availability of subsidies to purchase dental coverage.</li> </ul>
Recorded webinar available at: <a href="http://www.oralhealthkansas.org/ChoosingDentalCoverage.html">http://www.oralhealthkansas.org/ChoosingDentalCoverage.html</a>			
November 21, 2019	All WIC programs (68 people registered)	1-hour webinar	<ul style="list-style-type: none"> <li>*Impact of poor oral health on a child's overall health, development, and ability to learn</li> <li>*Causes of dental decay</li> <li>*Current evidence-based strategies for preventing decay in young children</li> <li>*3 sources for dental care and free oral health educational materials</li> </ul>
February 27, 2020	Early Childhood professionals	Breakout session; Kansas Division of Early Childhood Conference	<ul style="list-style-type: none"> <li>*Increase confidence in talking with families of young children about the importance of good oral health</li> <li>*List the current evidence-based strategies for preventing decay in young children</li> <li>*Learn how to integrate toothbrushing into the daily routine in community-based care.</li> </ul>

OHK and their partners (Children's Dental Health Project and Cover Kansas) discovered that many dental providers across the state, including safety net clinics, were not showing up on the Marketplace website. This became a priority for the group – to ensure more dental health providers are found during database searches, increasing access to services.

OHK created three new oral health resources based on the evaluation comments and requests specifically from WIC

personnel and home visitors. Both groups asked for simple one-page documents to assist them with providing best practices and recommendations on dental care when visiting with families during WIC appointments or home visits. Information about these resources can be found in the child domain section of this report.

- **Child Care Workshops:** A two-hour workshop for child care providers included oral health education and information on how to integrate strong oral health practices into the child care setting. A second workshop (90 minutes) 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 Educational Resources:** 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. <https://khap.kdhe.state.ks.us/c-f/oralhealthresources.html>

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**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) and that was especially important during the COVID-19 pandemic. With direct support from Title V, LPHP staff led 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.

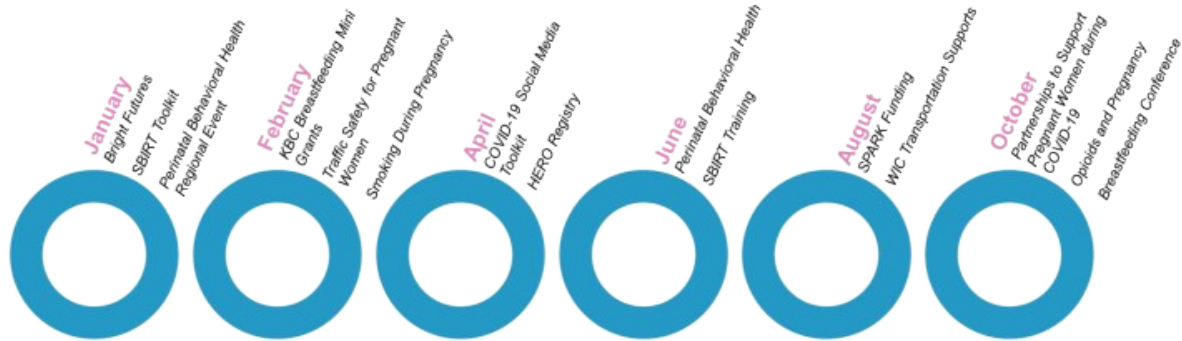
Population Health Webinars	Regional Meetings
<ul style="list-style-type: none"><li>• Targeted for local health department staff and other public health system partners</li><li>• Focused on disease updates and outbreak information, training opportunities, and other timely information</li><li>• Monthly from September 30, 2019 through February 28, 2020</li><li>• Redirected to daily COVID-19 updates on March 1, 2020 through May 31, 2020, then three times a week (Monday, Wednesday, Friday) after June 1<sup>st</sup></li></ul>	<ul style="list-style-type: none"><li>• Targeted for local public health agency administrators</li><li>• Purpose of furthering statewide collaboration on public health topics and providing workforce development to the public health system</li><li>• Each regional meeting included an update on state MCH activities and opportunity for KDHE MCH staff to deliver relevant content</li><li>• 17 Meetings held<ul style="list-style-type: none"><li>• In-Person (between September 30, 2019 and March 1, 2020)</li><li>• Virtual (after March 1, 2020) and were consolidated from 6 to 3 regions</li></ul></li></ul>

**Public Health Connections (PHC):** LPHP develops and distributes the monthly newsletter, [Public Health Connections](#), sent to approximately 1,000 professionals, including staff of KDHE as well as LHDs, FQHCs, public health partner organizations, and other community organizations. PHC provides public health professionals, including the MCH workforce, with information on upcoming training and funding opportunities, recent public health research, and updates on changes in the state system. It often features information that allows the MCH workforce to increase their knowledge and skills to better address the needs of their communities. This newsletter was monthly until March 2020, when it shifted and became bi-monthly to address the COVID-19 pandemic.



## 2020 Public Health Connections Newsletter

MCH-Related Content



Note: This is not an exhaustive list of inclusions that benefit MCH-serving programs/partners. Only those directly tied to Title V and the Bureau of Family Health.

**Objective: Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.**

**Perinatal Behavioral Health:** BFH was awarded the HRSA *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program* Cooperative Agreement funding in October 2018. The 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 managed by the Behavioral Health Consultant. Through this alignment, several KCC workforce capacity opportunities were made available to local MCH agencies:

- **Every Mom Thrives! Regional Training:** In March 2020, KCC held the second of this 6-hour training, focused on building skills to implement mental health and substance use screening, referral, and treatment support into participants' organizations. The training was facilitated by Melissa Hoffman, DNP, APRN, PMHNP-BC, and Christina Boyd, LCSW, LCAC.
- **Project Extension for Community Healthcare Outcomes (ECHO) Series:** In April 2020, KCC held its second ECHO in partnership with KU Medical Center. The series included four, 1-hour sessions on various topics related to perinatal behavioral health. A total of 160 providers registered to participate with an average of 90 providers attending each session.
- **Screening, Brief Intervention, and Referral to Treatment (SBIRT) Online Learning Collaborative:** In June 2020, an online learning series provided interactive learning instruction over six weeks and included content related to utilization and implementation of SBIRT services and opportunities for questions, interaction, and networking with others in the state. Session topics included: strategies to reduce stigma related to substance use; introduced the components of SBIRT and creative ways to leverage technology in the administration of these services; and provided strategies for implementing SBIRT with patients. While the SBIRT process evidence base for effectively identifying risk and intervention is with substance use, the BFH promotes use of the process to any behavior risk, including perinatal mood and anxiety disorders. 30 providers participated in this online learning collaborative.
- **Maternal Mental Health 101:** This 1-hour introductory training was targeted to Department for Children and Families (DCF) Economic and Employment Services staff. The training focused on maternal mental health and its wide-reaching impacts on individuals, families, and communities. Facilitated by Melissa Hoffman – a provider and someone with lived experience – emphasized the importance of using non-stigmatizing language, being non-judgmental, and conveying empathy when working with someone experiencing a mental health condition. Total participants included 60 DCF staff and contractors/community partners. Following the training, KCC received the following feedback from a participant:

*"The afternoon following the training, I was working with a pregnant client who was struggling with mental health symptoms. I was able to quickly identify signs and felt comfortable talking to the client about my observations. The client opened up to me sharing some details about how she had been feeling. I provided the client with resources and connected her to local support services."*

**Maternal Mental Health 101 Participant**

- **Perinatal Provider Mental Health Learning Collaborative:** Participants from local MCH programs, completed [PSI's Frontline Provider Training](#) at no cost in September 2020. This training is designed to equip frontline healthcare providers with skills necessary to assess patients for perinatal mental health complications and, as appropriate, provide treatment with medication(s) or connect individuals with additional resources and care. After completing the webinar, providers could then participate in three, 1-hour session learning collaboratives focused on applying information learned and translating it into practice. All sessions included a case study and discussion allowing participants to receive on-the-spot consultation for challenges they are currently facing.

The first edition of the KCC E-Newsletter, the *Perinatal Press*, was released in April 2020. The newsletter includes information about KCC activities (e.g., Project ECHO sessions, Consultation Line, telehealth services, SBIRT Learning Collaborative) and perinatal behavioral health resources, like the integration toolkits. The newsletter is released on a quarterly basis and shared with MCH partners. Each newsletter edition includes a "spotlight." In one edition, KCC featured Crawford County Health Department (CCHD), a local MCH program. CCHD shared information on their maternal depression screening implementation process and offered advice to other MCH ATL agencies trying to implement perinatal mood and anxiety disorder screenings into their programs.

## SPOTLIGHT

Crawford County Health Department (CCHD) has been an enrollee in the KCC project since December of 2019 and provides perinatal screenings (using the Edinburgh Postnatal Depression Scale) at:

- Prenatal classes (Becoming a Mom)
- Teen pregnancy program
- Healthy Start home visits
- WIC (newly implemented)
- Family Planning (newly implemented)

To support this robust screening initiative, CCHD has written their procedure into policy and developed an MOU with their local mental health center (using the policy template available in KDHE's [Mental Health Integration Toolkit](#)). Check out Lisa's advice and referral success story below!



**"A postpartum mother transferred her WIC care into our clinic [and was] screened with the EPDS...When discussing her positive score...referrals were provided for counseling and she was given a next day appointment and resources for medical providers in our area."**

- Lisa Goins, a nurse at CCHD

**Lisa's advice for perinatal screening**

**Warm handoffs** Staff can call mental health center and then hand over phone to client to complete appointment.

**MOUs** Agreement to fast track pregnant/postpartum moms for counseling appointments.

**Patient choice** Ask clients who they prefer to see.

**Timing** Make every effort to make referral appointment while client is in office.

**Challenges** Plan ahead for solutions to a client refusing treatment/medication, transportation barriers, perinatal clients who are also minors, etc.

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*How to put Lisa's advice into action? Visit KDHE's Perinatal Integration Toolkits ([Mental Health](#) and [SBIRT](#)) to find guidance on integrating screenings into clinic practice, including tips for providing a warm handoff, sample MOUs, workflow algorithms, and more!*

**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, a Collaborative launched in July 2020. The opportunity provided five local MCH programs to partner with the BFH to receive targeted technical assistance, 1:1 interaction, and networking across programs on a quarterly basis to gain ideas and guidance. The goal is for MCH programs to implement perinatal behavioral health screenings, brief interventions, and referrals to treatment into their practice that meets the benchmark standards recently established. These "standards" can be used as a guide by local programs to strengthen their perinatal behavioral health practices. Once a participant completes both benchmarks, they will be recognized as an *MCH Leader in Perinatal Behavioral Health*.



Addressing perinatal behavioral health and improving health outcomes is much broader in scope than screening alone. 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. Examples of these components are included below.

**MCH Benchmark Leader in Perinatal Mental Health:** Implement perinatal mood and anxiety disorders (PMADs) screenings, brief interventions, and referrals to treatment into clinical practice that includes both level one and level two components.

**MCH Benchmark Leader in Perinatal Substance Use:** Implement perinatal substance use screenings, brief interventions, and referrals to treatment into clinical practice that includes both level one and level two components.

**Level 1 Components:**

- Create, inform staff, and adhere to a universal PMAD screening policy for pregnant and postpartum women. The policy should include a response protocol for positive screens and crisis intervention. Individual(s) with lived experience of PMADs should be engaged in this process.
- Adopt the Edinburgh Postnatal Depression Scale (EPDS) as the validated PMAD screening tool used in practice.
- Determine screening frequency.
- Conduct validated PMAD screening during the established timed patient encounters. Provide brief interventions and referrals to treatment, when indicated. Screenings, brief interventions, and referrals to treatment should meet compliance with the adopted policy.
- 100% of all screens and action plans are entered into DAISEY.
- Utilization of the Perinatal Provider Behavioral Health Consultation Line, as needed.
- Establish at least one organization-level educational initiative (e.g., class, brochures/handouts, posters, etc.) aimed at increasing awareness, decreasing bias, and providing information to perinatal women and their families about PMADs.

**Level 2 Components:**

- Establish a Memorandum of Agreement/Understanding (MOA/MOU) with a local substance use treatment provider for substance use assessments and/or with a substance use treatment provider who will conduct assessments using telehealth.
- Follow the established IRIS Community Standards for making referrals and “closing the loop” communication practices. For non-IRIS communities, make referrals for treatment, when indicated, and follow up to ensure patient was able to access treatment services.
- Participate in a training focused on brief intervention skills-building.
- Establish local standards for recognition and response to measure compliance, understand individual performance, and track outcomes. Use DAISEY reports to guide quality improvement projects.
- Establish and/or promote a community perinatal support group. The group should be registered on <http://SupportGroupsInKansas.org>.
- Establish at least one community-level educational initiative (e.g., social media campaign, multi-media advertisements, etc.) aimed at increasing awareness, decreasing bias, and providing information to perinatal women and their families about perinatal substance use.
- Establish a local system of care for perinatal women and their families, which should include (where available), but is not limited to, MCH programs, an obstetrician/gynecologist, a pediatrician/family physician, a substance use treatment provider, and a person with lived experience of perinatal substance use. Members of the local system of care should establish community standards that include building and maintaining a non-judgmental culture of safety and care.

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 fathers experience PPD, and

prevalence can increase up to 50% when the mother is also experiencing perinatal depression. It is important for providers to understand the signs, symptoms, and onset differences between paternal and maternal depression to increase identification and early interventions. For example, women experience stress, crying, sleep problems, and loss of interest or pleasure in things they usually enjoy at significantly greater rates than men. Alternatively, men experience anger attacks/aggression, substance abuse, and risk-taking behavior due to depressive symptoms at significantly higher rates than woman. Preliminary research suggests 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 six-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.

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). Components of the package will be used to further 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. In addition, 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 was reviewed by [Geared Up Dads](#), a fatherhood initiative in Geary County. Using feedback received from Geared Up Dads, the infographic was modified into a tri-fold brochure (excerpts below).



Plans are in development for integration of a PPD component into the KPCC BaM curriculum and group support environment during sessions 6 and session 7, which is slated for a phased implementation period of July 2021-July 2022.

**Other Perinatal Behavioral Health Activities:** 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 virtual screening via a smartphone or tablet may help make reliable, validated screening tools available to the clients, overcoming some of the barriers and empowering individuals and families to engage in the process of identifying and understanding their own needs. In partnership with grant partners, KCC supported a perinatal behavioral health screening app feasibility study in 2020. KCC was seeking a better understanding of provider perspectives on current screening practices, and screenings in general, using a human-centered design approach, then developed recommendations for a technical solution to overcome barriers to screening (below).



*Improving effective screening processes comes with both technical and adaptive challenges. The Screening App Feasibility Study work highlighted a variety of considerations related to the development and implementation of an effective technical solution:*

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Providers need to understand why they are screening, the impact of regular screening in a variety of areas and be able to translate the purpose and importance of screening to clients.

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Reported barriers to screening include lack of training with screening tools, lack of training responding to positive screens, referral gaps, and lack of reimbursement. These barriers will not be addressed by an electronic tool.

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Screening workflows differ between social service agencies and medical settings. While the patterns look similar in practice, each setting has vastly different constraints. Screening processes in medical settings are highly driven by electronic health system workflows.

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Completing screenings on paper has a number of challenges including low completion rates when mailed to a client, physical maintenance of individual documents, required data entry for tracking, delayed identification of trends, and lack of clarity about when screenings are required.

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When screening electronically, particularly outside of a clinic setting, clear protocols must be in place to address concerning positive screens.

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Not all screening tools are validated for self-completion.

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When using an electronic tool outside of a visit, clients will have questions about where the information is being sent and who can see the results.

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Integration of an electronic screening tool, outside of a clinic or office setting, will require a different workflow for providers than when screenings are administered in-house. Launch of any electronic screening tool should be accompanied by implementation and workflow guidance.

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Electronic screening tools rely solely on the client's ability to understand the questions without anyone to answer questions or provide clarification. This process impacts the rapport building that might otherwise happen as a provider engages with a client around risk-related questions.

