Maternal and Child Health Services Title V Block Grant

State Narrative for Kansas

Application for 2013 Annual Report for 2011

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

To obtain a copy of the signed Assurances and Certifications, contact:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Over seventy individuals and organizations were invited to provide input into the MCH Block Grant five year needs assessment process. The group reviewed past priorities and activities undertaken to address them. They reviewed current data and selected new priorities. All of the materials generated through this process were placed on a website along with workplans for the coming year. Listserv's were used to advertise the availability of the website for public comment: Kansas MCH Advisory Council, CSHCN, Families Together, local health departments, school nurses, and other.

Dear Maternal and Child Health (MCH) stakeholders:

Thanks to those of you who participated in the five-year MCH needs assessment and planning meetings these last few months.

This spring, KDHE Bureau of Family Health staff developed logic models based on information provided by stakeholders during the November 2009 and January 2010 meetings. In completing the planning process, some priorities and strategies were modified based on expected capacity and available resources to implement over the next five years.

We wanted to give you a special invitation to review the latest results online if you haven't already. Go to this page to see the MCH 2015 priorities, strategies, and logic models: http://www.datacounts.net/mch2015/results.asp

On behalf of the KDHE Bureau of Family Health, we welcome your comments, suggestions, and questions! Thank you again for your interest and work in improving maternal and child health in Kansas.

For a copy of other comments received, please contact Bureau of Family Health.

/2012/ For the 2012 application and 2010 annual report, a new methodology was used to obtain public comment. A draft document was posted for 30 days prior to submission on the Bureau of Family Health homepage requesting public comments on the plan. This posting was announced through all MCH/CYSHCN listserv's and newsletters. Comments received were incorporated into the final document prior to submission to the extent that they were feasible. Public comments are available through the office of the Bureau of Family Health. //2012//

/2013/ Dear Maternal and Child Health (MCH) stakeholders,

On behalf of the KDHE Bureau of Family Family, we want to provide a special invitation to review the latest results of our our 2013 application and 2011 annual report. We welcome your comments, suggestions, and questions regarding the information.

Thank you for your time, interest, and commitment to improving maternal and child health in Kansas.

For the 2013 application and 2011 annual report, a draft document was posted for 15 days prior to submission on the Bureau of Family Health homepage requesting public comments on the plan. The posting was announced through all MCH/CYSHCN listserv's and newsletters. Comments received were incorporated into the final document prior to submission to the extent possible. Public comments are available through the office of the Bureau of Family Health. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/ Needs Assessment Update for Interim Year.

a. Changes in the population strengths and needs in the State priorities since the last Block Grant application.

Changes in the population strengths and needs have not been noted since the last Block Grant application.

b. Changes in the State MCH program or system capacity in those State priorities since the last Block Grant application.

Since the last Block Grant application, there have been changes in system resource capacity to address Priority Needs. The agency is currently involved in strategic planning to align human/economic resources with priority outcomes.

The Governor's Roadmap for the State of Kansas is on economic growth to help build strong families. Within this framework, the state will continue to grow the Kansas economy, reform state government, excel in education and protect families.

MCH/CYSHCN has requested technical assistance through this Block Grant Application to assist in identifying new opportunities for coordination and collaboration with the merger of the Division of Health Care Finance (Medicaid) within the (KDHE) agency.

c. Brief description of ongoing needs assessment activities, such as data collection and analysis, evaluations, focus groups, surveys, that enable the State to continue to monitor and assess, on an ongoing basis its priority needs and its capacity to meet those needs.

MCH epidemiologists collaborate with program(s) staff to coordinate needs assessment activities including data collection, analysis, evaluations, and surveys for the annual MCH Block Grant application that includes State priority needs. A CYSHCN Family Survey to gather information from children and familiies participating in CYSHCN sponsored medical specialty clinics concluded in August of 2011. Family feedback survey results identifying and prioritzing unmet service needs will be included in future program planning decisions.

d. Brief description of any activities undertaken to operationalize the 5-year Needs Assessment such as establishing an advisory group to monitor State progress in addressing the findings and recommendatins resulting from the Needs Assessment.

