

Kansas Maternal & Child Health Service Manual



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

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KANSAS
MATERNAL &
CHILD HEALTH

Vision: Title V Maternal & Child Health envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission: To improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

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Forward

The Maternal and Child Health (MCH) Services Manual reflects a commitment of the Children and Families Section and Special Health Services Section within the Bureau of Family Health (BFH), Kansas Department of Health and Environment (KDHE), to promote the KDHE mission: To protect and improve the health and environment of all Kansans.

This manual was developed specifically for use by the workforce delivering services to women, infants, children, youth and their families.

100 - Overview of Maternal & Child Health (MCH) Services in Kansas

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101 Bureau of Family Health Mission

The mission of the Bureau of Family Health is to provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.

102 Bureau of Family Health Services Philosophy

Holistic health services and health promotion for children and youth, including those with special health care needs, and their families should be made available and accessible through integrated systems that promote individualized, family-centered, community-based and coordinated care. These services are founded on sound theoretical and evidence-based principals within current standard of health practices. Gaps and barriers to essential services must be identified and addressed in a delivery model that sustains broad based efforts for the promotion and maintenance of optimum health.

103 History of MCH in Kansas

A legislative mandate created the Kansas Division of Child Hygiene in 1915 “that the general duties of this Division of the State Board of Health shall include the issuance of educational literature on the care of the baby and the hygiene of the child, the study of the causes of infant mortality and the application of preventive measures for the prevention and suppression of the diseases of infancy and early childhood.” These original charges have served as the framework for the Kansas Maternal and Child Health program which has evolved over the last 100 years and are an integral component of our present services.

The Kansas Maternal and Child Health Service was organized as a bureau in 1974 when legislation established a Department of Health and Environment with a Secretary of Cabinet status in the Governor’s office to replace the original Board of Health.

104 MCH Goal & Standards

The following MCH goal and standards is the framework for services to women and their families. Each community has unique health needs and priorities. Each MCH grantee must determine the needs of their community through a local community needs assessment process and assure that consideration is given to address health priorities for Kansas.

Goal: Maternal and Child Health (MCH) services enhance the health of Kansans in partnership with families and communities.

Standard 1: Community Needs Identification

Specific MCH program services provided by local agencies are to be determined by the local grantees in collaboration with community partners/stakeholders of the MCH population using information from a community need and resource assessment as a basis for coordination, planning and evaluation. Once local needs are identified, it is desired to align needs with the state MCH priorities to determine how to allocate resources for greatest impact.

- **Rationale:**

An important element of public health infrastructure is the ability of local health departments to assess and monitor the health of their community, to disseminate timely information and to identify emerging threats.

The community assessment includes a current demographic, cultural and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. Public health professionals must effectively address health disparities of racial/ethnic populations assuring services are culturally and linguistically accessible during health priority setting, decision-making and program development. Ensuring access to services based on community and regional needs facilitates the provision of care to all childbearing women, their infants, children, adolescents and families.

To learn more about community needs assessments, go to:

- Center for Disease Control and Prevention Community Health Improvement Navigator ¹ <https://www.cdc.gov/chinav/index.html>
- Healthy People 2020. “A Guide to Using Healthy People 2020 in Your Community.”² <http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning>
- **Local agency grantees:**
 - Identify, define and prioritize specific interventions addressing the specific health care needs of the community.
 - Ensure ongoing community involvement in the planning, implementation and evaluation of the program.
 - Ensure involvement of representatives of the cultural, racial, ethnic, gender, economic and linguistic diversities within the community.
 - Provide educational materials and services in a manner and format that best meets cultural, linguistic, cognitive, literacy and accessibility needs of the community.
 - Move toward full compliance with the four mandated Culturally and Linguistically Appropriate Service standards (CLAS).
<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53> (standards and fact sheet)
 - Establish or maintain a committee of community partners/stakeholders, including family representatives, that advises on community MCH health issues. It is desired that at least 25% of committee membership be held by consumers served by local MCH programs.
 - Work with other local, state and federal entities in the community to develop a network of complementary services.
 - Make every attempt to employ staff that is representative of the population being served.
 - Build systems of coordinated health care within your community and/or region.
 - Provide Translation/Interpreter services or have bilingual staff available.

¹ CDC Community Health Improvement Navigator <https://www.cdc.gov/chinav/index.html>

² Healthy People in Healthy Communities: A Community Planning Guide Using Healthy People 2010 <http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning>

Standard 2: Infrastructure

Public health infrastructure is maintained to protect the MCH and special health care needs populations' health and safety, provide credible information for better health decisions and promote good health through a network of partnerships that works to achieve measurable improvements in operational efficiencies and most importantly, to improve the quality of available health care.

- **Rationale:**

Public health infrastructure is defined as a complex web of practices and organizations, public and private, governmental and nongovernmental entities that provide services to the MCH population. An important element of public health infrastructure is the ability of local health departments to assess and monitor the health of their community, to disseminate timely information and to identify emerging threats.

The client record and data system facilitate systematic, service integrated documentation of care coordination and any direct service provided to all MCH clients. A systematic, integrated method for documentation of assessments, referrals, follow-ups and care coordination provided is the basis for an initial client specific plan of care, need for modifications of the care plan and evaluation of expected outcomes. Documentation should indicate evidence of health, nutritional and psychosocial assessments and interventions, to include health promotion, anticipatory guidance and risk-appropriate education.

Documentation serves as:

- Legal protection for the client and the health care provider
- Evidence of the client's response to care and recommendations
- Evidence of informed consent
- Communication methodology between providers
- A method for the evaluation of service methodologies through chart review and quality assurance

Internet access, electronic collection of data and linkages between local, state and federal data systems are important to data collection, analysis and program evaluation activities.

- **Local agency grantees:**

- Employ adequate staff members to address the identified needs of the population to be served in the community.
- Establish written fiscal management policies and procedures that include, but are not limited to: payment of debts, payroll, record keeping, auditing and receivables/expenditures.
- Utilize sound accounting and business practices.
- Develop and implement the Disaster Response Framework with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing and human services recovery needs of pregnant women, children and adolescents.
- Establish and implement reporting and billing systems including a sliding fee scale for all clients receiving MCH billable services.
- Obtain income information from every client, document and updated at least annually. The client's income is used to determine the amount to be charged for services or supplies on a sliding fee schedule of discounts.

- Establish and implement a sliding fee scale of discounted charges. Scale must include at least four levels of reduced billing using the federal Poverty Guidelines of income and number of people in the family. This scale meets the low-income guidelines for those who are eligible for free or reduced charges for billable services. For information on Federal Poverty Guidelines³ go to <http://aspe.hhs.gov/poverty/index.cfm>.
- Establish a written fee collection policy which will be applied consistently for all clients. The policy will include a list of reasonable efforts made to collect outstanding client balances. Under no circumstances shall client confidentiality be jeopardized.
- Utilize electronic data collection of client visits and capture all required data elements via the web-based shared measurement system, DAISEY (Data Application and Integration Solutions for the Early Years). See more under Section 312 (Data Collection).
 - Provide adequate automation of data transmission systems to ensure direct and timely communication to KDHE.
 - Notify KDHE of any issues, concerns or questions regarding the MCH program.

Standard 3: Outreach

Services are available for all women, children and adolescents; however, outreach methods are employed to identify and reach the targeted low income and most at-risk for poor outcomes in the MCH population to encourage their participation in MCH program services and link them into Medical Home/Health Home systems of care.

- **Rationale:**

Poor outcomes are consistently related to selected risk factors that include demographic, health, socio-economic and other barriers to care. Because each community has unique socio-demographic factors, system factors, client factors, health and environmental factors, outreach methods must be tailored to each community. Barriers to MCH care must be identified and addressed with specific strategies.

A priority should be placed on identifying and serving:

- Pregnant adolescents
- Families exposed to tobacco smoke in the household
- Families in which substances are used or abused
- Families exposed to violence and physical abuse
- Families that have a member with special health care needs
- Families that have a member with mental health issues
- Women and children at health, nutritional, or psychosocial risk and/or experiencing barriers to care (e.g. financial, lack of providers)
- Families with a potential for not entering into and/or complying with health care recommendations
- Those at risk for poor health outcomes

³ Federal Poverty Guidelines <http://aspe.hhs.gov/poverty/>.

- **Local agency grantees:**
 - Review the service area data for who is and who is not accessing care; communicate with hospitals, school and local medical providers; establish linkages between the Kansas Department for Children and Families (DCF) and other social, religious and community service agencies; advertise program services; and develop referral systems and strategies to create linkages to needed care.
 - Provide direct outreach and family support from Kansas MCH Home Visitors or community health outreach staff to pregnant women at high risk. Projects must ensure that the pregnant women and mothers with infants have ongoing sources of primary and preventive health care and that their basic needs (housing, psychosocial, nutritional and educational and job skill building) are met.
 - Demonstrate through staff job descriptions the designation of outreach responsibilities to specific staff members.
 - Provide home visits and other outreach methodologies in reaching targeted pregnant women and mothers with infants eligible for MCH service provision. See MCH Home Visiting Services, Section 410.
 - Utilize the Kansas Resource Guide as a referral tool for families.

Standard 4: Care Coordination

Care coordination of services is provided to pregnant women, mothers and their infants, children and adolescents, including those with special health care needs, and their families in accessing resources and reaching optimal health outcomes.

- **Rationale:**

Care coordination is defined by the Kansas program as a patient and family-centered approach that utilizes team-based and assessment activities 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.

Care coordination involves a series of logical and appropriate steps and interactions within service networks geared towards maximizing the opportunity for a client to receive needed services in a supportive, timely and efficient manner. Care coordination assures that parents understand the need to follow through with the recommended referrals resulting from health screenings and assistance is provided to reduce barriers in accessing those services. Care coordination involves case management through a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. The care coordinator serves as a liaison between the client, the physician, other providers and the insurer/payer to identify what services might also be needed and promote the best level of well-being.

Nurses and social workers are particularly suited to provide care coordination and case management to high risk pregnant women, children, including those with special health care needs and their families. Both nursing and social service embodies several elements of case management: It is complex, highly interactive, facilitates client's self-care capability, teaches clients to navigate the health care systems and provides environments which assist clients to gain or maintain health and promotes efficient use of community resources.

Many families are unfamiliar with how to navigate the health care and community service systems. Care Coordinators help families feel more comfortable accessing services by modeling how to make appointments and get needed services by phone, assure that they arrive at their appointed time and reinforce that they follow the care instructions provided by the medical provider. Positive health outcomes are possible with equipped families who can advocate for needed services, direct their services and care, and engage as a partner with their providers.

- **Local agency grantees:**
 - Work with local prenatal medical care providers to assure early entry (first trimester) into early and adequate prenatal care.
 - Use the results of a comprehensive health risk assessment as a tool to link families with available resources to address their identified needs.
 - Assist families to find solutions to barriers in accessing services (e.g. telephone service, skill in appointment scheduling, transportation, time-off work from employment to attend the appointment, fuel in car, tires inflated, valid driver's license, access to public transportation, etc.,)
 - Reinforce and assess client understanding of provider's recommendations or care and treatment instruction following appointment.
 - Identify and problem-solve with the client any barriers they may have in following provider recommendations.
 - Support families in understanding how to navigate the healthcare systems and use resources available to them, including how to make appointments and keep appointments, cancel appointments, understand their fiscal responsibilities and how to complete any financial responsibilities in order to maintain continued care.

Standard 5: MCH Service Team

MCH clients access a multidisciplinary team with expertise in health, nutrition and psychosocial assessment and receive brief intervention with referral and linkage to the provision of the required services based on the individual client's identified problems/needs. Follow-up after referral to ascertain completion of health care services improves utilization of available community resources to strengthen and support families and their communities.

- **Rationale:**

The MCH Service Team, a multidisciplinary compassionate, respectful and innovative team, consists of three core areas: health, nutrition and psychosocial care and support. The team, using an integrated approach to address these components, completes a comprehensive assessment; brief intervention⁴ including health education and risk reduction counseling; and initiate connection with appropriate health and human services and links to resources, as indicated by the assessment and family' choice. The individual components of care should not be provided in isolation, but collaboratively planned and provided. Risk assessment, health promotion and development of a plan of care, early intervention and linkage into systems of care with follow-up are activities that should increase detection and/or prevention of risk factors that could negatively affect the outcomes of pregnant women, infants, children and adolescents, including those with special health care needs and family life.

- **Local agency grantees:**

- Show evidence that the agency employs or contracts for MCH services from staff with expertise in health, nutrition and psychosocial areas to provide such professional expertise for assessment, evaluation and facilitate client entry into the system of care for the three core areas.
- Show evidence that new hires receive orientation and that all staff are given periodic on-going and annual professional development opportunities regarding Title V concepts and services. Make revisions to job descriptions as applicable.
- Provide staff with required training and opportunities to acquire professional competencies to meet the needs of their MCH clients.
- Provide an initial nutrition (basic nutrition services) and on-going nutrition assessments (at least one per trimester and one post-partum) to all pregnant women with referral to a registered/licensed dietitian if determined to be nutritionally at high risk.
- Provide nutritional assessments and provide guidance to all children, adolescents and their parents with referral to registered/licensed dietitian if determined to be nutritionally at high risk.
- Provide an initial psychosocial screen for depression, Alcohol, Tobacco and Other Drugs (ATOD) use and family violence on all new clients with on-going assessments (at least once per trimester and once postpartum) until discharge to all pregnant women, with referral to a licensed social worker for additional assessment and interventions based on individual risks.
- Provide developmental and psychosocial assessments, ATOD exposure and child abuse or maltreatment assessment of all children and adolescents. Provide anticipatory guidance regarding health and safety issues to all children, adolescents and their parents with referral to a licensed social worker for additional assessment and interventions based on individual identified risks.

⁴ Brief Intervention is defined here as recognizing a problem, or potential problem, as soon as possible and mitigating the harm that the problem will cause. It includes creating opportunities to raise awareness, share knowledge and support a person in thinking about making changes to improve their health.

Standard 6: Family-Centered Care

Provide MCH services with a family-centered focus of care and develop a Family Care Plan (FCP) with the family in collaboration with the MCH team.

- **Rationale:**

The family is defined as a “unique social group involving generational ties, permanence and a concern for the total person, heightened emotionality, care giving, qualitative goals, an altruistic orientation to members and a primarily nurturing form of governance.” A family can be comprised of many different configurations, not just a husband, wife and children. Vulnerable families are those families who may need additional supports to live a healthy lifestyle due to poverty, substance abuse, mental illness or other factors. Children in these families are susceptible to a high-risk environment for detrimental behaviors. These families should be supported by professionals through education, assessment, intervention and follow up.

The FCP clearly defines the family’s goals, service content, frequency and duration and responsibilities of the MCH team and the family in working toward meeting the goals. The FCP is a working document, produced collaboratively by program staff and the family members, that contains the agreed upon MCH services. At a minimum the FCP should:

- Identify appropriate frequency of primary care visits within a Medical Home for all family members/talking points that involve the family in their own care
 - Identify the family’s social, emotional and physical health goals
 - Identify the family’s goals around nutrition, physical activity and family activities.
 - Recognize each family is on an ever-changing journey of life-long learning that begins with pregnancy and birth continuing through adulthood, where the cycle starts again.
 - Recognize that all families are independent of one another and services must be individualized to a certain extent to support that family.
 - Recognize that what may affect one member of the family will impact other members of the family in some way.
 - Recognize that families impacted by a situation will react differently than another family, even if in the exact same situation.
 - Recognize each family exists in the context of a greater community and engage these communities as resources for supports and services.
- **Local agency grantees:**
 - Respect that every family has their own unique culture and MCH honors the values of each family’s neighborhood, community and extended family.
 - Tailor support and services to each family to meet its own unique needs and circumstances.
 - Work as equal partners with each family and with the people and service systems in the family’s life.
 - Assist families in identifying a Medical Home that consists of a provider for and a payer for any services rendered by the provider.
 - Inform of KanCare (Medicaid) services and assist families through the application process.

Standard 7: Health Risk Assessment & Screening

Families served by the MCH program receive a complete and comprehensive health risk assessment that includes family health history.

- **Rationale:**

Gathering a family health history is the first step toward personalized preventive health care. Targeted prevention approaches consist of identifying people at increased risk of disease who can be offered more intensive intervention than is recommended for the general population. Assessment of risk followed by information/education and early intervention regarding smoking, tobacco and drug use, alcohol consumption, physical exercise, healthy eating and management of weight, hypertension, diabetes and asthma are cost-effective interventions.

The purpose of the Comprehensive Health Risk Assessment and Visit is to provide the early identification of health needs and to link families to available community services to prevent or mitigate poor health and/or developmental outcomes. Population-based education and health promotion activities are instrumental in reducing chronic diseases.

- **Standard of Care Resource:**

Bright Futures (<https://brightfutures.aap.org>) is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the Maternal and Child Health Bureau, Health Resources and Services Administration. The *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (4th Edition)* provides health care professionals with updated background and recommendations for pediatric health promotion, health supervision, and anticipatory guidance. The 4th edition presents a new focus on the social determinants of health and on lifelong physical and mental health. The Bright Futures/AAP Periodicity Schedule presents the screenings, assessments, physical examinations, procedures, and timing of anticipatory guidance recommended for each age-based visit. (periodicity schedule: www.aap.org/en-us/Documents/periodicity_schedule.pdf)

Bright Futures content can be incorporated into many public health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed especially for families are also available.

The primary goal of Bright Futures implementation is to support primary care practices (medical homes) in providing well-child and adolescent care. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities.

<https://brightfutures.aap.org/materials-and-tools/nutrition-and-pocket-guide/Pages/default.aspx>



A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Academic health institutions, health professional organizations, state agencies, and health insurance companies are equally committed to helping health care practitioners and other professionals who work with children, youth, and families achieve the above goals. These combined efforts support parents in their role as health promotion experts for their family and allow them to partner effectively with all their health professionals.

- **Local agency grantees:**
 - If providing well visits, ensure they follow preventive guidelines (Bright Futures) and are comprehensive in nature. Comprehensive visits include: History, Surveillance, Physical exam, Screening, Immunizations, Anticipatory guidance
 - Identify evidence-based resources including visit questionnaires, screening tools, documentation forms, patient/parent education/handouts.
 - Develop an approved screening process for all participants and refer to other programs/funding sources as appropriate.
 - Develop a working relationship with other programs to ease the referral process for clients.
 - Develop a referral system with effective follow-up for all screenings and referrals.
 - Screen families for the use of Alcohol, Tobacco and Other Drugs (ATOD) and provide education about the associated risks.
 - Educate families about depression; provide screening and referral to appropriate mental health providers.
 - Educate families about health and safety in the home and community.
 - Educate families about interpersonal violence; provide screening and referral to community support and protective services.
 - Educate parents and assess families for child abuse and neglect and report suspected child abuse and neglect to Department for Children and Families (DCF) appropriately.

Standard 8: Education & Prevention

Health education, anticipatory guidance and preventive health instruction and services are available to families.

- **Rationale:**

Basic to health education is a foundation of knowledge about the interrelationship of behavior and health, interactions within the human body and the prevention of diseases and other health problems. Experiencing physical, mental, emotional and social changes as one grows and develops, provides a self-contained “learning laboratory.” Comprehension of health promotion strategies and disease prevention concepts enables clients to become health literate, self-directed learners and establishes a foundation of leading healthy and productive lives.

Prenatal health education should be included as a part of the comprehensive plan of prenatal care coordination. This education should encourage a woman and her support systems to participate in and share the responsibility for health promotion and understand pregnancy as a normal state. Health education enables a woman to learn the warning signs and symptoms of impending preterm delivery.

Critical strategies to improve the health care provided children and adolescents, including those with special health care needs, are to meet parents' informational needs and elicit their concerns in a systematic, standard way. A primary component of well-child care is Anticipatory Guidance and Parental Education. [Bright Futures](#) Anticipatory Guidance Cards help “cue” health professionals and families to review key developmental goals for children and adolescents: confidence, success in school, responsibility and independence. Other topics range from safety and healthy eating to fitness and family relationships⁵. The most reliable and valid approach to measure whether parent’s informational needs are being met is to ask parents directly.

- **Local agency grantees:**
 - Adjust the level of and approach to providing health education to the client’s need, current level of knowledge and understanding, utilizing sensitivity to social, cultural, religious and ethnic resources, family situation, coping skills, literacy level and economic background.
 - Provide general health education for all the MCH population. Provide additional education for those with specific medical, nutritional and psychosocial conditions and identified health risks.
 - Provide reproductive health education and link family members’ access to reproductive, primary and pediatric medical care and other community services.
 - Provide reproductive health education and counseling regarding the benefits of birth spacing and information about STI/HIV prevention.
 - Provide breastfeeding education and support services.
 - Provide nutrition education and support services
 - Inform and assist local business and industries in the community to become workplace breastfeeding friendly.

Standard 9: Medical Home

Every pregnant woman, child/youth and family is assisted to establish and utilize a Medical Home for access to basic primary health care.

- **Rationale:**

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 [policy statement](#), the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective care.

In March 2007, a consensus statement on medical home principles was developed and jointly endorsed by American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Osteopathic

⁵ <https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>

Association (AOA), and AAP. Understanding the unique needs of children, youth, and families, the AAP highlights certain critical pediatric medical home principles as follows.

1. Patient and Family-centered partnership: Trusting, collaborative, working partnership with families, respecting their diversity and recognizing that they are the constant in a child's life
2. Community-based system: Family centered- coordinated network designed to promote the healthy development and well-being of children and their families
3. Transitions: Provision of high-quality, developmentally appropriate, health care services that continue uninterrupted as the individual moves along and within systems of services and from adolescence to adulthood
4. Value: Appropriate financing to support and sustain medical homes that promote system-wide quality care with optimal health outcomes, family satisfaction, and cost efficiency

A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary health care. In a medical home, a physician or medical provider works in partnership with the family/patient to make sure that all the medical and non-medical needs of the patient are met. Through this partnership, the doctor can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support and other public and private community services that are important to the overall health of the pregnant woman, child/youth and family.

The public health role is to assist individuals and families without identified medical homes. Families will be assisted in selecting a medical home, applying for insurance and securing payer assistance for which they may qualify. Families will be taught to navigate the health care system and partner with physicians and medical providers to assure that all available community resources are known and utilized appropriately.

It is important to let the medical home doctor or other primary care provider know about any medical or health related services the individual is receiving. The medical home provider needs to know this to provide comprehensive primary care, advice to the family, assure care coordination and serve as the central repository for all medical and health related records for the individual and family.

- **Local agency grantees:**
 - Convene a county-based Medical Home Leadership Group of physicians, medical providers and community public and private resource partners.
 - Develop community resource lists and package them in formats appealing to busy medical offices.
 - Work with local community and regional medical providers to accept individuals and families into primary health care services and to serve as their medical home.
 - Assist uninsured individuals and families to complete the Medicaid/KanCare application.
 - Problem-solve situations with families that many doctors' offices do not have the time or knowledge to do.
 - Serve as care coordinator for high risk families.
 - Provide direct medical services only if there are no medical providers in the region.

- Coach and encourage families to ask questions, document symptoms, voice their needs and priorities, provide feedback and otherwise develop an effective medical home partnership with the primary care provider and other health care providers.
- Educate families about early intervention and school and community services.
- Support medical homes by providing or assisting to provide care coordination and family support and education. Public Health staff is often the single best source of up-to-date information about what services are available locally and the exact steps needed to access them.

105 MCH Grants to Local Agencies

Local agencies implement work plans that align with needs of the target area/community and the most current MCH State Plan priorities and performance measures. Programs may facilitate or provide access to:

- preconception health services including annual well visits and individualized health plans including goals for behaviors promoting optimal health;
- prenatal care services, with a focus on increasing access and utilization of services and first trimester enrollments in prenatal services (care, education, other services needed based on screening and assessment);
- comprehensive prenatal and postnatal health care;
- follow-up services for the mother and infant up to one year post-delivery;
- pediatric health services, including well-child visits and immunizations, reduction of unintentional and intentional injuries in children, high-risk infant follow-up, smoking cessation efforts, perinatal mood disorders and identification and referral for substance abuse;
- reproductive health services including contraception and reproductive life planning (see example Reproductive Life Plan in the Appendix), screening, and STI testing and treatment;
- health, psychosocial and nutrition assessments through a collaborative effort between public health and private medical providers;
- Multidisciplinary health professional teams, on site and/or through referral to the appropriate professional(s) within the community or grantee's service area, including but not limited to: a physician; registered nurse, including clinicians, practitioners and/or midwives; registered dietitian; and licensed social worker.

All MCH grantees are expected to implement/provide:

- comprehensive screening to identify risk and needs;
- trauma-informed practices (See Appendix for a list of toolkits and resources);
- referral for any MCH essential services (age/developmentally appropriate) not provided through the local agency (Ex: home visits, immunizations, developmental screening [<https://helpmegrow.org>], etc.);
- support to determine eligibility for/access to health insurance/coverage; *
- access to multi-lingual translator services;
- culturally-competent services and supports;
- statewide and community-based referrals for needed specialty care, care coordination, and other services; and
- patient- and/or family-centered services, assuring all patients/families are recognized as partners in their health care MCH.

*Local MCH grantees must assist clients with accessing health coverage. This includes informing clients of the services available from KanCare (Kansas Medicaid). The local

agency staff should assist clients with completing the eligibility application or refer clients to the local contact for this support. It is expected that through these outreach and enrollment efforts, there will be a reduction in the need for primary care services/resources and that these resources will be redirected to other MCH system development and support activities. The local MCH program is the payor of last resort pursuant to Federal Law. This means all other sources/payors must be exhausted prior to using MCH grant funds. All measures must be taken to collect reimbursement for services from third-party payors.

106 MCH Programs & Services

MCH interventions emphasize the reduction of risks (e.g. substance use/abuse; late or no prenatal care; environmental and psychosocial stressors; nutritional needs; and family violence and abuse), poor pregnancy outcomes (e.g. premature labor/delivery, low birth weight and infant death), and improvement in quality of life for women, children, and families, including children and youth with special health care needs and their families. Services include, but are not limited to the following:

- Preconception and Reproductive health services*
 - Preconception counseling and referral as indicated
 - Linkage to early comprehensive prenatal medical care
 - Well visits
 - STI testing and treatment
 - Risk screening
 - Link to genetic counseling services
 - Pregnancy testing, counseling, and referrals as indicated
- Care coordination
 - Reproductive health and reproductive life/family planning services
 - Prenatal care and education
 - Supplemental food and nutrition programs such as Women, Infants and Children (WIC) nutrition program
 - MCH Home Visitor and other community home visiting services
 - High-risk infant case management
 - Early intervention referral and follow-up
 - Care coordination for individuals with special health care needs
 - Direct Assistance Programs for individuals with special health care needs
 - Child health and safety information
 - Community resource linkages
- Risk reduction and counseling
 - General health screens/assessments and treatment linkage
 - Tobacco/smoking, alcohol and substance use cessation
 - Healthy weight counseling
 - Domestic violence referral assistance
 - Identification of perinatal mood disorders
 - Depression screening with mental health service linkage
 - Prenatal education classes
 - Childbirth education classes
 - Parenting education classes
 - Family advocacy and leadership classes
 - Care coordination training for families of children with special health care needs

- Pediatric (infant, child, and adolescent) health services, including but not limited to (See [Bright Futures](#)):
 - Well-child health assessments
 - Immunizations
 - Child development and mental health screening
 - Reduction of unintentional and intentional injuries
 - Healthy weight guidance
 - Mental health screening and referral as indicated
 - Parenting education with anticipatory guidance

*Coordination with Reproductive Health and Family Planning (Title X) Programs/Clinics: Enhanced services are available through the Reproductive Health and Family Planning Program for pre-pregnancy counseling, infertility option education and annual health screenings. The Reproductive Health and Family Planning program constitutes primary care for many of the clients served. A complete health history is taken on each client followed by a physical assessment that may include a Pap smear, urinalysis, screening for anemia, hypertension and abnormal conditions of the breast and cervix as indicated. Pregnancy testing and appropriate counseling is available. Information regarding early and continuous prenatal care is provided if the pregnancy test and/or exam findings are positive for pregnancy.

Local clinics also offer a variety of contraceptive methods including abstinence. Instruction concerning effectiveness, proper use, indications/precautions, risks, benefits, possible minor side effects and potential life-threatening complications of contraceptive methods is provided. Screening and treatment for sexually transmitted diseases are a part of the initial and annual visits. Immunization status is routinely addressed.

107 Qualified MCH Workforce

Local agencies must recruit and retain qualified public health professionals to assure a workforce that possesses the knowledge, skills and attitudes to meet unique MCH population needs. Credentials of licensure and certifications must be current and in good standing. Prior professional MCH service experience is helpful.

The following orientation and training (initial and ongoing/annual) requirements apply to all MCH grant/program staff included in the application and organization chart. A sample checklist to track MCH training requirements is available in the Appendix; however, MCH grant requirements can be recorded and tracked along with other orientation and training requirements specific to the local agency on a form developed by the local agency. All documentation should be provided upon request of the MCH Program Consultant during monitoring visits.

ORIENTATION for ALL MCH Program Staff: Orientation of each new MCH staff member should be **completed within 60 days (two months)** of grant award or hire, whichever applies. Orientation includes the following:

1. Training and review of relevant agency/local policies and procedures
2. Consultation with the nurse or social work supervisor or other designated professional staff regarding public health services in Kansas
3. Orientation to all programs and staff in the local agency
4. Orientation to referral resources in the local community, county, and service areas
5. Child Abuse and Neglect Reporting. A Guide for Reporting Child Abuse and Neglect in Kansas
(www.dcf.ks.gov/services/PPS/Documents/GuidetoReportingAbuseandNeglect.pdf)
6. Confidentiality related to the Health Insurance Portability and Accountability Act (HIPAA) www.hhs.gov/ocr/hipaa/
7. Complete review of the Maternal and Child Health Services Manual
8. Review of the MCH Aid to Local Grant/Contract Application and Reporting Guidelines with the supervisor

INITIAL/Foundational Training Requirements for ALL MCH Program Staff:

All MCH program staff (existing) and supervisors must complete MCH training via the online [MCH Navigator](#). Two courses must be completed within three months of grant award or hire, whichever applies.

- [MCH 101](#)
- [MCH Orientation](#)

Complete the module that best fits your role in the agency/program for each required course. Documentation of training completion must be maintained in the personnel file.



NOTE: The MCH Navigator does not provide certificates or records of completion, so it is important to document the course and date completed OR capture a screen shot of the completion page for each course.

ANNUAL/ONGOING training requirements for ALL MCH Program Staff:

- **Technical Assistance Calls/Webinars:** At least one person from the local MCH program is required to attend technical assistance calls and webinars provided by KDHE quarterly. A summary of key information gained must be shared with other MCH program/grant personnel that did not attend the call/webinar.
- **Professional Development Plan:** Local agencies must develop a professional development plan that identifies education needs and plans for providing or obtaining the needed training for staff annually.
- **Governor's Public Health Conference:** At least one member of the local MCH professional staff will attend the annual Governor's Public Health Conference or a statewide conference as approved by KDHE MCH staff and provide a summary of key information gained to other MCH program/grant personnel that did not attend the conference.

- **Addressing Tobacco Use in Kansas: Brief Tobacco Intervention Online Training:**

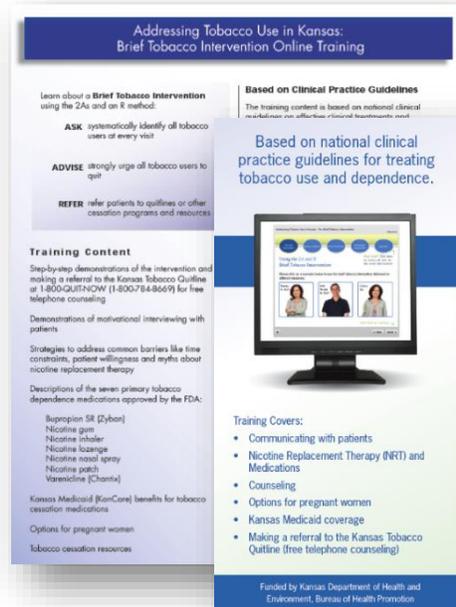
Tobacco use is the leading cause of preventable death and disease in Kansas. You can help.

All local MCH program staff are required to complete *Addressing Tobacco Use in Kansas: Brief Tobacco Intervention Online Training* (kstobaccointervention.org), a free interactive, online course for health care providers demonstrating a “brief tobacco intervention” providers can use with patients who use tobacco products.

*Addressing Tobacco Use in Kansas: Brief Tobacco Intervention Online Training**

- Takes about 30 minutes to complete
- Based on national clinical guidelines
- Appropriate for any member of the health team including front office staff and clinical care staff
- Learn how to effectively talk to your patients about tobacco cessation in 3 minutes.

*Funded by the KDHE Bureau of Health Promotion



Conference Alternative Option:

If MCH program staff are unable to attend the required annual Governor’s Public Health Conference, staff will need to assess their knowledge and skills in addressing the MCH Leadership Competencies by completing the [MCH Navigator Self-Assessment](#) to identify/match your learning needs to appropriate trainings based on your current knowledge and skill level.

- Complete two courses identified in the “Personalized Learning Plan.”

Find more information about the MCH Navigator and online self-assessment in the *Professional Development Resources* Section.



RECOMMENDED/OPTIONAL: Additional training opportunities:

- A list of available trainings can be found on KS-TRAIN www.train.org/ks. KS-TRAIN maintains records of all trainings completed.
- Training opportunities are included in *Public Health Connections* at http://www.kdheks.gov/olrh/public_health_connections.htm.

- The [MCH Navigator www.mchnavigator.org/](http://www.mchnavigator.org/)), an online learning portal for MCH professionals funded by the Federal Maternal and Child Health Bureau, which provides free foundational and essential training/education for those working to improve the health of women, infants, and families. *NOTE: The MCH Navigator does not provide certificates or records of completion, so it is important to document the course and date completed OR capture a screen shot of the completion page for each course.*

MCH Navigator Self-Assessment & Personal Development Plan: Go beyond as an MCH professional supporting women, children, and families in your community and state! If you aren't sure where to begin learning and/or you'd like to use a structured approach that ties training to personal and organizational goals, start by assessing your knowledge of and skills in addressing the MCH Leadership Competencies. The [MCH Navigator Self-Assessment](#) is an easy-to-use online tool with an automated process that can be used individually or as part of a group. Learn more in the *Professional Development Resources* Section.

- Kansas Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Service/KAN-Be-Healthy Resources

KAN-Be-Healthy (KBH) is the Kansas name for the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) process that is recommended by the American Academy of Pediatrics (AAP) for all children but is **REQUIRED** for all children enrolled in Medicaid (KanCare).