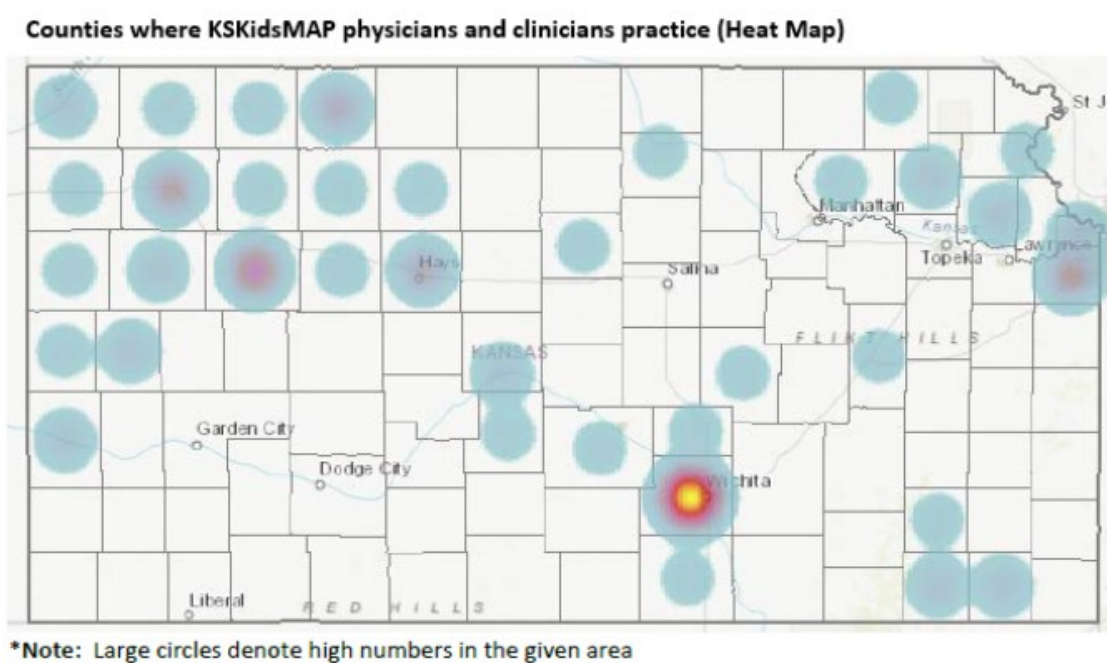
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Due to the complexity of developing this tool, BFH determined the best investment would be to expand beyond perinatal behavioral health screening tools. BFH is currently developing a pre-screening questionnaire that will include general health, social determinants of health, behavioral health, physical or sexual abuse, substance use, and reproductive health questions based on validated pre-screening tools for each category (e.g., adult female clients would respond to the PHQ-4 pre-screening questions; if pre-screen is positive, guidance would indicate a full screen using the PHQ-9 is warranted). BFH is researching and exploring screening technology options utilizing secure SMS services.

*Pediatric Mental Health:* 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 primary care providers (PCPs) filling the gap. KDHE BFH was awarded HRSA's *Pediatric Mental Health Care Access Program* Cooperative Agreement funding in July 2019. The program provides the opportunity to promote behavioral health integration into pediatric primary care by supporting mental health care telehealth access programs. The project, KSKidsMAP to Mental Wellness (KSKidsMAP), has led to the establishment of a pediatric practitioner consultation line, training, technical assistance, and care coordination for PCPs to diagnose, treat, and refer children with behavioral health conditions. KSKidsMAP collaborated with practitioners who attended the REACH trainings for a soft launch of consultation line services in December 2019. KSKidsMAP consultation line services fully launched statewide in January 2020.

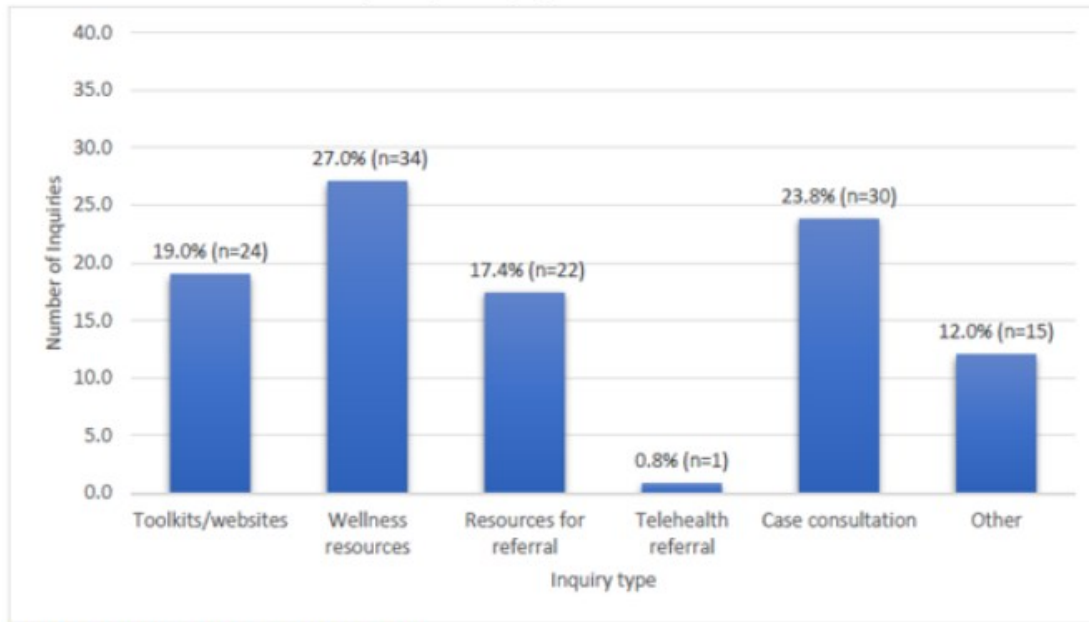
The Consultation Line is staffed weekdays from 8 am-5 pm by a Social Work Care Coordinator. The Coordinator assists PCPs by providing mental health and community resources, toolkits, best practice guidelines, referral information, and physician wellness recommendations. The Coordinator is also responsible 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 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. A map of where providers who consulted with KSKidsMAP follows.



KSKidsMAP had a very successful first year (July 2019-June 2020); multimodality outreach efforts (e.g., email/mail, in-person meetings and presentations, media releases, videoconference meetings) resulted in the enrollment of 72 physicians/clinicians who serve children and adolescents in 38 counties. Enrolled practitioners utilized the consultation line 104 times, resulting in 126 inquiries from the soft-launch in December 2019 through June 2020.

**KSKidsMAP Consultation Line Inquiries, as of 6/30/2020**



\*Note: Telehealth referral is not yet active.

KSKidsMAP launched a TeleECHO Clinic in April 2020 following the Project ECHO model. This 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. The KSKidsMAP pediatric mental health care 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. As this is an ongoing virtual learning opportunity, practitioners commit to participating for six months, which has contributed to highly interactive clinic sessions and connection between practitioners in different areas of the state. An average of 12 practitioners attend each TeleECHO Clinic session.

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:

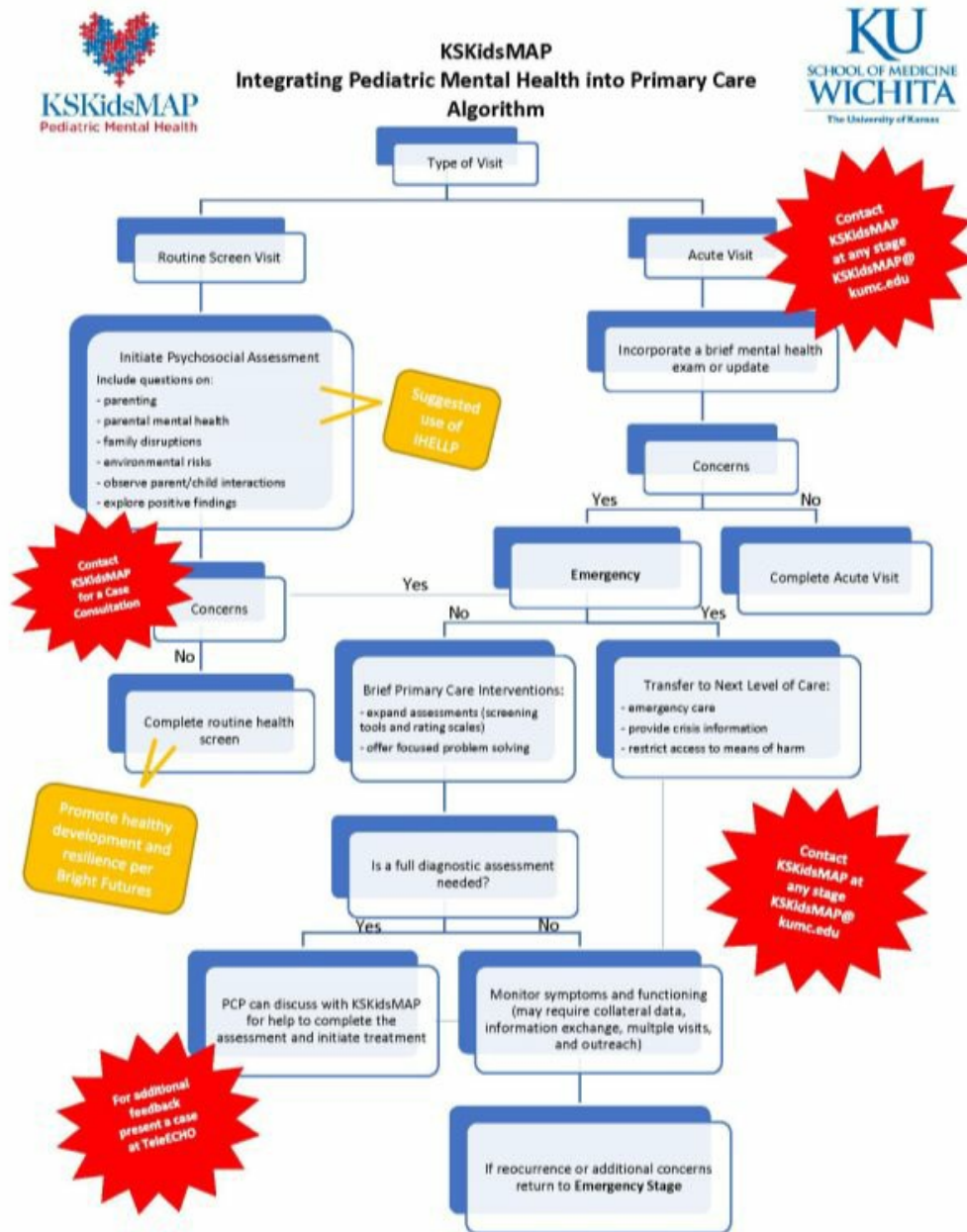
- First line pharmacotherapy
- Dosage adjustment and medication changes
- Self-harm, suicidality and referrals
- Trauma
- Sleep hygiene
- Aggression



KSKidsMAP adapted the American Academy of Pediatrics' (AAP) [algorithm for integrating mental health care into pediatric primary care practice](#) to a Kansas-specific resource. Included on the simplified algorithm are decision points in which the



KSKidsMAP Consultation Line could be accessed to support the PCP in the identification and/or treatment of children/adolescents with behavioral health concerns during a well-child/adolescent visit or other primary care appointments. The algorithm (below) and support materials serve as a reminder of the recommended components of a well-child/adolescent visit, increase the identification of those exhibiting signs and/or symptoms, strengthen the quality of the visit, and enhance treatment mechanisms of children and adolescents with behavioral health concerns.



**Behavioral Health During the COVID-19 Pandemic:** In response to the COVID-19 pandemic and in partnership with the Division of Emergency Management and Department for Aging and Disability Services, a *Kansas: Stronger Together* resource guide was developed.

- [Resource Guide](#) (print)
- [Media Toolkit](#) (print)

Through the partnership, Kansas was successful in its application for crisis counseling assistance and training program

funding, receiving both the Immediate Services Program and the Regular Services Program awards to increase access and availability of crisis services. In addition, resources were created for the state's COVID-19 Resource Center to help Kansans, including health care workers, cope with the stress resulting from the pandemic.



## TAKING CARE OF YOURSELF DURING COVID-19

# Resources for Healthcare Workers

	<a href="#"><u>American Foundation for Suicide Prevention "Mental Health &amp; COVID 19"</u></a>		<a href="#"><u>CDC National Institute for Occupational Safety and Health Emergency Preparedness Resources</u></a>		<a href="#"><u>National Child Trauma Stress Network (NCTSN) Taking Care of Yourself Checklist</u></a>
	<a href="#"><u>American Psychiatric Nurses Association (APNA) "Managing Stress and Self-Care During COVID-19: Information for Nurses"</u></a>		<a href="#"><u>Mental Health America "Mental Health and COVID-19: Information and Resources"</u></a>		<a href="#"><u>Professional Quality of Life "Helper Pocket Card"</u></a>
	<a href="#"><u>Centers for Disease Control and Prevention (CDC) Coronavirus 2019 "Stress and Coping"</u></a>		<a href="#"><u>National Alliance on Mental Illness (NAMI)</u></a>		<a href="#"><u>Substance Abuse and Mental Health Services Administration</u></a>
	<a href="#"><u>Centers for Disease Control and Prevention (CDC) "Emergency Responders: Tips for Taking Care of Yourself"</u></a>		<a href="#"><u>National Center for PTSD "Managing Healthcare Worker's Stress Associated with the COVID-19 Outbreak"</u></a>		<a href="#"><u>University of Colorado "Healthcare Worker Well-Being During COVID-19"</u></a>





For more information, visit [kdheks.gov/coronavirus](https://kdheks.gov/coronavirus)

## 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:** 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 a centralized telehealth network with an expert pediatric mental health care team that supports primary care physicians (PCPs) and clinicians in treating behavioral health conditions within their clinical practice.

The KSKidsMAP team facilitates TeleECHO Clinic sessions (virtual, twice monthly) and offers mentorship to support knowledge in practice for case consultation and didactic learning on childhood/adolescent mental health needs. 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. 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.



The graphic features a hand holding several colorful puzzle pieces (red, yellow, blue, green) that form a heart shape. The background is a gradient of green and blue with a pattern of small white dots. The text "KSKidsMAP TeleECHO Clinic" is prominently displayed in white, followed by the tagline "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 will continue to be staffed to assist PCPs by providing mental health and community resources, toolkits, best practice guidelines, referral information, and physician wellness recommendations.



The graphic features a hand holding a heart shape made of colorful puzzle pieces (red, yellow, blue, green) against a yellow background with white dotted patterns. The title 'KSKidsMAP Case Consultation For Pediatric Mental Health' is written in blue serif font.

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](mailto:KSKidsMAP@kumc.edu)  
[wichita.kumc.edu/KSKidsMAP](http://wichita.kumc.edu/KSKidsMAP)



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CHILD HEALTH

**ECHO**  
Health Care Extension Program

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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.

*Perinatal Behavioral Health:* There are three 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:

- *Pediatrics Supporting Parents (PSP) Workgroup:* A new maternal depression screening payment policy has been adopted by Kansas Medicaid, effective January 2021. The policy supports reimbursement for up to three screenings during the prenatal period under the mother's Medicaid plan, and up to five screenings during the 12-month postpartum period under the child's Medicaid plan supporting child social and emotional development and healthy family functioning. BFH will continue to support implementation by assisting with any necessary guidance to providers, developing any needed training materials and analyzing Medicaid claims data to determine provider or clinic training or technical assistance needs.
- *Kansas Connecting Communities (KCC):* Through KCC, a Perinatal Provider Consultation Line was established to support perinatal providers through case consultations, providing best-practices information, and offering multiple training opportunities. The line is accessible 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. 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.
- *Paternal Postpartum Depression (PPD):* Title V will continue to promote the 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.

*Child Resilience/Preventing Adverse Childhood Experiences (ACEs):* MCH staff will continue its partnerships with other state agencies and local grantees to prevent adverse childhood experiences and provide training opportunities on not only the impact that trauma and toxic stress has on a developing child's brain but to shine a light on how small, everyday encounters can build resiliency skills and create an environment where children can thrive.

The Title V Child/Adolescent Consultant became a trainer in January 2021 for the four-hour curriculum, [Connections Matter](#). Connections Matter allows the public to learn about intersecting topics of ACEs, trauma, brain development, and resilience and how caring connections and trauma-informed communities can serve as a primary buffer on the negative effects of trauma in children and their development. In partnership with the [Kansas Children's Service League](#) (KCSL) Title V will provide at least two trainings to early childhood professionals, educating a minimum of 30 people, by March 24, 2022. Kansas is one of seven states that is launching this evidence-informed program that was developed in response to ACEs and developed by Preventing Child Abuse Iowa.

KCSL presented to the Family Advisory Council (FAC) in April 2021 regarding the Connections Matter curriculum and will be working with the Title V Family and Consumer Partnership (FCP) Consultant to integrate the teachings of this curriculum into training offerings for FAC Members and Support Peers through the Supporting You: Peer to Peer Network. This will be discussed with the Alumni, Mentorship, and Policy (AMP) Team when it is convened in the coming year.

*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. Having effective partnerships or collaboration is critical when creating and sustaining a local community of care. Title V developed a [Creating Effective Partnerships to Improve Behavioral Health Outcomes](#) guide for local MCH programs. The guide includes steps for developing effective partnerships (e.g., determine your needs, create new relationships), creating new relationships, enhancing existing relationships, and determining levels of involvement. Title V will

develop a marketing strategy to promote use of the report by local MCH programs.