The CYSHCN program through strengthened collaborations with Families Together (FT) and Kansas Youth Empowerment Academy (KYEA) has organized both Family Advisory and Youth Advisory work groups whose missions align with identified needs assessment priorities. The workgroups advance strategies to advance activities, goals, and outcomes embedded throughout 5 year priorities and needs assessment logic model.

The Kansas Maternal and Child Health Council (KMCHC) combines child/adolescent and perinatal/infant workgroups to address needs assessment priorities. //2013//

III. State Overview

A. Overview

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

Geography/Demography

Located in the central plains region of the United States, Kansas encompasses 81,815 square miles or about 2% of the land area of the U.S. It is bordered on the north by Nebraska, on the south by Oklahoma, on the east by Missouri, and on the west by Colorado. The topography of the state changes from hills and wooded areas in the east to flat, treeless high plains in the west.

Population Density/Distribution

There were 34.2 persons per square mile in the state in 2008 compared to 86.0 for the U.S. Five cities in the state, all located in the eastern half, have populations that exceed 100,000, including Wichita (366,046), Overland Park (171,231), Kansas City, 142,562), Topeka (123,446), and Olathe (119,993). In 2008, 35 of 105 counties in Kansas had population densities of less than 6.0 persons per square mile. These are located mostly in the western part of the state. The most sparsely populated county was Wallace along the Colorado border with a density of 1.5 persons per square mile. The most densely populated county was Johnson with 1,119.7 persons per square mile. This county is on the eastern border of the State.

Urban/Rural

Most of the population growth over the past decade occurred in the eastern portion of the state, where the majority of the population lives. While there are many rural areas in eastern Kansas, particularly in southeastern Kansas (Kansas Ozarks), the most rural counties are located in western Kansas. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates.

Population Growth/Change

The 2008 population estimate for Kansas was 2,802,134 or about 1% of the U.S. population (U.S. Census Bureau). Percent growth for Kansas' population from 2000-2008 was lower than for the U.S. 4.2% compared to 8.0%. For younger age groups, however, the population growth rate was slightly higher for Kansas than for the U.S. For children under age 5, the growth rate was 7.2% for Kansas compared with 6.9% for the U.S. For children under age 18, Kansas' population growth was 25% versus 24.3% for the U.S. Women comprise 50.3% of the population roughly comparable to the U.S.

Age

Kansas' population is aging but at a slower pace than the rest of the U.S Median age is 36.2 years which is only slightly younger than the national median age of 36.8. Since 2002, Kansas' population of school age children has decreased 2.5 percent while the older cohorts have steadily increased. The school age population (age 5-17 years) is expected to remain stable through 2010 and then gradually increase.

The under age 5 cohort was unchanged from 2002 to 2005. Since 2005, it has steadily increased. Proportionally, this cohort represents 7.2 percent of the total state population, up 3.3 percent from 2007 to 2008. In 2008, there were 41,815 resident births in Kansas.

Women of reproductive age (15-44) accounted for 19.8%, or 553,481 of the estimated 2.8 million people in the State. There were about 57,321 women ages 15 to17.

Twenty eight percent (28%), or 788,500, of the State's population were children age 19 and younger. In 2008, there were an estimated 521,400 children and adolescents aged 5 to 17.

Race/Ethnicity

White persons comprise a higher proportion of Kansas' population (88.7%) than the proportion for the U.S. (79.8%), There is a lower proportion (6.2%) of Black persons in Kansas compared to the proportion for the U.S. (12.8%). American Indian and Alaskan Native persons are 1.0% for both Kansas and the U.S. Asian persons comprise 2.2% of Kansas' population, but 4.5% of the U.S. population. The proportions for those reporting two or more races are roughly comparable for KS and for the U.S., 1.8% and 1.7% respectively.