In 2011, KDHE discontinued the requirement for credentialed staff to be “certified” to conduct these screenings (Provider Bulletin #10138), though certification continues to be required to conduct associated vision and hearing screens. (www.kmap-state-ks.us/)

The American Academy of Pediatrics (AAP) launched the *Bright Futures* guidelines to support providers conducting EPSDT screenings. To access the *AAP Recommendations for Preventative Pediatric Health Care* – also known as the AAP Periodicity Schedule on age appropriate assessment and screenings. Free information, tools for each stage of development, and training for providers related the *Bright Futures* Guidelines and best practices for implementation can be found on the Bright Futures website. (<https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx>)

The Kansas Medical Assistance Program (KMAP) website (www.kmap-state-ks.us/) offers access to KBH Forms, billing information, and beneficiary information in English and Spanish. KMAP issued a bulletin in April 2016 that outlines the forms that can be used to document KBH visits. Detailed training about the EPSDT program requirements and services in Kansas is available from the KDHE Division of Health Care Finance. In addition, the KanCare Managed Care Organizations (MCO) each provide EPSDT training that is readily available on their respective websites or you may contact your organization's MCO provider relations representatives for additional training and support.

Performance appraisals/evaluations must be conducted annually. Each grantee supervisor is responsible for the timely and equitable assessment of the performance and contribution of subordinate employees. It is recommended that supervisors meet with their team members at least once per month to provide feedback and talk about their work and motivations.

108 Professional Development Resources

MCH Navigator: The [MCH Navigator](#), an online learning portal for MCH professionals funded by the Federal Maternal and Child Health Bureau, provides foundational and essential knowledge for those working to improve the health of women, children, adolescents, and families in an ever-changing environment. www.mchnavigator.org/

If you aren't sure where to begin learning, or you'd like to use a structured approach that ties training to personal and organizational goals, start by assessing your knowledge of and skills in addressing the MCH Leadership Competencies. The [MCH Navigator Self-Assessment](#) is a new online tool that employs an automated 3-step process that can be used individually or as part of a group to:

1. Identify your strengths and learning needs by asking you to rate your knowledge of and skills in the 12 MCH Leadership Competencies and to assess the current importance of each for your professional role.
2. Match your learning needs to appropriate trainings based on your current knowledge and skill level.
3. Receive a [personalized learning plan](#) that specifies your goals, specific training needs, learning opportunities that address your needs, potential mentors and resources for guidance, time frames, markers of success, and strategies to keep you motivated to learn more. Putting your goals, strategies, and time frame in writing will help you hold yourself accountable. The Learning Plan also can enrich the process of performance evaluation, demonstrating your commitment to building skills that help achieve organizational goals.

MCH Leadership Competencies: The [MCH Leadership Competencies](#) outline the knowledge and skill areas needed to improve the quality of training and practice for MCH professionals. Tools for both graduate and continuing education must be readily accessible to MCH students and MCH professionals. MCH knowledge and skill areas provide a foundation for MCH curriculum development and evaluation at the graduate education level, and a framework for continuing education for the practicing MCH professional. <http://leadership.mchtraining.net/>

National Maternal and Child Health Workforce Development Center: The [National Maternal and Child Health Workforce Development Center](#) at UNC Chapel Hill (the Center) offers state and territorial Title V MCH leaders training, collaborative learning, coaching and consultation in implementing health reform using a variety of learning platforms. <http://mchwdc.unc.edu/>

Core Public Health Competencies: The Core Public Health Competencies are a set of skills desirable for the broad practice of public health, reflecting the characteristics that staff of public health organizations need as they work to protect and promote health in the community. The competencies are designed to cover the essential services of assessment, policy development and assurance. www.phf.org/resourcestools/Pages/Core_Public_Health_Competencies.aspx

109 References

American Academy of Pediatrics (AAP) www.aap.org/
American Academy of Family Physicians (AAFP) www.aafp.org/online/en/home.html
American College of Obstetricians and Gynecologists ACOG) www.acog.org/
Association of State and Territorial Health Officials (ASTHO) www.astho.org/
Bright Futures brightfutures.aap.org/
Center for Disease Control and Prevention (CDC) www.cdc.gov/
Maternal and Child Health Bureau (MCHB) www.mchb.hrsa.gov/
National Academy for State Health Policy (NASHP) www.nashp.org
National Association of County and City Health Officials (NACCHO)
www.naccho.org/topics/infrastructure/index.cfm
National Institute for Children's Health Quality www.nichq.org

150 - MCH Background

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151 Title V Block Grant to States

Vision: Title V envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission: To improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

Legislatively-Defined State MCH Population Groups

1. Pregnant women, mothers, and infants up to age 1;
2. Children; and
3. Children with special health care needs.

MCH Population Health Domains

1. Women/Maternal Health
2. Perinatal/Infant Health
3. Child Health
4. Children and Youth with Special Health Care Needs
5. Adolescent Health
6. Cross-Cutting or Life Course

Title V legislation and the MCH Services Block Grant Program enables states to:

- Provide and assure mothers and children access to quality MCH services;
- Reduce infant mortality and the incidence of preventable diseases;
- Provide rehabilitation services for blind and disabled individuals; and
- Provide and promote family-centered, community-based, coordinated care, and facilitate the development of community-based systems of services.

Significant Concepts

1. Title V is responsible for promoting the health of all mothers and children, which includes an emphasis on Children with Special Health Care Needs (CSHCN) and their families; and
2. The development of life course theory has indicated that there are critical stages, beginning before a child is born and continuing throughout life, which can influence lifelong health and wellbeing.

As one of the largest Federal block grant programs, Title V is a key source of support for promoting and improving the health of all the nation's mothers and children. When Congress passed the Social Security Act in 1935, it contained the initial key landmark legislation which established Title V. This legislation is the origin of the federal government's pledge of support to states and their efforts to extend and improve health and welfare services for mothers and children throughout the nation. To date, the Title V federal-state partnership continues to provide a dynamic program to improve the health of all mothers and children, including children with special health care needs (CSHCN.)

The Maternal and Child Health Bureau (MCHB) is the principal focus within Health Resources and Services Administration (HRSA) for all Maternal and Child Health (MCH) activities within the Department of Health and Human Services (HHS). MCHB's mission is to provide national leadership through working in partnership with states, communities, public/private partners, tribal entities and families to strengthen the MCH infrastructure, and to build knowledge and human resources. Its mission also includes ensuring continued improvement in the health, safety, and well-being of the MCH population. To achieve its mission, MCHB directs resources towards a combination of integrated public health services and coordinated systems of care for the MCH population.

Under Title V, MCHB administers the Block Grant. The purpose is to develop service systems that address MCH challenges, such as:

- Significantly reducing infant mortality
- Providing comprehensive care for all women before, during, and after pregnancy and childbirth
- Providing preventive and primary care services for infants, children, and adolescents
- Providing comprehensive care for children and adolescents with special health care needs
- Immunizing all children
- Reducing adolescent pregnancy
- Preventing injury and violence
- Putting into community practice national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents
- Assuring access to care for all mothers and children
- Meeting the nutritional and developmental needs of mothers, children and families

152 Maternal and Child Health⁶

Maternal and Child Health (MCH) is “the professional and academic field that focuses on the determinants, mechanisms and systems that promote and maintain the health, safety, well-being and appropriate development of children and their families in communities and societies in order to enhance the future health and welfare of society and subsequent generations” (Alexander, 2004).

MCH public health is distinctive among the public health professions for its lifecycle approach. This approach integrates theory and knowledge from multiple fields including human development, as well as the health of women, children and adolescents. MCH professionals are from diverse backgrounds and disciplines but are united in their commitment to improving the health of women and children. To meet this ambitious goal, it is essential that MCH professionals work with a broad group of other professionals and organizations.

The MCH program is required by law to serve as a gap-filling provider for families served through the Medicaid program. A partnership exists between the Maternal Child Health Services and Medicaid to serve high risk families. The Maternal and Child Health (MCH) Services Block Grant and Medicaid, authorized by Title V and Title XIX of the

⁶ Adapted from the Introduction to MCH 101 in-depth module at the HRSA MCH Timeline.
<https://mchb.hrsa.gov/training/resources-teach-learn.asp>.

Social Security Act (SSA), serve complimentary purposes and goals. Coordination and partnerships between the two programs greatly enhance their respective abilities, increase their effectiveness and guard against duplication of effort. Such coordination is the result of a long series of legislative decisions that mandate the two programs to work together.

Interagency Agreements (IAAs) required by both Title V and Title XIX legislation, serve as key factors in ensuring coordination and mutual support between the agency that administers the two programs. The Division of Health Care Finance at KDHE coordinates with the Title V MCH program to ensure mutual support of programs and services for Medicaid eligible children and families. The IAA exists between the Title V MCH program and the Kansas Medicaid program to receive the contact information of pregnant Medicaid women to enable MCH services to extend outreach and family support to this high-risk population.

153 MCH Essential Services

The MCH program has identified 10 essential services that serve as the guide for providing services to families:

1. Assessment and monitoring of maternal and child health status to identify and address problems
2. Diagnosis and investigation of health problems and health hazards affecting women, children and youth
3. Information and education to the public and families about maternal and child health issues
4. Mobilizing community partnerships between policy makers, health care providers, families, the general public and others to identify and solve maternal and child health problems
5. Providing leadership for priority setting, planning and policy development to support community efforts to assure the health of women, children, youth and their families
6. Promotion and enforcement of legal requirements that protect the health and safety of women, children and youth and ensuring public accountability for their well-being
7. Linking women, children and youth to health and other community and family services and assure quality systems of care
8. Assuring the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs
9. Evaluation of the effectiveness, accessibility and quality of personal health and population-based maternal and child health services
10. Support for research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems

154 MCH (Title V) Funding

The Maternal and Child Health Bureau (MCHB)⁷ within HRSA administers the Maternal and Child Health Services Block Grant (Title V). Every year Kansas joins other states and territories in submitting an application to the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) for MCH funding.

⁷ Maternal and Child Health Bureau. <http://mchb.hrsa.gov/>

Applications for funding must include:

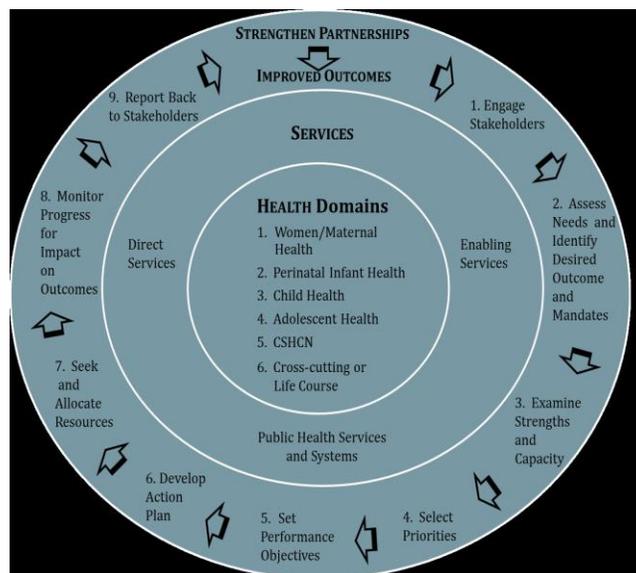
- Needs assessment and priorities
- Measurable outcomes
- Budget accountability
- Documentation of matching funds
- Maintenance of efforts
- Public input

Each state receives an amount based on the proportional number of children in poverty according to the U.S. Census. As poverty levels improve or worsen within states, funding amounts to states fluctuate. States are required to provide a match amount of three dollars for every four dollars in Federal funding expended. Accountability for funds and outcomes measures is part of the [Title V Information System \(TVIS\)](https://mchb.tvisdata.hrsa.gov/). <https://mchb.tvisdata.hrsa.gov/>

In Kansas, Title V funds are primarily distributed to county health departments or local agencies to provide services for MCH populations, specifically women, mothers, children and adolescents. The amount is calculated using a funding formula. Each year the recipient health departments complete a plan that indicates how they will use the funding to address documented MCH needs within their community. To assist agencies in the planning process, the state provides county specific data from the Office of Health Assessment in reports and analysis. The [Kansas Information for Communities \(KIC\)](http://kic.kdheks.gov/index.html) allows data users to perform special analyses by county, sex, race, age group and in many instances Hispanic origin. <http://kic.kdheks.gov/index.html> State MCH program staff with expertise in various aspects of MCH is available to provide technical assistance as needed.

155 State Comprehensive 5-Year MCH Needs Assessment

Every five years, Kansas completes an in-depth MCH needs assessment and prepares a grant application to receive federal Title V funding. The consecutive four years involves submitting an application and annual report with an update on progress made and plans for the coming year based on the selected goals and priorities. The image below depicts the state Title V MCH program needs assessment process.



The 5-year MCH needs assessment resulted in the most current state plan “MCH 2020”, which includes the selected state priorities and associated national and state performance measures for the five-year period 2016 through 2020.

MCH2020 represents a cycle of continuous improvement for maternal and child health programs and services. Between 2016 and 2020, actions and strategies will be

implemented, results will be monitored and evaluated, and adjustments will be made as necessary to continue to enhance the health of Kansas women, pregnant women, infants, children, and adolescents, including children and youth with special health care needs and their families. The MCH plan will also address cross-cutting priorities. State priorities and measures are reviewed annually in July and may change based on emerging health needs for the MCH populations.

156 State MCH Priorities

The State MCH Priorities and associated population domains identified as a result of the most current 5-year needs assessment are below.

State MCH Priorities (2016-2020)	Population Domain
1. Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	Women/Maternal Health
2.	
3. Developmentally appropriate care and services are provided across the lifespan.	Child Health
4. Families are empowered to make educated choices about infant health and well-being.	Perinatal/Infant Health
5. Communities and providers support physical, social, and emotional health.	Adolescent Health
6. Professionals have the knowledge and skills to address the needs of maternal and child health populations.	Cross-cutting
7. Services are comprehensive and coordinated across systems and providers.	Children with Special Health Care Needs
8. Information is available to support informed health decisions and choices.	Cross-cutting

157 MCH Performance and Accountability

MCH Programs are accountable for continually assessing needs, assuring that services are provided to the MCH population and developing policies consistent with needs. MCH public health professionals are accountable to the public and to policymakers to assure that public dollars are being spent in a way that is aligned with priorities. Some of the factors for which MCH is accountable include: the core public health functions outlined by Centers for Disease Control and Prevention National Public Health Performance Standards Program (NPHPSP)⁸; collecting and analyzing health data; developing comprehensive policies to serve the MCH population; and assuring that services are accessible to all.

National Performance Measure Framework

National Outcome Measures (NOMs)



National Performance Measures (NPMs)



State-Initiated Evidence-based/informed Strategy Measures (ESMs)

A number of tools and measures have been developed to measure performance and document accountability. The MCHB uses performance measurement and other program evaluation to assess progress in attaining goals, implementing strategies and

⁸ Centers for Disease Control and Prevention (CDC). (9 December 2010). 10 essential public health services. www.cdc.gov/nphpsp/essentialServices.html

addressing priorities. Evaluation is critical to MCHB policy and program development, program management and funding. Findings from program evaluations and performance measurement are part of the ongoing needs assessment activities of the Bureau.

158 National Outcome Measures

National Outcome Measures (NOMs)	
1.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
2.	Percent of delivery or postpartum hospitalizations with an indication of severe morbidity
3.	Maternal mortality rate per 1000,000 live births
4.1	Percent of low birth weight deliveries (<2,500 grams)
4.2	Percent of very low birth weight deliveries (<1,500 grams)
4.3	Percent of moderately low birth weight deliveries (1,500-2,499 grams)
5.1	Percent of preterm birth (<37 weeks)
5.2	Percent of early preterm births (<34 weeks)
5.3	Percent of late preterm births (34-36 weeks)
6.	Percent of early term births (37, 38 weeks)
7.	Percent of non-medically indicated early term deliveries (37, 38 weeks) among singleton term deliveries
8.	Perinatal mortality rate per 1,000 live births plus fetal deaths
9.1	Infant mortality rate per 1,000 live births
9.2	Neonatal mortality rate per 1,000 live births
9.3	Post neonatal mortality rate per 1,000 live births
9.4	Preterm-related mortality rate per 1,000 live births
9.5	Sudden Unexpected Infant Deaths (SUID) mortality rate per 1,000 live births
10.	The rate of infants born with fetal alcohol syndrome per 10,000 delivery hospitalizations
11.	The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations
12.	Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens that are followed up in a timely manner (DEVELOPMENTAL)
13.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
14.	Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months
15.	Rate of death in children aged 1 through 9 per 100,000
16.1	Rate of death in adolescents age 10-19 per 100,000
16.2	Rate of deaths to children aged 15-19 years caused by motor vehicle crashes per 100,000
16.3	Rate of suicide deaths among youths aged 15 through 19 per 100,000
17.1	Percent of children with special health care needs
17.2	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
17.3	Percent of children diagnosed with an autism spectrum disorder
17.4	Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity disorder (ADD/ADHD)
18.	Percent of children with a mental/behavioral condition who receive treatment
19.	Percent of children in excellent or very good health
20.	Percent of children and adolescents who are overweight or obese (BMI at or above the 85 th percentile)
21.	Percent of children without health insurance
22.1	Percent of children ages 19-35 months, with the 4:3:1:3(4):3:1:4 combined series of vaccines
22.2	Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza
22.3	Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine
22.4	Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine
22.5	Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine

159 National Performance Measures

National Performance Measures (NPMs)*	Population Domain
NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit)	Women/Maternal Health
NPM 4: Breastfeeding (Percent of infants who are ever breastfed; Percent of infants breastfed exclusively through 6 months)	Perinatal/Infant Health
NPM 6: Developmental screening (Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool)	Child Health
NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)	Child Health
NPM 10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)	Adolescent Health
NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)	Children with Special Health Care Needs
NPM 14: Smoking during Pregnancy and Household Smoking (Percent of women who smoke during pregnancy; Percent of children who live in households where someone smokes)	Women/Maternal Health

* States select 5 of 15 that address the state priority needs; at least one for each population domain area.

160 State Performance Measures

At the state level, the MCHB performance and accountability cycle begins with a needs assessment. Analysis of the needs assessment data and other information leads to the identification of state priority needs. The national performance and outcome measures the state selects are meant to address those needs and appropriate resources are allocated. Program implementation, ongoing monitoring and evaluation follow.

To address state priorities not addressed by the National Performance Measures, the state develops three to five State Performance Measures (SPMs). The state MCH Performance measures must be relevant to the related priority and national performance measure, activities, programs, and funds allotted. The measures should be prevention focused, important and understandable to MCH partners, policymakers and the public with logical linkage from the measure to the desired outcome.

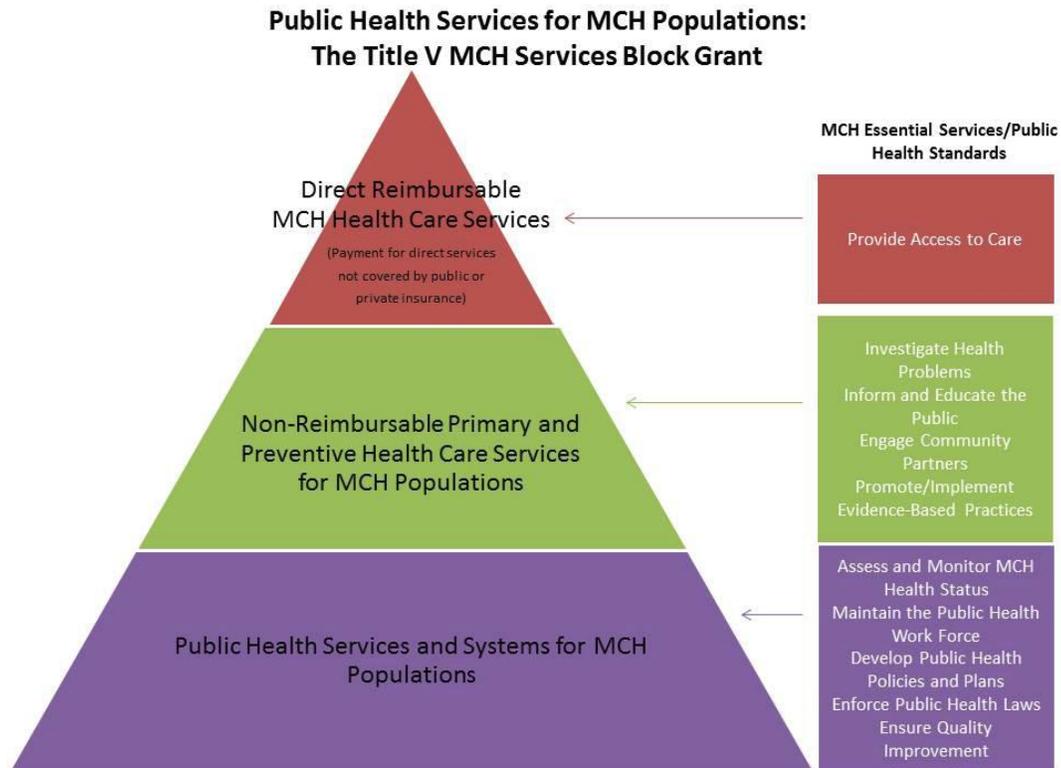
Performance measures help to quantify whether:

- Capacity was built or strengthened
- Processes or interventions were accomplished
- Health status was improved

State MCH Performance Measures (SPMs)
1. Percent of preterm births (<37 weeks gestation)
2. Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes/day
3. Number of Safe Sleep (SIDS/SUID) trainings provided to professionals
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
5. Number of MCH grantees, families and partners that participated in a state-sponsored workforce development event

161 MCH Pyramid

As depicted on the MCH Pyramid, the working framework for the Title V MCH Block Grant to States Program aligns with the 10 MCH Essential Services and consists of three levels. In developing systems of care, States should assure that they are family centered, community based and culturally competent.



Public Health Services and Systems

Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Public health services and systems include, but are not limited to:

- the development of standards and guidelines
- needs assessment
- program planning, implementation and evaluation
- policy development
- quality assurance and improvement
- workforce development
- population-based disease prevention
- health promotion campaigns for services such as
 - newborn screening
 - immunization
 - injury prevention
 - safe-sleep education
 - smoking prevention and cessation

State reporting on public health services and systems should not include costs for direct clinical preventive services, such as immunization, newborn screening tests, or smoking cessation.

Enabling Services

Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes. MCH Services Block Grant funds are used to finance these services. Enabling services include, but are not limited to:

- case management
- care coordination
- referrals
- translation/interpretation
- transportation
- eligibility assistance
- health education for individuals or families
- environmental health risk reduction
- health literacy
- outreach

This category may include salary and operational support to a clinic or program that enable individuals to access health care or improve health outcomes. Examples include the salary of a public health nurse who provides prenatal care in a local clinic or compensation provided to a pediatric specialist who provides services for children with special health care needs.

Direct Services

Direct services are preventive, primary, or specialty clinical services to pregnant women and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts.

Direct services include, but are not limited to:

- preventive (well visits/care), primary or specialty care visits
- emergency department visits
- inpatient services
- outpatient and inpatient mental and behavioral health services
- prescription drugs
- occupational and physical therapy
- speech therapy
- durable medical equipment and medical supplies
- medical foods
- dental care
- vision care

162 Essential Public Health Services to Promote Maternal & Child Health

The 10 Essential Public Health Services were cross walked with the MCH Block Grant to States Program resulting in the following strategies:

- Mobilize partners, including families, at the federal, state and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services and developing supportive policies;
- Integrate systems of public health, health care and related community services to ensure access and coordination to assure maximum impact;

- Conduct ongoing assessment of the changing health needs of the MCH population (as impacted by cultural, linguistic, demographic characteristics) to drive priorities for achieving equity in access and positive health outcomes;
- Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and efficient use of resources;
- Inform and educate the public and families about the unique needs of the MCH population;
- Promote applied research resulting in evidence-based policies and programs;
- Promote rapid innovation and dissemination of effective practices through quality improvement and other emerging methods; and
- Provide services to address unmet needs in healthcare and public health systems for the MCH population (i.e. gap-filling services for individuals.)

163 Local Core MCH Public Health Services for Women/Maternal Health

Direct Services

- Well Women Care for Uninsured Women (gap filling)
- Comprehensive prenatal care (gap filling)
- Health screening and exams not provided through other programs (gap filling)
- Genetic Screening, counseling and diagnosis (gap filling)

Enabling Services

- Medicaid/KanCare information and outreach
- Health Literacy and eligibility assistance
- Translation/transportation services
- Resources, referrals and/or care coordination
- Health education regarding healthy lifestyles: physical activity and nutrition; smoking cessation; substance abuse; breastfeeding; immunizations; injury prevention

Public Health Services and Systems

- Public education and social marketing campaigns related to healthy lifestyles
- Countywide public health projects and outreach
- Coalition leadership and collaboration
- Community needs assessment, program planning and evaluation

164 Local Core MCH Public Health Services for Perinatal/Infant Health

Direct Services

- Provision of perinatal and postnatal care services (gap filling)
- Provision of infant care services (gap filling)
- Well care/visits and screenings (See [Bright Futures](#) and Appendix for KAN Be Healthy and EPSDT resources)
- Immunizations (gap filling)
- Genetic Screening, counseling and diagnosis (gap filling)

Enabling Services

- Medicaid/KanCare information and outreach including Early and Periodic Screening Diagnostic and Treatment (EPSDT) service (See Appendix for more information on EPSDT)
- Health Literacy and eligibility assistance
- Translation/transportation services

- Resources, referrals and/or care coordination
 - Childbirth and parenting classes
 - Newborn metabolic screening follow-up
 - Newborn hearing screening follow-up
- Health education regarding healthy lifestyles: safe sleep; breastfeeding; newborn care; infant growth and development; immunizations; physical activity and nutrition; injury prevention; parent-infant bonding.

Public Health Services and Systems

- Public education and social marketing campaigns related to healthy lifestyles
 - Safe Haven
 - text4baby
- Countywide public health projects and outreach
- Coalition leadership and collaboration
- Community needs assessment, program planning and evaluation

165 Local Core MCH Public Health Services for Child Health

Direct Services

- Well child care/visits and screenings (See [Bright Futures](#) and Appendix for KAN Be Healthy and EPSDT resources) (gap filling)
- Immunization (gap filling)
- Developmental screenings (including social/emotional) [find information and resources at <https://helpmegrowks.org/>]
- Vision and hearing screenings

Enabling Services

- Health education regarding fitness, nutrition, motor vehicle safety, emergency preparedness, immunization, pregnancy prevention, substance abuse
- Providing Medicaid/KanCare information and eligibility requirements to families with young children including Early and Periodic Screening Diagnostic and Treatment (EPSDT) service (See Appendix for more information on EPSDT)
- Resources, referrals and/or care coordination
- School readiness activities
- Providing information regarding quality childcare and after school activities

Public Health Services and Systems

- Public education and outreach related to:
 - Child Abuse Prevention
 - Injury Prevention
 - Importance of immunizations
- Collaborating with schools to improve health, nutrition and fitness
 - Administration of medication
 - School screening and entry examinations
 - Providing health related assistance to school nurses
- Early childhood collaborations and coalitions

166 Local Core MCH Public Health Services for Children and Youth with Special Health Care Needs

Direct Services

- Well care/visits and screenings (See [Bright Futures](#) and Appendix for KAN Be Healthy and EPSDT resources) (gap filling)
- Immunizations (gap filling)
- Developmental screenings (including social/emotional) [find information and resources at <https://helpmegrowks.org/>]
- Vision and hearing screenings
- Provision of Specialty Care in Specialty Clinics (gap filling)
- Diagnostic Services in Diagnostic and Evaluation (D&E) Clinics (gap filling)

Enabling Services

- Health Consultation for Medical Home, Specialty Care, Transition to Adult Health Care, Early Intervention and School Services.
- Individual and Family Care Coordination Services Health Care Resources, Referrals and Care Coordination for CYSHCN, Families and Providers
- Health education regarding fitness, nutrition, motor vehicle safety, emergency preparedness, immunization, pregnancy prevention, and substance abuse
- Providing Medicaid/KanCare information and eligibility requirements to families with young children including Early and Periodic Screening Diagnostic and Treatment (EPSDT) service (See Appendix for more information on EPSDT)
- Resources, referrals and/or care coordination
 - Family Advocacy and Support
 - Newborn metabolic screening follow-up
 - Newborn hearing screening follow-up
- School readiness activities
- Providing information regarding quality childcare and after school activities

Public Health Services and Systems

- Public education and outreach related to:
 - Child Abuse Prevention
 - Injury Prevention
 - Importance of immunizations
- Collaboration and coordination with early intervention and public schools special education, social services and family support services
- Early childhood and school-based collaborations and coalitions
 - Administration of medication
 - School screening and entry examinations
 - Providing health related assistance to school nurses
- To ensure adequate health services for children with special health care needs by partnering and collaborating with:
 - Primary care,
 - Habilitative and rehabilitative services,
 - Other specialty medical treatment services,
 - Mental health services and
 - Home health care

167 Local Core MCH Public Health Services for Adolescent Health

Direct Services

- Adolescent well visits/care (See [Bright Futures](#) and Appendix for KAN Be Healthy and EPSDT resources) (gap filling)
- Immunization (gap filling)
 - HPV (male and female)
 - Flu shot
- Vision and hearing screenings
- Sexual and reproductive health (gap filling)
- Education and counseling (healthy relationships, preventive health, risky behaviors)
- Behavior/mental health support and development
- Providing Medicaid/KanCare information and eligibility requirements including Early and Periodic Screening Diagnostic and Treatment (EPSDT) service (See Appendix for more information on EPSDT)

Enabling Services

- Health education regarding fitness, nutrition, motor vehicle safety, pregnancy prevention, substance abuse, sexual and relationship behaviors, unintentional and intentional injuries
- Providing Medicaid/KanCare information and eligibility requirements including Early and Periodic Screening Diagnostic and Treatment (EPSDT) service (See Appendix for more information on EPSDT)
- Resources, referrals and/or care coordination
 - Suicide prevention hotline
 - Abstinence education
 - Counseling services

Public Health Services and Systems

- Public education and outreach related to:
 - Healthy relationships
 - Physical activity and nutrition (wellness)
 - Injury prevention
 - Risky behaviors
 - Teen pregnancy prevention
- Collaborating with schools to improve health, nutrition and fitness to include:
 - Administration of medication
 - School screening and entry examinations
 - Providing health related assistance to school nurses

168 Local Core MCH Public Health Services for Health Across the Life Course

Cross-Cutting or Life Course refers to public health issues that impact multiple MCH population groups. Title V programs have begun to utilize the life course model as a framework for addressing identified needs. The life course approach points to broad social, economic, and environmental factors as underlying contributors to health and social outcomes. This approach also focuses on persistent inequalities in the health and well-being of individuals and how the interplay of risk and protective factors at critical points of time can influence an individual's health across his/her lifespan. MCH life course/cross-cutting services include, but are not limited to:

- Access to health care – Medical Home
- Adequate insurance coverage
- Behavioral health/mental health
- Cultural competence
- Emergency planning
- Injury
- Intimate partner violence
- Nutrition
- Oral health
- Physical activity
- Sexually Transmitted Infections (STI)
- Smoking and Substance Abuse

200 - Social Determinants of Health & Disparities

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201 Description of Social Determinants

The resources we have available throughout our lives (education, family income, employment) influence the quality of our lives and our health outcomes. Community, family, neighborhood, and school environments shape our early development. Along with the work environments we enter as adolescents and young adults, these factors continue to influence the way that adulthood and old age unfold (“Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the US” John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health).

These determinants of health (often referred to as social determinants of health) are a combination of many factors that affect the health of individuals and communities. Where we live, learn, work and play have considerable impact on health although most of our funding is concentrated on health care services (access and use).

<http://www.healthequityks.org/>

202 Social Determinants of Health

The following information was taken from the Healthy People 2020 website:

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

Healthy People 2020 highlights the importance of addressing the social determinants of health by including “Create social and physical environments that promote good health for all” as one of the four overarching goals for the decade. This emphasis is shared by the World Health Organization, whose Commission on Social Determinants of Health in 2008 published the report, *Closing the gap in a generation: Health equity through action on the social determinants of health*. The emphasis is also shared by other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy.

The Social Determinants of Health topic area within Healthy People 2020 is designed to identify ways to create social and physical environments that promote good health for all. All Americans deserve an equal opportunity to make the choices that lead to good health. But to ensure that all Americans have that opportunity, advances are needed not only in health care but also in fields such as education, childcare, housing, business, law, media, community planning, transportation, and agriculture. Making these advances involves working together to:

- Explore how programs, practices, and policies in these areas affect the health of individuals, families, and communities.
- Establish common goals, complementary roles, and ongoing constructive relationships between the health sector and these areas.
- Maximize opportunities for collaboration among Federal-, state-, and local-level partners related to social determinants of health.

Understanding the relationship between how population groups experience “place” and the impact of “place” on health is fundamental to the social determinants of health - including both social and physical determinants.

Examples of *social determinants* include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

Examples of *physical determinants* include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)

By working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, we can improve health for large numbers of people in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society, and workforce.

Healthy People 2020 Approach to Social Determinants of Health

A “place-based” organizing framework, reflecting five (5) key areas of social determinants of health (SDOH), was developed by Healthy People 2020. These five key areas (determinants) include:

1. Economic Stability
2. Education
3. Social and Community Context
4. Health and Health Care
5. Neighborhood and Built Environment



Each of these five determinant areas reflects a number of critical components/key issues that make up the underlying factors in the arena of SDOH.