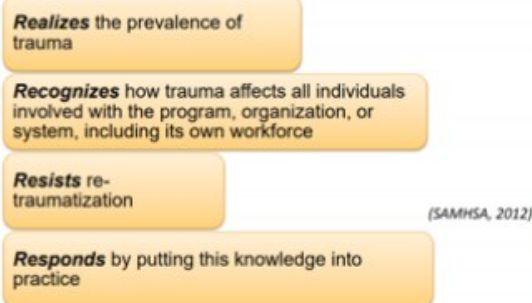
**Objective: Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction and healthier work environments.**

Now more than ever it is essential that the MCH workforce recognize how trauma and stress impact their own wellbeing, just as much as of those they serve, related to both “normal” practices and the short- and long-term impacts of COVID-19 to their community. To be successful in addressing the needs of the MCH populations within their community, they must be well. Title V will promote the SAMHSA [Culture of Wellness Organizational Self-Assessment](#) (COW-OSA) to assist programs in gathering baseline information about their organization’s strengths and shortcomings related to fostering a culture of wellness and resiliency. The COW-OSA includes ten domains and related standards that are characteristic of an organizational culture of wellness. MCH agencies will be encouraged to use this self-assessment to identify wellness-related strengths and areas requiring further exploration and development. Title V will provide support to local agencies accordingly, as well as identify support opportunities for the entire MCH network.

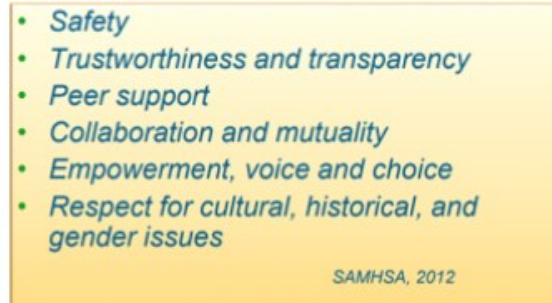
Title V is currently finalizing a resource guide, *Trauma-Informed Care Resource Guide: Resources to Support and Build Agency Resilience*, that includes vetted resources including: leadership and management during a public health crisis, building a resilient team, trauma-informed human resources best practices, and referral resources. The guide will be distributed to local partners and one-on-one technical assistance will be available upon request.

As healthcare providers begin to move beyond pressing needs of the pandemic, we will continue to provide additional resources and tools on how to provide patient-facing trauma-informed care. Being “trauma informed” is much more than being sensitive or empathic 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:

### Trauma-Informed Approach



### Principles of a Trauma-Informed Approach



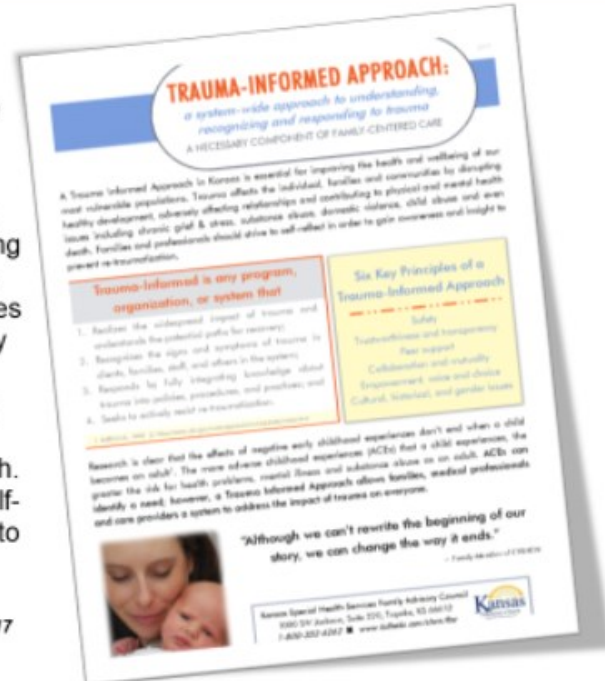
In 2017, FAC families developed the a [Trauma-Informed Approach Fact Sheet](#) specifically to address the importance of providers utilizing trauma-informed approaches when working with families. When the AMP Team is convened, this will be reviewed to determine current relevancy and to inquire about recommendations for revision, expansion, or proposed strategies to implement into other workforce development efforts written in this narrative. The following from a presentation about the fact sheet.



## Trauma-Informed Approach from the Family Perspective

"A Trauma-Informed Approach in Kansas is essential for improving the health and wellbeing of our most vulnerable populations. Trauma affects the individual, families, and communities by disrupting healthy development, adversely affecting relationships and contributing to physical and mental health issues including chronic grief and stress, substance abuse, domestic violence, child abuse and even death. Families and professionals should strive to self-reflect in order to gain awareness and insight to prevent re-traumatization."

Kansas Special Health Services Family Advisory Council, 2017



**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:

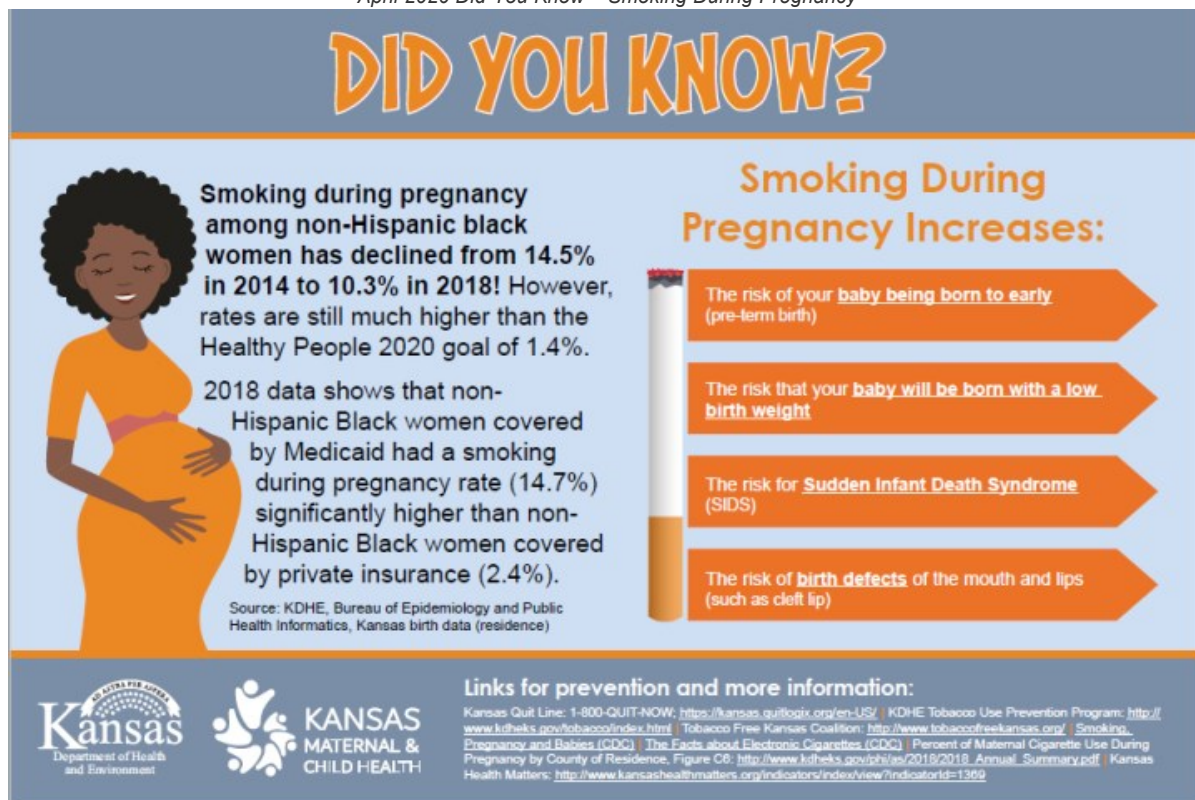
- Complete two online ACEs learning modules
- Attend a full-day in-person training and one group coaching call (45-60 days post training)
- Participate in evaluation of Lemonade for Life Curriculum
- Commit to showing the Brain Builder video during the first three months (before the 6<sup>th</sup> visit) 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 (MCHOP): 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 MCHOP with seven local MCH agencies to advance local efforts to assure equal opportunities for MCH populations regardless of income, education, age, race/ethnicity, or where people live. The 2<sup>nd</sup> cohort of the MCHOP will be launched in July 1, 2021, 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 rates of infant mortality rates for black infants and those of other races. Black infants in Kansas are nearly three times more likely to die than white or Hispanic infants. 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 (KAAAC) in 2020. Following a robust marketing campaign with the tag line “Did You Know” which began in January of 2020 and continued throughout the year, Title V is committed to continuing to raise awareness in communities across Kansas and offer prevention and educational information where people can learn more. The collective of this campaign 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. In April of 2021 Title V created a webinar presentation focused on black maternal health disparities in the state, and projects that are underway to further explore and address

these issues. The resulting webinar include data from the 2019 Pregnancy Risk Assessment and Monitoring (PRAMS) report and the Kansas Maternal Mortality Review Committee. In addition, the webinar included presentations from Title V partners and highlighted past MCH Opportunity grant awardees and upcoming collaborations to facilitate focus groups with black mothers across the state. The presentations can be viewed in their entirety on the [KDHE Integration Toolkits website](#) and will continue to be shared with MCH, Title X, and WIC professionals.

**Birth Defects Prevention Campaign:** The Centers for Disease Control and Prevention states that one in 33 children are born with a birth defect each year. Kansas is no exception; in 2018, Kansas recorded 36,247 births to resident mothers with a reported 1,021 of the 47 most common, reportable birth defects. The goal is to lower the incidence rate of birth defects in children born to Kansas families by increasing awareness, education and information going to families about birth defects.

To reach MCH populations, a large social media presence will be implemented January 2022, and each year that follows, to align with the National Birth Defects Prevention Month. Each day in the month of January will highlight new information targeted towards MCH populations using KDHE-generated materials, data, and other pre-developed materials provided by the Centers for Disease Control and Prevention, the National Birth Defects Prevention Network, and March of Dimes. To further reach populations, hard-copy brochures will be provided to Kansas birthing providers for distribution to those without access to social media. Included in the materials will be information about programs offered for families that may help pay for things such as prenatal vitamins and healthcare provider visits. The remainder of the year, the Birth Defects Surveillance (BDS) program will provide content for Screening and Surveillance Unit social media campaigns. Materials will be posted in both Spanish and English, as shown below.



### 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 FY22 grant year, staff will survey home visitors to select the most requested topic for the upcoming training to be held in September 2021. National speakers will be recruited to do the opening and closing presentation for this conference, while state experts will be asked to do breakout sessions. The training may need to be delivered virtually this year if in-person is not allowed.

*DAISEY Learning Collaborative:* 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. Due to the high demand of COVID-19 responsibilities of Local MCH Agencies, the DAISEY Learning Collaborative was put on hold during SFY2021. This opportunity will be offered in the coming year. Participating agencies will receive expert technical assistance and support from Title V as well as the University of Kansas Center for Public Partnership and Research (KU-CPPR) DAISEY team. Each agency will use their local DAISEY data to identify an area of opportunity for improvement within their practice. Participants will:

- Implement Plan-Do-Study-Act (PDSA) cycles to make small-scale changes
- Use DAISEY data to measure impact
- Participate in a kick-off event (preferably in-person) to identify their project
- Technical assistance webinars (a total of three)
- Participate in a wrap-up session (teams summarize their project/impact)

The local MCH agencies will be asked to present a summary of their project, primary impact, lessons learned, and the challenges they encountered during the 2022 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 the 2022 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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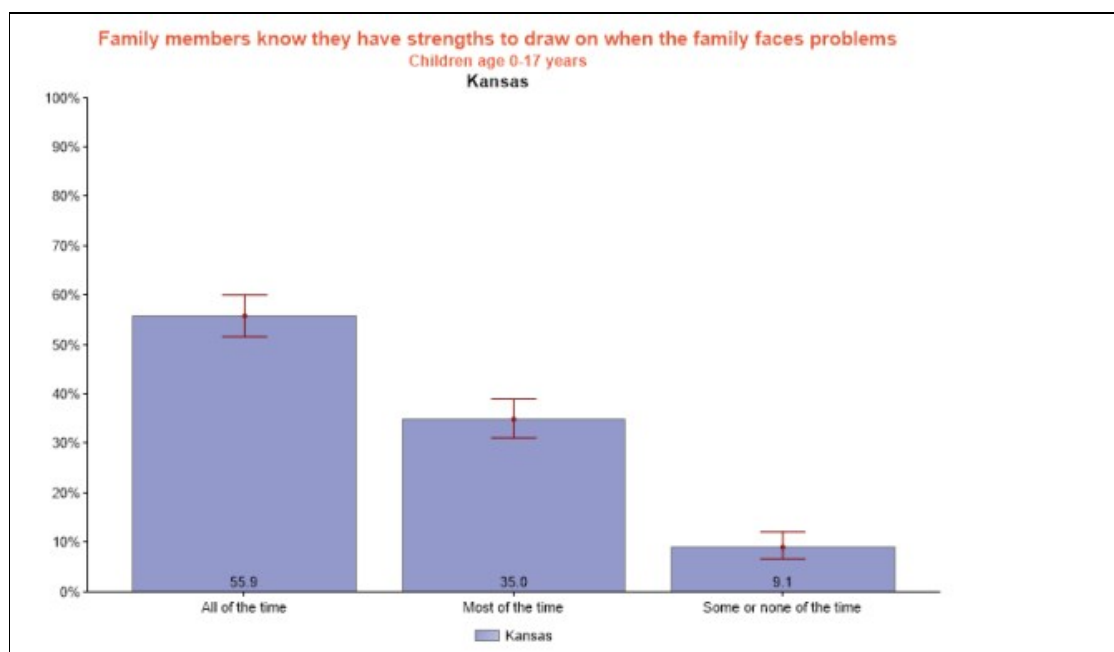
**PRIORITY:** Strengths-based supports and services are available to promote healthy families and relationships.

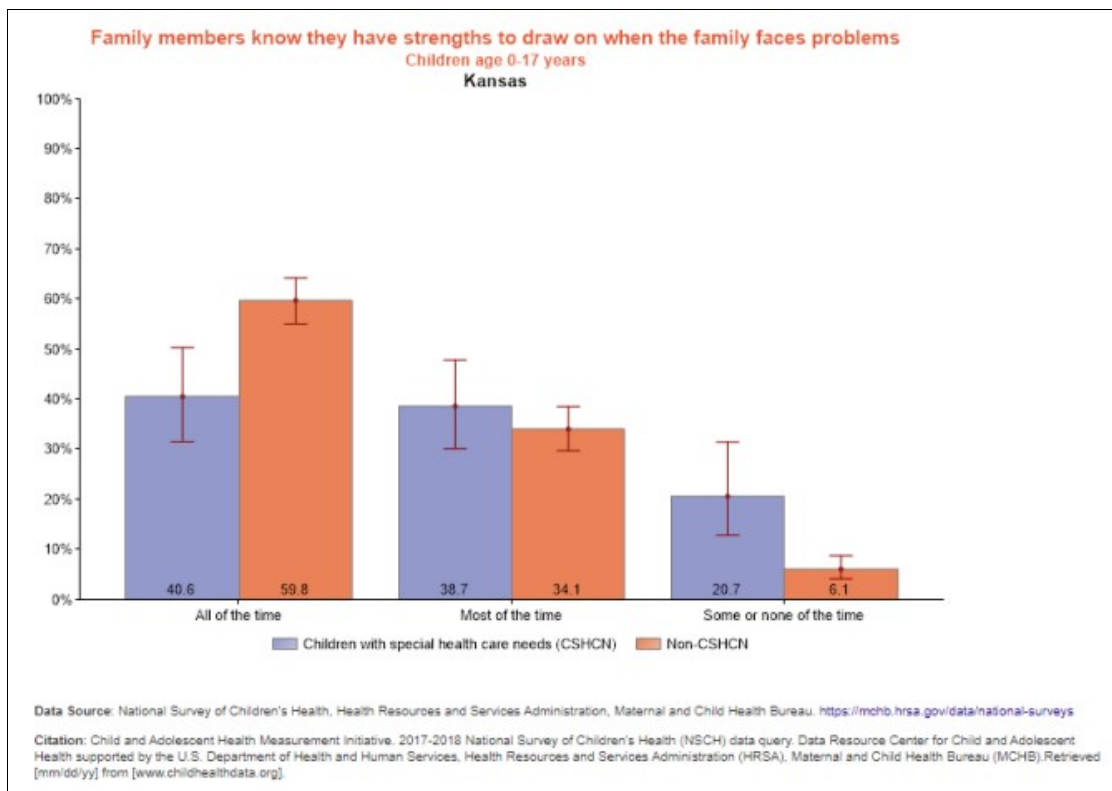
**SPM 4:** Percent of children whose family members know all the time they have strengths to draw on when the family faces problems

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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 2017-2018 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 or 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, statewide and local programs have struggled with operationalizing family and consumer engagement opportunities, outside of the CSHCN program/population. With the adoption of this priority, the Title V Family and Consumer Partnership (FCP) Program has been established, 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 peer supports, advisory opportunities, leadership and development, and technical assistance. An image depicting these four program areas can be found in the Family Partnership narrative. This dedicated program will provide a framework for family engagement, 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. In partnership with the Family Leadership Team and the Early Childhood Recommendations Panel, Title V will be participating in the development of a FCP Implementation Toolkit. In addition to a strategy under the Kansas Title V plan, this toolkit is also integrated into the All in for Kansas Kids Strategic Plan as part of their family engagement strategy guide, “Support family engagement efforts at the local level by developing toolkit of family engagement strategies and highlighting best practices and effective models In Kansas during biweekly webinar.”