The proportion of persons reporting Hispanic origin is only 9.1% for Kansas compared to 15.4% for the U.S.

Diversity/Languages

Kansas' population is fairly homogenous. Only five percent (5%) of Kansas' population is foreign born compared with 11.1% for the U.S. Percent homes in which languages other than English are spoken is only 8.7% compared with 17.9% for the U.S. Refugee health program data for 2009 are representative of about half the annual recent arrivals to Kansas. Of approximately 500 foreign born immigrants in 2009, 21% spoke Nepalese, 18% Burmese,16% Karen, 11% Arabic, and the remaining 34% Chinese, Dari, Farsi, Kayaw, Kurdish, Kunama, Laotian, Somali, and Vietnamese. Refugees located mostly in about five counties in the state: Wyandotte (KC), Sedgwick (Wichita), Johnson, Finney, and Douglas.

Education

Kansas compares favorably with the U.S. average in terms of educational attainment with an 86.0% high school graduation rate compared with 80.4% for the U.S. Twenty five percent (25.8%) of Kansans have a bachelor's degree or higher compared with 24.4% for the U.S.

Income/Poverty

The median household income for Kansas in 2008 was $50,174 compared to $52,029 for the U.S. Per capita income for Kansas was $20,506 compared with $21,587 for the U.S. Proportionately fewer Kansans live below the federal poverty level, 11.3% compared with 13.2% for the U.S. See attachment for distribution of number of children in poverty by county and distribution of percent children in poverty by county.

Economy

The Kansas economy entered a significant downturn in 2009 following the U.S. and global economic downturns. There was a slow period of employment growth through most of 2008, followed by significant job losses in manufacturing during 2009, especially in Wichita's aircraft manufacturing industry. Unemployment for the first 3 months of 2010 was 7.2, 6.8, and 6.9 percent, these compare unfavorably with rates in late 2008 that were approaching 4 percent. http://klic.dol.ks.gov Consumer spending slowed considerably as did State revenues. For the state fiscal year starting July 1, 2010 state legislators faced a projected budget shortfall for the

3rd year in a row. The projected shortfall was estimated at $500 million.

Health Insurance Coverage

In 2007-2008, 12.4 percent of Kansans were uninsured, not statistically different from either the 12.5 percent who were uninsured in 2006-2007 or the 11.3 percent in 2005-2006, but greater than the 10.5 percent who were uninsured in 2004-2005. The percentage of Kansas children (under 19) without health insurance in 2007-2008 was approximately 9.6 percent, up from 7.8 percent in 2006-2007 and 7 percent in 2005-2006. The percentage of Kansans without health insurance in 2007-2008 (12.4 percent) was lower than 15.3 percent for the U.S. Approximately 338,000 Kansans were without health insurance in 2007-2008. Based on 2006-2008 three-year averages, the Kansas uninsured rate was higher than 13 other states and lower than 26 other states. See attachment for percent of children that were uninsured by county for 2006.

Counties with high percent uninsured children per county are clustered in the southwestern part of the state, a largely Hispanic populated area and presumably many are not Medicaid or SCHIP eligible. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with large number/percent of children in poverty but the children are less likely to be uninsured than those in the southwestern part of the state.

Health Care Delivery Environment

Primary Care Access/Workforce

The most prominent barrier to care in Kansas is lack of financial access as measured by income and uninsurance rates. Although the most recently available data for the uninsured rate in Kansas, the U.S. Census Bureau's March 2008 Current Population Survey, is from before the current economic recession, it found that approximately 340,000 Kansans were uninsured in 2006-2007, up from 307,000 in 2005-2006. Of these, 61.4% were considered low-income (household incomes at or below 200% of the federal poverty level) and likely unable to afford the cost of health insurance premiums or the full cost of personal health care services when needed. Kansas was one of 10 states that showed an increase in its uninsured rate during this period. Kansas moved from 11th to 20th among states with lowest uninsurance rates. Kansans with insurance still had access issues due to the lack of primary care providers throughout the state.