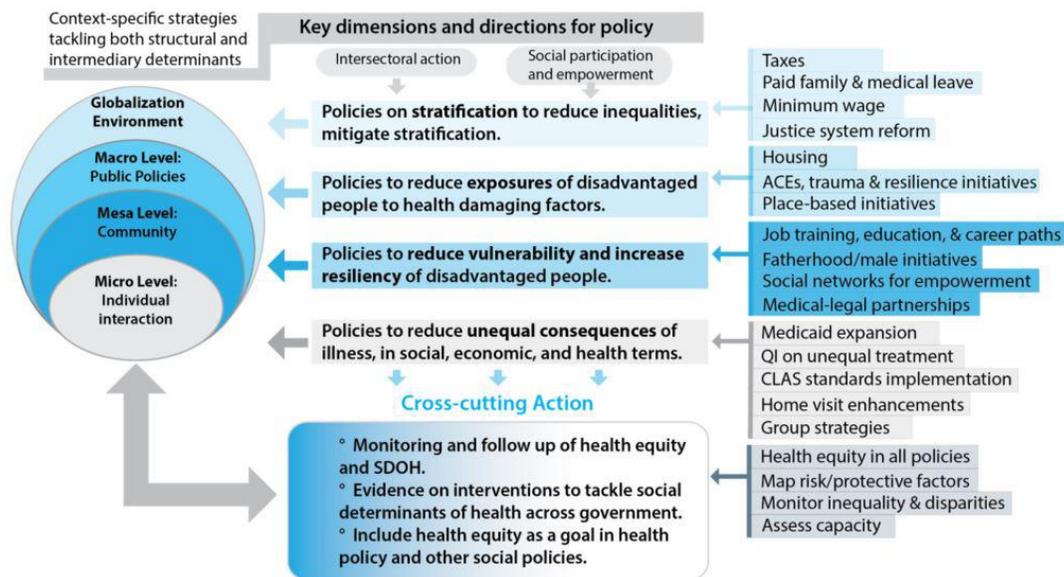
- Economic Stability
 - Poverty
 - Employment
 - Food Security
 - Housing Stability
- Education
 - High School Graduation
 - Enrollment in Higher Education
 - Language and Literacy
 - Early Childhood Education and Development

- Social and Community Context
 - Social Cohesion
 - Civic Participation
 - Discrimination
 - Incarceration
- Health and Health Care
 - Access to Health Care
 - Access to Primary Care
 - Health Literacy
- Neighborhood and Built Environment
 - Access to Healthy Foods
 - Quality of Housing
 - Crime and Violence
 - Environmental Conditions

This organizing framework has been used to establish an initial set of objectives for the topic area as well as to identify existing Healthy People objectives (i.e., in other topic areas) that are complementary and highly relevant to social determinants. It is anticipated that additional objectives will continue to be developed throughout the decade. In addition, the organizing framework has been used to identify an initial set of evidence-based resources and other key tools/examples of how a social determinants approach is or may be implemented at a state and local level.

See Appendix for the World Health Organization's framework adapted by the National Institute for Children's Health Quality for the Infant Mortality CoIN initiative.

WHO Framework for Tackling Social Determinants of Health and Infant Mortality CoIN SDOH Recommended Strategies



Infant Mortality CoIN/SDOH Learning Network Recommended Strategies 4/30/15

203 Health Equity & Health Disparity Defined

Healthy People 2020 defines *health equity* as the “attainment of the highest level of health for all people (<http://www.minorityhealth.hhs.gov/>). Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable

inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” (Source: U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010 [Internet]. Chapter 1: Introduction)

Healthy People 2020 defines a *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

204 Public Health & Disparities

Over the last two decades, overall health in the United States has improved. However, there are striking disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, Asians, and Pacific Islanders, and underserved groups such as disadvantaged rural Whites.

The most striking disparities include shorter life expectancy as well as higher rates of cardiovascular disease, cancer, diabetes, infant mortality, stroke, asthma, sexually transmitted diseases and mental illness. These disparities are believed to be the result of complex interactions among biological factors, the environment, and specific health behaviors.

According to Healthy Kansans 2020 (set of recommendations to improve the health of all Kansans that is aligned with Healthy People 2020), lower socioeconomic and education levels, inadequate and unsafe housing, lack of access to care, quality of care, and living in close proximity to environmental hazards disproportionately affect racial, ethnic, and underserved populations and contribute to poorer health outcomes.

Disparities are evident in nearly every health indicator in Kansas (i.e. heart disease, diabetes, obesity, elevated blood level, low birth weight). And disparities in income and education levels are associated with differences in the occurrence of these health indicators. (NIH “Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities,” Volume 1, Fiscal Years 2002 – 2006, US Department of Health and Human Services, p. 4).

300 - MCH Administrative Grant Management

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301 Grant Applications

The Maternal and Child Health (MCH) program grant application is part of the Aid-To-Local (ATL) process within the Kansas Department of Health and Environment. In January of each year, the Grant Application Guidelines and Grant Reporting are available on the Kansas Grant Management System (KGMS) <https://kchap2.kdhe.state.ks.us/KGMS>

Applications are available on January 15 and are due on March 15. No new applications or edits to applications will be accepted after that date.

NOTE: Existing/previous grantees have received a KGMS user name and password. New applicants should contact Karen Kelley at Karen.Kelley@ks.gov.

Applicants should thoroughly review the MCH Service Manual, consider community and local needs for the legislatively mandated MCH and special health care needs populations, and develop a work plan and budget that aligns with the MCH priorities and measures. Generally, preference will be given to applications which indicate a collective impact approach and coordination with other programs, including food and nutrition, education, children and family services, family planning and other health and community service programs.

- **Continuation Grants:** Highest priority is to continue funding of local agencies that demonstrate progress toward specific objectives, meet program requirements and participate in education updates.
- **New Grants:** Awards for new projects are subject to the availability of funds and community needs assessment.

302 Contracts and Subcontracts

Contracts are issued for one-year periods based on review of the application, contract agency performance and compliance with both general and special conditions of the contract. Additional details regarding contracts are below.

- The MCH grantee shall notify KDHE in writing within ten (10) working days of any change of key personnel.
- KDHE shall be notified of any change in office or service location from that shown in the contract at least ten (10) working days prior to such change.
- Changes in the services to be provided by the MCH grantee as outlined in the contract require prior written approval by KDHE. Discontinuation of any service may result in a decrease in the contract amount or termination of the contract.
- A request for approval of program adjustments must be submitted in writing to the Bureau of Family Health, Children & Families section if there is a ten (10) percent or more variance in the line item of the current budget. Approval must be granted before changes are implemented. The request should indicate what portion of the narrative or budget will be changed along with justification. (See more in Section 303).
 - Adjustments less than ten (10) percent of a line item may be made within the budget without prior approval. This includes moving less than 10 percent of the total budget amount for a program within the budget, revisions to the “other funds” categories and changes in a single category of personnel of less than .20 FTE. Examples include replacing one full-time nurse with two part-time nurses.
- Amendments - A contract amendment is in order when an actual increase or decrease to the grant award amount is made. These are typically initiated by

KDHE. KDHE and local agencies monitor expenditures to assure budget allocations are adhering to contract agreements. (See more in Section 303).

- Single or multi county/agency applications will be accepted. Multi county/agency applicants must designate a lead organization for application. The lead organization will serve as the fiscal agent and grant management entity. Each participating county/agency must provide a letter of commitment that includes agreement with designation of the lead organization.

Universal Contract

KDHE Aid-To-Local Program

1. Disclose personal health information (PHI) to the State Agency as requested or as required by law [45 C.F.R. 165.512(b)] unless disclosure is prohibited by the Health Insurance Portability and Accountability Act (HIPAA).
2. Comply with all relevant federal requirements.
3. Comply with statutes, rules and regulations pertaining to public health, including but not exclusively K.S.A. 65-101 et seq.
4. The Local Agency, its agents or subcontractors, shall provide services which have meaningful access to persons with Limited English Proficiency (LEP) pursuant to Title VI of the Civil Rights Act [(42.U.S.C. 2000d et seq.) and 45 C.F.R. 80.3(b)].

Notice of Grant Award Amount and Summary of Program Objectives

Grantee will be asked to submit a revised final budget for the amount awarded.

Awarding Funds

Grants will be awarded annually on a competitive basis. Grants are subject to availability of funds. No part of the grant money shall be used for any political purposes. Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment. Payment may be held for failure to meet contract requirements and/or submit timely reports.

- Base funding awards will be calculated using a formula that includes the population of children 0-22 years and Females 23-44 years in the county according to the most current US Census Bureau statistics and number of children under 18 years in poverty according to the most current American Community Survey (ACS).
- Additional funds will be awarded for applicants providing MCH programming and services in other counties (when not already available or provided).
- Additional funds will be awarded to applicants demonstrating coordinated efforts, strong community collaboration, and use of evidence-based practices and/or models and interventions.
- Funds will be used to maintain and improve the MCH programming at the local level. Priority should be given to advancing shared areas of work/issues identified in the community needs assessment and most current MCH state needs assessment and action plan for the following populations: women, pregnant women, infants, children, adolescents, and children and youth with special health care needs.

Subcontracts

Contract agencies may subcontract a portion of the project activity to another entity. If a contract agency exchanges personnel services with another entity, a written legal agreement describing the exchange is required. This agreement may be written as a memorandum of understanding (MOU) or a memorandum of agreement (MOA). At a minimum, the agreement should address the scope of work to be performed, assurance of qualified personnel, financial exchange, reporting requirements and time period. Both parties (contract agency and subcontractor) must review the subcontract annually.

303 Contract Revisions

All parts of the Title V MCH related programs grant application are a part of the contract between a contract agency and the department. This includes budget, grant objectives, narrative and reported data. Any program changes require a written revision to the application.

A request for approval of program changes must be submitted in writing to the Bureau of Family Health, Children & Families section and approval must be granted before changes are implemented. The request should indicate what portion of the narrative or budget will be changed along with justification.

Adjustments - An adjustment is a written request from the grantee to KDHE if there is a 10 percent or more variance in the line item of the current budget. The deadline is June 20 to process the budget adjustment by June 30.

Routine Adjustments - Adjustments less than 10 percent of a line item may be made within the budget without prior approval. This includes moving less than 10 percent of the total budget amount for a program within the budget, revisions to the "other funds" categories and changes in a single category of personnel of less than .20 FTE. Examples of routine adjustments include replacing one full-time nurse with two part-time nurses or adjusting time between two programs.

Routine adjustments must be made in the approved budget. Notify the Bureau of Family Health by submitting a cover letter with applicable narrative outlining the change on the budget form. Year-end expenditures will be compared against the revised line item amount.

Amendments - A request to prepare a contract/attachment and/or amendment is in order when an actual increase or decrease to the grant award amount is made. These are usually done by KDHE depending on funding.

Process

The process for requesting a grant application revision is as follows:

1. The agency will send an e-mail or letter to the assigned lead consultant for the agency outlining what they wish to change, the justification for doing so and supporting documentation.
2. The lead consultant will review the proposed changes and provide feedback to the supervisor and/or bureau chief.
3. A letter or e-mail will be sent to the agency from the lead consultant, or other-directed staff, to notify the agency of the request status.
4. Upon approval the agency will incorporate the revisions into their plan and provide the department with the most current version of the plan for their permanent file.

304 Budgets

Plan to prepare two budgets. The first budget is the amount that it actually costs to run the MCH program in your agency. The second budget or what is called the “Final Budget,” will be completed after you receive the Notice of Grant Award letter with the final MCH grant amount to be awarded in the coming fiscal year. You may simply shift the dollar amounts from the grant column to the local or match column. The “Final” or second budget must be submitted to KDHE by July 15.

Local agency must follow the KDHE Fiscal Policy on Indirect Rates and Costs. Agency budgeting for and claiming indirect costs must provide documentation of an approved rate and apply costs in accordance with Uniform Grant Guidance. The KDHE Fiscal Policy on Indirect Rates and Cost is available at:

https://kchap2.kdhe.state.ks.us/KGMS/KGMSContent/documents/2020%20Documents/Policy_Indirect_Rates_Costs_Final_4-8-19.pdf (copy and paste into a browser to view).

305 Allowable Grant Expenditures

MCH grant funds may be used for the following activities:

- Provision of health services (including planning, administration, education/training, and evaluation) as outlined in the approved application and budget*
- Salaries for local program staff included in the application budget
- Education and counseling (including current written materials from credible sources) *
- Program/service assessment, including technical assistance
- MCH funds for direct medical services and non-major medical equipment supplies only if identified as a need/gap and as a last resort, if not reimbursed by third party payer or no other local funds are available

MCH grant funds may **not** be used for:

- Inpatient services
- Political purposes
- Food or entertainment
- Cash payments to participants/patients
- Land or buildings
- Major medical equipment
- Research or training to any entity other than a public or nonprofit private entity

If a local agency is in doubt as to whether or not an expense is allowable, contact the KDHE Program Consultant.

*Local agency must recover, to the maximum extent feasible, third party revenues to which it is entitled for MCH services provided regardless of county of residence; garner all other available Federal, state, local, and private funds; and charge beneficiaries according to their ability to pay for services without creating a barrier to those services. Where third party payers, including Government agencies, are authorized or are under legal obligation to pay all or a portion of charges for services, all such sources must be billed for covered services, and every effort must be made to obtain payment. Each service provider receiving Federal funds, either directly or indirectly, must have a procedure to identify all persons served who are eligible for third party reimbursement.

306 Documentation of Local Match

- Local matching funds must be equal to or greater than 40% of the grant funds requested and awarded. Local program revenues may be utilized to meet the match requirements. Federal funds may not be used for match.
- Non-cash contributions or In-kind donations may be used to meet the required local match. In-kind or non-cash support may include:
 - Personnel time, space, commodities or services.
 - Contributions at a fair market value and documented in the local health agency accounting records.
- Sources that may be used for matching funds are reimbursement for service from third parties such as insurance and Title XIX, client fees, local funds from non-federal sources or in-kind contributions. In-kind contributions must be documented in accordance with generally accepted accounting principles. Records for tracking match must be made available for review upon request.
- Costs associated with inpatient care are non-allowable.
- Resources that are used to match other federal, state or foundation grants cannot be used as match MCH Grant funds.
- Federal funds, with two exceptions, are not allowable as match. Exceptions:
 - Medicaid dollars received for services provided
 - Native American Tribes eligible under P.L. 93-638 may use those federal funds for match.

Local agency must follow the KDHE Fiscal Policy on Match Requirements. Agencies applying for a grant that requires match must document sources for match in accordance with KDHE policy. The KDHE Fiscal Policy on Match Requirements is available at:

<https://kchap2.kdhe.state.ks.us/KGMS/KGMSContent/documents/2020%20Documents/Policy%20Match%20Requirements%20Final%204-8-19.pdf> (copy and paste into a browser to view).

307 Financial Accountability

Financial management and accounting procedures must be sufficient for the preparation of required reports. In addition, the financial operations must be sufficient enough to trace revenue and expenditures to source documentation as part of a financial review or audit.

- All records and supporting documentation must be available for review.
- Accounting records must be supported by source documentation such as canceled checks, paid bills, payroll, time and attendance records and similar documents that would verify the nature of revenue and costs associated with the MCH Grant-funded program.
- The accounting system must provide for:
 - Accurate, current and complete disclosure of expenditures
 - Accounting records that adequately identify source of funds (federal, cash match, in-kind) and the purpose of an expenditure
 - Internal control to safeguard all cash, real and personal property and other assets and assure that all such property is used for authorized purposes
 - Budget controls that compare budgeted amounts with actual revenues and expenditures

Fringe Benefits

Personnel whose salaries are supported in part or in full by the MCH contract must receive the same package of fringe benefits available to other employees of the MCH grantee.

Fringe benefits may only be requested on that portion of the employee's salary supported by the MCH contract and must be based on the salary rate specified in the MCH application.

The fringe benefits provided must be enumerated in the written personnel policies and in the contract agency's MCH application. The fringe benefits rate(s), expressed as a percentage of wages and salaries must be shown in the budget of the approved contract.

Financial Status Report (FSR) / Affidavit of Expenditures

Follow the KDHE ATL reporting process and utilize the required FSR through KGMS.

1. The State Fiscal Year begins on July 1 each year.
2. 25 percent of the total grant amount shall be available to the local agency for the period July 1 through September 30.
3. Agency must spend the grant money and 40 percent match dollars by the end of the fiscal year, June 30.
4. All salary amounts charged must be supported in your agency accounting records and by the individual employee time sheets.
5. Fringe benefits may only be requested on that portion of the employee's salary supported by the MCH contract and must be based on the salary rate specified in the MCH application.
6. The "TRAINING" category on the FSR should include expenses related to fees, accommodations, mileage, etc. Travel costs directly tied to training should go in this category instead of "TRAVEL".
7. The "OTHER" category on the FSR must be itemized. "MISC" or "OTHER" responses will not be accepted. This category could include phones, internet charges, etc.
8. At least half (50 percent) of your grant award should be spent and reported by December 31. At least half (50 percent) of the required match amount should be spent and reported by December 31.

Reminder: Capital Equipment purchases \$500 or more require prior written approval.

308 Reporting Schedule

Quarterly – Submit in KGMS by October 15, January 15, April 15 and July 15:

- Financial Status Report (FSR)
- Quarterly Progress Report

MCH Reporting Schedule			
Quarters	Grant Reporting Period	Due Date	Forms Due
1	7/1 to 9/30	October 15	<ul style="list-style-type: none"> Financial Status Report (FSR) MCH Progress Report
2	10/1 to 12/31	January 15	<ul style="list-style-type: none"> Financial Status Report (FSR) MCH Progress Report
3	1/1 to 3/31	April 15	<ul style="list-style-type: none"> Financial Status Report (FSR) MCH Progress Report
4	4/1 to 6/30	July 15	<ul style="list-style-type: none"> Financial Status Report (FSR) MCH Progress Report

309 Fiscal Record Retention

State/KDHE

The KDHE Legal Department maintains the record retention schedule. Pursuant to the Retention Records Schedules (RRS), retention could be between 5-15 years. If it is “Aid to Counties Program Audit Reports,” the RRS requires that KDHE must retain the records for seven (7) years. After that time records can be destroyed. For “Federal Grant Programs Control and Reference Files,” the RRS requires fifteen (15) years and after that, they are sent to the archives. Find more about retention schedules at www.kshs.org. The KDHE Division of Management and Budget keeps the audits, financial status reports, budgets and authorizations for the same five years then archives them.

See Section 350 for more information about patient/clinical record retention.

Local

Retention policies for individual organizations may vary. Please check with the lead agency/applicant’s legal department to determine the requirements.

310 Inventory or Capital Equipment

When listing inventory or capital equipment on the budget, the following must be approved in advance:

- Items costing \$500 or more;
- Items with a useful life greater than one year; and
- Items purchased from State (grant) funds.

You must justify these items in support of your contract requirement for MCH funding. You may be required to submit a budget adjustment to re-allocate money from your approved budget.

Equipment

1. Equipment is defined as any item having a useful life of one year or more and a unit acquisition cost of \$2,000 or more.
2. Items such as office supplies, medical supplies and data system supplies are excluded from the definition of equipment and thus considered supplies.
3. If any agency desires to purchase equipment that was not approved as part of the current application budget line item, prior approval is required.

4. MCH funds may not be used to purchase motor vehicles.
5. Contract agencies may request in writing to delete equipment from their inventories if the equipment has been lost, stolen, broken, is obsolete, or no longer meets the definition of equipment as defined in this policy. The Bureau of Family Health will return a written approval letter or authorized E-mail.

311 Income

Program Income

Program income means gross income earned by the contract agency resulting from activities related to fulfilling the terms of the contract. It includes, but is not limited to, such income as fees for service, cash donations, third-party reimbursement, Medicaid and private insurance reimbursements and proceeds from sales of tangible, personal or real property. The requirement of Title V/MCH Block Grant to serve all mothers and children emphasizes that there are no eligibility requirements established at the federal level to qualify for services paid by Title V/MCH Block Grant. However, high priority is placed on services to mothers and children who are under served or low income. To maximize federal funds to serve the low-income populations, it is expected that MCH Grant-funded programs will determine the health care coverage of persons they serve, determine coverable services and pursue reimbursement from that source as allowable.

Program income shall be used for allowable costs of the MCH program. Program income shall be used before using the funds received from the department. A contract agency may use up to five percent of unobligated program income for special purposes or projects, provided such use furthers the mission of the MCH program and does not violate state or federal rules governing the program.

Program income cannot be carried over from year to year. As program income is earned, it must be utilized to enhance the program, either as cash match or additive, resulting in a zero balance on the final financial report of each fiscal year.

Cash Donations

- Cash donations are allowed as optional - but not required - for persons served.
- No person should be denied service from a MCH Grant-funded program for not offering a cash donation. Donations should not be solicited from an individual who is covered by Medicaid.
- Cash donations are program income and should be so reflected on the Financial Status Report (FSR). Donations must be re-invested in the MCH Grant-funded program as cash match or additive.

Other Sources of Funding

The contract agency must develop other sources of financial support for the MCH program activities, including the following:

1. Recover as much as possible of all third-party revenues to which the contract agency is entitled as a result of services provided (e.g., private insurance).
2. Garner other available federal, state, local and private funds (e.g., Medicaid).
3. Charge clients according to their ability to pay for services provided, based on a sliding fee schedule. The sliding fee schedule must be based on standardized guidelines provided by the health department. Any changes from these guidelines must have prior written approval by the department. Client billing and collection procedures must be consistent with those established and provided by the county. Services funded partially or completely by the health department will not be denied to a person because of his or her inability to pay a fee for the

service. Individual and/or immediate family income and family size are used in developing the sliding fee schedule.

4. Any changes in funding sources developed or funding sources added during the contract period must be reported to the department.

Determining Income

Income information will be obtained from every client, documented and updated at least annually. The client's income will be used to determine the amount to be charged for services or supplies. Clients unwilling to provide income information will be charged full fees for services and supplies.

In order to determine whether a client should be charged the full fee, no fee or a fee based upon a schedule of discounts, the local agency may request proof of income, but they may not require it. If a client has no proof of income, but provides a self-declaration of income, the local agency should accept the self-declaration and charge the client based upon what has been declared.

Assessment of income is a local agency option, but cannot be a barrier to services. The local agency may not assess the client at 100 percent of the charge because they do not have proof of income, as this may present a barrier to the receipt of services or supplies.

When income assessment is adopted, the local agency will establish a written policy which will be applied consistently for all MCH clients. The policy must address the management of income documentation if a client does not have income documentation at the time of the client's visit.

Income shall be calculated using the following definitions:

- Family and Household are used interchangeably and defined as individuals, related or non-related, living together as one economic unit. References for this definition are based on Federal Register, Vol. 45, No. 108, June 3, 1980, Part 59, Subpart A, Section 59.2 and Federal Register, Vol. 61, No. 43, March 4, 1996, Annual Update of the HHS Poverty Guidelines, Definitions, Paragraph (c).
- Income is defined as total annual gross income available to support a household. The only exception to using gross income is using net income for farm and other types of self-employment.
 - Income shall include, but is not limited to: wages, salary, commissions, unemployment or workmen's compensation, public assistance money payments, alimony and child support payments, college and university scholarships, grants, fellowships and assistantships, etc.
 - Income shall not include tax refunds, one-time insurance payments, gifts, loans and federal non-cash programs such as Medicare, Medicaid, food stamps, etc.

Income for minors who request confidential family planning services must be calculated solely on that minor's resources (e.g., wages from part-time employment, stipends and allowances, etc.). Those services normally provided by parents/guardians (e.g., food, shelter, etc.) should not be included in determining a minor's income.

If a minor is requesting services and confidentiality of services is not a concern, the family's income must be considered in determining the charge for the services.

The U.S. Department of Health and Human Services annually publishes in the Federal Register the annual income figures defining poverty based upon income and family size. 100 percent of poverty is the threshold. The MCH program uses a higher standard or threshold, such as 200 percent of poverty.

Sliding Fee Scale

A Sliding Fee Scale is required with a minimum of four increments and implemented for all MCH services provided. See Appendix for an example. Learn more about poverty guidelines and use for determining eligibility here: <https://aspe.hhs.gov/poverty-guidelines>

Income and Discount Eligibility Guidelines

There is a color-coded example available by request. This is a tool to help ask the hard question about personal finances. This information is a requirement of the MCH Block Grant. The local agency must ask about family size and income, but need not require physical documentation of income. This should be defined in the agency's fiscal policy and procedures.

312 Data Collection

In order to KDHE to fulfill obligations under Kansas Public Health Law (K.S.A. 65-101) and meet state and federal reporting requirements, minimum data elements must be collected and reported by each local agency.

Authority to collect the data is pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and Kansas Law as follows: HIPAA provides that a covered entity may disclose protected health information to a public health authority that is authorized by law to collect such information for the purpose of preventing or controlling disease, injury, or disability. *45 C.F.R. § 164.512(b)(1)(i)*. KDHE is a public health agency that is authorized by state law to investigate the causes of disease and is charged with the general supervision of the health of the state. *K.S.A. 65-101*

DAISEY - Shared Measurement System: **DAISEY**, which stands for Data Application and Integration Solutions for the Early Years, is a shared measurement system designed to help communities see the difference they are making in the lives of at-risk children, youth and families.

DAISEY is the data collection and reporting system KDHE Bureau of Family Health developed to collect data on clients served and services provided by the following funded programs: Maternal & Child Health (including Home Visiting and Becoming a Mom), Family Planning, Teen Pregnancy Targeted Case Management, and Pregnancy Maintenance Initiative. Implementation of this shared measurement system allows the KDHE Bureau of Family Health and their grantees to improve data quality, track progress toward shared goals, and enhance communication and collaboration.

Local grantees are required to make available in DAISEY client demographics and visit/encounter data on a real-time basis. All required client and visit data must be collected and entered into DAISEY by the 10th of each month. Access to necessary equipment and secure internet service is required. **NOTE:** Real-time data captured in a system of record other than DAISEY (EHR for example) must be entered into DAISEY by the 10th of each month.

Learn more about the DAISEY team and system, visit: <http://daiseyolutions.org/wp-content/uploads/2014/03/about-daisey.pdf>.

Getting Started with DAISEY:

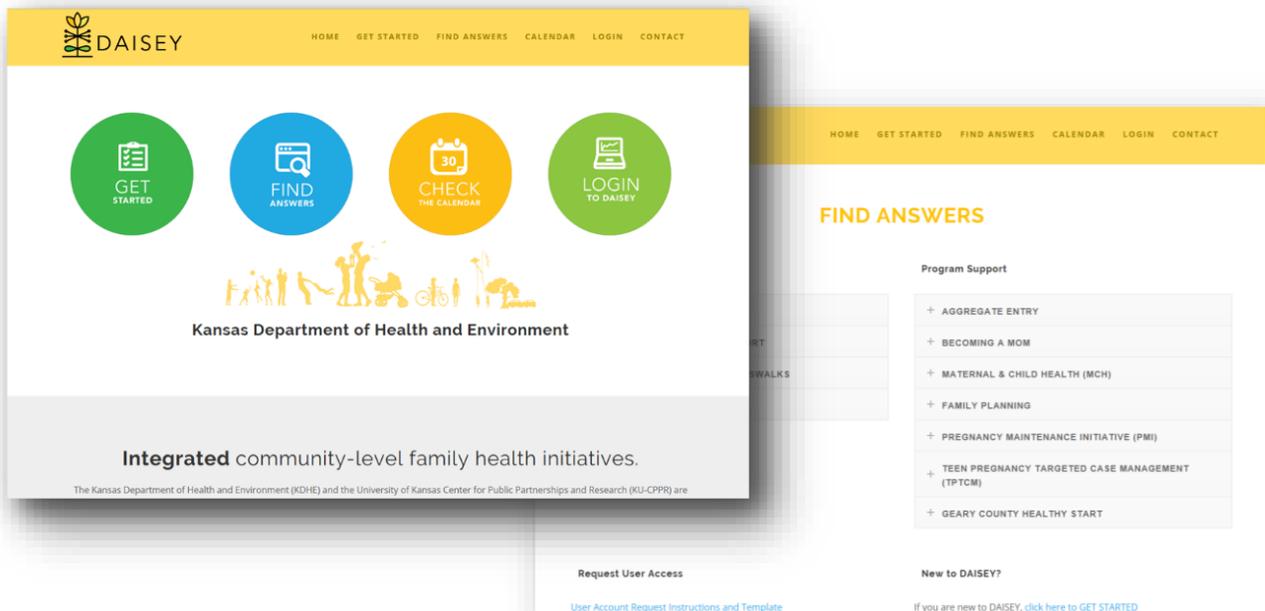
The DAISEY for KDHE website provides all of information you need to get started.

1. Visit the “New to DAISEY” page: <http://daiseysolution.com/kdhe/> and click “Get Started”
2. Watch the *Getting Started in DAISEY* webinar for an overview of DAISEY Implementation tools and resources.
3. Check out DAISEY Implementation at a Glance.
4. Request User Access

For more information regarding the DAISEY forms and the data to be collected during a visit, refer to the **DAISEY Solutions for KDHE Website**.

<http://daiseysolutions.org/kdhe/>

Click on Find Answers → Maternal & Child Health (MCH)



Available Reports via DAISEY Tableau Server

We have developed Tableau Reports for grantees who enter client-level data. This allows MCH agencies to monitor progress related to our shared performance measures and priorities and demonstrate impact. The following reports are available in DAISEY.

1. Number of Clients
2. Clients by Population Served and Children with Special Healthcare Needs
3. Population Served by Race and Ethnicity
4. Primary Healthcare Coverage
5. Prenatal Care Initiated for Pregnant Clients
6. Births & Infants Within the Last Year and Breastfeeding Status
7. Smoking Status
8. Medical Home and Number of Visits by Setting
9. Services Provided
10. Education Provided
11. Healthy Start Home Visits: Number of Clients
12. Healthy Start Home Visits: Total Visits and Pregnancy Status
13. Healthy Start Home Visits: Setting and Provider Information
14. Prenatal Care Initiated for Pregnant Healthy Start Home Visit Clients

15. Healthy Start Home Visits: Births and Infants Within the Last Year and Breastfeeding Status
16. Healthy Start Home Visits: Smoking Status
17. Healthy Start Home Visits: Education Provided
18. MCH Referral Report

313 Site Visits

Site visits are conducted to evaluate the performance of local agencies. Site visits are also a mechanism for State staff to receive feedback from local agency staff as well as to provide technical assistance and training. Unless otherwise notified, all aspects (clinical, community outreach and information, fiscal and administrative) of the MCH program may be reviewed. Agencies will receive a 30-day notice before the scheduled site visit.

The following items should be available for review and provided to KDHE MCH staff upon request:

1. Local protocols, policies and procedures appropriate for the program
2. Fiscal policies, including chart of accounts
3. Schedule of fees/Schedule of discounts
4. Personnel policies and job descriptions
5. Referral forms
6. Examples of local brochures or promotional materials which demonstrate outreach efforts
7. Client charts
8. Customer service reports, input, feedback, etc. (Ex: Client Survey Card data)

Audit or Examination of Records

1. Sub-recipients of Federal funds are required to have an audit made in accordance with the provisions of OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations. The Department may require, at any time and at its sole discretion, that recipients of state funds have an audit performed. A copy of audit reports acquired and (subject to OMB Circular A-133, State regulations or otherwise required) shall be forwarded to the Department upon receipt and at no charge. The MCH grantee may be required to comply with other prescribed compliance and review procedures. The MCH grantee shall be solely responsible for the cost of any required audit unless otherwise agreed in writing by the Department. When the Department has agreed in writing to pay for the required audit services, the Department reserves the right to refuse payment for audit services which do not meet Federal or State requirements. Audits are due within nine (9) months following the end of the period covered.
2. The audit report shall contain supplementary schedules identifying by program the revenue, expenditures and balances of each contract.
3. Upon completion of the audit, one (1) copy of the audit report shall be submitted to the Department within thirty (30) working days of its issuance, unless specific exemption is granted in writing by the Department. To be submitted with the audit is a copy of the separate letter to management addressing non-material findings, if provided by the auditor.

A report of the visit and any findings or recommendations will be sent to the local agency upon completion of the review. If deficiencies are noted, the local agency must submit a corrective plan of action within 30 days that includes activities that will be taken to address deficiencies with timelines for completion. KDHE will approve a plan of

action. Compliance with the plan will be determined through ongoing technical assistance and monitoring visits.

Grant Compliance

At any time your agency is not in compliance with the grant requirements, then your agency may be placed on provisional status and monies will be held until requirements are met. Reasons to withhold payments or monies include, but are not limited to the following:

- Financial Status Report (FSR) is not received
- Quarterly Progress Report is not received or has missing/incomplete sections
- Data is not current in DAISEY by the 10th of each month
- A response to a site visit is past due, corrective action plan was not received, or corrective action plan is not complete
- Home Visitor did not attend the required Fall Regional training
- Any other requested information to determine compliance with contract requirements is not received

Withholding of Support

Temporary withholding of funds does not constitute just cause for the MCH grantee to interrupt services to clients.

Suspension

1. When determined by KDHE that a MCH grantee has materially failed to comply with the terms and conditions of the contract, KDHE may suspend the contract, in whole or in part, upon written notice. The notice of suspension shall state the reason(s) for the suspension, any corrective action required and the effective date.
2. A suspension shall be in effect until the MCH grantee has provided satisfactory evidence to KDHE that corrective action has been or will be taken or until the contract is terminated.

Contract Termination

Failure to comply with the contract may result in reduction of funds or loss of contract.

Changes of Key Personnel

The MCH grantee's personnel specified by name and title are considered to be essential to the work or services being performed. If, for any reason, substitution or elimination of a specified individual becomes necessary, the MCH grantee shall provide written notification to KDHE. Such written notification shall include the successor's name and title. The MCH grantee shall notify KDHE in writing within ten (10) working days of any change of key personnel.

Changes in Location

KDHE shall be notified of any change in office or service location from that shown in the contract at least ten (10) working days prior to such change.

Changes in Service

Changes in the services to be provided by the MCH grantee as outlined in the contract require prior written approval by KDHE. Discontinuation of any service requires an amended work plan and may result in a decrease in the contract amount or termination of the contract.

314 Client Satisfaction

The local grantee must develop a method to receive input on client satisfaction. Input should not be sent to KDHE, rather used internally at the local level to enhance or improve services and inform future activities. Client satisfaction is assessed as part of the monitoring process. The local grantee must develop and implement a program evaluation process that utilizes client satisfaction responses and community needs assessment information to assess the program and results in improvements or changes to services based on input.

350 - Guidelines for Records Management

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351 - Scope of Records Management

352 - Statutes and Laws for Records Management

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351 Scope of Records Management

Records management is crucial in provision of health services to families. Practitioners must be knowledgeable of the standard of practice for documentation of services and maintenance of records in health care delivery settings, including protection of patient information/confidentiality.

The scope of records management is too broad for the purposes of this manual. There are basic resources that can be used by administrators, clinicians and other professionals to serve as resources to creating policy and guidelines for documentation of services and retention of records. Examples of possible records kept by MCH providers include laboratory test results, health screening results, health supervision visits, home visiting, telephone consultation with providers/clients and reports of suspected child abuse.

352 Statutes and Laws for Records Management

Practitioners are directed to the [Kansas Legislature website](#) when seeking statutes related to records management. This website accesses bills and statutes by searching with specific bill or statute numbers or using key words. www.kslegislature.org/li/

353 Resources

Confidentiality and Protection of Health Information

Health Insurance Portability and Accountability Act (HIPAA) - United States Department of Health and Human Services: Office for Civil Rights

This site provides information for consumers and providers on the national standard to protect the privacy of health information of clients. Each local agency is required to notify clients of their right to confidentiality under HIPAA. Agencies are required to be knowledgeable on current state statutes and regulations that address confidentiality, protection of health information and when sharing of health information occurs in the event of a threat to public health.

Information on the HIPAA Privacy Rule is available at:
www.hhs.gov/ocr/hipaa/.