The toolkit will be designed to support programs across Kansas in all sectors and settings to establishing standards family

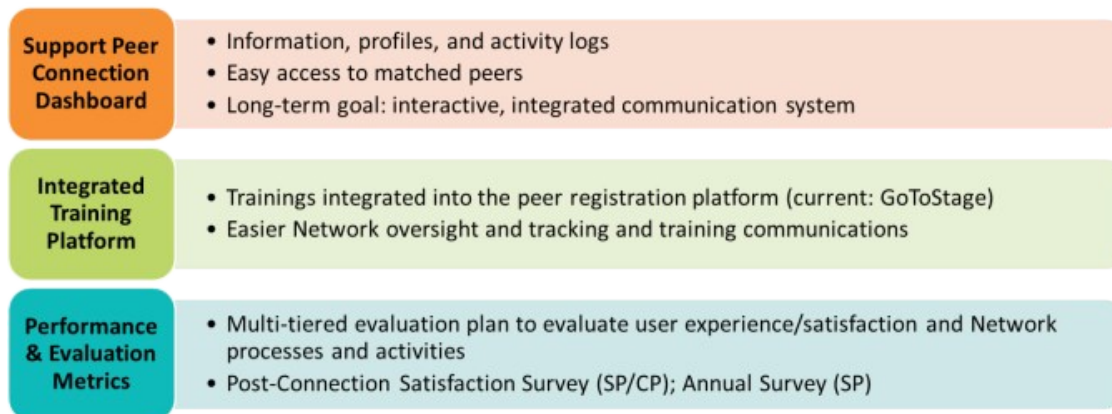


engagement and include contextual frameworks from various service delivery and family support systems (Title-V related are outlined in the Family and Consumer Partnership narrative in this application/annual report), resources and tools compiled from other state and national partners, and examples of practical and real-life implementation opportunities (toolkit outline is depicted to the right). Additionally, Title V will assure alignment with the MCH Leadership Competencies.

Upon completion 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. 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. Lastly, the Title V FCP Consultant will facilitate and lead, in collaboration with All in for Kansas Kids partners, a call for proposal for local community partners to implement components of the toolkit. The funding available for these will vary depending on the type of activity (e.g., focus groups, establishing an advisory council, family advocacy or leadership activity).

**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 includes adding two new Network Programs and enhancing the online data system. Two separate change requests have been completed, based on desired enhancements outlined last year. Ongoing enhancement activities include: a connection dashboard for Support Peers; an integrated training platform; and performance and evaluation metrics.



In addition to Network enhancements, Supporting You plans to expand by at least two additional programs to connect (1) parents and families associated with the child welfare system, and (2) the intellectual and developmental disability community (e.g., caregivers, self-advocates, providers). New programs will engage in a four-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.

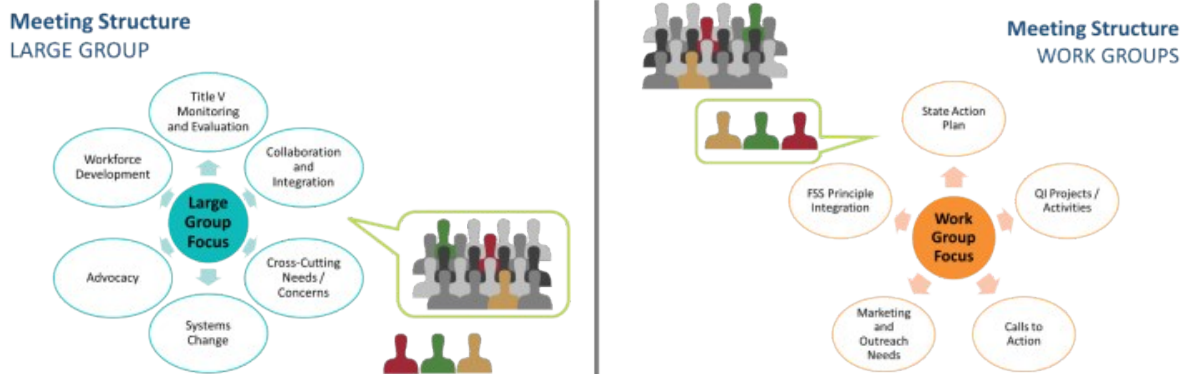
**Family Advisory Council (FAC):** As outlined in previous sections of this application, the FAC expanded not only in population domain focus, but also as an opportunity to more strategically align with the Kansas MCH Council (KMCHC), comprised primarily of professional organizations and providers. The FAC and KMCHC will meet at similar schedules (e.g., 3<sup>rd</sup> week of January, April, July, and October) to support timely discussion of similar topics and shared learning opportunities. This will also offer additional 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.

FAC Agenda Alignment		
KS MCH Council	All in for KS Kids	FAC Work Groups
<ul style="list-style-type: none"> <li>• KMCHC Small Group Discussion</li> <li>• Adapted for the FAC (as appropriate)</li> </ul>	<ul style="list-style-type: none"> <li>• Special presentations by key partners</li> <li>• Highlights informed by EC Recommendations Panel</li> </ul>	<ul style="list-style-type: none"> <li>• Title V SAP needs or targeted activities</li> <li>• Expanded knowledge and understanding of Title V programming</li> </ul>

One strategy to align the work across Title V and the Early Childhood Systems is as simple as agenda development. This alignment (below) assures connection to the KS MCH Council and the All in for Kansas Kids Strategic Plan, while maintaining the goal of flexibility and member-driven agendas. Large group agenda time is dedicated to the KMCHC and All In for Kansas Kids and then the FAC

Domain Work Groups dig in deeper to Title V activities and programming. The Executive Committee meets two weeks after FAC meetings to make recommendations and proposal for the next meeting agenda, based on the activities and discussions among FAC members during the recent meeting (framing the All In portion of the agenda). KDHE will make recommendations for the KMCHC aligned portion of the agenda as those Council meetings are planned. FAC Work Group agendas will be directly tied to the “next steps” identified by the members during their meetings or in ongoing discussion/coordination with the groups’ Co-Chairs.

As outlined below, large group discussions will focus on cross-cutting topics and updates for all populations. Population domain work groups will have dedicated time to focus on their specific priority work – which will be established with their Work Group charter.



For the first half of SFY22, the FAC will focus on completing the recruitment and expansion efforts, adding on the Adolescent Work Group in July and the Early Childhood Work Group in October 2021. These meetings will be dedicated to the following: establishing full work groups, member connections, and the development of the FCP Implementation Toolkit. In January 2022, all work groups are expected to be established, with nearly full membership. This will be a prime opportunity to “level-set” with all of the work groups and engage in some strategic planning activities around the specific population domain activities as outlined throughout this application. The FAC members will select their priority objective to frame their activities and work for the near future and establish their Work Group Charter, utilizing the FAC Work Group Charter Development Guide that was created to provide additional support for those new to these types of activities.

### Family Advisory Council Work Group Charter Development Guide

**What is a Work Group Charter?** The charter is a living document that guides the work of a group or team; consider it the “North Star” for this group. It should describe the group’s mission, scope, priorities and objectives, and commitment. Effective group charters outline the group’s focus, direction, and boundaries with a goal to reduce confusion, duplication, and repetition among other groups.

The groups’ Charter will identify their priority objective and outline what they hope to accomplish, and by when. This will serve as their “AIM” statement and guide their work. Groups are also asked to discuss the specific membership diversity they need to advance the work, and will be supported to identify ways to engage diverse populations not currently represented (e.g., recruit new members, engage a professional subject matter expert, conduct interviews/research to gain insight and the views of those populations). The Charters will also outline their groups’ communication preferences and plans, to assure all members are able to actively participate and engage in the outcomes, deliverables, or recommendations that come from the group. Lastly, this allows opportunity for all Council members to discuss their roles and responsibilities as a group member, as compared to the roles of the Co-Chairs. The following chart is outlined to provide them this guidance.

	Before Meeting	During Meeting	Between Meetings
<b>Work Group Co-Chairs</b>	Review the Facilitator Guidance, assuring: understanding of meeting objectives, familiarity with meeting materials, and facilitation expectations.	Follow the Facilitator Guidance and assure the group meets the desired objectives. The Facilitator should focus on listening and assuring understanding among the group and answer questions as asked by group members.	Work directly with the FCP Consultant and Program Coordinator on any follow-up needs in between meetings. Assure timely response to the Program Coordinator on follow-up needs. Monitor KDHE assignments associated with Work Group activities, needs, and progress. Engage the Title V Domain Program Coordinator and BFH Staff/Leadership as needed.
<b>BFH Staff Recorder</b>	Review the Recorder Guidance, assuring: understanding of meeting objectives and familiarity with meeting materials and data collection worksheets.	Take notes during the meeting, capture key conversations and document according to Recorder Guidance. Monitor group work time and assist the Chair as needed.	Compile meeting notes and submit to the Program Coordinator within 2 business days following meeting. Participate and take notes at any between-meeting discussions. Assure documentation of group information, data, and resource needs – including identification of who will be responsible for gathering and deadlines for completion.
<b>Title V Domain Program Consultants</b>	Review work group materials. Gather information, references, or data as needed to share with group members, as appropriate.	Serve as the subject matter expert. Provide insight or information as relevant to the group discussion. Provide context around the conversation as needed. Support Chair with facilitation if needed.	Review meetings notes and offer supports on any follow-up items. Assist with development of content as appropriate.
<b>Work Group Members</b>	Complete any assigned tasks prior to in-person meetings.	Actively participate in discussions and assuring consideration of all population needs. Request needed data, resources, information, or supports needed to complete the desired work of the group.	Actively participate in between meeting discussions or calls and respond timely to requested information, review, or input. Provide information, resources, and input on group activities, including assisting with content development as appropriate.

**Objective: Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration.**

**Holistic Care Coordination (HCC) Implementation Toolkit:** Title V recognizes the HCC model established and implemented by KS-SHCN, adapted in partnership from the Boston Children's Hospital, has shown to be effective in meeting the needs of those engaged in care coordination.

Title V desires to expand this model across Title V/MCH programs and beyond through the provision of resources, information, and targeted technical assistance. Building from the established KS-SHCN model, and aligned with the [National Care Coordination Standards for CYSHCN](#), an implementation toolkit is under development. This toolkit is intended to support providers, practices, and programs interested in establishing a care coordination model at different stages, both in public health and primary care settings. The toolkit will include foundational context, resources and tools for planning/implementation, evaluation and sustainability, sample job descriptions and training plans for care coordinators, and other resources to support needed technical assistance. Title V was already focused on this expansion beyond the KS-SHCN program and across other MCH programs. The All in for Kansas Kids plan has identified this as a strategy under Goal 2: Community-Level Coordination and in partnership with this work will include a focus on primary care settings.



# Community-Level Coordination

**Outcome Statement: Communities are empowered and equipped to create the best environments to raise a child.**

Kansans told us it is difficult for families to find and access services when they need them. Often, families must “connect the dots” themselves, and they tell us that better collaboration among providers would help.

We recognize that Goal 1: State-level coordination is critical to improving community-level coordination. Improved coordination, infrastructure, and technical assistance will help Kansas providers build partnerships within their communities – and statewide – to generate community-specific solutions. We envision communities will use shared tools and strategies to help families find information, access the right services, and navigate between systems. Communities will lift family voice, expand family choice, and engage a diverse representation of local champions to address their unique challenges.

## Key Findings



Accessibility



Navigation



Availability








Collaboration



## Strategy 2.1

**Develop localized comprehensive resource and referral networks that meet community-specific needs to drive quality referrals, coordinate care, and ease navigation for families.**

-  **2.1.1** Create the opportunity for providers and families to access information about the available resources in their community. This could include a community-specific and/or statewide centralized access point and resource guide.
-  **2.1.2** Establish a network of providers at the community level who refer families to services, communicate capacity and referral outcomes, and strengthen overall community partnerships and collaboration.
-  **2.1.3** Use evidence-based, standardized screenings such as the Ages & Stages Questionnaires (ASQ) and the Edinburgh Postnatal Depression Scale to identify need and connect families to the right services as early as possible.
-  **2.1.4** Offer families with newborns a developmental screening passport to track development and support communication between them and providers.
-  **2.1.5** Emphasize care coordination<sup>46</sup> that identifies and aligns with family needs and preferences across providers and settings.

The expansion for primary care will be led by the System of Support Section Director with support from the System of Care (SOC) Consultant, a new position established in November 2020 to support this expanded effort. The expansion across MCH programming will be led by the Community Partnerships Unit Director, who initially established the model and is leading the care coordination expansion efforts within the KS-SHCN program, Bridges. More information about Bridges can be found in the CSHCN Plan narrative. While these expansion efforts are happening in parallel, the synergy between all of these initiatives is complimentary and collaborative. Throughout the implementation toolkit development, the SOC Consultant has focused on outreach and promotion, provider input, and quality improvement focused development activities. To date, a video series was created (more information in the CSHCN Report narrative), a provider survey was conducted to assess knowledge, attitudes, and practices in holistic approaches to care coordination, four focus-group or roundtable input sessions were held to learn about interest in the Standard domains, and eight presentations to providers participating in the Turn a Page, Touch a Mind program. Ongoing and future activities include the establishment of a robust branding, marketing, and promotional campaign to promote the toolkit across primary care settings. The HCC website

([www.kdheks.gov/hcc](http://www.kdheks.gov/hcc)) was established to support ongoing awareness and transparency in this project.



In the coming year, following the analysis of the provider input activities, a short-term quality improvement project will engage provider offices to utilize a variety of quality improvement methods to implement key tools and resources within each of the Domain areas to provide input, feedback, and insight into the following areas:

- Planning needs
- Ease of implementation
- Evaluation opportunities
- Possible sustainability pitfalls

Practices will be asked to establish teams of three (provider, nurse, and patient/family member) to assist with the implementation. Each will be provided a tool or set of tools to implement and provide feedback on, based on their practice interest and application for the project. All participants will be reimbursed for their participation upon completion of submitted data, feedback, and/or recommendations. The target participation would include at least two teams per Domain, or a total of 12 teams from varying regions and areas of the state. We plan to offer this opportunity to include primary care pediatric, primary care family medicine, public health clinic, and federally qualified health centers in the effort to engage their input and build relationships for future implementation activities.

Upon completion of these short-term quality improvement projects the toolkit will be finalized and beginning Fall/Winter 2021, we will provide technical assistance through implementation pilots. Participating practices will be funded to establish a holistic care coordination program through development of policies, protocols, and processes that will support the



implementation of key activities to meet nationally developed care coordination standards. Practices will be incentivized to establish a patient advisory board to support the pilot project and will receive technical assistance through the KDHE Family and Consumer Partnership program, utilizing the completed FCP Implementation Toolkit, to establish practices that will support sustainability of the board.

Practices will engage in a “readiness assessment” to determine what they already provide as it relates to care coordination. Through this assessment, an individualized technical assistance plan will be developed. This may include one or more of the following: assisting with development of policy; establishing a job description and hiring a care coordinator; engaging in community-level conversations to support cross-system referrals and partnership development for the practice; training and support for the care coordinator (to be supported by the KS Special Health Care Needs Program); establishing evaluation strategies or plans; developing sustainability plans; recommendations for policy advocacy; or any other activity deemed of interest and within scope from the practice. Dependent on the assessment and where the practice is in terms of planning, implementing, or evaluating their care coordination efforts and their individual interest, they will be assigned to a 3, 6, or 12-month cohort. Just like HCC programs meet the family where they are, this approach will meet the providers and practices where they are and assure success. Those practices placed in the 3-month cohort will have already established some level of care coordination in their practice and already employ a care coordinator. Those placed in the 6-month cohort will have already established protocols and practices they intend to implement, however do not have the resources or supports to effectively hire or train a care coordinator. Those placed in the 12-month cohort will have a willingness to establish a program, however they have not yet begun planning.

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 that was modified from the Boston Children’s Hospital Model. Providers who are interested in replicating this model will be given these resources to structure their own care coordination process. 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.

### III.F. Public Input

#### FFY2022 Title V Block Grant Application/FFY2020 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.

Public Comment Period: The public comment period ran from July 19 through August 9, 2021 this year. The following image is what was visible through the Bureau of Family Health and Title V MCH website.

The Title V Block Grant plays a key role in the provision of maternal and child health services.  
**Check out the [Executive Summary](#) to learn more.**

***Request for Public Input***

**DRAFT Title V Maternal & Child Health Services Block Grant**  
**[2022 Application/2020 Annual Report](#) (498 pages)**

[Provide Feedback via Online Survey](#)

Click [here](#) for assistance with the survey.