Currently, Kansas has 84 federally-designated, primary care Health Professional Shortage Areas (HPSAs). These include entire counties, cities, or areas with underserved populations. Of the current primary care HPSAs, 28 are geographic HPSAs and 56 are population HPSAs, indicating both geographic and financial access problems among residents across the state. Only twelve of Kansas' 105 counties do not have a primary care HPSA within their borders. Only five others have primary care HPSAs that only make up a portion of their counties. In the remaining 88 counties, the entire county is federally designated as a Health Professional Shortage Area.

The state of Kansas has shown a commitment to funding the provision of medical services in underserved areas. In 1992, beginning with $800,000 in state funding for nine primary care medical projects targeted to uninsured and other underserved populations, the program has grown substantially, especially within the last four years. Current funding for state fiscal year 2010 is $7.48 million dollars in funding to 38 clinics around the state with sites in 31 Kansas counties. There has also been a rapid expansion in Federally Qualified Health Centers (FQHCs) in Kansas over the last few years, from 7 in 2000 to 15 FQHCs and one FQHC look-alike in 2010. The expansion of access to primary care services is a major achievement in the state but often the inability to find needed providers by these clinics has hindered their ability to provide primary care services at full capacity.

A number of reports are generated annually by state programs and other entities on primary care access. Among these are the "Primary Care Access Report" the "Annual Report of the

Statewide Farmworker Health Program" Special studies focus on workforce issues such as the aging of the workforce study -- www.kdheks.gov/ches/download/AgingPhysician2009.pdf

The state agency in partnership with the Dental Association and numerous other organizations has completed workforce analyses resulting in policy initiatives on dental workforce.

Public Health System

Kansas has 105 counties and just fewer than 300 school districts. Almost every county has a local health department (99 counties) and every county has some type of public health 'presence.' Many school districts utilize contracts with local public health nurses for school nursing services, particularly in the smaller counties. In order to meet national public health accreditation standards, many of the smaller county health departments have considered organizing as regional public health entities. Importantly, local health departments are not state operated. Rather, they are units of local and county government and operate autonomously of the State health department.

There is a strong partnership between the State and local public health departments that is manifest in collaborative activities such program planning and policy development. The Kansas Public Health Association provides a forum for many of these activities and the Kansas Association of Local Health Departments coordinates communications among local health departments and between the State health agency and local agency council. As well, there are many other joint conferences and events that serve to bring together state and local public health workers.

There are four very active health foundations in the state that are major drivers of public health policy. These include the Kansas Health Foundation, Sunflower Foundation, United Methodist Health Ministries, and Kansas City's REACH Foundation. The State has a very active public health-focused research institute, the Kansas Health Institute. It is a source of much public health information and analysis for policy making. The institute convenes legislators and public health staff in forums to consider policy options and these no doubt serve to inform public policy. Beginning in Fall 2009, the KHI initiated a series called "Children's Health in All Policies" convening MCH staff, legislators and others. This contributed to the many positive outcomes in the 2010 session such s reinstatement of funding for teen pregnancy prevention, protection of funding for social services, education, early childhood, and Medicaid.

State funding of public health is largely targeted towards specific activities and programs, unlike some other states that have large amounts of funding portioned out to counties on a per capita basis for core public health activities. This is not to say that there is no per capita funding, but the 75 cents per capita funding provided through the "State Formula Fund" is a very small portion of the overall state funding for local public health activities in the state.

Public Health Insurance

Previously located in the state social services agency, Kansas' Medicaid agency was relocated to the Kansas Health Policy Authority, a separate state agency, in 2005. The Authority is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. All health insurance purchasing by the State is now combined under the Authority including publicly funded programs (Medicaid, State Children's Health Insurance Program, and Medikan) and the State Employee Health Benefits Plan (SEHBP). The Authority is responsible for compiling and distributing uniform health care data in order to provide health care consumers, payers, providers and policy makers with information regarding trends in the use and cost of health care for improved decision making. The KHPA is governed by a nine-member board, including health care, business, and community leaders appointed by the Governor and the Legislature, as well as eight ex-officio members that include State Cabinet Secretaries and the Executive Director of KHPA.