Information on the other HIPAA Administrative Simplification Rules is available at
www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html.

Family Education Rights and Privacy Act (FERPA)

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students." The FERPA regulations and other helpful information can be found at:
www.ed.gov/policy/gen/guid/fpco/index.html.

Kansas Public Health Statutes and Regulations

Kansas Public Health Statutes and Regulations Book

The Kansas Public Health Association has available the Kansas Public Health Statutes and Regulations Book to assist those who work in public health with compilation of statutes and regulations that pertain to public health practice. For more information, go to www.kpha.us/documents/documents.html.

Medical Records Management for Public Health

Public Health Resource Manual

This document is from the Bureau of Community Health Systems and contains important information for nurses and other professionals working in public health. There are sections pertinent to a comprehensive public health program, including Medical Records Management.

www.kdheks.gov/olrh/download/PHNResourceGuidebook.pdf.

Records Retention

Records Retention in Government

Locate policies, programs and information for records retention and historic preservation at the Kansas Historical Society. Records management for State, local and municipal government agencies can be found at www.kshs.org/p/local-government/19122.

SERIES ID	0001-111
TITLE	Client Records
DESCRIPTION	Medical records, including laboratory reports, of persons treated in local health care facilities. Includes adult and child health, family planning, maternal health, mental health and primary care.
RETENTION	See Comments
COMMENTS	Retain 10 years after last contact, and then destroy. (For juvenile records, retain 10 years after last contact or until 21st birthday, whichever is later, then destroy.)
DISPOSITION	Destroy
RESTRICTIONS	K.S.A. 45-221(a)(3)
APPROVED	2008-07-17
K.A.R. NUMBER	53-2-156

400 – Women/Maternal and Perinatal/Infant Health

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401 Program Description

Maternal and infant health services, in MCH Program terms, encompass the work it takes to promote the health of pregnant women, infants (age birth-12 months, 0 days) and their families. In order to promote the health of pregnant women, it is important to consider what happens before an initial pregnancy (preconception health); during pregnancy (prenatal health); in the postpartum period (up to about one year after delivery); and between subsequent pregnancies (interconception health). The healthier a woman is coming into a given pregnancy, the greater are her odds of having an optimal birth outcome. Further, it is prudent to note the importance of living in a supportive home environment where few stressors exist and that of living in a healthy and supportive community in the promotion of optimal pregnancy and birth outcomes for women of childbearing age.

The portion of the MCH Program that is concerned with maternal and infant services promotes the provision and/or facilitation of access to comprehensive preconception, prenatal and postpartum health care and related services for the mother and her infant up to one year postpartum in local communities. This goal is accomplished by the promotion of service coordination that provides health, psychosocial and nutrition assessments and interventions through a collaborative effort between public and private providers skilled in the various disciplines.

402 Program Purpose

The purpose of the MCH Program's maternal and infant services is to improve pregnancy outcomes for mothers and infants by decreasing the incidence of low birth weight and infant death, maternal complications, infants born to adolescents and infants born less than 18 months apart. This is accomplished by promoting early entry into prenatal care and compliance with preconception, prenatal, postpartum and infant care.

403 Multidisciplinary Health Professional Team

The services of a multidisciplinary health professional team are to include, at a minimum, a registered nurse (including nurse practitioners, nurse midwives, etc.), a registered dietician (can be shared with other programs/organizations) and a professional to address psychosocial issues (includes those with professional designations regulated by the Kansas Behavioral Sciences Regulatory Board listed at: www.ksbsrb.org/) and to provide on-site and/or facilitate off-site access to physician or certified nurse mid-wife providers for prenatal and postpartum medical services. In addition, clients should have access to multi-lingual translator services and culturally appropriate care as needed. Finally, ready access must be provided to each discipline on the health professional team as defined by on-site services and/or through an established referral process (that should include a written formal plan) to an appropriate professional with the needed discipline(s) within the community or service area.

Interventions should emphasize risk reduction associated with poor pregnancy outcomes as well as quality of life for mothers, infants and families. Services should include, but not be limited to: outreach to identify high-risk pregnant women; pregnancy testing and case management for pregnant clients. Further, follow-up for the mother, infant and family that is based on identified risks should be available for one year postpartum. The overarching goal of the MCH Program's women and infant services can be summed up as: healthy mothers giving birth to healthy infants. This goal is accomplished by promoting public/private partnerships to facilitate ready access to affordable and risk appropriate care leading to a reduction in the negative consequences associated with preterm birth, low birth weight and infant mortality.

404 Information and Counseling Provided to Pregnant Women

Local agencies must be prepared to offer pregnant women information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and
- Pregnancy termination.

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any options(s) about which the pregnant woman indicates she does not wish to receive such information and counseling. Local agencies must have at least one referral resource (name and address) for all three options to provide to a woman upon request of a referral. The *Woman's Right to Know Directory of Services* may be accessed to identify organizations providing pregnancy services. Find more information on the Woman's Right to Know website here:

www.womansrighttoknow.org. Access the directory here:

www.womansrighttoknow.org/download/Directory_of_Services_English.pdf.

Medical records should include documentation of options discussed and reveal that all pregnant woman receiving initial prenatal counseling were assessed regarding their social support and referrals were made as needed.

410 – MCH Home Visiting Services



411 Description of Services & Program Outcomes

Description of Services

The Kansas Title V MCH program is an integrated delivery of services to the MCH population, providing services to families and children in a variety of settings including the home. In order to provide outreach and family support services, MCH grantees may opt to implement home visiting services.

MCH Home Visiting Program Purpose

To provide information/education, initiate referrals and assist with accessing community systems of care

Target Population

Pregnant Women, Mothers, Infants (birth to 12 months)

The MCH Home Visiting (MCHHV) program approach is strength-based. Strength-based approaches concentrate on the inherent strengths of individuals, families, groups and organizations, deploying personal strengths to aid recovery and empowerment. To focus on health and well-being is to embrace an asset-based approach where the goal is to promote the positive. KDHE will provide training or assistance as requested to assist local programs in understanding and applying this approach.

The program works as part of the MCH promotion and prevention services to support healthy pregnancies, improve birth outcomes, and promote healthy infant development. The program is universal in approach, available to all without eligibility requirements. Services are initiated during the prenatal period when possible and are short term, meaning either the family doesn't require additional services, or the family is referred for more intensive, longer-term home visitation services.

A home visitor works in tandem with and is supervised by professional staff such as licensed nurses or social workers as part of the constellation of MCH promotion and prevention services to improve birth outcomes and promote healthy infant development. Through home visits and other contacts, the home visitor provides outreach, support, and referrals to other community services to pregnant women and families with infants up to one year of age. The home visitor services are not provided independent of other MCH services but are intended to complement and assist with additional services delivered by many provider types to pregnant women, infants, and their families.

Home visiting services are intended to increase knowledge and positively impact behaviors (resulting in behavior change in some cases) by increasing the number of women accessing early and comprehensive health care and services before, during, and after pregnancy. A home visitor provides education on health and safety, parenting, and preventive programs relevant to the prenatal, post-partum/interconception, and parenting periods and infant development. Essential functions of a home visitor include screening for risk factors and providing assistance to families by linking them to resources through referral as well as supporting families with navigating access to coverage and systems of care. A critical responsibility of the home visitor is to have a broad knowledge of available community resources, necessary to carry out the essential functions.

Under supervision by professional-level staff, visitors provide in-home interventions such as education. In addition, home visitors have the potential to:

1. Increase the use of cost-effective preventive health care services such as prenatal care, family planning, immunizations, nutrition, and well visits/care.
2. Promote early entry into and ongoing access to prenatal care and education.
3. Promote healthy infant feeding decisions such as breastfeeding based on the mother and infant's needs.
4. Discourage unhealthy maternal behaviors such as alcohol and tobacco use.
5. Identify women, infants, children, and family members at risk and link them with services and supports.
6. Identify solutions to health and safety risks in the environment to prevent harm.
7. Improve and enhance parenting and problem-solving skills.
8. Reduce costs through use of paraprofessional visitors under nursing supervision.

Support and education for pregnant women and families with newborns can increase the use of preventive health services and reduce the incidence of poor outcomes for infants and their families. Basic assumptions underlying family-centered home visiting efforts include the following:

1. Preservation of the family as the foundation of our social structure is essential.
2. The rights and integrity of the family must be recognized and respected.
3. The family will make important decisions about its interactions with community resources.

Program Outcomes

Outcome objectives to be met by grantee agencies providing the MCH Home Visiting program include:

- Short-term Outcomes
 - Mothers and their families identify and use community resources
 - Pregnant women demonstrate improved health behaviors such as increasing healthy food intake and physical activity and decreasing substance use/abuse (e.g., cigarette smoking and alcohol use)
 - Pregnant women access early prenatal care and education to reduce the incidence of premature and low birth weight babies
 - Parents demonstrate nurturing parenting skills
- Intermediate Outcomes
 - Mothers and their families utilize cost-effective preventive health care services such as prenatal care, family planning, immunizations, WIC/nutrition, and well child services
 - Mothers and their families demonstrate enhanced parenting and problem-solving skills

412 MCH Home Visiting vs. Other Programs

Home visiting for families with young children is a longstanding strategy offering information, guidance, risk assessment, and parenting support interventions at home. The typical "home visiting program" is designed to improve some combination of pregnancy outcomes, parenting skills, and early childhood health and development, particularly for families at higher social risk. Visits should be initiated prenatally when possible to provide education and referral as soon as possible during pregnancy to reduce risks and address unhealthy behaviors.

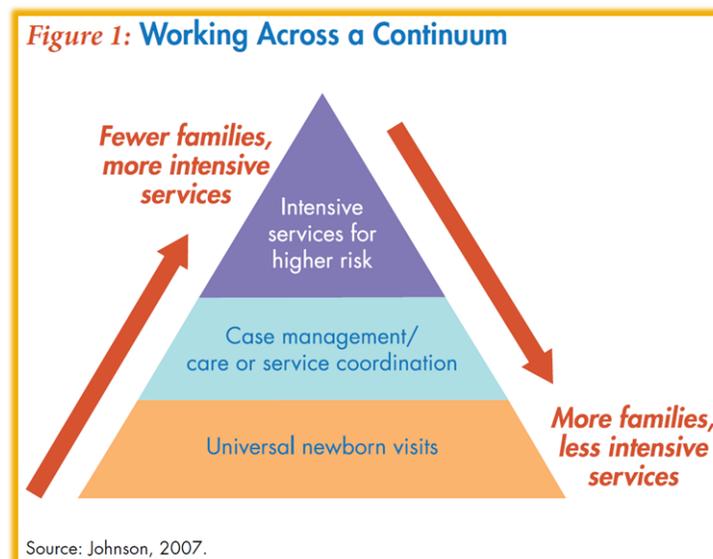
Universal home visiting programs such as MCH Home Visiting are short-term, providing just one to a few visits based on need, and are distinct from other longer-term, intensive home visiting programs. Universal program models have the following characteristics.

- Population-based approach (services available to all regardless of risk, income, education)
- Focus on all mothers/families receiving at least one visit

The leading Kansas program models that are more intensive and evidence-based include but may not be limited to:

- Parents as Teachers (PAT)
- Healthy Families America (HFA)
- Early Head Start (EHS)
- Nurse-Family Partnership (NFP)

Early Intervention programs/networks including Infant-Toddler Services (Part C) also deliver services through home visits. Research tells us that a range of program options can help fit the needs of different families through different supports and services (continuum of services). See Figure 1 below for an illustration.



413 Staff Qualifications & Responsibilities (Supervisors & Home Visitors)

Supervisor Minimum Qualifications & Experience

- Professional staff such as a licensed nurse, social worker, or other professional-level staff.
- At least one year of experience in public health, providing services to the target population (pregnant and post-partum women and infants).

Supervisor Responsibilities

- Gain a thorough understanding of the role of the home visitor and the requirements to be met for the MCH program/grant
- Recruitment: screening, interviewing, hiring, orientating, and supervising the home visitor
- Assist the home visitor with completing training requirements, ongoing professional development/learning plans, and additional training needs

- Oversee adherence to policies, procedures, and program requirements including screening and customer satisfaction
- Conduct face to face coaching sessions at least monthly to review:
 - Clients currently receiving services
 - Families in need of RN or Social Worker contact
 - Professional development needs and progress with training/learning plan
 - Local coordination/partnerships: opportunities, challenges, solutions
 - Outreach and recruitment/enrollment: opportunities, challenges, solutions
- Shadow the home visitor during at least two visits (one new and one existing client) annually to evaluate content of visits and effectiveness of the home visitor
- Document coaching/supervision and shadowing notes and feedback
- Complete an annual written performance review/evaluation
- Promote effective interagency cooperation with community resources/programs and assure coordination including cross-referral with the MCH, Family Planning, WIC, and other public health programs, if available
- Determine which families require a nurse visit after consultation with the home visitor to ensure that the nurse/social worker makes follow-up visits to families when the home visitor observes current or potential problems
- Ensure that the home visitor has appropriate supervisor access and support in the event of client crises or emergencies
- Consult with other professionals who have provided referrals to home visiting
- Assure outreach activities in the local community to promote home visiting
- Periodically review documentation completed by the home visitor
- Ensure that all reports are completed and submitted timely and accurately
- Participate in required training provided by KDHE

Home Visitor Minimum Qualifications & Skills

- Minimum of a high school diploma or GED
- Ability to differentiate between home visitor and nursing responsibilities
- Demonstrate the ability to respect the confidentiality of a client relationship
- Demonstrate effective communication skills
- Present a warm, concerned, culturally sensitive attitude toward families
- Be knowledgeable of available community resources and how to utilize them
- Take direction and carry out decisions made by supervisor
- Complete reports in a timely and accurate manner
- Work independently in a dependable manner
- Model a healthy lifestyle while interacting with clients
- Preferably have demonstrated, successful experience delivering support and education services

Home Visitor Responsibilities

The role of the home visitor is to provide support and information to each mother/family visited, serving as a screener in identifying potential problems to be referred to the professional supervisor. Services are ideally provided in the client's home; however, services can be provided in a variety of settings including the hospital, clinic, group settings (e.g., education/class), community and any other setting a mother may choose based on need, safety, or convenience. It is recommended that no transportation, child care, and/or errands are provided by the home visitor.

- Visit families to provide nonthreatening, friendly support
- Visit each mother/family currently expecting a baby or with an infant less than 12 month of age within two weeks (10-14 days of referral)

- Provide a resource list to families for local service options such as transportation, child care, financial support, health and medical services, social services, longer-term home visiting programs, etc.
- Refer to local resources as indicated, facilitate successful linkages, and follow up
- Follow-up with needed and appropriate educational information
- Observe families for any current or potential problems
- Alert supervisors of existing or potential problems
- Conduct return visits for ongoing education and support as necessary and determined with supervisor
- Seek client referrals from local health department programs, hospitals, physicians, child welfare/DCF, and all available local resources to initiate visits to a client prior to and during the hospitalization period
- Participate in outreach activities in the local community to promote home visiting
- Complete and submit reports accurately and timely
- Participate in required training provided by KDHE

414 Home Visitor Orientation Requirements

Orientation of each home visitor **must be completed within 3 months (90 days) of hire/grant award**, depending on previous experience. An orientation “checklist” or tool (see Appendix) should record progress towards completion of orientation and be maintained as a part of the local personnel file. All documentation should be provided upon request of the KDHE MCH Program Consultant during monitoring visits.

Prior to providing services, the home visitor will:

- Review the local agency MCH aid to local application to better understand the services, partnerships, and home visiting plan submitted to KDHE
- Review local policies and procedures regarding home visiting
- Complete Basic Home Visitor Online Training (more information in this section)
- Understand education, information, and resources/materials shared during visits
- Receive orientation to community partners, services, and resources
- Shadow 3 visits conducted by an experienced home visitor (to be determined by supervisor and KDHE MCH program consultant)
- Conduct at least 1 visit accompanied by the Home Visiting Program Supervisor

415 Training Requirements (Supervisors & Home Visitors)

An Individual Professional Development Plan or other system of documenting training requirements and continuing education must be maintained and available for review. The plan should be updated annually. The plan is a valuable record that documents and demonstrates educational objectives met by staff and can assist in determining other learning needs of staff.

INITIAL training requirements for Home Visiting Program Staff

Kansas Basic Home Visitation Training: Home visiting program staff must complete the Kansas Basic Home Visitation Training, developed in partnership between KDHE and the Kansas Head Start Association. The training includes two parts (online and face to face training). Supervisors must complete the online training (Part 1). Costs associated with training (travel, fees) should be reflected in the MCH grant budget at the time of application. Find more information about the Basic Home Visitation training on the Kansas Head Start Association website: <https://www.ksheadstart.org/>.

- Part 1 (online training, KS-TRAIN course ID# 1043474): Required for Home Visitors **and** Supervisors
 - Must be completed within 30 days of hire AND prior to providing services
 - Required for all home visitors and supervisors, regardless of profession/credential because content is specific to home visiting services

NOTE: The following trainings must be completed to receive full credit and before attending the face to face training (Part 2).

- **Abuse and Neglect** (KS-TRAIN course ID# 1043466)
 - **HIPAA Awareness – Module 1** (KS-TRAIN course ID# 1047429)
Healthcare/Public Health Workforce should also complete:
 - **HIPAA: Allowable Disclosures and Safeguards - Module 2** (KS-TRAIN course ID# 1072478)
 - **HIPAA: Right to Access and Documentation - Module 3** (KS-TRAIN course ID# 1072486)
- Part 2 (face to face training): Required for Home Visitors only
 - Must be completed (Level 1, 1 ½ days) within nine (9) months of hire
 - This does not need to be completed prior to conducting home visits.
 - This training is only offered once every 6 to 9 months depending on need/potential attendance. If the training is not offered within the first 9 months of hire, the home visitor must notify the KDHE MCH Program Contact and plan to attend a future scheduled training.
 - Topics covered include: Home visiting models, best practices and beliefs, confidentiality, taking care of yourself, dealing with stress, role of the home visitor, trust and respect, tools, listening skills, power of words, negative consequence of rescuer, boundaries, home visitor safety, understanding cultures, poverty, family in community and community resources, documentation.

NOTE: Level II face to face training (1/2 day) is available for home visitors providing services through a long-term, more intensive home visitation program such as Parents as Teachers and Early Head Start. MCH Home Visitors may attend as desired. Topics include: Ethical principles of home visitation, family systems, building a healthy self-reliance and interdependence, empowerment model, six principles of empowerment assessment, home visitor professional development

ANNUAL/ONGOING training requirements for Home Visitor Staff ONLY

Fall Regional Home Visiting Training: All home visitors are required to attend the fall regional training provided by KDHE (full day), which is provided in every region across the state. Supervisors are strongly encouraged to attend in order to provide adequate support and supervision to the home visitor and local agency program.

RECOMMENDED/OPTIONAL Continuing Education:

- Consider attending quality conferences and events such as the Governor’s Public Health Conference, Governor’s Conference for Prevention of Child Abuse and Neglect, and Kansas Public Health Association Conference.
- A list of available trainings can be found on KS-TRAIN <http://ks.train.org>. KS-TRAIN maintains records of all trainings completed through that site.
- Training opportunities are included in *Public Health Connections* at www.kdheks.gov/olrh/public_health_connections.htm.
- The [MCH Navigator www.mchnavigator.org/](http://www.mchnavigator.org/), an online learning portal for MCH professionals funded by the Federal Maternal and Child Health Bureau, which provides free foundational and essential training/education for those working to improve the health of women, infants, and families. *NOTE: The MCH Navigator does not provide certificates or records of completion, so it is important to document the course and date completed OR capture a screen shot of the completion page for each course.*

416 Provision of Services: Home Visiting Protocol

Location of Visits

An important aspect of promoting population health has been the tradition of providing services to individual families in their homes. Home visits give a more accurate assessment of the family structure and behavior in the natural environment. These visits provide opportunities to observe the home environment and to identify barriers and supports for reaching family health promotion goals. Meeting the family on its home ground also may contribute to the family’s sense of control and active participation in health planning and achieving health goals.

Home-based visits also support participation of the father and/or other support person; reveal other children in the home and potential need to address other issues such as developmental screening (find information and resources at <https://helpmegrowks.org/>), immunizations, special health care needs; and support the home visitor with assessing environment risk through observation and use of tools and resources to inform education and referrals.

Although a majority of the visits will occur in the mother’s home, be sure to consider convenience, safety, and maximum impact. Other potential locations may include:

- Clinic (MCH, WIC, Primary Care)
- Hospital or Women’s Center
- Community Setting

”Visits” should **never** take place by phone although it is expected that there will be follow up conversations between the home visitor and woman that will take place by telephone. Document the visit in narrative form. Phone discussions do not count as “visits” for the purposes of recording in DAISEY or reporting service numbers.

TIP: Meet the woman/mother when and where it’s most convenient for her and her support person, whenever possible. She may not be comfortable meeting in the home or it’s not as convenient as other locations she may already be visiting (clinic for example).

Every grantee agency providing home visiting services should have a well-understood and practiced safety policy. Additionally, a valuable and effective visit requires careful and systematic planning.

Phases and Activities of a Home Visit

<u>Phase</u>	<u>Activity</u>
1. Initiation phase	Identify source of referral for visit Clarify purpose for home visit
2. Pre-visit phase	Share information on reason and purpose of visit with family Initiate contact with mother/family Establish shared perception of purpose with mother/family Determine mother/family's willingness for home visit Schedule home visit
3. In-home phase	Review referral and/or family record Introduction of self and identity Social interaction to establish rapport Establish relationship
4. Exit phase	Implement educational materials and/or make referrals Review visit with mother/family Plan for future visits as needed
5. Post-visit phase	Record visit and plan for next visit Follow-up with educational materials and/or referrals

Initiation of Visits: Prenatal & Postpartum

- Prenatal visits should be initiated whenever possible
 - When home visits are initiated prenatally, at least one prenatal and one postpartum visit should be conducted

TIP: It can be difficult to reach women during pregnancy. Partner with community organizations, clinics (WIC, Health Center, Prenatal Education Providers, etc.) to promote home visiting services to increase access and incoming referrals.

- Enhanced outreach practices improve chances of prenatal visits
- Early access reduces risk and increases supports for mom and family
- Postpartum visits should be initiated within 2 weeks of the infant's birth (or as

TIP: When accepting a referral for a prenatal or postpartum mother, best practice is for the home visitor to initiate an in-person meeting with the mother and referring partner (warm handoff) to increase the opportunity for engagement.

soon after notification of the infant's birth) whenever possible. When home visits are initiated postpartum, at least one postpartum visit should be conducted.

Initial Assessment

During the first home visit, an assessment/screening of the health and well-being of the prenatal or postpartum woman should be completed. The need for a return visit and the

frequency of future visits (as needed) should be based on the assessment/risk and local procedure. There are a number of maternal health/risk screening forms in use by local, state, and national home visiting programs. It is important to determine what tool(s) will be most appropriate for use by your home visiting program depending on the scope of visits, credentials of home visitors, and data that needs to be collected and tracked. Screening tools are available for women and infants. Some are based on “period” or situation of the mother (preconception, prenatal, parenting, interconception, etc.). No matter what screening tools are used to assess for risk and next steps, a decision tree or service algorithm should guide the frequency of administration. See Appendix for an example.

It is important to determine the most preferred form of contact for the mother/family (phone call, text, email) as soon as possible. Make clear what form of contact will be used to schedule visits and reach the mother for reminders and follow up. Indicate that it may be someone other than the home visitor making the contact if that will be the case.

Frequency & Duration of Visits/Services

MCH Home Visiting services include 1-4 visits prenatally and postnatally. Generally 1-2 visits are conducted; however, the number of visits to be made is a decision of the supervising professional staff and the home visitor based on needs identified in the family.

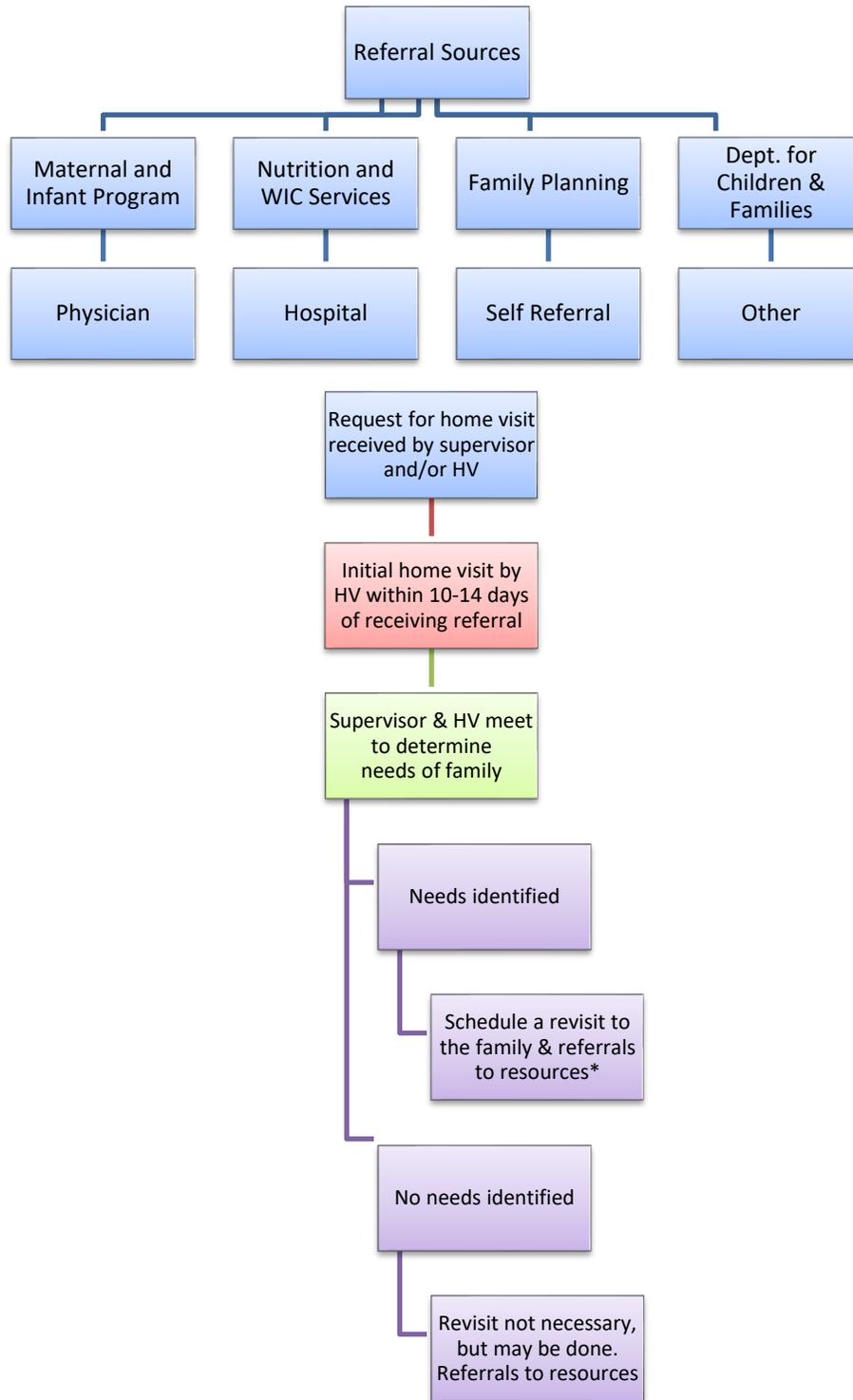
Regularly scheduled visits are not typically conducted more often than monthly in accordance with standard protocol. This does not prevent an additional visit outside of those regularly scheduled visits as necessary to respond to an urgent need related to safety, basic needs (food, shelter, utilities), or a crisis situation related to domestic violence, depression, substance use, etc. Typical home visits should last no more than 1 hour. Consider the circumstances and the setting of the visit. This is simply a standard and is not intended to mean that, on occasion, home visits may need additional time due to a prenatal woman’s/postpartum mother’s focus on other priorities or urgent matters. In those cases, if it is not a situation in which the home visitor can assist, it may be best to disband efforts for the moment and reschedule for another time.

TIP: Contact the mother/family 1 to 3 days prior to the scheduled visit to limit the frustration of unexpected or forgotten visits.

On other occasions, needs may be deeper, and the home visitor may spend longer completing a home visit. Duration of services/home visits will continue as long as deemed appropriate through ongoing assessment of the prenatal/postpartum mother and infant up until the infant’s first birthday (12 months). Visits should terminate upon the child’s first birthday. Mothers/families continuing to need/benefit from home visiting should be transitioned into a longer term, more intensive home visiting program where available. **NOTE:** If a mother/family could benefit from continued services and there is no other program to refer within the community, contact the KDHE MCH program consultant for guidance.

TIP: The key is to provide a manageable amount of information during a one-hour visit.

417 Example Home Visiting Process*



*Number of follow-up visits scheduled will depend on level of risk/need, and other community services to which the mother/family is or is not referred and linked. There are some areas of need that can be addressed by the home visitor through additional visits up to one year to the benefit of the mother, infant, and family.

418 Home Visiting Curriculum & Parent Education Topics

The local MCH Home Visiting program must have a base curriculum (standard MCH topics to be covered with each family) used for each prenatal and postpartum visit to provide consistency regarding education topics, resources provided, and anticipatory guidance. The base content/curriculum can be individualized as needed depending on the mother's pregnancy stage, infant's developmental age, parents' special health or life needs, and any infant health or developmental concerns.

The materials selected for use by the home visitor must be approved by the Home Visiting Supervisor. Educational materials approved by the Supervisor prior to use should be based on most current standards and/or practice, and evidence-based or -informed education and practice, whenever possible.

Parent Education Topics

Consider selecting education/materials related to the topics below.

- Birth Plans
- Car Seat Safety/Installation
- Child Care Search/Selection
- Child Development/Screening
- Community Resources
- Domestic Violence
- Father Involvement
- Health Care Coverage
- Immunizations
- Infant Care
- Infant Feeding (breast/formula)
- Injury Prevention/Safety
- Labor/Childbirth
- Oral Health (screening/care)
- Prenatal Risk/Exposures
- Prenatal/Postpartum Risk Screening
- Maternal Depression
- Medical Home
- Reproductive Health*/Family Planning
- Safe Haven for Newborns
- Safe Sleep
- Siblings (support, relationships)
- Smoking Cessation
- Substance Use/Abuse
- Well Child/Well Woman
- Work (returning to work)

*See example Reproductive Life Plan in the Appendix.

A review of materials and education used during home visits will be reviewed during monitoring visits.

Request assistance from the KDHE MCH Program Contact as necessary if you need guidance around content and sources. Referrals to home visiting experts will be made to provide you with needed support.

419 Community Collaboration & Local Coordination

Every community has varying organizations and services available. In every locality, opportunity exists for building cooperative relationships to benefit families served. The agencies and organizations listed below have the desire or requirement/authority to assist families. Contacting one or more supports home visitors with locating resources and information to assist families. These may be partners in local projects or initiatives to address health and safety needs of families. The list is not comprehensive and may not fully apply to each locality; however, these organizations are included to provide a starting point from which to explore community and regional resources.

Local coordination and collaboration, including referral sources, include:

- Local health department and public health services which may include:
 - Maternal and Infant/Child Health services (M&I/MCH)
 - Special Health Care Needs (eligibility and enrollment)
 - Women, Infants and Children (WIC) Nutrition services
 - Reproductive Health/Family Planning services
 - Immunization services and education
 - Child Care (technical assistance and referral)
 - Tobacco/smoking education, screening and cessation counseling
 - Developmental screening [find information and resources at <https://helpmegrowks.org/>]
 - Well Infant/Child/Adolescent visit (screenings and health assessment)
 - Chronic disease risk reduction
- Other home visiting programs (Parents as Teachers, Healthy Families, Early Head Start, Nurse-Family Partnership, etc.)
- Department for Children and Families (DCF)
- Head Start
- Hospital(s) that serve the community and/or county
- Physicians that serve pregnant women and infants
- Local and regional community health centers/safety net clinics (medical/dental)
- Mental/behavioral health centers and service providers
- School nurses and administrators
- Licensed child care facilities
- Information and referral services
- Ministerial alliances and faith-based organizations
- Early childhood educators, special education, and interventionists
- Retail businesses
- Transportation partners
- Food pantry(ies)
- Local health coalitions
- Foundations
- County extension offices
- Other available/needed services/supports based on availability in the community

420 Referral for Services

Consult with the Home Visiting Program Supervisor to initiate a referral if one or more of the following is needed:

- More intensive form of home visiting;
- Assessment by a nurse or doctor; and/or
- Home visits beyond the infant's first birthday.

Keep the following in mind related to referral and local networks:

- MCH Home Visiting is a part of a community's continuum of care
- Home visitors must understand their role within this continuum
- Referrals to other service providers are often needed
 - Focus on warm referrals whenever possible (meeting with woman and referring organization to support acceptance of the service and engagement)
 - Follow-up with the participant and/or service provider
 - Utilize electronic systems to minimize effort and increase coordination

- Signed consents to share specific information about the family with other providers as appropriate (consents must be documented and maintained in the parent file/chart)
- Communicate with other home visiting providers to coordinate services and avoid duplication of services

As part of the MCH Home Visiting services, every effort should be made to refer and transition enrolled families to long-term home visiting programs as needed (Healthy Families America, Parents as Teachers, Early Head Start, and Infant Toddler Services – Part C).

Monitoring visits will include review of records to ensure compliance with consent and authorization to release information. See Appendix for example release forms.

421 Home Visitor Services Outreach & Promotion/Marketing

In addition to locating resources, it is imperative that the home visitor provide education and outreach to other organizations to strengthen their understanding of the role of the MCH home visitor in addressing the health and safety of the mother both prenatally and after delivery up to one year.

Program Outreach/Recruitment

- Each local home visiting program will develop a **written outreach plan** to be included in the annual MCH grant application and made a part of the local policy and procedure manual. See Appendix for an example outreach plan.
- The plan will include conducting internal and external outreach and promotion of the home visiting services to recruit and engage participants.
 - **Internal outreach** (agency programs delivering services to prenatal and postpartum women), including but not limited to:
 - WIC
 - Family Planning
 - Special Health Care Needs
 - Teen Pregnancy Targeted Case Management
 - Pregnancy Maintenance Initiative
 - Community-based Primary Care
 - **External outreach** including, but not limited to:
 - Obstetricians
 - Hospitals
 - Community health providers
 - Social service programs
 - Early education partners
 - Local coalitions/coordinating councils
- Outreach methods should go beyond brochures and flyers posted in the community and should include:
 - Letters explaining services with accompanying program information
 - Meetings with referral organizations and community partners
 - Participation in local coalitions
 - Media promotion (radio, TV, social/online, billboards)
 - Health fairs and other community events

The local health agency will need to determine who would be the best person to open the doors for these referral sources, community partners, and coalitions.