**Deadline for Public Input: August 9, 2021**

*In accordance with federal requirements, KDHE must collect public input on the Title V Application and Annual Report prior to submission annually. The Block Grant is funded through the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), US Department of Health & Human Services.*

#### Methods

This year, our public input process included:

- Facilitated discussion with the Kansas Maternal and Child Health Council (KMCHC)
- Facilitated discussion with the Family Advisory Council (FAC)
- Public Input Survey/Comment Period

KMCHC Meeting – July 14, 2021: A total of 32 Council Members and guests participated in the meeting and received an overview of the Title V Block Grant and public input period. A high-level overview of each of the sections of the grant were reviewed. A copy of the agenda and presentation can be found on the [KMCHC Meeting Page](#). Following the presentation, Council members were split into one of four domain groups: Women/Maternal, Perinatal/Infant, Child, and Adolescent. The small groups were asked to review the updated data trend tables provided and reflect on what they saw, specifically calling out any contributing factors they might associate with the trends. They were asked to identify emerging needs, and potential solutions, we might anticipate in the coming years. Finally, they were asked to reflect on the upcoming activities from the State Plan in the Block Grant for their specific population domain and discuss the impact those activities might have. A summary of the work group comments and reflections are outlined below.

Small Group Discussion by Domain & Focus Area		
<b>Small Group Discussion</b> (Small Groups: Adolescent, Child, Women and Maternal, and Perinatal and Infant) Domain groups reviewed data trends for their populations and discussed the following: <ul style="list-style-type: none"> <li>- What contributing factors may be associated with the trend you are seeing?</li> <li>- What emerging needs might impact this trend in the next couple of years? How might we address those?</li> </ul> After the breakout, each group shared key points and action items discussed.		
	Data trend and contributing factor or emerging need	1-2 priority ways to advance plan activities
<b>Adolescent</b>	Mental/behavioral health. Need to educate parents to advocate for their child's mental health and need to increase mental/behavioral health workforce for the whole family.	More giveaways; social media focus; partner with high schools & teachers, local pediatricians with sports physicals, and local boys and girls clubs; K-State extension curriculum training teenagers to advocate for themselves within their communities
<b>Child</b>	NOM 22.1. Decreasing vaccination rates. Vaccine hesitancy is on the risk.	NOM 22.2 Increase in flu shot vaccination. Look what has worked and apply. Consistent messaging, bringing partners together, and helping families know where to go for good information.
<b>Perinatal/Infant</b>	Social determinants of health; look at data disaggregated by race/ethnicity	Look at data that highlights disparities by race/ethnicity, Medicaid vs. non-Medicaid. COVID is highlighting gaps that already exist. Determine who within MCH system may be better equipped to help advance work (e.g., first responders, extension, libraries)
<b>Women/Maternal</b>	Social determinants of health: increase in stress, anxiety, and trauma, as well as lack of access to services including transportation, childcare, nutritious food, etc.	Continue to connect and collaborate around issues such as postpartum Medicaid extension. How can we increase access to affordable care and patient and provider education?

Additionally, as part of the new KMCHC meeting structure, each meeting we ask the members to complete a Google Forms document and answer this question: "What is one way your organization (if applicable) will promote or advance one or more of the state action plan activities?" Some of the themes of the comments received after this meeting, as related to Title V Block Grant, included:

- Connecting with families and providers to promote the work to raise awareness (Guest)
- Promote behavioral health and well-child services within schools (Family Leader)
- Continue working on aligning the broader services with agency programming and develop resources inclusive of all MCH services (Guest)
- Work collaboratively to address injury surveillance and prevention (Member)
- Provide education to emergency medical services providers and emergency department employees on injury trends as it relates to children and adolescents (Member)
- Offer trauma-informed training to professionals caring for pregnant families (Member)
- Continue working on empowering primary care providers to address mental illness in children (Member)
- Address child and adolescent needs through school-based health activities (eg., school-based health centers, school nurse toolkits) (Member)
- Provide support on advocating for reimbursement, extension, and expansion of health coverage for pregnant and postpartum women (Member)

*FAC Meeting – July 17, 2021:* A total of 22 Family Leaders participated in the meeting and received an overview of the Title V Block Grant and public input period. The families were provided an abbreviated version of the same presentation as the KMCHC members and then engaged in the same discussion questions. A summary of the work group comments and reflections are outlined below.

**Family Advisory Council Meeting – Saturday, July 17, 2021**

*Sharing the input provided by the FAC after engaging in the same presentation/discussion questions with that group.*

Agenda Items	Discussion
<p><i>What trends stand out to you?</i></p> <p><i>What question(s) does any of this raise for you?</i></p> <p><i>What might have caused us to trend up or down? Or stay the same?</i></p> <p><i>What emerging needs might we need to consider in the coming year? How might we address those?</i></p>	<p><b>NOM 16: Adolescent Suicide/Death</b></p> <ul style="list-style-type: none"> <li>• Adolescent well-visits are decreasing, increasing those well-visits can be an additional method to identify and address concerns in a timely manner.</li> <li>• Suicide rate is concerning – large increase over the years in suicide rate.</li> <li>• Very concerning. How do we encourage more people to enter the field of mental health; trouble filling these positions. How many of those with post-partum are adolescents?</li> <li>• Would like to share this information with families, corporations, universities, and the workforce.</li> <li>• Will this continue to rise as a result of COVID?</li> <li>• School-based health centers in the middle and high schools could address this.</li> <li>• Sedgwick – reached out to bring a program called “zero reasons why”; getting some traction; teen-lead program to erase the stigma associated with mental health issues (program).</li> <li>• We must focus on the mental health piece.</li> </ul> <p><b>NOM 23: Teen Births:</b> Notable decrease in the number of teen births is good to see.</p> <p><b>NPM 4/SPM 2: Breastfeeding:</b> Would like to see more women breastfeeding, and support for women who breastfeed across the state. However, noted that it was great to see the breastfeeding rates increasing. Education has helped to make it more acceptable when in public and more business that welcome breastfeeding and having rooms for nursing mothers, so they don't have to use a restroom.</p> <p><b>NPM 6: Developmental Screening:</b> Worried that this is so low. Especially since many of the child care facilities are now doing the screenings.</p> <p><b>NPM 7: Child Injury:</b> Child injury increasing is alarming. More kids at home with working parents and not watched as closely during remote learning?</p> <p><b>NPM 8 Physical Activity:</b> High school kids are not getting enough physical activity. Physical activities during COVID remote learning/kids having more time on screens and video games.</p> <p><b>NPM 10: Adolescent Well Visits:</b> Why are the well-visits down? Is it because parents are unable to transport? Simply the fact that it's not seen as important or something that needs to keep going thought the course of life?</p> <p><b>NPM 14: Smoking in Household:</b> Children who are living in households who smoke increased, does this including vaping because vaping is increasing too?</p> <p><b>NPM 15: Adequate Insurance:</b> Wonder what the FAC could do to help push Medicaid expansion? Could the number of people not insured have to do with poverty, COVID, and politics?</p> <p><b>SPM 1: Postpartum Depression:</b> With postpartum depression, are they doing a better job asking these questions? Many people on the call said they were never asked when their kids were born. Ask significant other/husband if they notice any changes in mom. Where do people go with that information if they notice something is wrong? Focus on efforts on dad educating other dads. Are there resources for family members of single moms that offer places to seek help?</p>

**Public Input Survey/Comment Period:** A public input survey was developed and posted via Survey Monkey to collect information and feedback about the *DRAFT Application and Annual Report* from consumers and partners across the state. Details related to this year's public input process and period follow. A postcard was developed and distributed to partners and MCH Council members via email and in-person meetings.



## Kansas Maternal & Child Health Partner

### We need your feedback!

As part of the Title V Maternal & Child Health (MCH) Services Block Grant Federal-State partnership, Kansas is required to make our annual application and report available to the public for the purpose of gathering input. We have created an online survey to collect information, opinions and perspectives from consumers and partners across the state. As a key partner informed of and concerned about the needs of MCH populations, services and resources we invite you to share your input. Find more information online at:

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

**Your input is very important to us and will be kept strictly confidential.**

**Take the survey here:**

<https://www.surveymonkey.com/r/62Z65VZ>

The survey will open for public input on July 19 and close on August 6, 2021.

The following email was sent by the Title V Director to partners statewide (partner list to follow).

*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 2022 Application and 2020 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 2021-2025 (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 **August 9** 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 2021-2025 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 Gynecologists (ACOG) Kansas Section	Kansas Department of Aging and Disability Services	KSKidsMAP to mental wellness partners Local Health Department Administrators
Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)	Kansas Department for Children and Families	Managed Care Organizations
Birth Centers	Kansas Foundation for Medical Care	March of Dimes
Cerebral Palsy Research Foundation	Kansas Health Foundation	MCH grantees and partners
Child Care Aware of Kansas	Kansas Health Institute	Mother & Child Health Coalition of Greater Kansas City
Child Care Licensing System Improvement Team members	Kansas Hospital Association and members (hospitals)	Newborn Hearing Advisory Newborn Screening Advisory
Child Care Providers and Facility Owners	Kansas Maternal & Child Health Council members	Nutrition Physical Activity Collaborative
Children's Alliance	Kansas Maternal Mortality Review Committee members	Oral Health Kansas Part C (Tiny-K) networks
Early Childhood Comprehensive Systems Impact (ECCS) partners	Kansas Perinatal Community Collaborative (KPCC) sites	Pregnancy Maintenance Initiative grantees School nurses
Families Together, Inc.	Kansas Perinatal Quality Collaborative (KPQC) members	Special Health Care Needs (SHCN) specialty clinics and providers
Family Advisory Council	Kansas Public Health Leadership Institute and Core Public Health Programs	State Children's Institutions
Family Planning grantees	Kansas School Nurse Organization (KSNO) and members	State Home Visiting Leadership Team Sunflower Foundation
Federally Qualified Health Centers (FQHCs)	Kansas State Department of Education	Teen Pregnancy Targeted Case Management grantees
High 5 for Mom and Baby sites	Kansas State University	United Methodist Health Ministry Fund and grantees/partners
Home Visiting programs	Kansas University Medical Center (Kansas City and Wichita)	University of Kansas Center for Research
Kansas Academy of Family Physicians	KDHE Division of Health Care Finance/Medicaid	University of Kansas Health System – Kansas City, Topeka, and Wichita
Kansas Action for Children	Public Health Directors/staff	WIC Advisory Committee WIC grantees and program representatives
Kansas Association for the Medically Underserved	Kansas Connecting Communities (KCC) partners	
Kansas Breastfeeding Coalition	Kansas Infant Death and SIDS (KIDS) Network	
Kansas Chapter of American Academy of Pediatrics		
Kansas Children's Cabinet & Trust Fund		
Kansas Children's Service League		

A total of 13 responses were received, only one of which noted they were a parent of a child or adult family member with special health care needs. Although we had a low number of responses, 28.6% responded that this was their first-time providing feedback on a draft MCH application/annual report. One reviewer took note of some intentional changes the team integrated in this year's application:

*"The Core Principles and Values are good addition to the Report. The Success Stories help to bring home the impact of the work. Data helps to tell the story (e.g., the distribution of different levels of community engagement being used in the documented activities)."*

The majority of the respondents strongly agreed or agreed that they had a clear understanding of the state Kansas priorities for the MCH population, based upon the information in the Executive Summary.



Answers Choices	Strongly Agree	Agree	Disagree	Strongly Disagree	Total	Weighted Average
Women/Maternal Health (100%)	6	4	0	0	10	3.60
Perinatal/Infant Health (100%)	6	4	0	0	10	3.60
Child Health (100%)	5	5	0	0	10	3.50
Adolescent Health (100%)	5	5	0	0	10	3.50
CSHCN (100%)	5	5	0	0	10	3.50
Cross-Cutting (89.9%)	5	4	1	0	10	3.40

The majority of the respondents strongly agreed or agreed that the state's ongoing efforts to understand the emerging needs of MCH populations is effective and accurately describes the needs of women, infants, and children in Kansas.

Answers Choices	Strongly Agree	Agree	Disagree	Strongly Disagree	Total	Weighted Average
Women/Maternal Health (100%)	7	3	0	0	10	3.70
Perinatal/Infant Health (100%)	8	2	0	0	10	3.80
Child Health (100%)	7	3	0	0	10	3.70
Adolescent Health (100%)	6	4	0	0	10	3.60
CSHCN (100%)	5	4	0	0	9	3.56
Cross-Cutting (89.9%)	7	1	1	0	9	3.67

The majority responded that the 2022 Application and 2020 Annual Report:

Answers Choices	Strongly Agree	Agree	Disagree	Strongly Disagree	Total	Weighted Average
Clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities (100.0%)	4	6	0	0	10	3.40
Demonstrates strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas (100.0%)	5	5	0	0	10	3.50
Accurately reflects the capacity, work, activities across Kansas as they relate to the state priorities (100.0%)	4	6	0	0	10	3.40

After reviewing "Five Year State Action Plan" and "Expenditures, Budget Narrative and Forms", the majority responded that:

- the State Title V Program Purpose and Design were adequately addressed (100.0%);
- the State MCH Capacity to Advance Effective Public Health Systems: MCH Workforce Development, Family Partnership, MCH Data Capacity, MCH Emergency Planning and Preparedness, and Health Care Delivery System were adequately addressed (100.0%);
- the State Action Plan by MCH population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children with Special Health Care Needs, and Cross-Cutting was adequately addressed (100.0%); and
- the resource allocation/expenditures were adequately addressed (100.0%).

### 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.

KMCHC meets quarterly and remains actively involved in providing ongoing input and 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)
- Disparities and inequities in MCH populations across the life course (impact of Social Determinants of Health)
- 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 Councils

### **III.G. Technical Assistance**

#### ***Collecting Measurable Evidence for the CSHCN Population***

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 has also changed. 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 shift in capturing data for CSHCN from the National Survey for Children with Special Health Care Needs 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 many 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.

#### ***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 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. The primary reason for this is there are a number of local counties that do not have a "lead" MCH agency (no local agencies apply for the funding). This presents challenges around access to care at the community level. 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 as well as a combination of lead agencies serving as fiscal agents only with subcontractors for service delivery and fiscal agents also providing services. This is the approach Kansas needs to take considering many rural and frontier counties may not actually benefit from or be able to sustain a comprehensive MCH program. Coordinating services across county lines in many areas of the state would be more efficient and impactful.

Kansas Title V leaders participated in a Peer to Peer Exchange held on August 5 and 6 titled *How Do We Adequately Fund a Statewide MCH Infrastructure? State Title V Block Grant Sub-Award Strategies for Counties/Local Health Jurisdictions*. It was hosted by the California Title V Block Grant Program, with Support from MCHB/Division of State and Community Health. Four other states participated: California, Iowa, Montana, and Washington. The purpose was to facilitate sharing and peer learning among the participating states in support of adequate funding for statewide MCH infrastructure. Focus was on understanding of and potential improvements to states' Title V Block Grant sub-award funding methodologies, tracking, and monitoring for counties/local health agencies. Each state presented information about their approach to funding local agencies and monitoring to ensure the needs of MCH populations are being met through sustainable, equitable funding structures. The Kansas team learned a lot and left with many good ideas and strategies to consider as we work to transform the current MCH aid to local process.

In addition to examining other options for the funding structure, an efficiency study comparing the median social cost of delivering services versus the median social benefit of receiving services could greatly impact Kansas MCH service delivery. The goal would be to increase the reach and impact of MCH with existing/available funds.

### ***Implementing Maternal Health Quality Initiatives (+AIM Patient Safety Bundles)***

Kansas relaunched the Perinatal Quality Collaborative (KPQC) in 2017 with the implementation of a quality improvement effort around neonatal abstinence syndrome (NAS). Concurrently the Kansas Maternal Mortality Review Committee (KMMRC) was launched. Since that time, the NAS initiative concluded (Oct. 2020), and a new initiative is underway to reduce maternal mortality and morbidity. The Fourth Trimester Initiative (FTI) is the intervention to address the MMRC findings and recommendations through care teams and systems improvements for the mother, infant, and family within the context of the community. The Alliance for Innovation on Maternal Health (AIM) has created safety bundles that represent best practice for maternity care and are endorsed by national multi-disciplinary organizations. With both the KPQC and the MMRC working in close partnership, we plan to enroll in AIM during FFY 2022 and focus on implementing the postpartum transition bundle. This is complementary to the FTI and existing MCH investments that we know are making a difference (e.g., KPCCs, Maternal Warning Signs, behavioral health screening, home visiting). Technical assistance (in addition to support from AIM specifically) could help ensure alignment of all work, support integration of existing resources and investments, and drive success.

### ***Planning & Collaboration with Title X: Focus on Women's Health & Adolescent Health***

The KDHE Bureau of Family Health Children & Families Section includes the Title V MCH and Title X Family Planning programs. In the past, the programs spent meaningful time together reviewing shared priorities, goals, and objectives to identify linkages between MCH and Title X/Family Planning. Site visits have not been conducted due to the pandemic; however, the programs are interested in coordinating joint virtual or on-site visits for greater impact/gains. Additionally, the teams are committed to launching evidence-based reproductive health interventions, such as 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 among the state team and with the local agencies. Ongoing education around shared goals and work would be helpful. 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.