In some rural and frontier counties without these key partners, outreach should be to partners in neighboring counties and surrounding areas where prenatal and postpartum women receive services and/or deliver.

TIP: If agency staff are participating in local partnerships and coalitions, be sure that staff member initiates discussion about referral between agencies.

Promotion/Marketing

Source/Credit: Geary County Perinatal Health Coalition

Marketing and outreach materials can be accessed in the Home Visiting Tools section of the Kansas Home Visiting website: <http://kshomevisiting.org/outreach-materials/>.

Below is an example of how the *Delivering Change: Healthy Moms-Healthy Babies* program in Geary County markets their services and provides outreach in their community. They also partner with movie theaters to run ads, post billboards along the highway, and maintain website and Facebook pages.

Delivering Change
Healthy Moms - Healthy Babies
Geary County Perinatal Coalition

Delivering Change
Healthy Moms-Healthy Babies

When to contact the:
Delivering Change Navigators

- Pregnancy
- Mental Health Referrals
- Social Health Referrals
- Infants & children up to age 2
- Breastfeeding Support & Referrals
- Interconception Care

The Delivering Change Navigators are a warm connection between community agencies including healthcare providers.

Shirley Robinson
srobinson@gchks.org
Direct Line-238-0302

Mattie-Kay Stewart, LMSW
mstewart@gchks.org
Direct Line-238-0304

Main office:
Geary Community Healthcare Foundation Office
1310 W. Ash St., Suite A
785-238-0300

422 Confidentiality

Home visitors typically have a unique relationship with the families they serve. Often, parents confide in the home visitor about private matters. A family has the right to expect that what is seen and heard in the home will be kept in the strictest confidence. Written material, including the home visitor's working file and central file in the office must be kept confidential. In addition, confidentiality involves information that is shared verbally with others. Anytime home visitors discuss a family with other home visitors, program staff or agencies, it should be for the purpose of assisting the family or child. All sharing of health information must conform to the Health Insurance Portability and Accountability Act (HIPAA) and agency policy. For information regarding HIPAA visit www.hhs.gov/ocr/hipaa/.

Basic guidelines for maintaining confidentiality:

- Do not leave confidential records out in the open, including in a vehicle.
- Write only what is necessary, be objective and factual.

- Subjective information, assumptions and opinions should not be included in documentation. Consult with the supervisor for documentation standards.
- Parents have the right to read any and all portions of their files so be thoughtful about what you write.

423 Documentation of Contacts/Visits

Documentation is to be done in a timely, objective and accurate manner. Thorough and objective **documentation of the home visit should occur within 24 hours** following the visit. This documentation is part of the permanent client record. Be professional and objective in your writing and documentation of visits. Records could be subpoenaed in court and need to focus on what is seen, heard, and not assumed conclusions of the home visitor. Documentation of the home visits must be maintained in a secure file location. Each agency should have policies and procedures in writing that address documentation and maintenance of the client records.

For information on information management and patient-integrated records, consult the Kansas Public Health Nursing and Administrative Resources Guidebook (2011) available at www.kdheks.gov/olrh/download/PHNResourceGuidebook.pdf.

424 Client Visit Data

The home visitor collects and reports information from each visit. Visits are made with the mother prenatally and after delivery. Services provided to the infant or child are not documented as home visiting services. If the infant or child requires services, these services should be provided by the professional staff that documents their assessment and intervention. Visits can be completed by a home visitor and professional staff on the same day and at the same visit as these services are not duplicated and are not provided by the same level of practitioner.

Data obtained from home visitors assists MCH grantees in demonstrating progress being made toward meeting the National Performance Measures (NPM) and State Performance Measures (SPM) for the Title V MCH program. Data collected for home visiting services includes the following but not limited to:

- Where services were provided (setting)
- What education was provided
- What referrals were provided and completed
- Number of mothers served prenatal and postnatal
- Number of children and other family members impacted through visits
- Number of visits made overall

Grantees must capture all required client demographics and service/encounter data via the web-based shared measurement system, DAISEY (Data Application and Integration Solutions for the Early Years). Client and visit data must be entered/submitted no later than the 10th of each month. See more under Section 311 (Data Collection). Client-level data is captured on the following DAISEY forms:

- Adult Profile
- Child Profile (only if infant visit is included in the service)
- Program Visit Form (Adult or Child)
- MCH Service Form
- Referral Form

NOTE: The information above only applies to client-level data entry. Local agencies approved to provide aggregate reports enter data on the DAISEY MCH Aggregate Entry Form.

425 Federal Healthy Start Programs Serving Kansas

The Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services, funds a federal Healthy Start program that is utilized in disparate population/communities demonstrating high infant mortality rates across the U.S. Home Visiting, Case Management, and Care Coordination are core services. In Kansas, there are federally funded Healthy Start programs in Geary, Sedgwick, and Wyandotte counties. These programs are funded independently of the MCH Home Visiting services, although visitors with either of the programs should coordinate with the other program.

450 - Child Health and Adolescent Health

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Child Health

451 Program Description

It is the vision of the MCH Program that all Kansas children (ages one year through 11 years) are healthy and thriving. Specifically, child health emphasizes services that include:

- promoting and increasing the number of children who receive a developmental screening
- decrease the number of hospital admissions for non-fatal injuries among children zero through nine
- increase the number of children who are adequately insured; and
- increase access to compressive and developmentally appropriate health care including oral health

<https://mchb.hrsa.gov/maternal-child-health-topics/child-health>

The period of early childhood is critically important. Early childhood is a time of incredible brain development and formation, with more than a million neural connections each second happening from birth to age three. The brain architecture that is formed in the first three years of life can set a child's entire life trajectory. Many factors influence whether a child gets the best possible start in life including physical, mental, and emotional health of their mother, the strength of the family and home environment, their early childhood providers (including child care), if they have access to a safe neighborhood playground, or have access to fresh food, just to name a few. Everything and everyone that supports a child has an influence on their early childhood experience. It is critical that the early care and education system engages families in a meaningful and coordinated way. It is important that community systems support family voice and choice, educate families on healthy development and educate them how to support their child's healthy development. It is important that communities let families know about the services available to them and have a seamless system in place for making sure families are connected to those services. It is important that a community have a plan in place to recognize the needs of children and connect them to supports as early as possible, when it will make the biggest impact.

452 Child Health Services

Child Health Services should be designed to be community-based, family-centered, comprehensive, flexible, collaborative, coordinated, and culturally and developmentally appropriate.

Local grantees should be prepared to:

- provide families with information for exploring and obtaining the appropriate health insurance and establishing a medical home
- promote access to regular, periodic well child visits
- promote and support families in assuring that children are fully immunized
- provide developmental screening at appropriate intervals and empower adults by utilizing a parent-completed screening tool such as the Ages and Stages Questionnaire - 3rd Edition and the Ages and Stages Questionnaire: Social-Emotional, Second Edition
- provide appropriate referrals and timely follow-up procedures for additional services needed

Specific child-targeted goals can include, but are not limited to: ensuring children receive developmental screenings including screening for social-emotional

development, ensuring that children through age 8 ride in an age and size appropriate car seat, provide education and risk assessment for home safety and injury, provide information to ensure that children participate in at least 60 minutes of daily physical activity to decrease the risk of obesity, and ensure that all children complete all necessary immunizations.

Developmental Screenings

Developmental screenings are an effective and efficient tool for professionals to check a child's development, help parents celebrate their child's milestone achievements and learn what abilities to look for next, and more importantly to determine whether a developmental skill needs monitoring for progress or if additional early intervention services are necessary. Developmental screenings are critical as the first steps toward identifying any potential delays or disorders.

The American Academy of Pediatrics recommends that all children receive a general developmental screening at 9, 18, and 24 months using an evidence-based tool. It is also recommended that social-emotional screening is completed at regular intervals.

www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Recommendations.aspx

The Kansas MCH Program recommendation for an evidence-based screening tool is the Ages and Stages Questionnaire, Third Edition or ASQ-3 and the Ages and Stages Questionnaire: Social-Emotional, Second Edition or ASQ:SE-2. For more information regarding screening tools, schedule an ASQ training, and other helpful resources such as the developmental screening passports and milestone activity postcards visit the Help Me Grow website. <https://helpmegrowks.org/provider/>

If there is a concern about a child's development and a professional and/or the parent would like to refer for further evaluation, contact the following local partners:

- Kansas Infant-Toddler Services - For children under 3 years of age, contact the local tiny-k program/IDEA Part C. To find a local program, click on the "Local tiny-k Programs" tab on the Kansas Infant-Toddler Services page. www.ksits.org/
- For children 3 years and above, contact the local school district Early Childhood Special Education (ECSE) Services/IDEA Part B. A contact list of Part B ECSE contact list can be found on the Kansas State Department of Education website. www.ksde.org/Agency/Division-of-Learning-Services/Special-Education-and-Title-Services/Early-Childhood/Special-Education-Early-Childhood

The Centers for Disease Control and Prevention (CDC) provides professionals and parents with age appropriate developmental milestone checklists or the option of downloading a free milestone tracker app for cellphones.

www.cdc.gov/ncbddd/actearly/index.html.

Injury Prevention

Most child injuries are preventable. The below resources offer information on child safety and injury prevention.

- CDC child injury prevention topics can be used to educate families and create awareness media campaigns or local community awareness events. www.cdc.gov/safechild/
- The National Child Safety Council provides materials (English and Spanish) for various child safety topics. www.nationalchildsafetycouncil.org/materials/spanish-materials

- Safe Kids Kansas provides access to agencies that alert individuals of product recalls, a listing of local safe kids coalitions and car seat check and inspection events, and training opportunities to become car seat safety technicians. www.safekidskansas.org/
- The Kansas Department of Transportation's Bureau of Traffic Safety and DCCCA offer trainings, resources, and education program opportunities through the Kansas Traffic Safety Resource Office website. www.ktsro.org/

Physical Activity

Healthy habits begin to form in childhood. It is in these formative years where children learn and create patterns of behaviors that transition into adulthood. Educating parents and working to create a community that emphasizes healthy eating habits and staying active will see a decline in overweight, obesity, and other health risk rates.

- In 2018, the 2nd Edition of the Physical Activity Guidelines for Americans was created to be the primary resource on physical activity and fitness recommendations for ages 3 and up. <https://health.gov/paguidelines/about/> The website includes the current guidelines, Top 10 Things to Know about the newest edition, an article to be used in a blog, local newsletter or other publication, and tools to promote a "Move Your Way" promotional campaign. <https://health.gov/paguidelines/moveyourway/>
- The KDHE Bureau of Health Promotion offers links to bicycle and pedestrian resources to plan, coordinate, and promote healthier options for transportation in communities. www.kdheks.gov/bhp/healthy_ks_comm/bike_and_ped_resources.htm
- Partner with the local parks and recreation office, fitness centers, child care professionals, K-State extension office, high school, and higher education institutions to collaborate and increase additional opportunities for free indoor and outdoor physical activities for children, youth, and families.

Immunizations

Just like preventable injuries, many diseases are preventable as well. Educating families on the importance of vaccinations and striving to ensure 100% of children complete all the recommended childhood immunizations is crucial.

- Spread the Word on childhood immunizations throughout your community through CDC's multimedia materials and toolkits for National Immunization Awareness Month in August and National Infant Immunization Week in April www.cdc.gov/vaccines/partners/childhood/index.html
- For state level information and resources, go to the KDHE Kansas Immunization Program at www.kdheks.gov/immunize/index.html and the Immunize Kansas Coalition www.immunizekansascoalition.org/

453 Partnerships

There is great value in working together to complete a common goal. Finding traditional and non-traditional partners to collaborate with in your community is critical for success. The Center for Community Health and Development at the University of Kansas is nationally known for their community toolbox. Among many helpful topics and practical, easy-to-use toolkits is "Creating and Maintaining Partnerships."

<https://ctb.ku.edu/en/creating-and-maintaining-partnerships>

Change can happen in communities with a grass-roots approach where multiple organizations use the services and resources specific to their expertise and join with others to build or enhance the level of outreach and support to their families in a unified and coordinated manner.

Potential partners for child health could include:

- Medical organizations (i.e. health departments, pediatricians/family practitioners, dentists, Emergency Medical Technicians/paramedics)
- Educational organizations (i.e. child care professionals, school district, library, museums, K-State Research and Extension, higher education such as community colleges or university staff or students)
- Parks and Recreation Department
- Home Visiting organizations
- Community Organizations

Adolescent Health

454 Program Description

Adolescence (Ages 12 through 21 years) is a crucial developmental period of change transitioning from childhood into young adulthood. During this stage of life, youth are experiencing many dramatic transformations that include physical, behavioral, cognitive, and social-emotional development. More than ever caring adults need to surround them in the home, school, and community setting to assist them in navigating self-discovery, positive relationships, healthy habits, and becoming their own advocate. Professionals in the public health/healthcare field play a major part in all these milestones.

It is the overall goal of the MCH Program to build partnerships and strengthen capacity to address adolescent health from a resiliency and strength-based approach and to empower youth to have the ability to not engage in risky behaviors.

Local agencies can make an impact on this population by:

- Promoting and/or conducting annual adolescent comprehensive well visits (Kan-Be-Healthy) including age appropriate immunizations
- Providing education, evidence-based programs and community-wide initiatives to increase awareness, knowledge, and skillsets regarding physical, social, and emotional health
- Empowering youth to get involved in their health by assisting them in building their health literacy, sharing community resources with them, and inviting them to participate in creating youth-friendly environments, messaging, and policies.

455 Adolescent Health Services

Adolescent health services should be designed to be community-based, youth-centered, comprehensive, flexible, collaborative, coordinated, culturally, and developmentally appropriate.

The U.S. Department of Health and Human Services and national professionals and leaders in the adolescent health sector identified the following “Five Essentials for Healthy Adolescents”:

- 1) Positive connections with supportive people
- 2) Safe and secure places to live, learn, and play
- 3) Access to high-quality, teen-friendly healthcare
- 4) Opportunities for teens to engage as learners, leaders, team members, and workers

- 5) Coordinated, adolescent- and family-centered services, as needed.
www.hhs.gov/ash/oah/tag/why-tag/five-essentials-for-healthy-adolescents/index.html

Specific adolescent-targeted goals can include, but are not limited to: Educating on the importance of annual preventative and comprehensive promoting and/or performing adolescent well visits (Kan-Be-Healthy); increasing the completion of required and recommended immunizations such as Tdap, Meningitis, and HPV; education and program opportunities to empower youth to avoid risky behaviors through school and community-wide events; enhance community partnerships to educate youth and adults on mental health; and increase availability of nutritious food options and physical activities.

Adolescent Well Visits

High quality preventative services can play an important role in supporting youth by helping them establish a life health plan as they enter adulthood. In the adolescent years, sport physicals or sick care are the two main types of medical appointments usually undertaken. However, neither of those types of visits have the comprehensive prevention format that are vital to health. This trend deepens as youth go into college or the workforce due to their limited health literacy about setting up doctor appointments, understanding insurance policies, and medication monitoring/administration.

Bright Futures (4th Edition): Guidelines for Health Supervision of Infants, Child and Adolescence is recommended as the appropriate format of a well visit appointment (Kan-Be-Healthy). Bright Futures guidelines offers conversational starter questions to both the youth and the parent to review medical history; identify age appropriate surveillance of development; review specific body systems; what to observe during parent-child interactions; a checklist of a complete physical examination; possible screening options; immunization reminders; and anticipatory guidance topics that are timely for the age of the adolescent such as bullying, living situations and food security, family substance use, strengths and protective factors, oral health, body image, healthy eating, mental health, sexuality, physical activity and sleep, etc. There is also a Bright Futures Tool and Resource Kit, 2nd Edition option available through [shopAAP](http://shopAAP.org).
<https://brightfutures.aap.org/Pages/default.aspx>

Kan-Be-Healthy training includes instruction on completing a head-to-toe exam, developmental screenings, Bright Future resources and form guidance. These training will be held annually at the Governor's Public Health Conference.

The Got Transition website provides information on way to improve the transition from pediatric to adult healthcare through new and innovative strategies for public health/health care providers, youth and families. www.gottransition.org/index.cfm

Immunizations

The adolescent body alone cannot build a full response to fight off harmful diseases. The CDC recommends four vaccines for adolescents starting at the age of 11 or 12: Meningococcal, HPV, Tdap, and Influenza. If youth are not current with other vaccinations, follow proper guidelines to get them caught up in a safe manner.
www.cdc.gov/vaccines/schedules/downloads/teen/parent-version-schedule-7-18yrs.pdf

Utilize national awareness observation events to promote the importance of immunizations and educate youth and young adults the “why” behind getting vaccinated.



August is National Immunization Awareness Month. Preteen and teen immunization resources to assist local grantees and other community partners get the word out can be found at: www.cdc.gov/vaccines/partners/teens/index.html.

For National Influenza Vaccination Week check back on this site for awareness and promotional materials: www.cdc.gov/flu/resource-center/nivw/index.htm.

Contact KDHE, Bureau of Disease Control and Prevention for state-level immunization and STI/HIV needs. www.kdheks.gov/bdcp/index.html

Risky Behaviors

Experimenting and risk-taking are all part of adolescent development. Taking risks does not always have to be a negative experience that leads to factors that hinder the life of a young adult. Caring adults play an important role in encouraging and strengthening decision-making, developing skill sets for positive youth development including healthy risk taking, and empowering youth to make decisions that will strengthen their health and life.

Some risky behaviors include, but are not limited to reckless driving, drinking alcoholic beverages, experimenting with various drugs, entering unhealthy relationships that could have the potential of dating violence or unplanned pregnancies. Local communities have the opportunity to provide youth-friendly messaging that educate adolescents on the facts...debunking social media or society’s myths. Partnering with youth in the community to build messages and local media campaigns is a great way to capture the youth voice in your service area. Allowing youth to lend their voice to community messaging helps engage them and gives them a feeling of ownership.

Adolescents are willing and able to participate in these types of activities and can help draft messages that are attractive to their peers. If youth are included in the process this will give them buy-in. Youth developed information on risky behaviors will have a higher impact in the community while providing leadership and work experience that benefits youth development. See Section 457 - Youth Engagement for more information and tools regarding adult-youth partnerships.

Getting timely information to parents/guardians of youth and young adults is also critical. With the fast-paced lives of adolescents and the rate of multiple opportunities to engage in risky behaviors, it is hard for an adult to keep up with the latest trends. Here are some suggestions that can assist in getting appropriate information out to adults and parents with teens in the community:

- 1) Check state and local data sources such as Kansas Health Matters www.kansashealthmatters.org/tiles/index/display?alias=RiskyBehaviors or Kansas Communities That Care <http://kctcdata.org/>
- 2) CDC Information for Parents with Teens (Ages 12-19) - www.cdc.gov/parents/teens/
- 3) Check to see if there is a prevention collaborative in or around your area and get involved - <http://kansaspreventioncollaborative.org/>

- 4) Partner with local partners that are also focusing on adolescent development strategies such as school personnel (counselors, psychologists, social workers, school resource officers, nurses, health educators, family and consumer science educators, etc.), community mental health centers, healthcare facilities or FQHCs, juvenile detention services, foster care services, extension offices, etc.

Mental Health

It is common for children and youth to experience some emotional distress as they develop. Nervous emotions or slight anxiety about starting a new school year, going on stage for a performance, speaking in front of an audience, or preparing for their first date are considered normal social and emotional well-being. Adolescent depression or anxiety is something different and goes beyond moodiness or nerves. Mental health disorders are serious health conditions that impact every aspect of an adolescent's life. Many rebellious or unhealthy behaviors and attitudes may be indications of depression or anxiety.

Positive Youth Development is a movement that focuses on the development of mental health in youth and works to build resiliency and empowerment traits. Positive Youth Development teach kids how to become their own advocate, increase protective factors in their environment, and understanding the role of active and caring adults can play in their ability to deal with adversity.

Positive Youth Development resources include:

- Youth.gov <https://youth.gov/youth-topics/positive-youth-development>
- Act for Youth, Cornell University Bronfenbrenner Center for Translational Research www.actforyouth.net/
- Office of Adolescent Health www.hhs.gov/ash/oah/adolescent-development/positive-youth-development/index.html
- Developmental Relationship Framework, Search Institute www.search-institute.org/developmental-relationships/

Nutrition and Physical Activity/Wellness

Data from the CDC National Center for Health Statistics for 2015-2016 show that nearly 1 in 5 school age children between the ages of 6 to 19 has obesity.

www.cdc.gov/healthyschools/obesity/facts.htm

It is important that youth have a positive relationship with food and physical activity. Healthy food choices should be discussed in a fun and hands-on manner. Access to safe environments and the importance of physical activity for various ages and abilities should be available and promoted throughout the community.

KDHE, Bureau of Health Promotion offers strategies and resources to increase awareness about health and wellness (www.kdheks.gov/bhp/pan/index.htm). Other potential partners include:

- K-State Research and Extension agents across Kansas www.ksre.k-state.edu/humannutrition
- Local parks and recreation departments or commissions - see listing from Kansas Recreation and Park Association <https://krpa.wildapricot.org/page-1564875>
- School personnel

456 Partnerships

There is great value in working together to complete a common goal. Finding traditional and non-traditional partners to collaborate with in your community is critical for success. The Center for Community Health and Development at the University of Kansas is nationally known for their community toolbox. Among many helpful topics and practical, easy-to-use toolkits is “Creating and Maintaining Partnerships.”

<https://ctb.ku.edu/en/creating-and-maintaining-partnerships>

Change can happen in communities with a grass-roots approach where multiple organizations use the services and resources specific to their expertise and join with others to build or enhance the level of outreach and support to their families in a unified and coordinated manner.

Potential partners for adolescent health could include:

- Medical organizations (i.e. health departments, pediatricians/family practitioners, dentists, Emergency Medical Technicians/paramedics)
- Educational organizations (i.e. school personnel, school clubs/organizations, State Research and Extension, higher education such as community colleges or university staff or students)
- Parks and Recreation Department or Commissions
- Local businesses
- Faith-based organizations
- Community Mental Health Centers
- **YOUTH**

457 Youth Engagement

“Nothing About Us Without Us!” Author James Charlton used this slogan as a title of his book on disability oppression and empowerment in 1998. Today this phrase has been used by some organizations to illustrate that no action (policy, practice, process, initiative, etc.) should be decided only if/when there is full and direct participation of members of the intended audience or population. This is true for adolescent programs and initiatives. Youth NEED to be involved.

Authentic and meaningful youth engagement happens when young people are invited to play a key role in the planning, implementing, and evaluating phase of a program. However, 50/50 partnerships between adults and youth does not come easy. There needs to be intentionality and pre-planning to create a supportive environment and provide a space of respect and mutual collaboration.

The U.S. Department of Health and Human Services highlights eight successful youth engagement approaches (www.hhs.gov/ash/oah/tag/game-plan-for-engaging-youth/eight-approaches/index.html) such as youth councils, youth governance, youth serving on boards, youth voice, youth leadership programs, and youth advocacy, youth service, and youth organizing.

There are numerous benefits to including youth and young adults in your initiatives.

For **youth**, they get the opportunity to build job readiness skills, social competencies, self-confidence, identity exploration, civic competencies, and social capital.

For **initiatives**, there is access to the hard-to-reach populations, better access to collect data, improved data collection tools, and increased understanding and interpretation of initiative evaluation.

For **communities**, the opportunity to get a unique perspective of progress or challenges and barriers, creation of a new generation of youth leadership, increased activism and advocacy to new audience and new formats, and improved intergenerational communication.

For **programs/organizations**, visible improvements in programming, increased youth participation, and transformation of community culture.

www.actforyouth.net/youth_development/evaluation/benefits.cfm

Resources and websites that can help in developing a new youth partnership or enhance current efforts include:

- Act for Youth - www.actforyouth.net/
- U.S. HHS, Office of Adolescent Health - Think.Act.Grow (TAG) - www.hhs.gov/ash/oah/tag
- Youth.gov - <https://youth.gov/youth-topics/positive-youth-development/how-can-youth-be-engaged-programs-promote-positive-youth-development>

475 – Special Health Care Needs Satellite Office Guidance

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475 Description of Services

The Kansas Title V Special Health Care Needs (SHCN) Program is designed to provide care coordination and specialty medical services to infants, children and youth up to age 21 years who have eligible medical conditions and persons of all ages with metabolic or genetic conditions screened through the Newborn Screening Program. All participants must meet financial eligibility requirements.

The Special Bequest fund is available for qualified participants. This fund allows for specific requests for financial support of medical equipment, specialized care, education or other needed items that can improve health status, function, or quality of life for those with special health care needs. All requests are subject to Special Bequest Commissioner approval.

One-time diagnostic services may be authorized for individuals under 21 years of age who are at risk or suspected of having a significant medical disability or condition. Information about eligible conditions and financial guidelines can be found at: www.kdheks.gov/shcn.

The Special Health Care Needs Program also maintains and updates the Kansas Resource Guide (KRG), an informational service designed to connect Kansans and service providers with resources. www.kansasresourceguide.org

476 Eligibility for Services

All participants must meet the following eligibility criteria:

- Be a Kansas resident
- Meet age requirements (based upon diagnosed condition)
- Diagnosis meets medical eligibility (treatment services and care coordination only)

Those with metabolic or genetic conditions identified through the Newborn Screening program are eligible for assistance on a sliding fee scale based on the Federal Poverty Level. All other eligible conditions are covered to age 21 and qualify at 185% or below Federal Poverty level. For specific medical and financial criteria go to: www.kdheks.gov/shcn.

477 Program Philosophy and Priorities

The Kansas Special Health Care Needs (SHCN) Program promotes the functional skills of persons, who have or are at risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction.

Cross-System Care Coordination: “Patient and family-centered approach that utilizes team-based and assessment activities designed to meet the needs of children and youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and functional needs to achieve optimal health.”

Behavioral Health Integration: “Collaborative services for the prevention and treatment of emotional disorders that support the functioning of children, youth, and families in all settings, including home, community, school, and work. Efforts should be focused on keeping children in their homes and/or community.”

Family Caregiver Health: “Supporting the physical, emotional, social, and financial well-being of families with CYSHCN, particularly that of the family caregiver. A family caregiver is any individual, including siblings, who supports and cares for another person and may or may not be a biological relative.”

Direct Health Services and Supports: “Services delivered one-on-one between a health professional and patient, which may include primary, specialty, or ancillary health services, such as: inpatient and outpatient medical services, allied health services, drugs and pharmaceutical products, laboratory testing, x-ray services, and dental care. Access to highly trained specialists or services not generally available in most communities may also be included in this definition.”

Training & Education: “Supporting diversity in the provision of services for the special health care needs (SHCN) population through training and education of families, community members, medical and community providers, local and state service programs, and legislators. This includes family and youth leadership development in building a stronger advocacy network in Kansas.”

478 Local Agency Grantee Responsibilities

Requirements for Special Health Care Needs (SHCN) Satellite Office grantees only.

- a. Assist in efforts to expand KS-SHCN community-based services within the assigned region by:
 - i. Monitoring client status and communicate needs to families, as applicable
 - ii. Inputting client notes into web-based data system regarding interactions and communications made with KS-SHCN families
 - iii. Running update reports on a monthly basis to identify families that need updated applications, information or follow-up
 - iv. Participating in one in-person training in July. This training will cover basic satellite office work including Care Coordination.
 - v. Participating in 1.5-hour long webinar/conference calls by-monthly.
 - vi. Providing Care Coordination services for clients in your area as assigned by the Lead Care Coordinator
- b. Provide assistance with the application process to families interested in or needing KS-SHCN services by:
 - i. Assisting families in compiling necessary medical and financial information to KS-SHCN and other state and federal financial assistance programs; and
 - ii. Following up with families regarding referrals made to ensure support, collaboration and integrated service delivery across systems.
- c. Maintain proficiency in using the KS-SHCN web-based client monitoring system to support:
 - i. Entering potential clients in call center;
 - ii. Entering client applications;
 - iii. Monitoring client status and communicate needs to families, as applicable;

- iv. Inputting client notes into SHCN data system regarding interactions and communications made with SHCN families; and
- v. Running update and reminder reports on a monthly basis to identify families that need updated applications, information or follow up.
- d. Host KDHE for two (2) on-site visits, one in the fall and one in the spring, for new satellite offices and one (1) on site visit for existing offices during the contract period.
- e. Participate in the yearly in-person SHCN Satellite office training day and webinar/Brain Trust conference calls.
- f. Submit narrative, and KCSL Resource Reports on the required reporting form to KS-SHCN Topeka office.

479 Reporting and Financial Status Report (FSR) - SHCN Satellite Office

KS-SHCN services provided are part of the MCH contract and must follow the **Notice of Grant Award Amount and Summary of Program Objectives** in the MCH Service Manual on pages 50-55.

Progress Reports will be submitted quarterly in KGMS on the required reporting form(s) to the Special Health Care Needs Program. *Reporting form template(s) will be sent to all satellite offices.*

Personnel must be included within the personnel section with all other SHCN activities to be noted in the SHCN section of the Fiscal Status Report (FSR). Funding will be distributed as part of the total MCH allotments per MCH schedule.

Progress reports and FSR's will be reviewed and expenditures verified prior to releasing payments. Funds will be authorized as reimbursements for SHCN work completed during the reporting period.

480 Confidentiality

Grantee may have access to personal and confidential information of KDHE clients. Grantee is only authorized to use such information as may be minimally necessary to fulfill its duties. Grantee, for itself and on behalf of all its agents, employees and subcontractors agrees to keep all information confidential in accordance with KDHE statutes, regulations and policies.

500 – MCH Definitions

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500 - MCH Definitions

Adolescent - A child from age 12 through 21 years (excludes pregnant teens)

Children - A child from age one (1) through eleven (11) years

Children and Youth with Special Health Care Needs (CYSHCN) - Infants, Children, and Youth birth through 21 years who have, or are at risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally

Cultural Competence - A set of values, behaviors, attitudes and practices within a system, organization, program or among individuals and which enables them to work effectively cross culturally; refers to the ability to honor and respect the beliefs, language, inter-personal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices regarding health care; the respect of those differences and the development of approaches to health care with those differences in mind

Family Partnership - Patients, family, 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. This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course.

Federally Qualified Health Centers (FQHC) - public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs.

Infants - A baby under 1 year (<365 days)

Medical Home - An approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. A medical home extends beyond the four walls of a clinical practice. It includes specialty care, educational services, family support and more. Specific criteria to establish whether a child's health care meets the definition of a medical home includes:

1. The child has at least one personal doctor or nurse who knows him or her well and a usual source of sick care
 2. The child has no problems gaining referrals to specialty care and access to therapies or other services or equipment
 3. The family is very satisfied with the level of communication among their child's doctors and other programs
 4. The family usually or always gets sufficient help coordinating care when needed and receives effective care coordination
 5. The child's doctors usually or always spend enough time with the family, listen carefully to their concerns, are sensitive to their values and customs, provide any information they need, and make the family feel like a partner in their child's care
 6. An interpreter is usually or always available when needed
- <https://medicalhomeinfo.aap.org/Pages/default.aspx>

Objectives - A statement of intention with which actual achievement and results can be measured and compared to accomplish a goal; SMART objectives are Specific, Measurable, Achievable, Relevant and Time bound

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improvement health and well-being outcome. Health and well-being outcomes are usually longer term and tied to the ultimate program goal

Performance Measure - An intermediate outcome on the path towards a longer-term outcome measure of health and well-being that is used to more directly assess the impact of a program. Positive health behaviors and access to quality health care are common intermediate outcomes that may lead to health, reduced morbidity and mortality, or highly functioning systems of care

Performance Objectives - statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and the target populations. (for example, Increase the percentage of infants placed to sleep on their backs in Kansas by 10% over the next 5 years)

Perinatal - Period pertaining to immediately before and after birth. For example, the definition of perinatal mortality refers to fetal and early neonatal death between 28 weeks or more gestation through the first week of life (less than 7 days after birth)

Postpartum Woman - A woman up to 60 days after the end of pregnancy

Pregnant Woman (through 60 days postpartum) - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus. (includes pregnant teens)

Prenatal - Occurring or existing before birth, referring to both the care of the woman during pregnancy and the growth and development of the fetus

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions

Strategies - General approaches taken to achieve objectives: activities are specific actions to implement the strategies (for example, a strategy may be to improve provider training with activities that could include developing a training module, delivering or promoting the training, and monitoring utilization and/or knowledge improvement. Program activities for implementing the identified program strategies are discussed and updated annually)

Well Visit - Annual assessments that counsel patients about preventive care and to provide or refer for recommended services. These assessments should include screening, evaluation and counseling, and immunizations based on age and risk factors.

Woman - A woman 23-44 years (not pregnant or more than 60 days after the end of pregnancy)

600 – Appendix of MCH Resources

World Health Organization Social Determinants of Health Framework
Trauma-Informed Systems of Care Guiding Principles
Trauma-Informed Care Toolkits & Resources
Adverse Childhood Experiences (ACEs) (CDC Fact Sheet)
ACEs Questionnaire (adapted)
Resilience Questionnaire (adapted)
Lemonade For Life: A Guide to Using ACEs to Build Resilience & Hope
Sliding Fee Scale (Example)
Authorization/Consent for Release of Information* (2 Examples)
Annual Well-Woman Exam Infographic
Reproductive Life Plan
Reproductive Life Plan Tool for Health Professionals
My Maternal Well-Being Plan
Preventive Health Care Periodicity Schedule (Bright Futures)^
Tobacco Use Survey*
Maternal Depression Screening Form* (Edinburgh)
Referral Form (Example)
Home Visiting Flow/Algorithm/Process Map (Example)
Home Visiting Orientation Checklist (Example)
Home Visiting Coaching/Shadowing Tool (Template)
Home Visiting Outreach Plan (Example)
Home Visiting Home Safety Checklist
Early and Periodic Screening Diagnostic and Treatment Service+ (KAN Be Healthy) Quick Reference Guide
KAN Be Healthy Screening Form
Developing Program Goals and Measurable Objectives
Logic Model Guidance

*Available in English and Spanish in electronic form in DAISEY and PDF on the DAISEY website here: <http://daiseyolutions.org/find-answers/#111>.

An example of a DAISEY Data Sharing Memorandum of Agreement (MOA) for a community is available upon request. KDHE will assist with developing and executing an agreement for partners in communities that are interested in sharing information about program participants across agencies.

^Always access Bright Futures materials and resources for preventive health services online at <https://brightfutures.aap.org/Pages/default.aspx> to ensure the most current tools and schedule are utilized at all times. It is not recommended that you print documents, especially schedules, for use due to ongoing changes made by Bright Futures/American Academy of Pediatrics.

+Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a mandatory Medicaid service that was developed to provide preventive services and treatment to children enrolled in Medicaid.

WHO Framework for Tackling Social Determinants of Health and Infant Mortality CollIN SDOH Recommended Strategies

Context-specific strategies tackling both structural and intermediary determinants

Key dimensions and directions for policy

Intersectoral action

Social participation and empowerment

Policies on stratification to reduce inequalities, mitigate stratification.

Policies to reduce exposures of disadvantaged people to health damaging factors.

Policies to reduce vulnerability and increase resiliency of disadvantaged people.

Policies to reduce unequal consequences of illness, in social, economic, and health terms.

Cross-cutting Action

- Monitoring and follow up of health equity and SDOH.
- Evidence on interventions to tackle social determinants of health across government.
- Include health equity as a goal in health policy and other social policies (HEiAP).

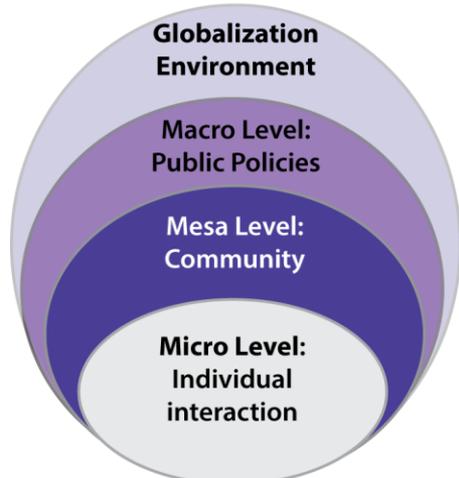
Taxes
Paid family & medical leave
Minimum wage
Justice system reform

Housing
ACEs, trauma & resilience initiatives
Place-based initiatives

Job training, education, & career paths
Fatherhood/male initiatives
Social networks for empowerment
Medical-legal partnerships

Medicaid expansion
QI on unequal treatment
CLAS standards implementation
Home visit enhancements
Group strategies

Health equity in all policies
Map risk/protective factors
Monitor inequality & disparities
Assess capacity



Guiding Principles

of Trauma-Informed Systems of Care

SAFETY

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

TRUSTWORTHINESS AND TRANSPARENCY

Organizational operations and decisions are conducted with appropriate transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

PEER SUPPORT AND MUTUAL HELP (RECOVERY)

The organization recognizes the value of "lived experience" by employing peer support staff or by offering peer support groups. Leadership recognizes that all people, and the organization itself, is capable, whole, and resourceful.

COLLABORATION AND MUTUALITY

There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach.
One does not have to be a therapist to be therapeutic.

EMPOWERMENT, VOICE AND CHOICE

Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the staff's, clients', and family members' experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This includes a belief in strengths and resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

CULTURAL, HISTORICAL AND GENDER ISSUES

The organization actively identifies and changes cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

Toolkits for Primary Care & Home Visiting

American Academy of Pediatrics – Toolkit for Primary Care

Six part series designed with the primary care practice in mind – those who may or may not be familiar with adverse childhood experiences (ACEs) and the process of asking families about exposure to ACEs or other traumatic events.

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx>

HealthCare Toolbox

This website that serves as a guide to helping children and families cope with illness and injury is a partnership between the National Child Traumatic Stress Network, Nemours Children's Health Network, Alfred I. duPont Hospital for Children, and The Children's Hospital of Philadelphia.

<https://www.healthcaretoolbox.org/>

NEAR@Home Toolkit: A Guided Process to Talk about Trauma and Resilience in Home Visiting

Home visitors knowledgeable about ACEs research are interested in bringing this information to families but worry about causing harm. The NEAR@Home toolkit addresses these concerns and provide strategies for engaging parents in discussing and using the ACEs questionnaire in a safe, respectful, and effective way for both home visitor and family.

<https://thrivewa.org/work/trauma-and-resilience-4/>

Trauma-Informed Primary Care Initiative (TIPCI)

In 2015, The National Council on Behavioral Health and Kaiser Permanente launched TIPCI with 14 pilot clinics across the country. This website includes the resources and tools they are using to implement TISC in those clinics.

<https://www.nationalcouncildocs.net/trauma-informed-care-learning-community/tic-in-primary-care>

Additional Resources for Primary Care Providers

Center for Youth Wellness - <http://www.centerforyouthwellness.org/>

Handbook on Sensitive Practice for HealthCare Practitioners - <http://www.integration.samhsa.gov/clinical-practice/handbook-sensitive-practices4healthcare.pdf>

Advancing Prevention Project (NY Academy of Medicine) – *Trauma-Informed & Resilient Communities: A Primer for Public Health Practitioners* <http://www.advancingpreventionproject.org/wp-content/uploads/2016/06/Trauma-Primer-Final.pdf>

National Council for Behavioral Health – *Four Ways to Make Patients with Traumatic Histories Feel Safe in Primary Care* <https://www.thenationalcouncil.org/BH365/2016/05/18/4-ways-make-patients-traumatic-histories-feel-safe-primary-care/>

SAMHSA-HRSA Center for Integrated Health Solutions - <http://www.integration.samhsa.gov/clinical-practice/trauma>

The Resilience Project (AAP) - <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/default.aspx>

Additional Resources (General)

ACE Interface - <http://www.aceinterface.com/>

ACEs Connection Network - <http://www.acesconnection.com/>

ACEs Too High - <https://acestoohigh.com/>

Centers for Disease Control and Prevention - <https://www.cdc.gov/violenceprevention/cestudy/>
CDC Essentials for Childhood Framework -
<https://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html>

Child Trauma Academy - <http://childtrauma.org/>

Childhood Trauma – Changing Minds™ - <https://changingmindsnow.org/>

Community Resilience Cookbook - <http://communityresiliencecookbook.org/>

Futures without Violence:

Healthy Moms, Happy Babies Curriculum -

https://www.futureswithoutviolence.org/userfiles/file/HealthCare/HV_Trainer's_Guide_Low_Res_FINAL.pdf

Making the Connection: Intimate Partners Violence and Public Health -

<https://www.futureswithoutviolence.org/making-the-connection-intimate-partner-violence-and-public-health/>

Kansas Department of Health and Environment - http://www.kdheks.gov/brfss/PDF/ACE_Report_2014.pdf

Kansas Power of the Positive - <http://www.kansaspowerofthepositive.org/>

Lemonade for Life - <http://lemonadeforlife.com/>

Lucid Witness - <https://lucidwitness.com/2016/09/25/index-to-lucidwitness/>

Resilience Trumps ACEs - <http://www.resiliencetrumpsaces.org/>

ResilientKC - <http://www.kcchamber.com/Resilient-KC/Home.aspx>

Robert Wood Johnson Foundation - <http://www.rwjf.org/en/library/collections/aces.html>

Substance Abuse and Mental Health Services Administration (SAMHSA) TIP 57 -
http://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

TraumaMatters KC - <http://www.marc2.org/traumamatterskc/>

The Sanctuary Model® (Dr. Sandra Bloom) - <http://sanctuaryweb.com/Home.aspx>

Videos

[ACEs Primer](#) – From KPJR Films, the producers of *Paper Tigers & Resilience*, this short video summarizes the ACEs study and what it means for population health. (Length – 4:59)

[Brain Builders](#) – From Alberta Family Wellness and the Harvard Center for the Developing Child, this animated video describes how toxic stress impacts early brain development (Length – 4:05)

[Harvard Center for the Developing Child](#) – The Harvard Center for the Developing Child has videos on a variety of topics including brain architecture and building resilience.

[How Childhood Trauma Affects Health across a Lifetime](#) – From TED.com, Dr. Nadine Burke Harris discusses the need for a public health approach to preventing Adverse Childhood Experiences (Length -15:59)

[Raising of America](#) (select scenes) – From California Newsreel, the producers of *Raising of America* (Various lengths and topics from the film series.)

ADVERSE CHILDHOOD EXPERIENCES

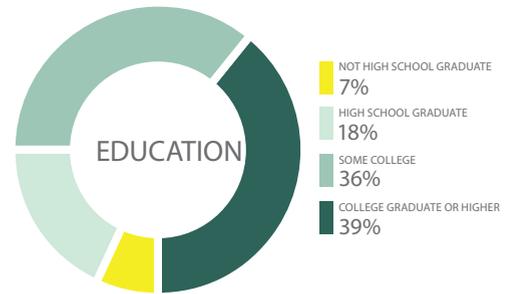
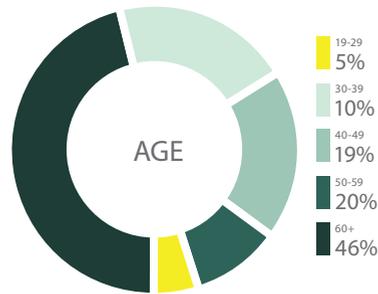
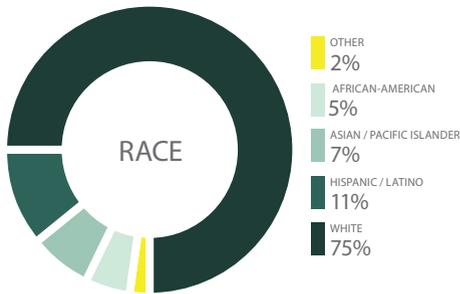
looking at how ACEs affect our lives & society

WHAT ARE ACEs?

Adverse Childhood Experiences (ACEs) is the term given to describe all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18. The landmark Kaiser ACE Study examined the relationships between these experiences during childhood and reduced health and well-being later in life.

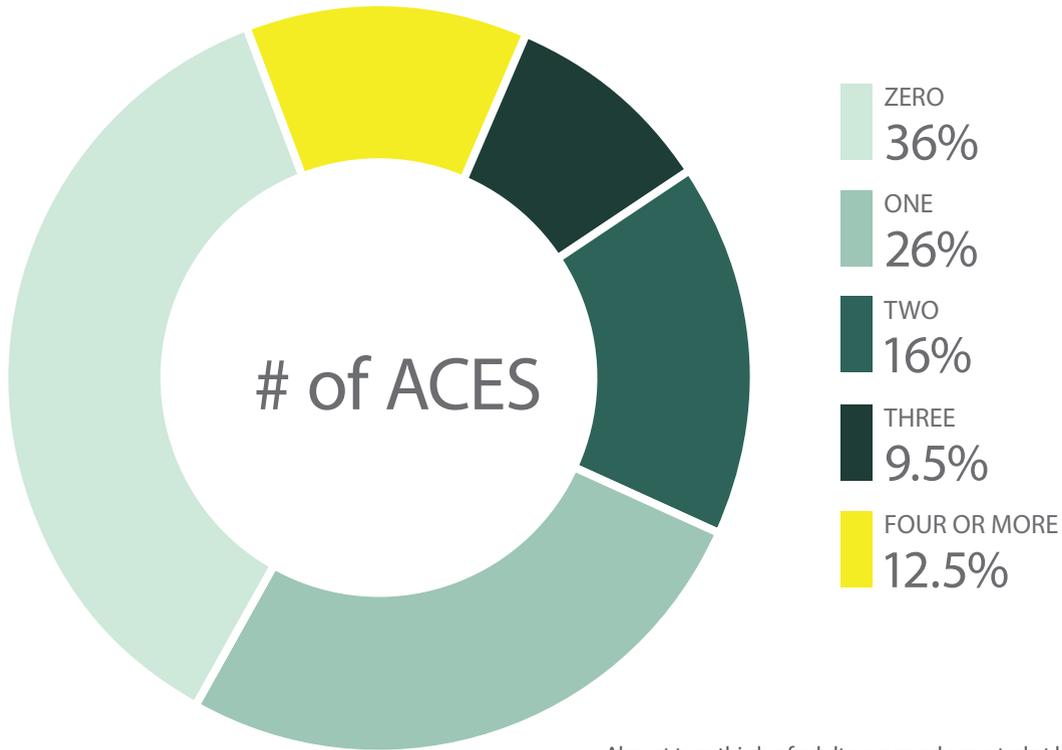
WHO PARTICIPATED IN THE ACE STUDY?

Between 1995 and 1997, over 17,000 people receiving physical exams completed confidential surveys containing information about their childhood experiences and current health status and behaviors. The information from these surveys was combined with results from their physical exams to form the study's findings.



*Participants in this study reflected a cross-section of middle-class American adults.

HOW COMMON ARE ACES?

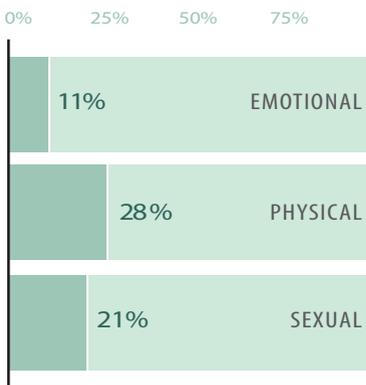


Almost two-thirds of adults surveyed reported at least one Adverse Childhood Experience – and the majority of respondents who reported at least one ACE reported more than one.

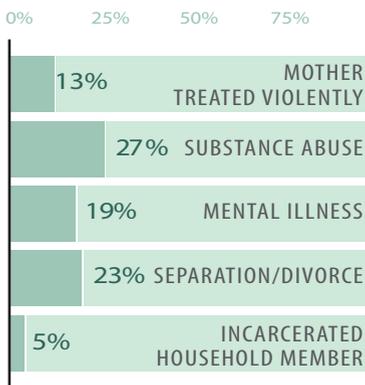
TYPES of ACES

The ACE study looked at three categories of adverse experience: **childhood abuse**, which included emotional, physical, and sexual abuse; **neglect**, including both physical and emotional neglect; and **household challenges**, which included growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation/divorce or had a member of the household go to prison. Respondents were given an **ACE score** between 0 and 10 based on how many of these 10 types of adverse experience to which they reported being exposed.

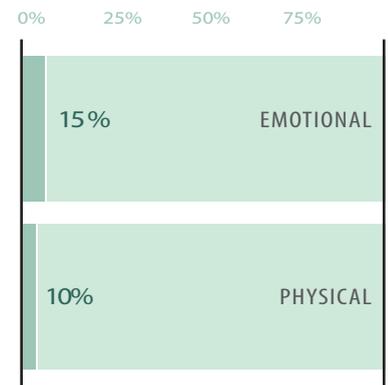
ABUSE



HOUSEHOLD CHALLENGES



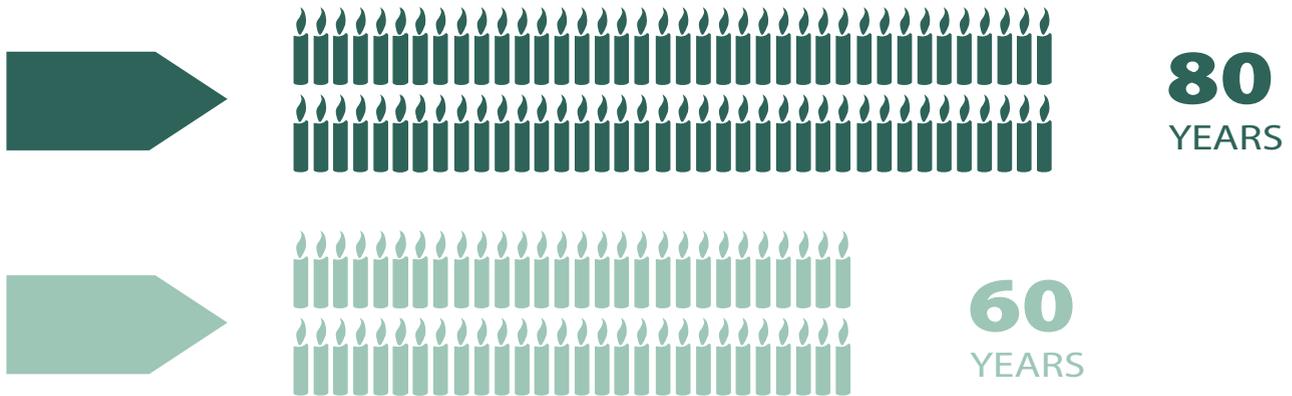
NEGLECT



HOW DO ACES AFFECT OUR SOCIETY?

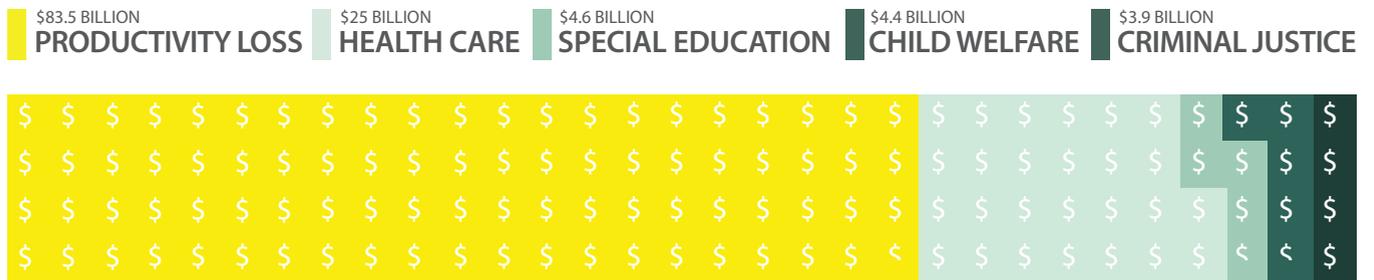
LIFE EXPECTANCY

People with six or more ACEs died nearly **20 years earlier on average** than those without ACEs.

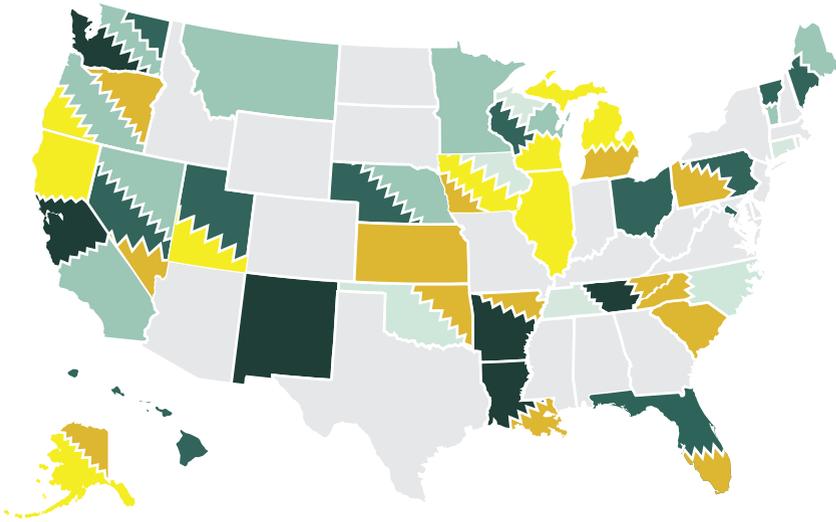


ECONOMIC TOLL

The Centers for Disease Control and Prevention (CDC) estimates that the lifetime costs associated with child maltreatment at **\$124 billion**.



THE ACE STUDY CONTINUES



- 2009
AR, CA, LA, NM, TN, WA
- 2010
DC, FL, HI, ME, NE, NV, OH, PA, UT, VT, WA, WI
- 2011
CA, ME, MN, MT, NE, NV, OR, VT, WA, WI
- 2012
CT, IA, NC, OK, TN, WI
- 2013
AK, CA, IL, IA, MI, OR, UT, WI
- 2014
AK, AR, FL, IA, KS, LA, NC, NV, OK, OR, PA, SC, TN, WI

Although the study ended in 1997, some states are collecting information about ACEs in their population through the Behavioral Risk Factor Surveillance System (BRFSS).

What *can* Be Done About ACEs?

These wide-ranging health and social consequences underscore the importance of preventing ACEs before they happen. Safe, stable and nurturing relationships **and environments** (SSNRs) can have a positive impact on a broad range of health problems and on the development of skills that will help children reach their full potential. Strategies that address the needs of children and their families include:

Voluntary home visiting programs can help families by strengthening maternal parenting practices, the quality of the child's home environment, and children's development.
Example: Nurse-Family Partnership



Home visiting to pregnant women and families with newborns



Parenting training programs



Intimate partner violence prevention



Social support for parents



Parent support programs for teens and teen pregnancy prevention programs



Mental illness and substance abuse treatment



High quality child care



Sufficient income support for lower income families

REFERENCES AND RESOURCES

REFERENCES

[ACE Study](#)

[Child Welfare Information Gateway](#)

[Economic Cost of Child Abuse and Neglect](#)

[Essentials for Childhood](#)



Adverse Childhood Experience Questionnaire (ACE-Q)

(short version)

Prior to your 18 th birthday...	No (Enter "0")	Yes (Enter "1")
1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?		
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were your parents ever separated or divorced?		
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?		
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?		
10. Did a household member go to prison?		
TOTAL "Yes" Answers (This is your ACE Score)		

RESILIENCE Questionnaire

Please mark the answer that is the most accurate for each statement.	Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True
1. I believe that my mother loved me when I was little.					
2. I believe that my father loved me when I was little.					
3. When I was little, other people helped my mother and father take care of me and they seemed to love me.					
4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.					
5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.					
6. When I was a child, neighbors or my friends' parents seemed to like me.					
7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.					
8. Someone in my family cared about how I was doing in school.					
9. My family, neighbors and friends talked often about making our lives better.					
10. We had rules in our house and were expected to keep them.					
11. When I felt really bad, I could almost always find someone I trusted to talk to.					
12. As a youth, people noticed that I was capable and could get things done.					
13. I was independent and a go-getter.					
14. I believed that life is what you make it.					

How many of these 14 protective factors did I have as a child/youth? (How many of the 14 were marked “Definitely True” or “Probably True”?) _____

Of the 14 that I marked “Definitely True” or “Probably True”, how many are still true for me? _____

NOTE: This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modeled after the ACE Study questions. The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.



Lemonade FOR Life

A guide to using ACEs to build resilience & hope

Turning Lemons into Lemonade

Researchers and practitioners know that early-life experiences can shape health across an entire lifetime and potentially across generations.

Landmark studies of early childhood tell us that the first years of life should be acknowledged as a point of intervention that can tip the scales and mitigate risk factors that lead to negative societal impacts. Our future health and well-being as individuals and as a society are undeniably linked to how successfully we support and facilitate the well-being of today's children.

The 1998 Adverse Childhood Experiences (ACEs) study provided a foundational understanding of the link between what happens during a child's early years and the health risk that child faces as an adult. Felitti and fellow researchers concluded that when young children experience or are exposed to adverse situations such as abuse, substance abuse, and mental illness, they are at higher risk for a litany of health problems, including chronic disease, mental illness and substance abuse (Felitti et al., 1998). The ACEs study underlines the importance of early intervention and parent support to help families *turn lemons into... **Lemonade for Life***©.

All the population, everybody of every age, were all at one time children. And they bring to their maturity and old age the strength and scars of an entire lifetime.

– Pauline Stitt, Maternal and Child Health Bureau, 1960

The **Lemonade for Life** program seeks to translate ACEs research into practice. While the ACEs research is well-known among practitioners, tools to support discussion of ACEs with families are lacking. To address this gap, the **Lemonade for Life** program trains professionals working with parents and caregivers on use of the ACEs Questionnaire to help prevent future exposure to ACEs and promote hope and resilience.



Anticipated Program Outcomes

- Professionals are empowered to talk about ACEs as a tool in their work with families.
- Parents have tools to understand why things in their life might be so hard.
- Parents feel hopeful they can make a difference in their children's lives because they now better understand their own experiences with adversity.
- Parents feel empowered to prevent the recurrence of adverse childhood experiences through the development of safe, stable, and nurturing relationships and environments.
- Parent and family engagement in services increases, attrition decreases, and program completion rates increase.

Training Modules

1. Welcome
2. Acknowledging ACEs
3. Lemonade for Life Recipe
4. Putting ACEs in Perspective
5. Having Conversations About Difficult Topics
6. Watching & Doing
7. Hope & Resilience
8. Developing a Resiliency Plan
9. My Lemonade Stand
10. Making Effective Referrals
11. Promoting Professionals' Resilience
12. Wrap Up & Closing

Opportunities for Impact

Early Learning

Early Learning professionals have unique relationships with families as partners in the care and education of young children. With Lemonade for Life, they can learn to recognize and understand ACEs and will receive guidance on how to provide appropriate supports.

Faith-Based Organizations

Faith-based organizations provide both concrete and intangible supports for families. By learning about the impact of ACEs on multiple generations, leaders and volunteers in faith-based organizations will be better equipped to help and refer.

Medical Community

Doctors, nurses, and medical specialists have a vested interest in ACEs as they care for the long-term health of patients. Lemonade for Life offers the Medical Community an opportunity to introduce ACEs screening, learn to identify risks, and support protective factors including resilience.

K-12 Education

In order to achieve positive academic outcomes, schools must consider and address the experiences that students and families bring to the classroom. Using a trauma-informed approach, teachers and staff learn to recognize the effects of ACEs and incorporate strategies to maximize resiliency in the school setting.

Community-Based

Cross-sector training offers the opportunity to bring together a diverse group of partners to build common knowledge and provide high-quality, ACEs-informed services and supports.

Contact

Melissa Zinn, Training Coordinator
Lemonade for Life
mmzinn@ku.edu

AUTHORIZATION FOR RELEASE OF INFORMATION
Kansas Department of Health and Environment
Family Health Comprehensive System

Service providers in your community are partnering to improve the services you may need. We do that by sharing information with each other. This means we know what services you need. It also makes it faster and easier for you to access those services.

If you agree to let us share your and your child(ren)'s protected health information between service providers, it will be stored in a secure electronic system that only other service providers in your community can access. All providers with access to the system are required to keep your information secure. We will only use your and your child(ren)'s information to coordinate services and share information among service providers within your community.

If you agree, information that will be shared in the system includes:

- Protected health information (Ex: name, gender, date of birth).
- Information about services you receive (Ex: health screening, education, home visits).
- Information about assessments you receive as part of a service (Ex: answers to questions about housing needs, tobacco use, prenatal care).

Do you agree to allow Family Health service providers in your community to share your information to provide better services?

Yes, my / my family's protected health information can be shared with only other community based Family Health service providers who will also secure my information. I understand that I can revoke my agreement at any time by notifying a participating service provider.

No, my / my family's protected health information cannot be shared. (If you select this option, your information will not be shared with other service providers in your community). I understand that my / my family's information will be included in the system, but my protected health information will not be shared between providers.

Signature

Date

Printed Name

Signature of Program Staff/Witness

Date

Participating Agency/Program



CONSENT FOR RELEASE OF INFORMATION



Applicant's Name: _____ Birth Date: _____

Home Address: _____ Apt. #: _____

City: _____ State: _____ County: _____

I hereby authorize Special Health Care Needs (Special Health Services-SHCN) to obtain medical information to and from the following (Checking the boxes affirms consent). Please include contact information.

- Checkboxes for Hospital, Parents As Teachers, School District #, Case Worker, Childcare Provider, Kansas Department for Children and Families, Other, Physician, Medicaid/KanCare, Private Insurance, CDDO, Early Head Start/Head Start, TRICARE, Other, Other.

Expiration: This authorization shall expire one year from the date signed. Purpose: Medical eligibility determination, care coordination, quality assurance of treatment services.

- Statements of Understanding: I understand the potential for Special Health Care Needs to re-disclose this information and may no longer be protected by federal law. I understand that I may revoke this authorization at any time. If I revoke this authorization, it will have no effect on actions already taken in reliance of this form. I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or I am authorized to "act on behalf of the applicant/patient as the applicant's personal representative.

Parent/Guardian Signature, if applicant is over 18 _____ Date _____

IF OVER 18: I authorize KDHE/SHCN to discuss my financial and medical information with the following individuals:

Name _____ Relationship to Applicant _____

Name _____ Relationship to Applicant _____





**CONSENT FOR RELEASE
OF INFORMATION**



TO BE COMPLETED BY SHCN STAFF

Information Being Requested: _____

Medical Record Information (since): _____ Date Requested: _____

SCHEDULE YOUR WELL-WOMAN VISIT TODAY!

Annual Well-Woman EXAMINATION

Top reasons why you should have an annual well-woman examination



Birth Control

Learn about choosing the right birth control method for you. Some examples include the birth control pill, intrauterine device (IUD), patch, condom, or implant.



Cancer Screening

Learn more about breast cancer, colon cancer, or other types of cancer.



Vaccinations

Get vaccinations against the flu, human papillomavirus (HPV), and more.



Health Screening

Get screened for high blood pressure, diabetes, bone density for osteoporosis, and more.



Depression Screening

Depression is a common but serious illness. Depression can be mild, moderate, or severe. To diagnose depression, your obstetrician-gynecologist or other health care provider will discuss your symptoms, how often they occur, and how severe they are.



Sexually Transmitted Infections Screening

Sexually transmitted infections (STIs), such as chlamydia, gonorrhea, and genital herpes, are infections that are spread by sexual contact.



Concerns About Sex

Discuss what happens during intercourse, pain during sex, hormonal changes that change interest or response to sex, or different forms of sex.



Weight Control

Learn about body mass index (BMI), exercise, obesity, diet, surgery, and health problems associated with being overweight.



Issues With Your Menstrual Period

Discuss premenstrual syndrome (PMS), painful periods, your first period, heavy bleeding, or irregular periods.



Preconception Counseling

If you are planning to become pregnant, it is a good idea to have preconception counseling. Your obstetrician-gynecologist or health care provider will ask about your diet and lifestyle, your medical and family history, medications you take, and any past pregnancies.



Other Reasons

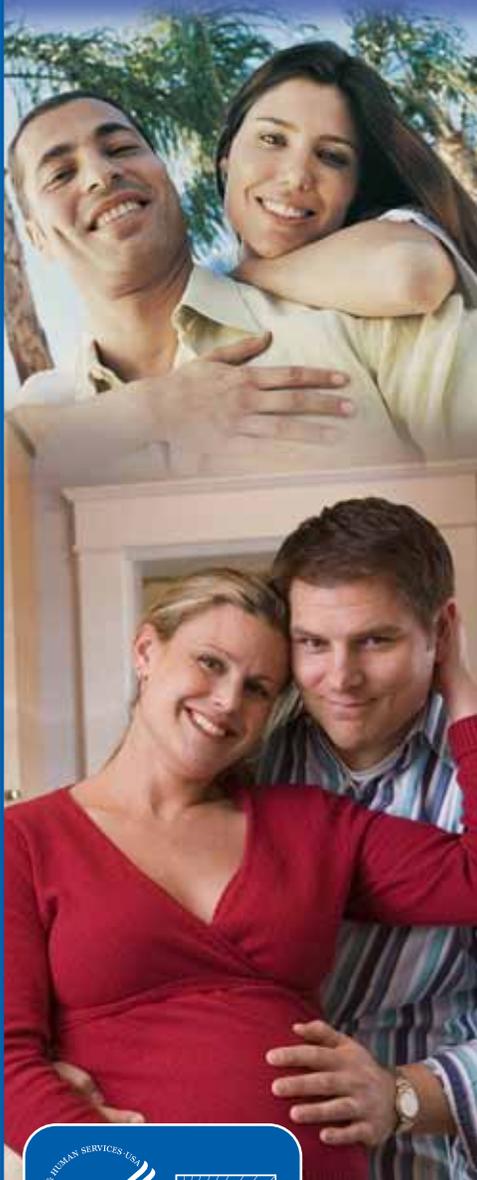
Get help with menopause symptoms, urinary incontinence, getting pregnant, or relationship problems.



Preconception Health and Health Care

My Reproductive Life Plan

Thinking about your goals for having or not having children and how to achieve those goals is called a *reproductive life plan*. There are many kinds of reproductive life plans. Your plan will depend on your personal goals and dreams.



How to Make a Plan

First, think about your goals for school, for your job or career, and for other important things in your life. Then, think about how having children fits in with those goals.

If you do want to have children one day, think about when and under what conditions you want to become pregnant. This can help ensure that you and your partner are healthy and ready when you choose to have a baby. If you do not want to have children (now or ever), think about how you will prevent pregnancy and what steps you can take to be as healthy as possible.

Try to include as many details as possible in your plan. Some people find it helpful to write their plan down on a piece of paper or in a journal. Be sure to talk with your health care professionals. Doctors and counselors can help you make your plan and achieve your goals.

Questions to Get Started

When making a reproductive life plan, the following questions might be helpful. These are probably not all of the questions that you will want to ask yourself, but they will help you to get started.

If you **DO NOT** want to have children, you might ask yourself:

- How do I plan to prevent pregnancy? Am I sure that I or my partner will be able to use the method chosen without any problems?
- What will I do if I or my partner becomes pregnant by accident?
- What steps can I take to be as healthy as possible?
- What medical conditions (such as diabetes, obesity, and high blood pressure) or other concerns (such as smoking, drinking alcohol, and using drugs) do I need to talk about with my doctor?
- Is it possible I could ever change my mind and want to have children one day?

If you **DO** want to have children one day:

- How old do I want to be when I start and when I stop having children?
- How many children do I want to have?
- How many years do I want between my children?
- What method do I plan to use to prevent pregnancy until I'm ready to have children? Am I sure that I or my partner will be able to use this method without any problems?
- What, if anything, do I want to change about my health, relationships, home, school, work, finances, or other parts of my life to get ready to have children?
- What steps can I take to be as healthy as possible, even if I'm not ready to have children yet?
- What medical conditions (such as diabetes, obesity, and high blood pressure) or other concerns (such as smoking, drinking alcohol, and using drugs) do I need to talk about with my doctor?



Examples of Plans

Following are some examples of reproductive life plans:

- I've decided that I don't want to have any children. I will find a good birth control method. Even though I don't want to have children, I will talk to my doctor about how I can be healthier.
- I'm not ready to have children now because I want to finish school first. I'll make sure I use effective birth control and protect myself from sexually transmitted diseases every time I have sex. Some day, I think I'd like to have two or three children about 2 years apart. Before I get pregnant, I will talk to my doctor about losing weight and eating healthy.
- I want to have children when I've saved some money. My partner has diabetes so, when it's time, I'll encourage her to see her doctor to make sure her body is ready for pregnancy. In the meantime, we're taking really good care of ourselves just for us.
- I might want to have children one day, but I'm not sure right now. For now I'm not going to have sex. Even though I'm not ready to have kids yet, I'm going to talk with my doctor about how I can be as healthy as possible.
- I am in a good relationship and I'm pretty healthy. I want to stop using birth control and try to get pregnant. I'm going to talk to my doctor to find out what I can do to have a healthy pregnancy.
- I've had two kids, and they were only a year apart. Both times, it just happened. I want to have another kid before I turn 36, but I want to wait at least 2 years. I'll talk to my doctor about birth control. This time, I'm going to make sure I get pregnant only when I want to.
- I'm going to let pregnancy just happen whenever it happens. Because I don't know when that will be, I'm making sure that I'm in the best health now, just in case!
- My partner and I are ready to have a child, but we'll need to use a sperm bank or fertility service to get pregnant. I'll make sure I'm in good health and financially stable before we use those services.