### **Other Technical Assistance Areas for Consideration**

- Collecting measurable evidence related to program impact
- Program monitoring and evaluation (MCH broadly and home visiting specifically)
- School health (funding, expanding services, measuring impact on health and academics)
- Strategies and approaches for empowering youth (reducing risky behaviors, improving self-image, building strong character/social-emotional development for children and youth, etc.)
- Youth engagement and leadership
- Substance use and mental health – Title V's role (screening, brief intervention, referral)
- Integrating services at the community level across settings and sectors

#### **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 - [01\\_Priorities-Measures-SAP.pdf](#)

Supporting Document #02 - [02\\_ATLProgramming.pdf](#)

Supporting Document #03 - [03\\_ProgramActivities-WM.PI.pdf](#)

Supporting Document #04 - [04\\_ProgramActivities-C.A.CSHCN.pdf](#)

Supporting Document #05 - [05\\_ProgramActivities\\_Stakeholder.Advisory.pdf](#)



## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [Organizational Chart REV 8-24-21 FINAL.pdf](#)

## VII. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Kansas**

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 4,737,310	
A. Preventive and Primary Care for Children	\$ 1,510,122	(31.8%)
B. Children with Special Health Care Needs	\$ 1,461,952	(30.8%)
C. Title V Administrative Costs	\$ 375,000	(8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 3,347,074	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,821,044	
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)	\$ 7,877,543	
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)	\$ 12,614,853	
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)	\$ 63,331,794	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 75,946,647	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	\$ 299,482
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 18,429
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 4,792,517
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	\$ 444,868
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health	\$ 316,545
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 232,582
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,535,491
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 536,298
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 49,713,148
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 4,282,434

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 4,780,598		\$ 4,734,589	
A. Preventive and Primary Care for Children	\$ 1,527,371	(31.9%)	\$ 1,468,750	(31%)
B. Children with Special Health Care Needs	\$ 1,481,251	(31%)	\$ 1,469,248	(31%)
C. Title V Administrative Costs	\$ 300,000	(6.3%)	\$ 360,000	(7.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 3,308,622		\$ 3,297,998	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,949,804		\$ 3,642,701	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 3,992,669		\$ 3,992,250	
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)	\$ 7,942,473		\$ 7,634,951	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,352,511				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 12,723,071		\$ 12,369,540	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 70,031,333		\$ 63,802,894	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 82,754,404		\$ 76,172,434	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 135,900	\$ 117,942
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 410,910	\$ 411,485
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 4,782,829	\$ 4,123,412
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	\$ 444,577	\$ 352,277
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health	\$ 648,994	\$ 540,120
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 249,995	\$ 238,286
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	\$ 941,475	\$ 891,652
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,614,946	\$ 2,808,025
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 53,786,823	\$ 49,196,374
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 4,309,122	\$ 4,304,078
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	\$ 318,599	\$ 127,558
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 583,299	\$ 447,987



OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	\$ 803,864	\$ 12,182
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > NBS SMA		\$ 67,438
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > NBS Evaluation		\$ 14,035
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ERASE Maternal Mortality Review		\$ 150,043

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Slight variation in reported admin costs due to fluctuating indirect cost rate for KDHE/KS.	

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Kansas**

**I. TYPES OF INDIVIDUALS SERVED**

<b>IA. Federal MCH Block Grant</b>	<b>FY 22 Application Budgeted</b>	<b>FY 20 Annual Report Expended</b>
1. Pregnant Women	\$ 695,118	\$ 718,296
2. Infants < 1 year	\$ 695,118	\$ 718,295
3. Children 1 through 21 Years	\$ 1,510,122	\$ 1,468,750
4. CSHCN	\$ 1,461,952	\$ 1,469,248
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 4,362,310	\$ 4,374,589

<b>IB. Non-Federal MCH Block Grant</b>	<b>FY 22 Application Budgeted</b>	<b>FY 20 Annual Report Expended</b>
1. Pregnant Women	\$ 1,679,407	\$ 1,600,767
2. Infants < 1 year	\$ 1,679,407	\$ 1,600,766
3. Children 1 through 21 Years	\$ 2,941,804	\$ 2,352,383
4. CSHCN	\$ 1,576,925	\$ 2,081,035
5. All Others	\$ 0	\$ 0
Non-Federal Total of Individuals Served	\$ 7,877,543	\$ 7,634,951
Federal State MCH Block Grant Partnership Total	\$ 12,239,853	\$ 12,009,540

**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**

<b>IIA. Federal MCH Block Grant</b>	<b>FY 22 Application Budgeted</b>	<b>FY 20 Annual Report Expended</b>
1. Direct Services	\$ 50,236	\$ 34,316
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	\$ 50,236	\$ 34,316
2. Enabling Services	\$ 1,944,036	\$ 1,998,589
3. Public Health Services and Systems	\$ 2,743,038	\$ 2,701,684
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		\$ 8,722
Physician/Office Services		\$ 15,749
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 4,039
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 4,817
Laboratory Services		\$ 33
Other		
audiology		\$ 956
Direct Services Line 4 Expended Total		\$ 34,316
<b>Federal Total</b>	<b>\$ 4,737,310</b>	<b>\$ 4,734,589</b>

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 40,867	\$ 36,067
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	\$ 40,867	\$ 36,067
2. Enabling Services	\$ 4,589,691	\$ 3,970,434
3. Public Health Services and Systems	\$ 3,246,985	\$ 3,628,450
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		\$ 196
Physician/Office Services		\$ 20,221
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 894
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 56
Other		
Provider Fees		\$ 14,700
Direct Services Line 4 Expended Total		\$ 36,067
<b>Non-Federal Total</b>	<b>\$ 7,877,543</b>	<b>\$ 7,634,951</b>



**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: 36,985**

**Data Source Year: 2019**

**1. Core RUSP Conditions**

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	36,980 (100.0%)	3,792	146	146 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric 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, $\beta$ -Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	$\beta$ -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 process until the diagnosis is confirmed and a referral to the Special Health Care Needs (KS-SHCN/Title V) program is made. The newborn screening and Title V programs established and launched (September 2020) a formal referral process to assure that at the time the diagnosis confirmation is received, the newborn screening programs (blood spot, hearing, and heart) will send a packet of information and 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. Once the applies for assistance through the KS-SHCN program, they are eligible for care coordination supports. They are also assessed for financial eligibility to receive assistance through the various direct assistance programs (DAPs) to support other needs. Families are asked annually to update their application and information to retain coverage.

**Form Notes for Form 4:**

Total births by occurrence (Source: KDHE Office of Vital Statistics) = Calendar Year 2019 = 36,985

As reported by the program:

NBS Blood Spot Screening: 36,818 (at least one screen); 3,128 (abnormal); 73 (diagnosed); 245 (diagnosed, including carriers); 73 (referred for treatment)

NBS Heart Screening: 36,789 (at least one screen); 36 (abnormal); 3 (diagnosed); 3 (referred for treatment)

NBS Hearing Screening: 36,980 (at least one screen); 628 (abnormal); 70 (diagnosed); 70 (referred for treatment)

Note: In 2018, the Total Births by Occurrence was 37,771 and Column A: Number Receiving at Least One Screen was 37,480. CCHD was added as a mandated screening in February 2019.

**Field Level Notes for Form 4:**

None

**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 2020

**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	8,578	37.9	0.1	36.3	17.0	8.7
2. Infants < 1 Year of Age	6,207	40.2	0.2	44.7	13.0	1.9
3. Children 1 through 21 Years of Age	12,189	46.9	1.8	25.3	17.0	9.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,620	63.3	0.1	21.9	6.8	7.9
4. Others	7,361	26.1	0.1	27.1	15.2	31.5
Total	34,335					

**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	35,395	No	37,163	77.9	28,950	8,578
2. Infants < 1 Year of Age	36,986	No	36,985	100.0	36,985	6,207
3. Children 1 through 21 Years of Age	833,794	Yes	833,794	81.2	677,041	12,189
3a. Children with Special Health Care Needs 0 through 21 years of age^	178,169	Yes	178,169	81.5	145,208	1,620
4. Others	2,044,195	Yes	2,044,195	2.6	53,149	7,361

^Represents a subset of all infants and children.

**Form Notes for Form 5:**

Please note that Forms 5a and 5b in this grant application may not be comparable to previous years. Improved methods have been applied.

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>
<b>Field Note:</b> Please note that Title V Total Served - Pregnant Women in this grant application should not be compared with previous years. Improved methods have been applied.  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 (Maternal and Child Health Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) = 6,911  MCH DAISEY non-direct entry grantees' aggregate = 44  Pregnancy Risk Assessment Monitoring System (PRAMS) - Postpartum Women Sampled = 1,623  Total = 8,578		
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>



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**Field Note:**

Please note that Title V Total Served - Infants in this grant application should not be compared with previous years. Improved methods have been applied.

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.

Newborn Hearing: All newborns who had failed the initial hearing screen in the hospital prior to discharge and on newborns not screened, transferred to NICU, transferred to another hospital, deceased, could not Test, scheduled but not completed, did not consent, Infant discharged before screening (missed), not screened/out of hospital births, and other.

Metabolic: All infants that come into the system as blank or abnormal. Therefore, any infants that had any of the following statuses would have had at least one phone call made on them: deceased, diagnosed, diagnosed-carrier, false positive, lost to follow up, low-risk normalized, parental notification, transferred, and other.

Critical Congenital Heart Defects (CCHD): Infants with a "Failed" CCHD screen.

Programs and services included:

MCH DAISEY direct entry grantees (MCH, Universal Home Visiting) = 2,153

MCH DAISEY non-direct entry grantees' aggregate = 116

Newborn hearing follow-ups, newborn metabolic screening follow-ups, and critical congenital heart defects follow-ups = 4,029

Total = 6,207 (after deduplication of 91 infants in both DAISEY and NBS follow-ups)

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3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**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 (Maternal and Child Health, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management, including CSHCN) = 10,029

MCH DAISEY non-direct entry grantees' aggregate reports, including CSHCN = 856

Children and youth with special health care needs in the Kansas Special Health Care Needs (SHCN) Program = 1,304

Total = 12,189

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4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs 0 through 21 Years of Age</b>
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<b>Fiscal Year:</b>	<b>2020</b>
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**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 = 1,304

MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) = 314

MCH DAISEY non-direct entry grantees' aggregate = 2

Total = 1,620

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5.	<b>Field Name:</b>	<b>Others</b>
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<b>Fiscal Year:</b>	<b>2020</b>
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**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 (Maternal and Child Health, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) = 7,292

MCH DAISEY non-direct entry grantees' aggregate = 69

Total = 7,361

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2020</b>
<b>Field Note:</b> Numerator: Outreach by MCH grantees (9,873) + Kansas Infant Death and SIDS Network (1,189) + Kansas Breastfeeding Coalition (9,314) + direct/enabling services (8,578) = 28,954  Denominator: 2019 live births (36,985) + stillbirths (178) = 37,163  Total % Served = 28,954 / 37,163 = 77.9%  Note: The number of outreach for pregnant women (9,873) by MCH grantees reflects SFY2020 (7/1/2019-6/30/2020), a reduction of 10.5% from SFY2019 (11,035) due to limited outreach during the COVID-19 pandemic. Grantees were busy providing COVID-19 services/contact tracing.		
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2020</b>
<b>Field Note:</b> Numerator: Infants served through newborn screening programs = 36,980 Denominator: Kansas vital statistics, occurrence live births = 36,985 Total % Served = 36,980 / 36,985 = 99.99%		
3.	<b>Field Name:</b>	<b>Children 1 Through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Field Note:**

Please note that children 1-21 population-based services and partnership outreach percentage in this grant application should not be compared with previous years. Improved methods have been applied.

Outreach by MCH grantees (37,700) + KIDS Network (2452) + Direct/enabling services (12,052) = 141,226

Title V and Child Care Aware of Kansas Partnership Training: 44 child care providers for school age children (ages 4-11) representing 13 counties = 175,916

Title V and Kansas State Department of Education Partnership - \*Interactive Youth Health Toolkit Resource (grades 7-12) and National Childhood Obesity Month materials distributed to members of the Health and Physical Education listserv (approximately 200 people representing 106 districts, 37% of 286 school districts in KS) = 81,017

\*Obesity Month materials were posted around the classrooms and gymnasiums; Youth Health Guide used for classroom discussions.

33 students representing 3 colleges participated in the focus groups and in the development of Youth Health Guide = possible/potential outreach ages 18-21 = undergraduate students/enrollments in 3 colleges = 10,835

Numerator: 676,900

Denominator: Reference Data = US Census Bureau Population Estimates, 2019= 833,794

Total % Served =  $676,900 / 833,794 = 81.2\%$

Note: The number of outreach for children 1 through 21 years of age (37,700) by MCH grantees reflects SFY2020 (7/1/2019-6/30/2020), a reduction of 35.6% from SFY2019 (58,541) due to limited outreach during the COVID-19 pandemic. Grantees were not allowed in the schools to provide outreach services. Grantees were busy providing COVID-19 services/contact tracing.

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4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs 0 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Field Note:**

Please note that CSHCN population-based services and partnership outreach percentage in this grant application should not be compared with previous years. Improved methods have been applied.

SHCN specific outreach through presentations and booths during SFY2020 (Aetna MCO, Arkansas City presentations, FCCT, Care Coordination, KYEA resource fair, Down Syndrome booth, Grace Medical Center, LEND) (918) + SHCN Direct/enabling services (1,620) = 2,538

Denominator: Reference Data = National Survey of Children's Health CSHCN Prevalence Estimates 1-17 (2018-2019) multiplied by US Census Bureau Population Estimates 1-21, 2019 = 178,169

Improved method - applied the formula for CSHCN = Child 5B% + (CSHCN 5A and Specific CSHCN Outreach Count \* (1 - Child 5B%) / CSHCN)

Given:

1. Child 5B% = 81.2% (Please read the detail outreach activities for children and youth in the notes)
2. CSHCN 5A and CSHCN Specific Outreach Count = 2,538
3. KS CSHCN reference data = 178,169

CSHCN outreach = 81.5%

Based on the formula above, during SFY 2020, the Kansas MCH and SHS programs provided population-based services and partnership outreach to over 80% of CSHCN.

Note: 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.

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5.	<b>Field Name:</b>	<b>Others</b>
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<b>Fiscal Year:</b>	<b>2020</b>
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**Field Note:**

Numerator: Outreach by MCH Grantees (17,313) + KIDS Network (28,997) + Direct service (7,361) = 53,671

Denominator: Reference Data = 2,044,195

Total % Served = 53,671 / 2,044,195 = 2.6%

Note: The number of outreach for women aged 22-44 years (10,173) by MCH grantees reflects SFY2020 (7/1/2019-6/30/2020), a reduction of 29.7% from SFY2019 (14,477) due to limited outreach during the COVID-19 pandemic. Grantees were busy providing COVID-19 services/contact tracing. However, during this period, tremendous outreach efforts were made for men aged 22+ (7,140). As part of the effort, in SFY 2020 an overall net gain of 19.6% in the "Others" population (17,313) was achieved from SFY2019 (14,477).

**Data Alerts: None**

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

**State: Kansas**

**Annual Report Year 2020**

**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	37,182	25,562	2,659	6,397	133	1,214	69	288	860
Title V Served	8,578	4,967	675	2,404	53	177	20	164	118
Eligible for Title XIX	13,914	7,352	1,793	3,137	183	2	7	0	1,440
2. Total Infants in State	36,985	25,443	2,629	6,362	133	1,208	69	286	855
Title V Served	6,207	3,621	653	1,351	28	194	15	83	262
Eligible for Title XIX	15,356	2,034	690	2,531	17	0	0	0	10,084



**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>

**Field Note:**

2019 Total Deliveries in State = live births (36,985) + stillbirths (197) = 37,182

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

**State: Kansas**

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 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	1-800-CHILDREN
3. Name of Contact Person for State MCH "Hotline"	Pamela Noble	Pamela Noble
4. Contact Person's Telephone Number	(316) 942-4261	(316) 942-4261
5. Number of Calls Received on the State MCH "Hotline"		916

B. Other Appropriate Methods	2022 Application Year	2020 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.hrm; www.kansasmch.org; https://1800childrenks.org/	www.kdheks.gov/c-f/mch.hrm; www.kansasmch.org; https://1800childrenks.org/
4. Number of Hits to the State Title V Program Website		11,417
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		193

## Form Notes for Form 7:

The State MCH 'hotline' is a partnership between the Kansas Children's Cabinet and Trust Fund (KCCTF), Kansas State Department of Education (KSDE), Kansas Department for Children and Families (DCF), and Kansas Department of Health and Environment (KDHE), and operated through the Kansas Service Children's League.

Data included for the number of calls to the "hotline" are potentially duplicated counts and are not specific to only Title V-related phone calls. It is noted the calls reduced from the previous reporting year and attributed to an increased campaign to the state's 2-1-1 system during the COVID-19 pandemic.

Hits to the MCH Website ([www.kansasmch.org](http://www.kansasmch.org)) are listed as the number of "pageviews" - which is defined as the total number of pages viewed. Repeated views of a single page are counted.

- Reporting Year 2019 - 6,764
- Reporting Year 2020 - 11,417

\*\*\*INCREASE OF 4,653!!!\*\*\*

Number of "Users" (Users who have initiated at least one session during the date range. In this case, unique users within each month.)