Take Action

Once you have a plan, take action. For example, if you've decided to use condoms to prevent pregnancy, be sure to use them every time you have sex. Or, if you've decided to quit smoking, follow through and get help if needed.

Keep in mind that your plan doesn't have to be set in stone. Life is unpredictable! So, make a plan today, give it some thought each year, and expect to make changes along the way.

For more information please visit: www.cdc.gov/preconception

This Reproductive Life Plan was developed in partnership with Merry-K Moos, RN, FNP, MPH, FAAN, Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill and is based on her webinar, "Reproductive Life Plans" (February 25, 2010) available at <http://www.beforeandbeyond.org/?page=cme-modules>.



Preconception Health and Health Care *Reproductive Life Plan* *Tool For Health Professionals*



Health care providers can encourage patients (women, men, and couples) to consider a **reproductive life plan** and educate patients about how their reproductive life plan impacts contraceptive and medical decision-making.



Do you plan to have any (more) children at any time in your future? *(Open ended and allows branching.)*

IF YES:

- How many children would you like to have? *(Encourages the person to consider that there is a choice about the number of children one has.)*
- How long would you like to wait until you or your partner becomes pregnant? *(Encourages the person to vision their own future.)*

Studies have shown an association between shorter birth intervals (less than 6 months between giving birth and conception), and several adverse fetal outcomes, including low birth weight, preterm birth, and small for gestational age. Intervals of 60 months or longer had higher risks for preterm birth and very small for gestational age.^{i,ii}

Many women are waiting until their 30s and 40s to have children. About one-third of couples in which the woman is older than 35 years have fertility problems.ⁱⁱⁱ

- What family planning method do you plan to use until you or your partner are ready to become pregnant? *(Gives the patient an opportunity to formulate and communicate a personal strategy.)*

About half of all pregnancies in the United States are unplanned. Slightly more than half of unintended pregnancies occur among women who were not using any method of contraception in the month they conceived.^{iv}

- How sure are you that you will be able to use this method without any problems? *(Encourages the patient to recognize that methods can have problems and to consider matching method choice to personal circumstances.)*

Contraception is highly effective; however, no method, including permanent sterilization, is perfect. In addition to nonuse of contraception, unintended pregnancies occur due to imperfect use of contraception (43%), and method failure (5%).^{iv}



IF NO:

- **What family planning method will you use to avoid pregnancy?** *(Gives an opportunity to formulate and communicate a personal strategy to achieve plan.)*

About half of all pregnancies in the United States are unplanned. Slightly more than half of unintended pregnancies occur among women who were not using any method of contraception in the month they conceived.^{iv}

- **How sure are you that you will be able to use this method without any problems?** *(Encourages recognition that methods can have problems and to consider matching method choice to personal circumstances.)*

Contraception is highly effective; however, no method, including permanent sterilization, is perfect. In addition to nonuse of contraception, unintended pregnancies occur due to imperfect use of contraception (43%), and method failure (5%).^{iv}

- **People's plans change. Is it possible you or your partner could ever decide to become pregnant?** *(Relays the message that plans can change and that it is okay, but deliberate decisions about becoming pregnant are possible and desirable.)*

Action Steps

Once your patient has a plan—encourage her or him to take action. For example, if she's decided to use the pill, ask her if she has thought about how to take the pill the same time every day; if his plan is to use condoms, ask if he has thought about how to have a useable condom available whenever needed.

Remind patients that the plan doesn't have to be set in stone. Life is unpredictable! So, encourage people to make a plan today, give it some thought each year, and expect to make changes along the way.

For more information please visit: www.cdc.gov/preconception

References:

- i. Salihi HM, August EM, Mbah AK, de Cuba RJ 2nd, Alio AP, Rowland-Mishkit V, Berry EL. The Impact of Birth Spacing on Subsequent Feto-Infant Outcomes among Community Enrollees of a Federal Healthy Start Project. *J of Community Health*. 2011 Jun 9. [Epub ahead of print]
- ii. Grisaru-Granovsky S, Gordon ES, Haklai Z, Samueloff A, Schimmel MM. Effect of interpregnancy interval on adverse perinatal outcomes—a national study. *Contraception*. 2009 Dec;80(6):512-8. Epub 2009 Jul 22.
- iii. CDC. <http://www.cdc.gov/reproductivehealth/infertility/index.htm#8>
- iv. Frost JJ, Darroch JE and Remez L. Improving Contraceptive Use in the United States, In Brief, New York: Guttmacher Institute, 2008, No.1.

This Reproductive Life Plan was developed in partnership with Merry-K Moos, RN, FNP, MPH, FAAN, Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill and is based on her webinar, "Reproductive Life Plans" (February 25, 2010) available at <http://www.beforeandbeyond.org/?page=cme-modules>.



My Maternal Wellbeing Plan

SLEEP

Prenatal

During pregnancy, you may find yourself wrestling in bed trying to get comfortable before falling asleep. Unfortunately, your regular sleeping positions may no longer work for you during pregnancy. There are a number of reasons for this new discomfort, but there are some sleeping positions that you can try that may help you get your much-needed rest. The best sleep position during pregnancy is “SOS” (sleep on side). Even better is to sleep on your left side. Sleeping on your left side will increase the amount of blood and nutrients that reach the placenta and your baby.

Postpartum

It is often very hard to get rest or sleep when you have a new baby, as a young baby is not meant to sleep through the night. It is normal for them to sleep in 2-3 hour stretches. This will change as baby grows. Sleep is important for your health. Your sleep will probably change after the baby comes, but you can try these things to help yourself get needed rest.

- You may need to sleep in 2-3 hour blocks at a time, strung together to get you the 7-9 hours you need.
- During that time, don't do anything except try to sleep. If you need to get up for feeding, do it, change his diaper, but don't play with him, and then go right back to bed. Keep lights off, low, or use a red bulb. Don't start watching TV, turn music on, or check your phone or other electronics.
- Create a healthy sleep environment—dark, quiet, comfortable, with not a lot of distractions.
- In addition to the main sleep time, rest or nap when the baby is sleeping. Don't use that time for house chores or any work.



EAT WELL

- Always have on hand: protein, veggies, fruit, whole grains.
- Prepack single-serve portions in baggies for easy eating.
- Keep healthy snacks where you sit to feed the baby.
- Drink water as you need it, have it easily available.

MOVE & GET OUTSIDE

- Aim for 30 minutes a day of movement. Start easy! Walk, light housework or gardening, quick trip to the store or errands or library.
- Try to get outside every day, even if just for a slow walk.

CONNECT

- Stay connected to supportive family and friends by phone, email and text.
- Encourage short visits and be very clear about “visiting hours”.
- Accept offers of help. Ask for it if you need it!

RESOURCES

Getting Good Sleep:

- National Sleep Foundation
www.sleep.org
- KIDS Network
www.kidsks.org
- Safe Sleep
www.safesleepkansas.org

Baby Development:

- Help Me Grow?
www.helpmegrownational.org
- Baby Buffer
www.babybuffer.org
- Ages & Stages Questionnaires (ASQ)
www.agesandstages.com

Nutrition for New Moms:

- Kansas Women, Infants & Children (WIC)
www.kansaswic.org

My Maternal Wellbeing Plan

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Have you been screened? If so, when?

JUST IN CASE

You may have mixed emotions about your pregnancy and your baby. This is completely normal. Here are some common signs that you should talk through with your midwife or health visitor:

- Tearfulness
- Feeling overwhelmed
- Being irritable/arguing more often
- Lack of concentration
- Change in appetite
- Racing thoughts
- Feeling more anxious
- Problems sleeping or extreme energy
- Lack of interest in usual things
- Some women can also have:
 - Intrusive thoughts
 - Suicidal thoughts
 - Strict rituals and obsessions
 - Lack of feelings for their baby
 - Having a new baby is a big change.

There are resources to help people figure out how to adjust. You can find help to keep you and your baby healthy, mentally and physically. If it's not going well, it's good to recognize that and get help.

GET HELP

It is not an emergency, but I need advice:

- Provider's office daytime: _____
- Provider/clinic after hours: _____
- Shawnee Mission Health Nurse Line
(Formerly ASK-A-NURSE) 913-676-7777

It is an emergency and I'm scared I will hurt myself or my baby:

- 911
- Pregnancy and Postpartum Resource Center of Kansas
913-677-1300
- National Suicide Prevention Lifeline Center for Kansas
1-800-273-8255 or 785-841-2345

PLAN AHEAD

My best place for relaxing is:

Healthy, easy foods I like to eat are:

Ways I like to exercise and connect with other people, which I could do with a small baby:

My early signs that I am feeling bad, depressed, or too anxious:

It can be difficult to talk about not doing well. If you feel like this, who are 3 people you would talk with?

1. _____
2. _____
3. _____

What will you say?

Credit is given to the Minnesota Department of Health for their work to create the *My Maternal Wellbeing Plan*, Oct. 26. <http://www.health.state.mn.us/divs/cfh/topic/pmad/pmadfs.cfm>



(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (<https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html>), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/home>) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (<http://pediatrics.aappublications.org/content/124/4/1193>).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (<http://pediatrics.aappublications.org/content/129/1/190.full>).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (<http://pediatrics.aappublications.org/content/138/1/e20161493>) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm>) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2>). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (<http://pediatrics.aappublications.org/content/126/3/583.full>).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx>) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (<http://pediatrics.aappublications.org/content/134/6/1224>).
33. Perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>). See "Maintaining and Improving the Oral Health of Young Children" (<http://pediatrics.aappublications.org/content/134/6/1224>).
34. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspstdnch.htm>). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://pediatrics.aappublications.org/content/134/3/626>).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://pediatrics.aappublications.org/content/134/3/626>).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2018 and published in March 2019.
For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents' (<http://pediatrics.aappublications.org/content/140/3/e20171904>). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' (<http://pediatrics.aappublications.org/content/138/1/e20161493>) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

HRSA

Health Resources & Services Administration

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Tobacco Use Survey

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

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

Section A

Please check the answer that best describes you:

PREGNANT	NOT PREGNANT
<input type="checkbox"/> I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.	<input type="checkbox"/> I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.
<input type="checkbox"/> I STOPPED smoking BEFORE I found out I was pregnant.	<input type="checkbox"/> I STOPPED smoking in the past ONE YEAR .
<input type="checkbox"/> I STOPPED smoking AFTER I found out I was pregnant, and I am not smoking now.	<input type="checkbox"/> I STOPPED smoking OVER ONE YEAR AGO .
<input type="checkbox"/> I smoke SOME NOW , but I CUT DOWN, SINCE I found out I was pregnant.	<input type="checkbox"/> I CURRENTLY smoke on a LESS THAN DAILY basis.
<input type="checkbox"/> I smoke REGULARLY NOW , and have NOT CUT DOWN since I found out I was pregnant.	<input type="checkbox"/> I CURRENTLY smoke on a DAILY basis.
Do you use electronic cigarettes or E-cigarettes? <input type="checkbox"/> yes <input type="checkbox"/> no	
Do you use smokeless tobacco products? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what kind of smokeless tobacco product do you use? _____	

Section B

Second Hand Smoke Exposure:

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

Section C

If you smoke:

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

Revised 7/2018

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me |
| <input type="checkbox"/> As much as I always could | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual |
| <input type="checkbox"/> Definitely not so much now | <input type="checkbox"/> No, most of the time I have coped quite well |
| <input type="checkbox"/> Not at all | <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things | *7. I have been so unhappy that I have had difficulty sleeping |
| <input type="checkbox"/> As much as I ever did | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Rather less than I used to | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Definitely less than I used to | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> Hardly at all | <input type="checkbox"/> No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Yes, some of the time | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Not very often | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> No, never | <input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason | *9. I have been so unhappy that I have been crying |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Hardly ever | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Only occasionally |
| <input type="checkbox"/> Yes, very often | <input type="checkbox"/> No, never |
| *5. I have felt scared or panicky for no very good reason | *10. The thought of harming myself has occurred to me |
| <input type="checkbox"/> Yes, quite a lot | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No, not much | <input type="checkbox"/> Hardly ever |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Never |

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale¹ (EPDS)

Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt **during the previous week**. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale (EPDS) Form Plan of Action

If score is 13 or greater, this is an indication of likely suffering from a depressive condition of varying severity and warrants the need for compassionate conversation, closer attention, referral, and follow up.

If client answers YES, quite often or Sometimes to question 10, follow the crisis intervention algorithm provided in the “Mental Health Integration Tool Kit.”

Was a brief intervention provided?

- Yes
- What brief intervention was provided?

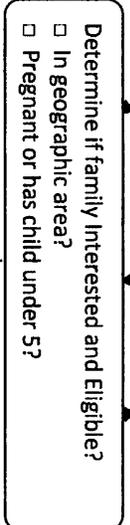
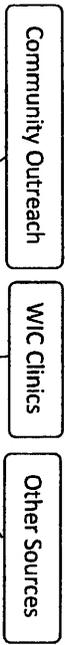
- No
- Why was a brief intervention not provided?

Was a referral provided?

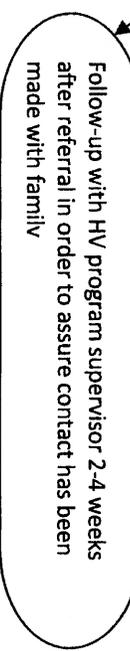
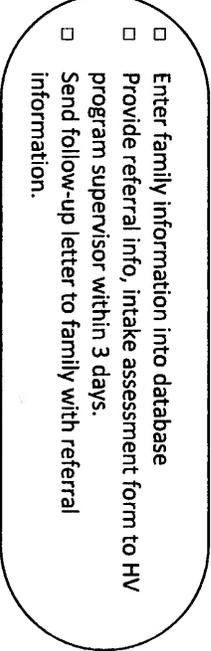
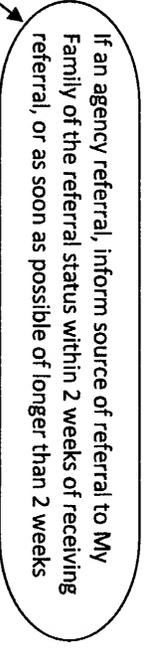
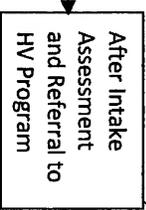
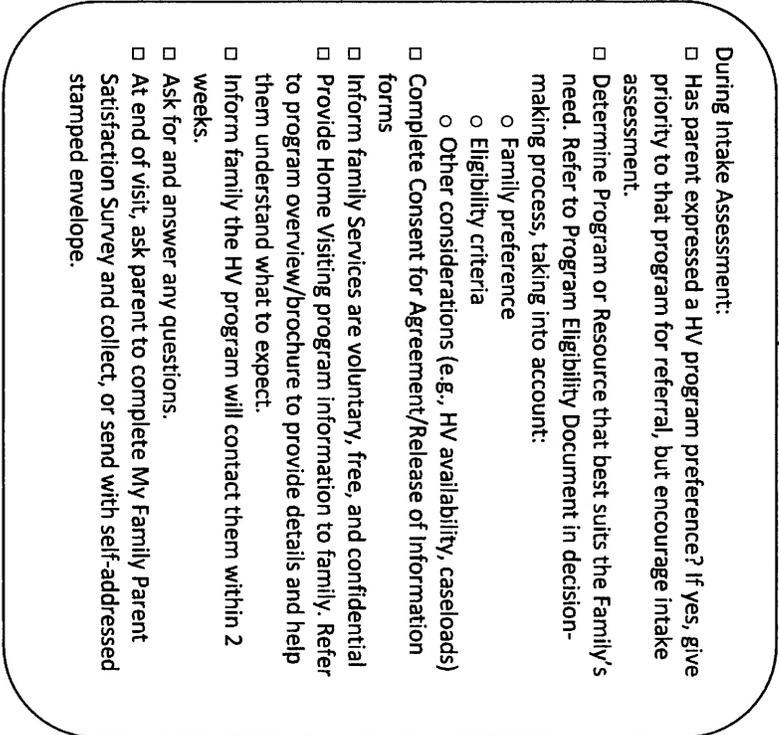
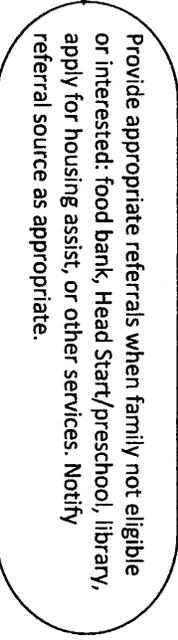
- Yes
- What Provider type was client referred to?
 - PCP
 - OB/GYN
 - Mental Health Provider
 - Support Group
 - Other
 - Please Specify other provider type: _____

If client was in crisis, what action was taken?

My Family Process Map



Yes



KDHE MATERNAL & CHILD HEALTH AID TO LOCAL PROGRAM
Home Visiting Coaching/Shadowing Document

MCH Local Agency:			
Home Visitor Name:			
Supervisor Name:			
Date of Visit:			
Time of Visit:	Start:	AM / PM	End: AM / PM
Client Status: (existing, new)			
Visit Setting:			

Home Visit Summary: Procedures Followed	Yes	No	Comments
<p><i>Initiation phase</i></p> <ul style="list-style-type: none"> Clarify source of referral for visit Clarify purpose for home visit Share information on reason and purpose of visit with family <p><i>Pre-visit phase</i></p> <ul style="list-style-type: none"> Initiate contact with mother/family Establish shared perception of purpose with mother/family Determine mother/family's willingness for home visit Schedule home visit Review referral and/or family record <p><i>In-home phase</i></p> <ul style="list-style-type: none"> Introduction of self and identity Social interaction to establish rapport Establish relationship Implement educational materials and/or make referrals <p><i>Exit phase</i></p> <ul style="list-style-type: none"> Review visit with mother/family Plan for future visits as needed <p><i>Post-visit phase</i></p> <ul style="list-style-type: none"> Document/record visit (narrative and data) Follow-up with educational materials and/or referrals Plan for next visit 			

Technical Assistance Provided to Home Visitor:

Next Steps (if applicable)

Home Visitor Signature:	Date:
--------------------------------	--------------

Supervisor Signature:	Date:
------------------------------	--------------

EXAMPLE

Home Visiting Outreach Plan

Source: My Family, Labette County

My Family is a coordinated outreach and referral system in southeast Kansas to support pregnant women and families with children birth to kindergarten entry in engaging with home visiting programs and other community services. The primary goal of My Family is to conduct community outreach to identify families eligible for home visiting partner programs, and provide referrals that are responsive to family needs, and support families in engaging with home visiting programs and other community resources.

It is important to keep an open dialogue with community partners to learn about the best methods for connecting with families within each community, and continue networking in order to increase and expand these opportunities to identify new families within each community. There are two elements to Community Outreach.

- My Family staff identify community organizations, agencies, or sites as sources for identifying and recruiting families. Outreach to community organizations, agencies, and sites is crucial to increasing the visibility and awareness of My Family, and ultimately reaching families.
- My Family staff collaborate with community organizations and conduct community outreach to identify and recruit families and provide referrals to community-based services.

To identify community organizations, agencies, and sites from which families can be identified, My Family conducts outreach within the community by:

- Attending local coalition meetings
- Staying up to date on local events through reading local newspapers
- Networking with other community agencies
- Attending community events
- Intentionally seeking out opportunities by other means, such as social media, word of mouth, etc.

My Family staff coordinate outreach and recruitment within their respective counties, but across counties the following sources of recruitment have been identified and partnerships have been established (see Appendix A for a detailed list of community contacts by county):

- County WIC Clinics
- Department of Children and Families
- Medical Providers (e.g., hospitals, clinics, including immunization clinics)
- Health Departments
- Mental Health Centers
- Childhood Coalition

EXAMPLE

- KVC Health Systems
- TFI Family Services
- Schools/Preschools/Child care centers/Home child centers (e.g., enrollment events)
- Law enforcement/juvenile intake
- Local health fairs and community events
- Local churches

My Family staff engage in community marketing efforts aimed at educating and informing the general public through the following methods (see Appendix B for sample recruitment materials):

- Newspapers and local publications
- Promotional packets specific to medical clinics or hospitals
- Social Media (Facebook, Instagram)
- Radio PSA
- Local cable or radio talk shows
- Dissemination of MIECHV briefs (links in Newsletters)
- Participate in community events (e.g., family events, back to school events, etc.)
- Movie theater advertisement

My Family also engages in targeted outreach to families in the community through a number of methods, including:

- Door to door outreach
- Family events (e.g., play day at park, hot dogs and play at a targeted apartment complex)
- WIC Clinics
- Events with community partners (e.g., Community Baby Shower)
- Local fairs, festivals, and carnivals
- Door hangers
- Tri-fold advertisement for restaurant tables
- Pizza box toppers

Establishing Relationships with Community Partners

My Family establishes relationships with community partners through the following processes:

1. Contact the community partners via phone, email, and/or formal letters (See Appendix C for sample emails, letters, scripts, etc.). This varies depending on the partner.
2. Explain the My Family to the community partner briefly, providing the mission and purpose of My Family in the phone call, email, or letter.

EXAMPLE

3. Schedule a time to meet with the community partner, and explain in detail what My Family provides, and how it works.
4. Provide the following materials, when appropriate, to the community partner during the meeting:
 - My Family brochures and informational resources (e.g., Conversations with Referral Sources)
 - Business cards
 - Referral sheets/forms
 - Other relevant promotional materials, such as magnets, pens, hand sanitizer, etc.
5. Follow up with the community partner after the meeting by sending out a “Thank you” letter, and provide information needed to move forward (e.g., logistics, scheduling, etc.)

Maintaining Relationships with Community Partners

After establishing a relationship with a community partner, My Family staff maintain consistent, open lines of communication with these partners on a regular basis. The following guidelines help maintain relationships with community partners:

- Communicate with partners on a monthly or bi-monthly basis (see Appendix C for samples), via email, phone, mail, or in person regarding outreach and recruitment efforts. Understand that the nature of these communications may change over time, but be sure to keep the lines of communication open and be responsive to partners so that these relationships are maintained and can grow over time.
- Provide data if possible on outreach and recruitment efforts associated with each partner (e.g., number of visits to a particular site, approximate number of families with whom you had contact, or were provided with a referral, and families engaged in home visiting).
- Contact referral sources with referral status updates.
- For relationships where there is a less involved presence (such as setting up a table at the grocery store, leaving flyers in waiting rooms, etc.), follow-up contacts are initiated on an as needed basis. For example, touch base each time you leave a flyer, set up a table, or periodically with referral data.
- Establish rules or guidelines for My Family’s presence within each site. For example, understand and document that My Family staff do not interrupt families at the WIC clinic while completing WIC paperwork. As these guidelines are established, be sure to document them, and adhere to them in future contacts.
- Acknowledge that relationships with community partners may evolve or change over time. Staffing, organizational, or logistical features might change (e.g., a new supervisor, new procedures, or even issues such as moves or construction). Be attuned to when these factors might impact My Family’s role, and respond accordingly. Bring these issues

EXAMPLE

to the My Family supervisors meeting so that other programs can learn from the experience.

Coordinating with Home Visiting Programs

As part of the outreach efforts, it is important that My Family staff are knowledgeable about each home visiting program's service delivery model, eligibility requirements, and caseload capacity. New My Family staff should be trained on this information for each program, and on the methods for maintaining frequent communication with home visiting programs about this information. New staff orientation procedures should include an initial meeting with each programs' supervisors and staff to facilitate introductions and ongoing collaboration.

Frequent contact with home visiting program staff and supervisors is crucial, as it is the coordinated efforts of intake specialists and home visitors that lay the foundation for parent engagement. A primary objective is to provide a quick and seamless transition from My Family to the home visiting programs, which assure that all families are warmly welcomed into the coordinated system of home visiting in southeast Kansas.

The following are the ways in which My Family and Home Visiting program staff communicate and coordinate efforts:

- Regular meeting, such as regional MIECHV meetings, and meetings with home visiting program staff to coordinate around outreach and recruitment, data reporting.
- Emails and calls to stay up to date on caseload capacity, and efforts to engage specific families.
- Follow-up after individual referrals, or when a home visiting program has had difficulty reaching or scheduling a visit with families.

These lines of communication should remain open to facilitate strong working relationships, and assure that all programs are able to collaborate and coordinate their efforts around outreach and recruitment. In regular meetings, and through email and phone contact, My Family and Home Visiting programs should be sure to:

- Coordinate with home visiting programs so that situations in which two organizations are recruiting at one site is avoided (e.g., My Family and a home visiting program), yet efforts are maximized by working together on coverage at community events.
- To facilitate coordination and avoid duplication of efforts, a shared outreach calendar has been developed to assure all organizations are aware of, and coordinating their efforts at community events.

EXAMPLE

Recruiting Families

My Family staff will come into contact with new families in a number of ways, including:

- Receiving family referrals directly from community partners
- Presenting My Family information to families directly through establishing a presence in WIC offices, grocery stores, and other locations within the community
- Families initiating contact with My Family after hearing about the program from flyers, postings, the My Family Facebook page, etc.

Family Recruitment Materials:

The following resources are available to assist with family recruitment (see Appendix B):

- Program information
- Flyers or brochures specific to My Family recruitment
- Community Resource Guide to assist with referrals to other agencies
- Sample promotional materials for specific events (e.g., baby shower promotional materials, pizza box flyers, door hangers)
- Kansas Home Visiting marketing materials (www.kshomevisiting.org) for logos, sample flyers, public service announcements, graphics for various flyers or promotional materials
- PSA scripts

Intake Assessment and Referral Process

After receiving parent information for a new family, or upon meeting a new family in person, My Family intake specialists meet with the family for an intake visit.

In cases where the intake specialist is scheduling a meeting with the family, the process for setting up the visit is as follows:

1. Within 24 hours of receiving the referral, the My Family Intake Specialist calls the family to set up a meeting. Use all known phone numbers for the family when attempting to set up the meeting.
2. If the family cannot be reached by phone, send a contact letter with a My Family brochure to the family or make a personal visit to the home within one business week. Sample contact letters used to establish initial contact, along with sample flyers and brochures, can be found in Appendix A.
3. If contact with the family cannot be established within 2 weeks, the Intake Specialist contacts the initial referral source at the end of the 2 weeks. Let the referral source know My Family Intake Specialists could not establish contact with the family. Ask the referral source if there is another way to contact the family (e.g. additional phone numbers, family members, etc.)

EXAMPLE

After establishing contact with the new family, or upon meeting a new family in person, My Family intake specialists introduce My Family and home visiting in a friendly and supportive manner. The following is included in the introduction:

- Greet the parent by identifying self and the My Family program.
- Engage in relationship building by asking questions regarding the family. Talking points include:
 - Ask questions about the child, if present. “How old is your child?”
 - Make positive comments about qualities of child, if present, such as: “He’s waiting so patiently.” “He talks really well for his age.” “He’s very alert.” etc.
 - If the parent is prenatal, ask about pregnancy. “When are you due?” “How have you been feeling?” “Who is your doctor?”
- Identify needs of the family. Probe only when in an appropriate setting and the comfort level of the parent is apparent.
- Ask if the parents are familiar with home visiting programs. Provide brochures on the various home visiting programs available to the family.
- Convey that home visiting programs have a lot to offer, as an additional support to parents:
 - Mention that home visiting is completely voluntary and free
 - Provide information on home visiting and the relevant program to the family.
 - Discuss the benefits of engaging with a home visiting program.
 - Give an example of what a home visit will entail, such as engagement and learning through literacy, music, games, play. The home visiting sites conduct developmental screenings to make sure kiddos are hitting their milestones. Parents and children have the opportunity to participate in play group activities. Parents can choose when the visits are scheduled for so they work around your schedule.
 - Describe home visiting as “the school comes to you.”
- If there is any interest in home visiting, complete the Intake Application (see Appendix D) with the family. This can take anywhere between 5 minutes to 1 hour to complete.
 - Have parents sign the Consent for Participation and Release of Information (read through together as needed; see Appendix D)
 - Determine which referrals to provide to the family based on:
 - Eligibility Guidelines, and
 - Parent choice
 - Provide the home visiting referral, describing the program and what to expect during their initial visit, and through their ongoing involvement.
 - Provide other relevant referrals, again describing what to expect in their initial contacts.

EXAMPLE

- If there is no interest in home visiting, describe other referrals that can be provided (e.g., emergency assistance, GED, job training, etc.). Family should still be encouraged to complete an Intake visit and application, even if they do not anticipate signing up for a home visiting program. Be sure to provide your contact information, and gather relevant information for follow-up, when a family declines a referral.
- Present a program token to the family (train, snack cup, etc.), as well as program materials such as the brochure, pen, and magnet.
- Present families with the Parent Satisfaction Survey, or a comparable survey specific to a recruiting event, to obtain parent feedback if applicable. Assure parents that their responses are confidential, unless they indicate on the survey they would like to be contacted after the intake visit.

Engaging Families in Home Visiting

In some cases, there may be challenges in engaging families in home visiting. Many of the interactions you have with parents can help to lay the foundation for their interest and their likelihood of engaging with you, and with home visiting programs in the future. The following are examples of strategies for building rapport and encouraging families to engage:

- Wait until parent is free to talk to you (not on phone or talking to others or completing paperwork).
- Offer a flyer about a free resource or family engagement activity (library flyer)
- If they need help carrying a diaper bag or car seat, offer your assistance.
- When parents seem hesitant or indicate they are not interested, ask if it is ok to leave your contact information with them, and encourage them to call if they have questions.
- If parents have indicated they have had bad experiences with home visiting or other agencies in the past, acknowledge this concern (e.g., “I’m really sorry to hear that”), and offer the choice of another home visiting program. Ask if they would like to talk about their experiences or if they would be interested in other types of referrals or information.
- When providing a referral, be sure to tell them what will be happening next, (e.g., “At the end of the day I will be faxing in your referral and someone from _____ will be contacting you within the next week or so. Then, I will be contacting you to make sure that everyone made contact, but don’t hesitate to call me if you have any questions”).
- In some cases My Family staff accompany the home visitor at their initial visit, if needed.



HOME SAFETY Checklist

Kansas Maternal & Child Health
Home Visiting

SAFE SLEEP

- Baby has a safe sleep environment (no co-bedding)
ABC's of Safe Sleep is practiced and shared with people who care for the child (child care providers, grandparents, family, friends and other caregivers)
 - A**lone (no blankets, bumpers, pillows, stuffed animals)
 - On their **B**ack
 - In a **C**rib, Bassinet or Pack 'n Play
- Firm crib mattress fits tight in crib (no more than 2 fingers distance between the mattress and crib frame.)
- Crib slats are no more than 2 3/8 inches apart or the width of a soda can

HOUSEHOLD

- Use safety gates at the top and bottom of stairs (attach to walls if possible)
- Use outlet plugs/covers on unused electrical outlets
- Safety latches/locks on cabinets and drawers that contain potentially dangerous items including:
 - Medicine/vitamins (prescription/over-the-counter) Use child resistant lids
 - Cigarettes, matches, lighters, vaping cartridges
 - Magnets, Plastic Bags, Coins, Balloons
 - Knives, scissors, razor blades
 - Cleaning supplies/Pesticides (Kitchen, Bathroom)
 - Guns and ammunition (trigger lock)
 - Alcoholic/energy drinks
- Smoke and Carbon Monoxide detectors are on every level of the home, tested regularly and batteries are replaced as needed (replace detectors after 10 years)
- Walls are free of any loose or peeling paint that may contain lead (home built before 1978)
- Heavy and unstable furniture (TV, book shelves, dressers, etc.) are anchored to the floor/wall
- The best toy box/chest does not have a lid (if there is a lid, make sure hinges are safe/do not pinch and have air holes in case child gets trapped inside)
- Pad edges and corners of tables
- Keep household plants, candles/warmers out of the child's reach
- Electrical cords and cords on blinds are out of child's reach
- Space heaters are out of child's reach

BATHROOM

- Adults are always present and within reach when child is in the bathtub
- Test water temperature with elbow/wrist before giving child a bath
- Hot water heater is never above 120°F
- Use non-skid mat/strips to avoid slipping
- Electrical appliances are unplugged and stored away from water and out of reach (hair dryer, curling iron, radio, etc.)
- Keep bathroom door closed and toilet seat down/latched

KITCHEN

- Use extra care when cooking in the kitchen
 - Keep children away from stove and oven when cooking
 - Use back burners and turn pot handles towards the back of the stove
 - Test food before serving to prevent burns
- Chairs and stools are away from counter and stove
- Small appliances are unplugged and pushed back/off counter (coffee maker, toaster, can opener)
- Placing an infant carrier, bouncer, or infant seat on an elevated surface/table with baby in it is unsafe and any movement can cause the seat to fall
- Use a sturdy high chair with a seat belt that straps between the legs
- Keep a fire extinguisher in the kitchen and know how to use it

OTHER SAFETY PRACTICES

- Use cool night-lights that do not get hot
- Have an emergency exit plan in place
- Introduce children slowly to household pets
- Choose appropriate toys for child's age and development (check product recalls)
- Remove small objects that are at child's eye level (button batteries, laundry pods, small toy parts)
- Poison Help number is posted or saved in your phone
- There is NO smoking in the house or around the child

CAR

- Children ride in age appropriate child safety seats that are properly installed
- All passengers wear safety belts to model good behavior when driving/riding in a vehicle
- Never leave your child alone in a vehicle

FUTURE SAFETY PRACTICES as your child gets older

- Playground Safety include:
 - Playground equipment is level and anchored to the ground. Additional safety measures to take into account:
 - Swings are made of soft material such as rubber, plastic or canvas
 - Use wood chips, mulch or shredded rubber under playground equipment. (Should be at least 9 inches deep)
- Water Safety includes:
 - Pools should be surrounded by a fence at least 4 feet high and have a latch that cannot be opened by children
 - Pool drains have special covers to keep arms and legs from being sucked in/trapped
 - Have rescue equipment (life preserver, shepherd hook) by the pool
 - All adults in the house know child CPR and how to dial 9-1-1 in case of emergency
 - Young children should NEVER be left unattended around water
 - If there is a pond, creek or other body of water around the neighborhood, have a plan in place to prevent accidental drowning/access by your child
- Household furniture is away from windows to prevent child from climbing up and falling out
- Windows are locked or have window guards/stops to prevent them from opening more than 4 inches
- Windows have screens that are secure and free from holes
- Space heaters have protective grating/covering, at least 3 feet from furniture/ curtains and are out of the child's reach
- Fireplace/wood burning stove have been inspected (chimney, stove pipes) and have a protective screen around to prevent the child from getting burned
- Door knob covers help prevent children from entering or exiting areas with possible dangers, but still allow a door to be opened quickly by an adult in case of an emergency

RESOURCES

Safe Kids Kansas: www.safekidskansas.org

- Child Passenger Safety: www.safekidskansas.org/child_passenger.htm
- Toy Safety: www.safekidskansas.org/toy_safety.htm

Safe Sleep: www.kidsks.org

Poison Control 1-800-222-1222: www.kumed.com/medical-services/poison-control

Consumer Product Safety Commission (CPSC) Recalls: www.cpsc.gov/recalls

KAN Be Healthy EPSDT Quick Reference Guide

Recommended EPSDT Periodicity Schedule

	Birth	2 weeks	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	24 months	30 months	3 years	4 years	5 years	6 years	7-21 Years
Children's Preventive Guidelines																	
History	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Height or length/weight	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Head circumference	√	√	√	√	√	√	√	√	√	√	√	√					Yearly
Body mass index (percentile if <16 years old)												√	√	√	√	√	Yearly
Blood pressure ¹	*	*	*	*	*	*	*	*	*	*	*	*	√	√	√	√	Yearly
Nutrition assessment/counseling	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Physical activity assessment/counseling ²													√	√	√	√	Yearly
Vision exam	*	*	*	*	*	*	*	*	*	*	*	*	√	√	√	√	Yearly
Hearing exam	√	*	*	*	*	*	*	*	*	*	*	*	√	√	√	√	Yearly
Developmental assessment	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Autism screening										√	√	√					
Psychological/behavioral assessment	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Alcohol/drug use assessment																	Yearly
Physical exam (un clothed)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Oral/dental assessment	*	*	*	*	*	√	√	√	*	√	√	√	√	√	√	√	Yearly
Dental referral ³													√			√	Refer
Immunization assessment	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Hematocrit or hemoglobin					*			√		*	*	*	*	*	*	*	Yearly
Lead screening						*	*	√		*	√	√	*	*	*	*	
Urinalysis																√	16 years
Tuberculin test if at risk			*			*		*		*	*	*	*	*			*
Dyslipidemia screening											*	*		*			*18-21
Sexually Transmitted Infection (STI) screening ⁴																	*11-21
Cervical dysplasia screening ⁴																	*11-21
Anticipatory guidance	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly
Counseling/referral for identified problems	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	Yearly

* Conduct a risk assessment. If high-risk conditions exist, perform a screening.

Notes:

- All well visits should include, at a minimum, an un clothed physical exam, developmental assessment, anticipatory guidance, age-appropriate screenings and immunizations as indicated.
- Health education should include counseling for issues and risk factors as well as information about the benefits of a healthy lifestyle, safety practices/accident avoidance and disease prevention.
- Screenings are as recommended by AAP and AAPD. An initial screening may be conducted at any time, even if the patient's age does not correspond to the periodicity schedule.

Please contact us if you are not receiving a monthly listing of your paneled Amerigroup members who have upcoming EPSDT services due.

9225 Indian Creek Parkway
Building #32
Overland Park, KS 66210

Use this chart to ensure your practice is following the appropriate age-specific guidelines for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

A visit should be scheduled for all new Amerigroup members within 60 days of enrollment. Subsequent visits should be scheduled based on the recommended guidelines at the following ages:

2 weeks	12 months
1 month	15 months
2 months	18 months
4 months	24 months
6 months	30 months
9 months	3-21 years

Any child who has not had the recommended service(s) should be brought up-to-date as soon as possible.

Helpful Hints

- Use your Amerigroup member listing of patients due or overdue for EPSDT services and contact those patients to schedule an appointment.
- Maximize every visit by making sure the child is current on EPSDT services.
- Be sure your office uses the correct coding.

For complete information, see:

- American Academy of Pediatrics (AAP) Periodicity schedule at <http://brightfutures.aap.org> > Clinical Practice > Recommendations for Preventive Pediatric Health Care
- American Academy of Pediatric Dentistry Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents Chart (AAPD) schedule at www.aapd.org > Policies & Guidelines.

¹ Children with specific risk factors should have their blood pressure taken at visits before age 3.
² National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set measure was added to the chart.
³ Refer for dental care anytime a problem is identified or a patient does not have a dental home. AAPD recommends a dental exam every 6 months at tooth eruption.
⁴ STI and cervical dysplasia screenings should be conducted on all sexually active females 11-21 years of age.

Immunizations															
Recommended Childhood Immunizations	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	23 months	2-3 years	4-6 years	Recommended Adolescent Immunizations	7-10 Years	11-12 Years	13-18 Years
Hepatitis B	Hep B	Hep B			Hep B							Tetanus, diphtheria, pertussis		Tdap	Tdap
Rotavirus			RV	RV	RV							Human papillomavirus		HPV (3 doses)	HPV series
Diphtheria, tetanus, pertussis			Dtap	Dtap	Dtap		Dtap				Dtap	Meningococcal	MCV	MCV	MCV
Haemophilus influenza B			Hib	Hib	Hib	Hib						Influenza	Influenza yearly		
Pneumococcal			PCV	PCV	PCV	PCV					PPSV	Pneumococcal	PPSV		
Inactivated poliovirus			IPV	IPV	IPV						IPV	Hepatitis A	Hep A series		
Influenza					Influenza yearly							Hepatitis B	Hep B series		
Measles, mumps, rubella						MMR					MMR	Inactivated poliovirus	IPV series		
Varicella						Varicella					Varicella	Measles, mumps, rubella	MMR series		
Hepatitis A						Hep A, dose 1				Hep A series		Varicella	Varicella series		
Meningococcal										MCV					

 Range of recommended ages for all children except certain high-risk groups	 Range of recommended ages for certain high-risk groups	 Range of recommended ages for catch-up immunizations
For complete information, visit the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip/index.html), AAP (www.aap.org) and the American Academy of Family Physicians (www.aafp.org).		

EPSDT Billing Codes

CPT	New Patient	CPT	Established Patient	Other Coding Tips	Codes	Description
99381	Preventive visit, Age < 1 year	99391	Preventive visit, Age < 1 year	Always use as primary. Z00.121-Z00129 routine child codes (excludes infant or child over 28 days) or Z00.00-Z00.01 general adult codes:	Z68.5(x)*	BMI percentile <ul style="list-style-type: none"> Code out to the level of specificity
99382	Preventive visit, Age 1-4	99392	Preventive visit, Age 1-4		97802-97804	Counseling for nutrition
99383	Preventive visit, Age 5-11	99393	Preventive visit, Age 5-11	ICD-10 codes: If a problem is found, use the appropriate code as the secondary diagnosis. Do not change the coding from a well visit to a sick visit.	Z68.(x)-Z68.5(x)*	Adult BMI
					271.89	Counseling for physical activity
					90471-90474	Immunization administration codes
Referral Codes						
99384	Preventive visit, Age 12-17	99394	Preventive visit, Age 12-17	Use antigen codes along with immunization administration codes.	AV	Patient refused referral
99385	Preventive visit, Age 18-21	99395	Preventive visit, Age 18-21		S2	Under treatment referred for diagnostic or for corrective health problem
					ST	New services requested — referral

Payment will be made for medically necessary diagnostic or treatment services needed to correct or ameliorate illnesses or conditions discovered through screening regardless of whether such diagnostic or treatment services are covered under the plan. **Note:** Any medically necessary noncovered service requires precertification.

It is critical that the federally required referral code be appropriate for the DX code. For example, a diagnosis code of Z00.121 (routine infant or child health check) would be appropriate with a referral code of U or NU (completed normal/no referral).

For electronic claims, submit online at providers.amerigroup.com/KS or call 1-800-590-5745 to initiate electronic filing.

For paper claims, submit the CMS-1500 forms to:
 Amerigroup Kansas, Inc.
 P.O.Box 61010
 Virginia Beach, VA 23466



KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Screening

ID number:

Name	Date of birth	Age	Date of screen

PHYSICAL GROWTH (An update of the growth chart is required at each screen.)

T	Weight (lbs/kg)	%		Head circumference (Birth-24 months)
P	Length (cm/in) Birth-24 months		Weight/length%	cm/in
R	Height (cm/in) (2-20 years)			%
BP	BMI*	%	Male <input type="checkbox"/>	Female <input type="checkbox"/>

*If the BMI is greater than or equal to 85%, recommend appropriate nutrition input and physical activity.

BENEFICIARY & FAMILY HISTORY

Refer to completed history form in chart. <input type="checkbox"/>	Present concerns
No changes in medical Hx unless indicated. <input type="checkbox"/>	
Patient currently in foster care, no previous Hx. <input type="checkbox"/>	Medications
Previous Hx reviewed from visit on:	
Allergies (food and drug)	Serious illness/accidents (If yes, date & type.) (including hospital or ER visits)
Birth history (measurements & complications)	Operations (If yes, date & type.)

Diseases & issues (Circle and indicate relationship: P - parent, G - grandparent, B - brother, S - sister, SELF.)

Asthma	Colds/sore throat	Epilepsy/seizures	Lung disease	Speech/visual/hearing
Birth defect	Diabetes	Headaches	Mental illness	Ulcers/colitis
Blood disorder/sickle cell	Drug or ETOH abuse	High blood pressure	Obesity	Urinary/bowel
Cancer	Earaches	Kidney/liver disease	Scoliosis/arthritis	Heart disease/stroke

BODY SYSTEMS (Check and comment appropriately.)

SYSTEMS	WNL	ABN	Comments (describe any abnormal findings)
General appearance			
Integumentary			
Head/neck			
Eyes/ears/nose/throat			
Oral/dental			
Pulmonary			Lung sounds?
Cardiovascular			Murmur?
Abdomen/gastrointestinal			
Genitourinary			Tanner score Menstrual bleeding evaluation Enuresis
Trunk/spine			
Musculoskeletal			
Neurological			

LAB/IMMUNIZATIONS (circle and complete as applicable)

Follow the recommended immunization schedule approved by the ACIP, AAP, and AAFP.

Copy of record in chart:	Parent requested	Referred to VFC provider	Current	Behind	Unknown
Immunizations given today:					
Obtain CBC with automated differential	Male – Age 15	Female – Time of menarche	9-12 mos	Annual *	

*Required depending on lifestyle and health needs. Reference the KBH-EPSDT Provider Manual.

Was CBC obtained? YES NO Indicate further follow-up in Plan of Care.

The Blood Lead Questionnaire is a separate document.	
<input type="checkbox"/> Negative screen	<input type="checkbox"/> Positive screen - draw blood level



VISION SCREEN

Ages 0-3: Corneal light reflex present YES <input type="checkbox"/> NO <input type="checkbox"/>	Ages 3-20 Bruckner exam Pass <input type="checkbox"/> Refer <input type="checkbox"/>
All ages Outer inspection	Distance acuity Score L _____ R _____ Both _____ Tool used _____
Eye tracking	Near acuity Score L _____ R _____ Both _____ Tool used _____
Ocular motility (strabismus/cross cover test)	Last exam

DENTAL

It is recommended assessment preventative dental services and oral treatments begin at 6-12 months of age and repeat every 6 months or as needed.

Sees dentist? Yes <input type="checkbox"/> No <input type="checkbox"/>	Fluoride varnish? Yes <input type="checkbox"/> No <input type="checkbox"/>
Last dental exam date:	Dental referral:

HEARING SCREEN

Maintain in record completed paper hearing screens and report or qualifying hearing screen procedure and report.

Birth-4 years	Risk Indicators for Hearing Loss & Hearing Developmental Scales	Pass <input type="checkbox"/>	Refer <input type="checkbox"/>
4-21 years	Hearing Health History	Pass <input type="checkbox"/>	Refer <input type="checkbox"/>
Screen procedure			

NUTRITION

WIC participant <input type="checkbox"/>	Referred to WIC <input type="checkbox"/>
Formula <input type="checkbox"/>	Breastfeeding <input type="checkbox"/>
Amount & frequency	

Number of servings per day

Bread/cereal	Fruit	Vegetable	Protein source	Dairy	Fat/sweet/sugar
--------------	-------	-----------	----------------	-------	-----------------

Fluid intake per day (ounces)

Water	Milk	Soda	Juice
-------	------	------	-------

PHYSICAL ACTIVITY (circle all that apply)

Biking	Basketball	Skating	Walking	Other sports	Playing outside
--------	------------	---------	---------	--------------	-----------------

DEVELOPMENTAL/EMOTIONAL Refer to the ACIP, AAP, and AAFP for recommended developmental tools.

A completed developmental screening tool (indicate tool used): _____

Birth-6 years	Include the screener's interpretation and report regarding meeting developmental milestones				
6-21 years	Include the screener's interpretation and report or document all developmental/emotional below				
Sleep habits		Tired/overactive?		Special education	
Discipline		Vocational concerns?		Special needs	
Grade level		Average grades		Exercise	
Emotional observations					

Pregnant? NO YES **If YES, complete the following:**

Prenatal vitamins? YES <input type="checkbox"/> NO <input type="checkbox"/>	Prenatal record initiated? YES <input type="checkbox"/> NO <input type="checkbox"/>	Referred for OB/GYN care? YES <input type="checkbox"/> NO <input type="checkbox"/>
Referred to:		

HEALTH EDUCATION & ANTICIPATORY GUIDANCE (circle all that apply)

Behavior/discipline	Family planning	Parenting	Oral/dental	Development	Physical activity	Substance abuse	Nutrition
Self breast exam	Self testicular exam	Sexuality	Safety/poisons	Immunization	Weapon safety	Exercise	Lifestyle
Other							

RESULTS/PLAN OF CARE

Screening results
Plan/referrals (dental, vision, hearing, dietary)
Recommended return date

Parent/caregiver and/or patient informed of KBH - EPSDT screen findings and verbalizes YES NO understanding of findings and recommendations.

Parent/caregiver or patient signature _____ Date _____

Screening provider signature _____

A licensed physician, ARNP, PA, or registered nurse can perform KBH - EPSDT screens.



KAN Be Healthy -Temprano y Periódico Chequeo, Diagnostico, y Chequeo de Tratamiento

Numero de ID:

Nombre	Fecha de nacimiento	Edad	Fecha de chequeo

CRECIMIENTO FISICO (Actualización del crecimiento físico es requerido en cada chequeo.)

T	Peso (lbs./kg)	%		Circunferencia de cabeza (Nacimiento-24 meses)
P	Largo (cm/in) Nacimiento-24 meses		Peso/Largo %	cm/in
R	Estatura (cm/in) (2-20 años)			%
BP	BMI* (índice de masa corporal)	%	Hombre <input type="checkbox"/>	Mujer <input type="checkbox"/>

*Si el BMI es más o igual al 85%, recomendamos aporte de nutrición apropiada y actividad física.

BENEFICIARIO E HISTORIA FAMILIAR

Consulte la forma historial completa en grafica <input type="checkbox"/>	Preocupación actual
No hay cambios Hx (Historia) a menos que se indique. <input type="checkbox"/>	
Paciente actualmente está en cuidado temporal, no hay Hx. <input type="checkbox"/>	Medicamentos
Hx anterior revisado de visita en:	
Alergias (comida o medicamento)	Enfermedad grave/Accidentes (Si hay, fecha y tipo.) (incluya hospital y visitas de emergencia)
Historial del parto (medidas y complicaciones)	Operaciones (Si hay, fecha y tipo.)

Enfermedades y Complicaciones (Circule e indique el parentesco: P - padres, G - abuelos, B - hermanos, S - hermanas, MISMO/A.)

Asma	Cátaro/dolor de garganta	Epilepsia/convulsiones	Enfermedad de Pulmón	Habla/visual/auditivo
Malformación Congénita	Diabetes	Dolor de Cabeza	Enfermedad Mental	Úlcera/colitis
Trastorno de Sangre/célula falciforme	Drogas o abuso de ETOH (alcohol)	Presión Alta	Obesidad	Urinario/intestinos
Cáncer	Dolor de oído	Enfermedad de Riñón/hígado	Escoliosis/artritis	Cardiopatía/derrame cerebral

SYSTEMA DEL CUERPO (Marque y complete apropiadamente.)

SYSTEMAS	WNL	ABN	Comentarios (describa si encontró algo anormal)
Apariencia General			
Tegumentario			
Cabeza/ Cuello			
Ojos/oídos/nariz/garganta			
Oral/dental			
Pulmonar			Sonidos de pulmón?
Cardiovascular			Murmullo?
Abdomen/gastrointestinal			
Genitourinario			Marcador Tanner Evolución menstrual sangrante Enuresis
Tronco/espina dorsal			
Musculo esquelético			
Neurológico			

LABORATORIO/INMUNIZACION (Circule y complete como aplique.)

Siga el recomendado horario de inmunización aprobado por ACIP, AAP, and AAFP.

Copia de dráfica de registro:	Solicitado por cual padre	Referido al proveedor de VFC (vacunas para niños)	Actual	Atrasado	Desconocido
Inmunización dada hoy:					
Obtener CB con diferencial automático	Hombre –15 años	Mujer – cuando menarquia	9-12 meses	Anual*	

*Requerido dependiendo en el tipo de vida y necesidades de salud. Refiérase al manual de proveedor de KBH - EPSDT.

CBC fue obtenido? SI NO Indique si seguimiento con su plan de salud.

El Cuestionario de Plomo en la Sangre es un documento separado.	
<input type="checkbox"/> Chequeo negativo	<input type="checkbox"/> Chequeo positivo – extraer nivel de sangre



KAN Be Healthy -Temprano y Periódico Chequeo, Diagnostico, y Chequeo de Tratamiento

CHEQUEO DE VISION

Edades 0-3: reflejo de luz corneal presente SI <input type="checkbox"/> NO <input type="checkbox"/>	Edades 3-20 Examen de Bruckner Aprobado <input type="checkbox"/> Referir <input type="checkbox"/>
Todas edades Inspección externa	Calificación de distancia aguda I _____ D _____ Ambos _____ Herramienta usada
Rastreo de Ojo	Calificación de aguda cerca I _____ D _____ Ambos _____ Herramienta usada
Motilidad ocular (Estrabismo/prueba de oclusión cruzada)	Ultimo examen

DENTAL

Se le recomienda servicios preventivos y tratamientos orales empezando de 6-12 meses de edad y repetir cada 6 o más si es necesario.

Ve al dentista? SI <input type="checkbox"/> NO <input type="checkbox"/>	Barniz de flúor? SI <input type="checkbox"/> NO <input type="checkbox"/>
Fecha de su último examen dental:	Referencia dental:

CHEQUEO AUDITIVO

Mantenga registro de chequeos auditivos completas en papel y reporte o procedimiento de chequeos auditivos calificases y reportes.

Nacimiento-4 años	Indicadores de alerta de pérdida de audición y escuchar escalas de desarrollo	Aprobado <input type="checkbox"/> Referir <input type="checkbox"/>
4-21 años	Historia de la salud auditiva:	Aprobado <input type="checkbox"/> Referir <input type="checkbox"/>
Procedimiento de chequeo		

NUTRICION

Participante de WIC <input type="checkbox"/>	Referir a WIC <input type="checkbox"/>
Formula <input type="checkbox"/> Amamantamiento <input type="checkbox"/>	Cantidad y frecuencia

Numero de porciones al día

Pan/cereal	Fruta	Vegetables	Fuente de Proteína	Lechería	Grasa/dulces/azúcar
------------	-------	------------	--------------------	----------	---------------------

Ingesta de líquidos por día (onzas)

Agua	Leche	Soda/Refresco	Jugo
------	-------	---------------	------

ACTIVIDAD FISICA (circule todas las que aplique)

Ciclismo	Baloncesto	Patinar	Caminar	Otros Deportes	Jugar Afuera
----------	------------	---------	---------	----------------	--------------

DESARROLLO/EMOCIONAL Referir a ACIP, AAP, and AAFP para herramientas de desarrollo recomendadas.

Herramienta de desarrollo completa (indique la herramienta usada): _____

Nacimiento-6 años	Incluya la interpretación del paciente y reporte en referencia a desarrollos en juntas	
6-21 años	Incluya la interpretación del paciente y reporte o documento todo desarrollo/ emocional abajo	
Hábitos de dormir	Cansado/hiperactiva?	Educación especial
Disciplina	Preocupación vocacional?	Necesidades especiales
Nivel de grado	Promedio de grados	Ejercicio
Observaciones emocionales		

Embarazada? NO SI Si si, conteste lo siguiente:

Vitaminas prenatales? SI <input type="checkbox"/> NO <input type="checkbox"/>	Grafica prenatal iniciada? SI <input type="checkbox"/> NO <input type="checkbox"/>	Fue referida a un obstetra? SI <input type="checkbox"/> NO <input type="checkbox"/>
Referida a:		

EDUCACION DE SALUD & ORIENTACION ANTICIPADA (circule todas las que aplique)

Conducta/disciplina	Inmunización	Oral/dental	Seguridad de armas	Desarrollo	Actividad física	Ejercicio	Nutrición
Autoexamen testicular	Auto examen de los senos	Sexualidad	Seguridad/venenos	Crianza de los hijos	Planificación familiar	Abuso de sustancias	Tipo de vida
Otras							

RESULTADOS/ PLAN DE CUIDADO

Resultados del chequeo
Plan/referencia (dental, visión, auditivo, dietético)
Recomendado fecha de retorno

Padre/cuidador y/o paciente informado de KBH - EPSDT resultados del chequeo y vocaliza SI NO

entendimiento de resultados y recomendaciones.

Firma de padre/cuidador o paciente _____ Fecha _____

Firma del proveedor que realizo el chequeo _____

Medico con licencia, ARNP, PA, o enfermera registrada puede hacer los KBH - EPSDT chequeos.

What is Medicaid?

Medicaid is a federal/state health insurance program administered by the states and funded from federal and state revenues. The program assists states in the provision of adequate medical care to eligible persons. The Medicaid program varies from state to state, and states can make alterations in their programs from year to year. Within broad national guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets payment rates; and administers its own program.

What is EPSDT?¹

Early and Periodic Screening Diagnostic and Treatment (EPSDT) is a mandatory Medicaid service that was developed to provide preventive services and treatment to children enrolled in Medicaid. The components of EPSDT are as follows:

Early: Assessing a child’s health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

Periodic: Assessing a child’s health at key points in her/his life to assure continued healthy development;

Screening: Using tests and procedures to determine if children being examined have conditions requiring closer medical (including mental health) or dental attention;

Diagnostic: Determining the nature and cause of conditions identified by screenings and those that require further attention; and

Treatment: Providing services needed to control, correct, or reduce physical and mental health problems.

EPSDT services for eligible children include:

- Screening services, including the following:
 - a comprehensive physical and mental health assessment,
 - a regularly scheduled physical examination,
 - laboratory tests, including blood lead level,
 - dental services, including restoration of teeth and maintenance of dental health,
 - immunizations, and
 - health education.
- Vision testing and services, including eyeglasses,
- Hearing testing and services, including hearing aids,
- Referral to mental health practitioners for follow-up screening and diagnosis,
- Assistance with transportation and scheduling of appointments, and
- Any other health care service covered by Medicaid necessary to correct or improve illnesses and conditions found in screening, even if the service is not included in a state’s Medicaid plan but could have been elected by the state.

When was EPSDT established and why?

First enacted by Congress in 1967, EPSDT was designed to ensure that children enrolled in Medicaid receive comprehensive services before conditions become serious enough to impair their growth and development. In 1989, Congress strengthened the EPSDT program by requiring states to provide medically necessary treatment even if the treatment is an optional service that the state has chosen not to provide for the rest of the Medicaid population.

Who is eligible for EPSDT?

EPSDT services are available to all children under age 21 who are eligible for Medicaid. If a family receives adoption assistance under the federally funded title IV-E program, then the adopted child is automatically eligible for EPSDT services. Adopted children in families receiving state-funded adoption assistance are also eligible for EPSDT services if they receive Medicaid.

Who can provide EPSDT services?

A physician, nurse practitioner, pediatrician, or other type of health care provider who is certified by the state Medicaid program to be a Medicaid provider may provide EPSDT services. Certified health care providers can be located at local child care or Head Start programs, school-based health centers, state or local health departments, managed care organizations (MCO), physician offices, Indian Health Service Centers or Community Health Centers .

A child may need more than one provider to receive the full range of EPSDT services for which he or she is entitled. If more than one provider is needed to complete the full range of EPSDT services to a child, these services should be coordinated to ensure the child receives all the necessary services and to avoid duplication. However, most children who have a family health care provider will receive most of their EPSDT screening, diagnostic, and treatment services from the same provider.

When are services available?

Each state sets a timetable as to when screening services are available. Screening services are always available between regularly scheduled exams if there is reason to suspect an illness or condition.

Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation. The purpose of diagnosis is to determine the nature, cause, and extent of the problem found by the screening examination. This diagnosis may then result in development of a plan for treatment.

Treatment services are covered whenever they are medically necessary to correct or improve abnormalities, physical or mental illnesses, or other conditions discovered through an EPSDT screening.

¹The federal law for EPSDT can be found at: 42 C.F.R. §441.50, and §441.55-441.60

Required State Activities

- Seek out eligible children and families to:
 - encourage their participation in Medicaid/EPSDT
 - inform them of the availability and benefits of preventive services,
 - provide assistance with scheduling appointments and transportation, and
 - help families use health resources effectively and efficiently;
- Assist families in finding EPSDT providers;
- Assure that providers assess health needs through initial and regular periodic examinations; and
- Assure that detected health problems are diagnosed and treated early before those problems become more complex and their treatment more costly.

Three ways states may limit services:

By law, states may limit services in three ways.

- 1) States can cover only medically necessary services. While each state ultimately decides what services will be covered as medically necessary, this decision cannot ignore the assessment of the treating physician. The decisions must be made on a case-by-case basis.
- 2) States may establish limits on EPSDT services (e.g., a limit of 10 physical therapy visits) but states may not deny necessary health care. The application of such a limit must be determined on a case-by-case basis.
- 3) States may limit EPSDT treatment settings or providers to the most cost-effective means possible.

Regardless of the limitations states impose, they must cover certain services including immunizations, hearing aids, eyeglasses, relief of pain and infections, restoration of teeth and maintenance of dental health (including medically necessary orthodontic care).

Determining what is medically necessary

For a service to be covered, it must be deemed ‘medically necessary.’ Each state determines what is ‘medically necessary.’ Determinations are to be made on a case-by-case basis and must include the judgments of the treating physician.

A state’s determination of what is ‘medically necessary’ under EPSDT must include an individual determination of whether it promotes the child’s overall growth and development, prevents disability, or permits a child to achieve or maintain maximum functional status. Treatment may not be delayed until a child’s condition reaches a certain level of severity. This method provides

consistent care for a child’s treatment needs and allows states flexibility in determining cost-effective settings for treatment.

EPSDT and Managed Care

States have the authority to enter into contractual agreements with managed care entities to carry out Medicaid services. Services not contracted to private entities remain the direct responsibility of the state Medicaid agency.

States and managed care plans often must coordinate and contract with providers outside of the managed care plans’ provider networks to ensure that EPSDT services are provided. States may ‘carve out’ (not include) an EPSDT covered service within a managed care plan. When a service is carved out, managed care plans are not obligated to provide the service. EPSDT beneficiaries may then go to any other Medicaid provider to receive the carved out service.

When a state Medicaid agency enters a contract with a Medicaid provider, the state agency is still responsible for ensuring that federal regulations for EPSDT services are followed.

EPSDT: Bridging the Gap in Medicaid Coverage from State to State

When a family with a child receiving adoption assistance moves from one state to another, the family may find that services that were provided in their previous state of residence for their child are not covered under Medicaid in their new state. Although all states have Medicaid programs, the services offered in individual states vary greatly.

For example, if a child receiving speech therapy through Medicaid in State A (the adoption assistance state) moves to State B where speech therapy is not a covered service under Medicaid, the family could request this service through EPSDT. State B can accept State A’s determination that speech therapy is ‘medically necessary’ or can require that the child be screened in State B. If State B determines that speech therapy is medically necessary for the child, State B can provide the service to the child through EPSDT.

EPSDT can provide children consistency in receiving health care services when moving from state to state. It provides a mechanism for children to receive any medically necessary service allowed under Medicaid, even if that service is not included in a particular state’s Medicaid plan. EPSDT is a valuable service for families with Medicaid-eligible children who move to a new state.

This document is available at: <http://aicama.org>

What You Need to Know About EPSDT

EARLY: Assessing and identifying problems early

Children covered by Medicaid are more likely to be born with low birth weights, have poor health, have developmental delays or learning disorders, or have medical conditions (e.g., asthma) requiring ongoing use of prescription drugs. Medicaid helps these children and adolescents receive quality health care.

EPSDT is a key part of Medicaid for children and adolescents. EPSDT emphasizes preventive and comprehensive care. Prevention can help ensure the early identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. It is important that children and adolescents enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

PERIODIC: Checking children's health at age-appropriate intervals

As they grow, infants, children and adolescents should see their health care providers regularly. Each state develops its own "periodicity schedule" showing the check-ups recommended at each age. These are often based on the American Academy of Pediatrics' Bright Futures guidelines: [Recommendations for Preventive Pediatric Health Care](#). Bright Futures helps doctors and families understand the types of care that infants, children and adolescents should get and when they should get it. The goal of Bright Futures is to help health care providers offer prevention-based, family-focused, and developmentally-oriented care for all children and adolescents. Children and adolescents are also entitled to receive additional check-ups when a condition or problem is suspected.

SCREENING: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems

All infants, children and adolescents should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. A well-child check-up includes:

- A comprehensive health and developmental history, including both physical and mental health development assessments;
- Physical exam;
- Age-appropriate immunizations;
- Vision and hearing tests;
- Dental exam;
- Laboratory tests, including blood lead level assessments at certain ages; and
- Health education, including anticipatory guidance.

DIAGNOSTIC: Performing diagnostic tests to follow up when a health risk is identified

When a well-child check-up or other visit to a health care professional shows that a child or adolescent might have a health problem, follow up diagnostic testing and evaluations must be provided under EPSDT. Diagnosis of mental health, substance use, vision, hearing and dental problems is included. Also included are any necessary referrals so that the child or adolescent receives all needed treatment.

TREATMENT: Correct, reduce or control health problems found

EPSDT covers health care, treatment and other measures necessary to correct or ameliorate the child or adolescent's physical or mental conditions found by a screening or a diagnostic procedure. In general, States must ensure the provision of, and pay for, any treatment that is considered "medically necessary" for the child or adolescent. This includes treatment for any vision and hearing problems, including eyeglasses and hearing aids. For children's oral health, coverage includes regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health. Some orthodontia is also covered.



Developing Program Goals and Measurable Objectives

Program goals and objectives establish criteria and standards against which you can determine program performance. You will need to identify the goals and objectives of the program component or intervention you plan to evaluate. Logic models are a useful tool that can help you do this.

Goal	Objectives
<p>A broad statement about the long-term expectation of what should happen as a result of your program (the desired result). Serves as the foundation for developing your program objectives.</p> <p>Criteria: 1) Specifies the STD problem or STD-related health risk factors; 2) Identifies the target population(s) for your program.</p>	<p>Statements describing the results to be achieved, and the manner in which they will be achieved. You usually need multiple objectives to address a single goal.</p> <p>Criteria: SMART attributes are used to develop a clearly-defined objective.</p>

Attributes of **SMART** objectives:

- **Specific:** includes the “who”, “what”, and “where”. Use only one action verb to avoid issues with measuring success.
- **Measurable:** focuses on “how much” change is expected.
- **Achievable:** realistic given program resources and planned implementation.
- **Relevant:** relates directly to program/activity goals.
- **Time-bound:** focuses on “when” the objective will be achieved.

Objectives can be **process** or **outcome** oriented.

For more information and examples, see Steps 2.2–2.3 in the Practical Use of Program Evaluation among STD Programs manual.

<http://www.cdc.gov/std/program/pupestd.htm>



TIP: Complete Exercise 2: “Writing Goals and Smart Objectives” on pages 64–65 of the manual.

Process objectives describe the activities/services/strategies that will be delivered as part of implementing the program. Process objectives, by their nature, are usually short-term.

Example of a SMART process objective:

By (month/year), (X%) of providers who reported incorrect gonorrhea treatment in County Z will be contacted within 1 month.

Outcome objectives specify the intended effect of the program in the target population or end result of a program. The outcome objective focuses on what your target population(s) will know or will be able to do as a result of your program/activity.

Example of a SMART outcome objective:

By (month/year), increase the percentage from (X%) to (Y%) of providers in County Z that fully adhere to the CDC-STD treatment guidelines for appropriate treatment of gonorrhea. [Intermediate objective]

Outcome objectives can be classified as short-term, intermediate, or long-term.

Well-written and clearly defined objectives will help you monitor your progress toward achieving your program goals.

Short-term outcome objectives are the initial expected changes in your target population(s) after implementing certain activities or interventions (e.g., changes in knowledge, skills, and attitudes).

Intermediate outcome objectives are those interim results that provide a sense of progress toward reaching the long-term objectives (e.g., changes in behavior, norms, and policy).

Long-term objectives are achieved only after the program has been in place for some time (e.g., changes in mortality, morbidity, quality of life).

Note: Objectives are different from listing **program activities**. *Objectives* are statements that describe the results to be achieved and help monitor progress towards program goals. *Activities* are the actual events that take place as part of the program. Following is an example of how program activities differ from objectives.

Example: Activity versus Objective

Goal: Reduce gonorrhea rates among male adolescents in County Z.

Activity: Educate providers on appropriate treatment for gonorrhea.

SMART process objective: By (month/year), (X%) of providers who reported incorrect gonorrhea treatment in County Z will be contacted within 1 month.



Logic Model Guidance

What is a Goal?

A broad statement about the long-term expectation of what should happen because of your program (the desired result)

A goal is:

- “Warm and fuzzy”
- Non-specific
- Non-measurable

Strategies (activities)

The actions carried out to achieve the program’s objectives, such as training and outreach.

Partnerships

Other stakeholders who share a commitment to improving the health of the community they serve

Baseline Data & Source

Baseline data is basic information gathered before strategies are implemented. It provides a sense of where the data is now and helps guide where the data should go.

SMART Outcome

Outcomes define the expected result and should be specific and concise statements that state **who will make what change, by how much, where and by when.**

Specific	Measurable	Achievable	Realistic	Time-bound
Who is the target population? What will be accomplished?	Is the outcome quantifiable? Can it be measured? How much change is expected?	Can the outcome be accomplished in the proposed time frame with the available resources and support?	Does the outcome address the goal? Will it have an impact on the goal?	Does the outcome propose a timeline when it will be met?

MCH Example:

Priority	Goal	Strategies	Partnerships	Data & Source	SMART Outcome
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy (Domain: Woman & Maternal)	Improve first trimester prenatal care among MCH clients	All positive pregnancy test clients are referred to BaM prenatal education classes	Local physicians Family Planning FQHC	75.35% (KIDS COUNT)	Increase the percent of pregnant women served by the local MCH agency that receives prenatal care in the first trimester of pregnancy from 75% to 80% during SFY2020.