- Reporting Year 2019 - 1,692
- Reporting Year 2020 - 2,682

\*\*\*INCREASE OF 990!!!\*\*\*

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

- Reporting Year 2019 - 2,574
- Reporting Year 2020 - 4,297

\*\*\*INCREASE OF 1,723!!!\*\*\*

Hits to Facebook page ([www.facebook.com/kansasmch](https://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 2019 - 468, September 2020 - 661, difference of 193 "new" likes).

The top 10 MCH Facebook Posts reached 29,422 Views, 196 Shares, and 362 Reactions.

1. COVID-10 FAQ's: Reach: 16,754, Shares: 99, Reactions: 115
2. Well Visits During the COVID-19 Pandemic: Reach: 2,319, Shares: 13, Reactions: 28
3. Pregnancy & Infant Loss Awareness Month: Reach: 1,760, Shares: 11, Reactions: 81
4. #BeThe1ToFollowUp: Reach: 1,760, Shares: 13, Reactions: 19
5. Healthy Pregnancy: Get the Facts: Reach: 1,388, Shares: 15, Reactions: 21
6. Symptoms of Flu: Reach: 1,264, Shares: 13, Reactions: 28
7. Tobacco and Pregnancy: Reach: 1,081, Shares: 8, Reactions: 17
8. Safe Sleep: Reach: 1,044, Shares: 12, Reactions: 33
9. Masks for Children: Reach: 1,031, Shares: 6, Reactions: 6
10. Wash Your Hands: Reach: 1,021, Shares: 6, Reactions: 14

**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 St.
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	cassandracc@cox.net

**Form Notes for Form 8:**

None



**Form 9**  
**List of MCH Priority Needs**

**State: Kansas**

**Application Year 2022**

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 9 State Priorities – Needs Assessment Year – 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
2019	83.5 %	0.2 %	29,364	35,164
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

State Provided Data	
	2020
Annual Indicator	80.9
Numerator	28,281
Denominator	34,970
Data Source	Kansas Vital Statistics
Data Source Year	2019

**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
2018	62.1	4.4	205	33,029
2017	57.7	4.1	196	33,974
2016	56.1	4.0	197	35,105
2015	70.6	5.2	188	26,635
2014	60.7	4.1	216	35,613
2013	61.9	4.2	219	35,361
2012	59.8	4.1	219	36,652
2011	60.4	4.1	220	36,403
2010	58.0	4.0	216	37,215
2009	56.7	3.8	219	38,629
2008	46.8	3.5	183	39,137

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

	<b>2020</b>
<b>Annual Indicator</b>	65.9
<b>Numerator</b>	214
<b>Denominator</b>	32,453
<b>Data Source</b>	Kansas Hospital Discharge Data
<b>Data Source Year</b>	2019

**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
2015_2019	16.7	3.0	31	185,382
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
2019	7.6 %	0.1 %	2,685	35,387
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**State Provided Data**

	2020
Annual Indicator	7.6
Numerator	2,689
Denominator	35,394
Data Source	Kansas Vital Statistics
Data Source Year	2019

**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
2019	10.1 %	0.2 %	3,574	35,384
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	10.1
<b>Numerator</b>	3,569
<b>Denominator</b>	35,373
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**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
2019	27.2 %	0.2 %	9,611	35,384
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**State Provided Data**

	2020
Annual Indicator	27.2
Numerator	9,608
Denominator	35,373
Data Source	Kansas Vital Statistics
Data Source Year	2019

**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
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
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
2018	6.2	0.4	225	36,351
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	5.3
<b>Numerator</b>	189
<b>Denominator</b>	35,483
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**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
2018	6.4	0.4	231	36,261
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	5.3
<b>Numerator</b>	189
<b>Denominator</b>	35,395
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**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
2018	4.4	0.4	161	36,261
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	3.3
<b>Numerator</b>	118
<b>Denominator</b>	35,395
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**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
2018	1.9	0.2	70	36,261
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	2.0
<b>Numerator</b>	71
<b>Denominator</b>	35,395
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**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
2018	201.3	23.6	73	36,261
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	152.6
<b>Numerator</b>	54
<b>Denominator</b>	35,395
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

**NOM 9.5 - 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
2018	115.8	17.9	42	36,261
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	101.7
<b>Numerator</b>	36
<b>Denominator</b>	35,395
<b>Data Source</b>	Kansas Vital Statistics
<b>Data Source Year</b>	2019

**NOM 9.5 - Notes:**

None

**Data Alerts: None**



**NOM 10 - Percent of women who drink alcohol 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, since it is supposed to be in the same skip pattern with the other alcohol questions we ask.

CDC plans to deploy the Phase 9 survey in the field in April of 2023 (Calendar year 2023 births).

**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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

## Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.8	0.3	124	32,483
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

## State Provided Data

	2020
Annual Indicator	3.6
Numerator	116
Denominator	32,249
Data Source	Kansas Hospital Discharge Data
Data Source Year	2019

### 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
2018_2019	11.7 %	1.4 %	78,002	663,899
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
2019	17.3	2.2	60	346,369
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

**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	17.3
<b>Numerator</b>	60
<b>Denominator</b>	346,369
<b>Data Source</b>	Kansas Vital Statistics and U.S. Census Bureau
<b>Data Source Year</b>	2019

**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
2019	37.7	3.1	151	400,397
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

**State Provided Data**

	2020
Annual Indicator	37.5
Numerator	150
Denominator	400,397
Data Source	Kansas Vital Statistics and U.S. Census Bureau
Data Source Year	2019

**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
2017_2019	14.8	1.6	89	601,045
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

**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	14.6
<b>Numerator</b>	88
<b>Denominator</b>	601,045
<b>Data Source</b>	Kansas Vital Statistics and U.S. Census Bureau
<b>Data Source Year</b>	2017-2019

**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
2017_2019	19.6	1.8	118	601,045
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	19.6
<b>Numerator</b>	118
<b>Denominator</b>	601,045
<b>Data Source</b>	Kansas Vital Statistics and U.S. Census Bureau
<b>Data Source Year</b>	2017-2019

**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
2018_2019	20.5 %	1.6 %	144,750	705,972
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
2018_2019	20.8 %	3.5 %	30,156	144,750
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
2018_2019	0.9 %	0.2 %	5,275	587,523
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
2018_2019	9.2 %	1.1 %	53,723	582,714
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
2018_2019	55.9 % ⚡	5.4 % ⚡	51,477 ⚡	92,092 ⚡
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
2018_2019	93.3 %	1.1 %	658,139	705,121
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
2018	13.7 %	0.2 %	2,880	21,050
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
2019	15.1 %	1.3 %	20,586	136,020
2017	13.1 %	0.9 %	18,148	138,921
2013	12.6 %	1.0 %	17,821	141,855
2011	10.2 %	0.8 %	13,952	136,688
2009	12.2 %	1.0 %	16,124	132,280
2007	11.0 %	0.9 %	14,088	127,528
2005	11.8 %	1.0 %	16,679	141,896

**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
2018_2019	10.6 %	1.4 %	32,815	309,990
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
2019	5.8 %	0.6 %	40,670	700,401
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 who have completed the combined 7-vaccine series (4:3:1:3\*:3:1:4) by age 24 months**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	67.9 %	3.8 %	26,000	38,000
2015	73.2 %	4.2 %	29,000	40,000
2014	73.1 %	4.0 %	29,000	40,000
2013	74.0 %	3.6 %	30,000	41,000
2012	72.7 %	3.8 %	30,000	41,000
2011	66.6 %	4.3 %	27,000	41,000

**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
2019_2020	66.1 %	1.8 %	441,191	667,460
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
2019	65.9 %	3.2 %	130,157	197,406
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
2019	91.9 %	1.6 %	181,462	197,406
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
2019	80.7 %	2.6 %	159,389	197,406
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
2019	19.2	0.5	1,857	96,680
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**State Provided Data**

	<b>2020</b>
<b>Annual Indicator</b>	19.2
<b>Numerator</b>	1,858
<b>Denominator</b>	96,680
<b>Data Source</b>	Kansas Vital Statistics and U.S. Census Bureau
<b>Data Source Year</b>	2019

**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
2019	13.5 %	1.4 %	4,466	33,035
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 unable to obtain needed health care in the past year**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.8 %	0.8 %	19,454	699,245
2017_2018	2.0 %	0.5 %	13,994	708,029
2016_2017	2.1 %	0.5 %	14,729	712,436
2016	1.8 % ⚡	0.5 % ⚡	13,044 ⚡	713,854 ⚡

**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 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	2020
Annual Objective					73.4
Annual Indicator				71.4	71.7
Numerator				351,350	351,743
Denominator				492,351	490,367
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

**i** Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.7	73.7	74.8	75.8	76.9	77.9

**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	2020
Annual Objective		
Annual Indicator	84.8	84.4
Numerator	28,021	27,690
Denominator	33,030	32,822
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.7	87.0	88.3	89.6	90.9	92.3

**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	2020
Annual Objective		
Annual Indicator	37.0	41.2
Numerator	11,666	13,034
Denominator	31,547	31,644
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.3	45.4	47.7	50.1	52.6	55.2

**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	2020
Annual Objective		
Annual Indicator	49.1	54.1
Numerator	15,627	17,106
Denominator	31,810	31,621
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.8	59.6	62.6	65.8	69.0	72.5

**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	2020
Annual Objective			43.7	39.7	36.3
Annual Indicator		41.6	37.8	34.6	36.9
Numerator		33,290	30,554	27,890	31,330
Denominator		79,958	80,931	80,611	84,875
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	38.7	40.7	42.7	44.9	47.1	49.4


**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	2020
Annual Objective			80.8	78.5	78.5
Annual Indicator		79.8	77.5	77.5	75.8
Numerator		185,414	184,888	184,888	186,069
Denominator		232,249	238,418	238,418	245,601
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	76.7	77.7	78.7	79.7	80.7	81.7

**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 to prepare for the transition to adult health care - Children with Special Health Care Needs**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2019	2020
Annual Objective		
Annual Indicator	20.9	30.0
Numerator	13,192	19,882
Denominator	63,103	66,317
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.5	33.1	34.7	36.5	38.3	40.2

**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	2020
Annual Objective	87.2	88.6	90	89.7	90.9
Annual Indicator	83.8	77.1	83.6	88.0	84.6
Numerator	32,783	29,183	30,314	29,928	26,783
Denominator	39,126	37,866	36,276	34,017	31,642
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	87.2	88.6	90	89.7	90.9
Annual Indicator	87.4	88.1	88.5	88.7	88.9
Numerator	34,078	33,429	32,162	31,987	31,339
Denominator	38,998	37,937	36,331	36,066	35,234
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	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	2020
Annual Objective	27.7	29.4	26	26.8	27.4
Annual Indicator	23.4	24.5	26.1	31.4	31.6
Numerator	9,025	9,095	9,159	10,404	9,812
Denominator	38,643	37,166	35,100	33,125	31,016
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

**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	2020
Annual Objective	80.9	75.1	114.5	113.4	110.4
Annual Indicator	80.8	135.5	116.4	119.1	123.0
Numerator	325	406	461	468	476
Denominator	402,420	299,709	395,930	392,943	386,956
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018


State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	80.9	75.1	114.5	113.4	110.4
Annual Indicator		111.9	112	109.1	131.7
Numerator		443	440	422	456
Denominator		395,930	392,943	386,956	346,369
Data Source		Kansas Vital Statistics and U.S. Census Bureau	Kansas Vital Statistics and U.S. Census Bureau	Kansas Vital Statistics and U.S. Census Bureau	Kansas Vital Statistics and U.S. Census Bureau
Data Source Year		2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

**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	2020
Annual Objective			39.6	48.4	50.8
Annual Indicator		38.6	46.1	52.3	57.1
Numerator		56,808	68,059	75,646	82,683
Denominator		147,272	147,776	144,559	144,750
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

 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	2020
Annual Objective	11.4	10.7	9.5	9.4	8.8
Annual Indicator	11.0	10.2	10.1	9.5	8.5
Numerator	4,298	3,877	3,683	3,440	2,994
Denominator	39,083	37,965	36,434	36,155	35,284
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	11.4	10.7	9.5	9.4	8.8
Annual Indicator	11	10.2	10.1	9.5	8.5
Numerator	4,294	3,878	3,680	3,438	2,994
Denominator	39,052	37,961	36,374	36,161	35,280
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	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**

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	14.7	13.5
Numerator	4,930	4,466
Denominator	33,605	33,035
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	12.8	12.2	11.6	11.0	10.4	9.9

**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	2020
Annual Objective		
Annual Indicator	31.4	31.6
Numerator	10,404	9,812
Denominator	33,125	31,016
Data Source	NIS	NIS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.4	33.2	34.0	34.9	35.8	36.6

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	75.0	80.0	85.0	90.0	95.0

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data Source: MCH sponsored workforce post-event surveys (To be developed)
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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	2020
Annual Objective		
Annual Indicator	55.9	55.9
Numerator	389,023	387,759
Denominator	695,564	694,108
Data Source	NSCH	NSCH
Data Source Year	2017-2018	2018-2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	58.7	51.6	64.7	67.9	71.3	74.9

**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	2020
Annual Objective		8.3	8.9	9.1	8.7
Annual Indicator	8.8	9.1	9.6	9.5	10.1
Numerator	3,423	3,454	3,490	3,438	3569
Denominator	39,102	38,031	36,438	36,238	35,373
Data Source	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics	Kansas Vital Statistics
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	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	2020
Annual Objective		29.6	35.4	28	29.4
Annual Indicator	28.2	32	26.7	26.8	32.7
Numerator	133,276	77,678	60,041	63,077	84,794
Denominator	473,426	242,379	224,657	234,934	258,969
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2016	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NSCH 2016 data cannot be compared with previous years.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NSCH 2016 and 2016-2017 data cannot be compared with previous years.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NSCH 2016, 2016-2017, and 2017-2018 data cannot be compared with previous years.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NSCH 2016, 2016-2017, 2017-2018, and 2018-2019 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	2020
Annual Objective			55	100	105
Annual Indicator	36	50	93	177	279
Numerator					
Denominator					
Data Source	KIDS Network	KIDS Network	KIDS Network	KIDS Network	KIDS Network
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	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	2020
Annual Objective		44.7	7	6.8	6.6
Annual Indicator	47	7.2	7.9	7.9	7.9
Numerator	987,775				
Denominator	2,101,649				
Data Source	Kaiser Family Foundation	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2008	2016	2018	2018	2018
Provisional or Final ?	Provisional	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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	2020
Annual Objective			1,000	1,500
Annual Indicator			1,126	2,009
Numerator				
Denominator				
Data Source			State sponsored workforce development events	State sponsored workforce development events
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<p><b>Field Note:</b>            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&amp;F Meeting (workforce development)            * Governor's Public Health Conference (workforce development)</p>	
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<p><b>Field Note:</b>            State sponsored workforce development events include:            * MCH TA Webinars (workforce development)            * MCH Check-In Meetings (one-on-one)            * MCH-HV Fall Trainings (workforce development)            * Regional C&amp;F Meeting (workforce development)            * Governor's Public Health Conference (workforce development)            * Kansas Connecting Communities (KCC) and KSKidsMAP trainings</p> <p>Due to COVID-19, no MCH Site Visits were conducted.</p>	

**Form 10**  
**Evidence-Based or –Informed Strategy Measures (ESMs)**  
**State: Kansas**

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

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	78.5	
Numerator	5,412	
Denominator	6,896	
Data Source	DAISEY	
Data Source Year	2019	
Provisional or Final ?	Provisional	

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	80.5	82.5	84.5	86.6	88.8	91.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Preliminary data subject to change Include: MCH, Kansas Perinatal Community Collaborative (Becoming a Mom), Pregnancy Maintenance Initiative, and Teen Pregnancy Targeted Case Management Program	
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> 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**

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

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	94.2	95.2	96.1	97.1	98.1	99.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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**

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	89.5	
Numerator	214	
Denominator	239	
Data Source	DAISEY	
Data Source Year	2020	
Provisional or Final ?	Provisional	

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	91.3	92.2	93.1	94.1	95.0	96.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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	2020
Annual Objective		90	72.7	25	27.5
Annual Indicator	12.7	21.4	22.3	15	15
Numerator	243	347	340	256	256
Denominator	1,907	1,621	1,524	1,707	1,707
Data Source	DAISEY	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.5	35.0	37.5	40.0	42.5

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> CY2016: MCH service data	
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> CY2017: MCH service data	
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> CY2018: MCH service data	
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Preliminary data subject to change CY2019: MCH service data	
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> 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	2020
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	2026
Annual Objective	38.3	40.2	42.3	44.4	46.6	48.9

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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	2020
Annual Objective		
Annual Indicator	50	16.7
Numerator	2	1
Denominator	4	6
Data Source	Welligent	Welligent
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	52.5	55.1	57.9	60.8	63.8	67.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	SFY2019
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data for ESM 12.1 was identified as having reporting gaps that will be corrected in the next few month. Staff training needs were identified when pulling this data that showed care coordinators were not adding the completion dates and/or target dates to the client goals. Both dates are required to get valid data. A training webinar is being planned for September 2021 and a new process will be developed to monitor the data monthly moving forward.

**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	2020
Annual Objective		20	30	30	35
Annual Indicator	24.7	28	25.9	25.1	24.4
Numerator	1,604	1,773	1,702	2,147	1,502
Denominator	6,496	6,335	6,578	8,570	6,163
Data Source	DAISEY	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> 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.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> 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.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> 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.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Preliminary data - subject to change CY2019: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom data	
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Preliminary data - subject to change CY2020: 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	2020
Annual Objective		22.5	15	17.5	20
Annual Indicator	14.1	13.9	13.7	13.1	12.7
Numerator	943	990	966	1,319	1,185
Denominator	6,671	7,121	7,075	10,035	9,314
Data Source	KWIC	KWIC	KWIC	KWIC	KWIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<p><b>Field Note:</b>            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)</p> <p>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)</p>	
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<p><b>Field Note:</b>            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)</p> <p>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)</p>	
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>



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**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)

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4. **Field Name:** 2019

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**Column Name:** State Provided Data

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**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)

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5. **Field Name:** 2020

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**Column Name:** State Provided Data

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**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)

**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	2020
Annual Objective		1,050	1,100	1,000	1,050
Annual Indicator	969	1,094	961	1,019	1,002
Numerator					
Denominator					
Data Source	Kansas Traffic Safety Resource Office	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	2019
Provisional or Final ?	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	2020
Annual Objective		30	40.3	32.5	35
Annual Indicator	24.4	32.6	30.3	48.1	41
Numerator	1,098	1,318	1,118	1,919	575
Denominator	4,492	4,042	3,690	3,986	1,404
Data Source	DAISEY	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	CY2016: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	CY2017: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	CY2018: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Preliminary data subject to change CY2019: MCH and Kansas Perinatal Community Collaborative/Becoming a Mom service data
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Preliminary data subject to change CY2020: 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	2020
Annual Objective		5	5	70	75
Annual Indicator	0	0	66.7	62.9	85
Numerator			18	22	17
Denominator			27	35	20
Data Source	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services	Kansas Special Health Services
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	It is currently being piloted. The data will be available in January of 2018.
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	It is currently being piloted. The data will be available in January of 2018.
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data are from the last three quarters of CY2018: Q2, Q3, and Q4.
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	SFY2019
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	SFY2020

**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	2020
Annual Objective		15	30	50	55
Annual Indicator	31.1	38.9	43.5	32	32.9
Numerator	42	96	104	89	55
Denominator	135	247	239	278	167
Data Source	DAISEY	DAISEY	DAISEY	DAISEY	DAISEY
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

**Field Level Notes for Form 10 ESMs:**



1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> CY2016: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> CY2017: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> CY2018: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Preliminary data - subject to change  CY2019: Pregnant women (MCH and Kansas Perinatal Community Collaborative/Becoming a Mom) and referral service data	
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Preliminary data - subject to change  CY2020: 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**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	To reduce the prevalence of postpartum depression	
<b>Definition:</b>	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
	<b>Numerator:</b>	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)
	<b>Denominator:</b>	Number of women with a recent live birth
<b>Healthy People 2030 Objective:</b>	Not Available	
<b>Data Sources and Data Issues:</b>	Pregnancy Risk Assessment Monitoring System (PRAMS)	
<b>Significance:</b>	<p>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.</p> <p>Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. American Journal of Obstetrics &amp; Gynecology. 2009;200(4):357-364.  <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3918890/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3918890/</a></p> <p>Screening for perinatal depression. Committee Opinion No. 630. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:1268–71.  <a href="http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression">http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression</a></p>	

**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:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Number of infants breastfed exclusively through 6 months
	Denominator:	Number of infants born in a calendar year
Healthy People 2030 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 15: Increase the proportion of infants who are breastfed exclusively through 6 months (Baseline: 24.9% of infants born in 2015, Target: 42.4%)	
	Related to MICH Objective 16: Increase the proportion of infants who are breastfed at 1 year (Baseline: 35.9% of infants born in 2015, Target: 54.1%)	
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. <a href="http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552">http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552</a>	

**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:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of participants who reported increased self-efficacy after attending a state sponsored workforce development event</td></tr><tr><td>Denominator:</td><td>Number of participants who attended a state sponsored workforce development event</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	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									
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									
Healthy People 2030 Objective:	Not Available									
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:	Unit Type:	Percentage
	Unit Number:	100
	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
Healthy People 2030 Objective:	Not Available	
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. <a href="https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Promoting-Resilience.aspx">https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Promoting-Resilience.aspx</a> 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. <a href="https://www.aap.org/en-us/Documents/resilience_messaging-at-the-intersections.pdf">https://www.aap.org/en-us/Documents/resilience_messaging-at-the-intersections.pdf</a>	

**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:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of live births before 37 weeks of complete gestation</td></tr><tr><td>Denominator:</td><td>Number of live births</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of live births before 37 weeks of complete gestation	Denominator:	Number of live births
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of live births before 37 weeks of complete gestation									
Denominator:	Number of live births									
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:	<p>Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and “early term” (37, 38 weeks’ gestation) are more likely than full-term babies to experience morbidity and mortality.</p> <p>Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth.</p> <p>Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.</p>									

**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:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of children ages 6 through 11 (NSCH) who report being physically active at least 60 minutes per day in the past week</td></tr><tr><td>Denominator:</td><td>Number of children ages 6 through 11 (NSCH)</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	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									
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)									
Healthy People 2020 Objective:	<p>Related to Physical Activity (PA) Objective 4.1: Increase the proportion of the Nation’s public and private elementary schools that require daily physical education for all students. (Baseline: 3.8%, Target: 4.2%)</p> <p>Related to Physical Activity (PA) Objective 3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. (Baseline: 18.4%, Target: 20.2% for adolescents to meet current physical activity guidelines for aerobic physical activity)</p>									
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:	<table><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>1,000</td></tr><tr><td>Numerator:</td><td>Number of professionals who have received Safe Sleep training</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	1,000	Numerator:	Number of professionals who have received Safe Sleep training	Denominator:	
Unit Type:	Count									
Unit Number:	1,000									
Numerator:	Number of professionals who have received Safe Sleep training									
Denominator:										
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:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them</td></tr><tr><td>Denominator:</td><td>Number of adults aged 18 or older</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	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									
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									
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:	<p>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.</p> <p>Reference: Graham S, Brookey J. Do Patients Understand? Perm J. 2008 Summer; 12(3): 67–69.</p>									

**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:	<table><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>20,000</td></tr><tr><td>Numerator:</td><td>Number of MCH grantees, families and partners that participated in a state sponsored workforce development event</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	20,000	Numerator:	Number of MCH grantees, families and partners that participated in a state sponsored workforce development event	Denominator:	
Unit Type:	Count									
Unit Number:	20,000									
Numerator:	Number of MCH grantees, families and partners that participated in a state sponsored workforce development event									
Denominator:										
Healthy People 2020 Objective:	NA									
Data Sources and Data Issues:	Kansas Maternal & Child Health - Community Check Box									
Significance:	<p>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.</p> <p>Source: <a href="https://mchwdc.unc.edu/knowledge-tools/skills-to-support-the-national-performance-measures/">https://mchwdc.unc.edu/knowledge-tools/skills-to-support-the-national-performance-measures/</a></p>									

**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**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	To increase the number of women that receive well visits/preventive health care	
<b>Definition:</b>	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
	<b>Numerator:</b>	Number of women program participants (18-44 years) who have had a well visit during the last 12 months
	<b>Denominator:</b>	Number of women program participants (18-44 years)
<b>Data Sources and Data Issues:</b>	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	
<b>Evidence-based/informed strategy:</b>	<p>1. 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.</p> <p>2 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.</p> <p>3 Utilize peer and social networks for women, including peer group education models, to promote and support access to preventive care.</p> <p>4 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.</p> <p>5 Promote and support Medicaid policy change to expand pregnancy coverage through 12 months post-partum and the inclusion of screening for Perinatal Mood and Anxiety Disorders (PMADs) as a covered service.</p>	
<b>Significance:</b>	A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, 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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of infants placed to sleep on their backs and on a separate approved surface, without soft objects or loose bedding								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td><td>Percentage</td></tr> <tr> <td><b>Unit Number:</b></td><td>100</td></tr> <tr> <td><b>Numerator:</b></td><td>A) Number of mothers reporting that they place their baby to sleep on their back</td></tr> <tr> <td><b>Denominator:</b></td><td>Number of infants with information reported</td></tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	A) Number of mothers reporting that they place their baby to sleep on their back	<b>Denominator:</b>	Number of infants with information reported
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	A) Number of mothers reporting that they place their baby to sleep on their back								
<b>Denominator:</b>	Number of infants with information reported								
<b>Data Sources and Data Issues:</b>	Kansas Perinatal Community Collaborative (KPCC)/Becoming a Mom (BaM) Birth Outcome Card								
<b>Evidence-based/informed strategy:</b>	<ol style="list-style-type: none"> <li>1. 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.</li> <li>2. 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.</li> <li>3. 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.</li> <li>4. Assist local MCH service providers in creating opportunities for real conversations with parents and caregivers identifying true barriers to implementing safe sleep practices.</li> </ol>								
<b>Significance:</b>	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. <a href="http://pediatrics.aappublications.org/content/128/5/1030">http://pediatrics.aappublications.org/content/128/5/1030</a>								

**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of infants placed to sleep on their backs and on a separate approved surface, without soft objects or loose bedding								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td><td>Percentage</td></tr> <tr> <td><b>Unit Number:</b></td><td>100</td></tr> <tr> <td><b>Numerator:</b></td><td>B) Mothers reporting that their baby sleeps in a crib/bassinet, or portable crib</td></tr> <tr> <td><b>Denominator:</b></td><td>Infants with information reported</td></tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	B) Mothers reporting that their baby sleeps in a crib/bassinet, or portable crib	<b>Denominator:</b>	Infants with information reported
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	B) Mothers reporting that their baby sleeps in a crib/bassinet, or portable crib								
<b>Denominator:</b>	Infants with information reported								
<b>Data Sources and Data Issues:</b>	Kansas Perinatal Community Collaborative (KPCC)/Becoming a Mom (BaM) Birth Outcome Card								
<b>Evidence-based/informed strategy:</b>	<ol style="list-style-type: none"> <li>1. 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.</li> <li>2. 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.</li> <li>3. 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.</li> <li>4. Assist local MCH service providers in creating opportunities for real conversations with parents and caregivers identifying true barriers to implementing safe sleep practices.</li> </ol>								
<b>Significance:</b>	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. <a href="http://pediatrics.aappublications.org/content/128/5/1030">http://pediatrics.aappublications.org/content/128/5/1030</a>								



**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of children who receive a developmental screening								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td><td>Percentage</td></tr> <tr> <td><b>Unit Number:</b></td><td>100</td></tr> <tr> <td><b>Numerator:</b></td><td>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</td></tr> <tr> <td><b>Denominator:</b></td><td>Number of children, age 9 through 35 months</td></tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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	<b>Denominator:</b>	Number of children, age 9 through 35 months
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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								
<b>Denominator:</b>	Number of children, age 9 through 35 months								
<b>Data Sources and Data Issues:</b>	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								
<b>Evidence-based/informed strategy:</b>	<ol style="list-style-type: none"> <li>1. 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</li> <li>2. 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.</li> <li>3. 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).</li> <li>4. 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).</li> </ol>								
<b>Significance:</b>	<p>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.</p> <p>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. <a href="http://pediatrics.aappublications.org/content/118/1/405">http://pediatrics.aappublications.org/content/118/1/405</a></p>								



**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.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of adolescents who have a preventive medical visit								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td><td>Percentage</td></tr> <tr> <td><b>Unit Number:</b></td><td>100</td></tr> <tr> <td><b>Numerator:</b></td><td>Adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months</td></tr> <tr> <td><b>Denominator:</b></td><td>Adolescent program participants, ages 12 through 17</td></tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months	<b>Denominator:</b>	Adolescent program participants, ages 12 through 17
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months								
<b>Denominator:</b>	Adolescent program participants, ages 12 through 17								
<b>Data Sources and Data Issues:</b>	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								
<b>Evidence-based/informed strategy:</b>	<ol style="list-style-type: none"> <li>1. Engage partners to promote a stronger cross-system recommendation to conduct complete annual well visits during adolescence utilizing all elements of the Bright Futures™ guidelines.</li> <li>2. Conduct annual provider educational efforts to support provider knowledge acquisition regarding the importance of comprehensive, quality adolescent well visits and the Bright Futures™ Guidelines.</li> <li>3. 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.</li> <li>4. Engage local health agencies to implement youth-friendly care approaches from the Adolescent Health Institute in their facilities.</li> </ol>								
<b>Significance:</b>	<p>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.</p> <p>National Adolescent and Young Adult Health Information Center (2016). Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to age 18. <a href="http://nahic.ucsf.edu/adolescentguidelines">http://nahic.ucsf.edu/adolescentguidelines</a>.</p>								



**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 to prepare for the transition to adult health care**

Measure Status:	Active									
Goal:	To ensure that youth with special health care needs are better equipped to transition into adult life									
Definition:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>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</td></tr><tr><td>Denominator:</td><td>Number of youth program participants with special healthcare needs, ages 12 to 21</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	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									
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									
Data Sources and Data Issues:	KS-SHCN Care Coordination Measurement Tool (Welligent)									
Evidence-based/informed strategy:	<ol style="list-style-type: none"><li>1. 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.</li><li>2. 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.</li><li>3. Partner with health care professional organizations to engage with insurers to support adequate reimbursement for transition care services.</li></ol>									
Significance:	<p>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.</p> <p>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. <a href="http://pediatrics.aappublications.org/content/110/Supplement_3/1304">http://pediatrics.aappublications.org/content/110/Supplement_3/1304</a>.</p>									

**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To ensure supportive programming for well woman visits/preventive health care.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td><td>Percentage</td></tr> <tr> <td><b>Unit Number:</b></td><td>100</td></tr> <tr> <td><b>Numerator:</b></td><td>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</td></tr> <tr> <td><b>Denominator:</b></td><td>Number of MCH women (including pregnant and postpartum, ages 18-44) program participants</td></tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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	<b>Denominator:</b>	Number of MCH women (including pregnant and postpartum, ages 18-44) program participants
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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								
<b>Denominator:</b>	Number of MCH women (including pregnant and postpartum, ages 18-44) program participants								
<b>Data Sources and Data Issues:</b>	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								
<b>Significance:</b>	A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, shots, screenings, education, and counseling.								

**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:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of WIC infants breastfed exclusively through six months in communities that have reached the designation of a “Community Supporting Breastfeeding”</td></tr><tr><td>Denominator:</td><td>Number of WIC infants in communities that have reached the designation of a Community Supporting Breastfeeding</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	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									
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									
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:	<table><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>5,000</td></tr><tr><td>Numerator:</td><td>Number of free car seat safety inspections completed by certified child passenger safety technicians</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	5,000	Numerator:	Number of free car seat safety inspections completed by certified child passenger safety technicians	Denominator:	
Unit Type:	Count									
Unit Number:	5,000									
Numerator:	Number of free car seat safety inspections completed by certified child passenger safety technicians									
Denominator:										
Data Sources and Data Issues:	Kansas Traffic Safety Resource Office									
Significance:	<p>Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.</p> <p>Motor vehicle injuries are a leading cause of death among children in the United States. A correctly used car seat or seatbelt can keep a child from being ejected during a car crash. Many times, child restraint systems are used incorrectly. An estimated 46% of car and booster seats (59% of car seats and 20% of booster seats) are misused in a way that can reduce their effectiveness. The Community Preventive Service Task Force recommends car seat laws and car seat distribution plus education programs to increase restraint use and decrease injuries and death to child passengers.</p>									

**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:	Unit Type:	Percentage
	Unit Number:	100
	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
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. <a href="http://nahic.ucsf.edu/adolescentguidelines">http://nahic.ucsf.edu/adolescentguidelines</a> .	

**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:	Unit Type:	Percentage
	Unit Number:	100
	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.
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:	<p>Care coordination involves the “deliberate organization of patient care activities between two or more participants (including the patient) involved in the patient’s care to facilitate the appropriate delivery of health services.” Care coordination is a key function of the medical home.</p> <p>The Family Advisory Council for Kansas defines care coordination as a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and financial needs to achieve optimal health. Key activities of care coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.</p> <p>The care coordination curriculum 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.</p>	

**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:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted services</td></tr><tr><td>Denominator:</td><td>Number of pregnant women program participants who smoke referred/enrolled to an evidence-based program</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	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									
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									
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](#)

**Form 12**  
**MCH Data Access and Linkages**

**State: Kansas**

**Annual Report Year 2020**

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	3		
2) Vital Records Death	Yes	Yes	Quarterly	3	Yes	
3) Medicaid	Yes	Yes	Daily	3	Yes	
4) WIC	Yes	Yes	Daily	0	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	18	Yes	

**Other Data Source(s) (Optional)**

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Birth Defects	Yes	Yes	Daily	0	Yes	



**Form Notes for Form 12:**

None

**Field Level Notes for Form 12:**

None