The interface between Title V MCH and Title XIX Medicaid is documented in the KHPA/KDHE Interagency Agreement. The document is updated at regular intervals to clarify roles and responsibilities and the most recent update of this document is dated September, 2009. KHPA staffs participate in Title V activities such as the MCH Advisory Committee and they advise on matters pertinent to both agencies.

State Health Agency Current Priorities and Initiatives

The state health agency's current priorities and initiatives were apparent in the initiatives introduced and shepherded through the 2010 legislative session: clean air act (smoking ban in public places); expansion of child care licensing inspections to registered family day care homes (the so-called Lexie's Law - health and safety while in out-of-home care); changes to the Vital Statistics statutes to allow use of birth certificates for maternal surveillance purposes such as PRAMS and FIMR; maintenance of dedicated use of tobacco settlement funds for programs serving children ages birth through five (including MCH home visiting, Infant Toddler Services, and Newborn Screening); primary seat belt law, requirement for Kansas colleges to have a plan for controlling tuberculosis on campuses; opt-out for HIV infection screening of pregnant women; audiologist licensure requirement of doctorate or equivalent; certification of radon technicians; prohibition of texting while driving.

Obesity reduction measures such as school vending, menu labeling, and tax on sugar sweetened beverages did not pass despite considerable public approval for these measures. Likewise, increased taxes on cigarettes and other tobacco products did not pass. It is anticipated that obesity and tobacco use reduction measures will move forward into the next legislative session. The state school board has moved on the school vending machine proposal.

The state health agency focus is on prevention/wellness, social determinants of health, life course perspective, and health equity. The agency has established a bureau of environmental health encompassing Environmental Public Health Tracking, lead screening and abatement, radon and radiation protection and control, among others. There has been renewed focus on reducing racial and ethnic health disparities with the office of minority health taking a larger role and the establishment of the Blue Ribbon Panel on Infant Mortality.

Title V MCH Roles and Responsibilities in Agency Initiatives

The mission statement for the Bureau of Family Health embodies its roles and responsibilities both outside and within the agency: to provide leadership to enhance the health of Kansas women and children in partnership with families and communities. While other bureaus in the division of health have initiatives relating to the health of women and children, none has as its exclusive mission the health and wellbeing of women and children.

A major focus of all the policy and program initiatives is partnership. There is stakeholder involvement in all Title V activities that includes both providers and consumers. Title V MCH is a leader in the agency in drawing on key players to help them play important roles in shaping the future of the state. Through existing forums, Title V has engaged stakeholders in advocacy for improving the health status of women and children. Title V has provided or assisted in project management for special groups such as the Governor's Child Health Advisory Committee, Early Learning Coordinating Council, State Genetics Plan Stakeholders, Newborn Screening Advisory Council, Families Together, the Blue Ribbon Panel on Infant Mortality, and the emergent Kansas Breastfeeding Coalition. Title V has provided staffing and resources support to other emergent issues including H1N1, bioterrorism coordinating council, Developmental Disabilities Council, Autism Task Force, Food Security Task Force, Health Department Accreditation, and Healthy Kansas 2020. The Kansas MCH Coalition (a merger of the Kansas Perinatal Council and the Kansas AAP Advisory Group) has served as a forum for policy and priority issues relating to the health of Kansas mothers and children.

A good example of partnership activities during the past year is the ABCD+ initiative. This initiative focuses on behavioral and mental health screening and treatment. Survey data of healthcare providers on the issues of mental health diagnosis and treatment for children and adolescents revealed pediatric providers are uncomfortable diagnosing and managing mental health disorders even common ones such as depression and anxiety. It was also apparent that an overwhelming majority of providers experienced a lack of resources. Finally, most primary care physicians were willing to provide these services if given adequate training and resources

The Kansas Chapter, American Academy of Pediatrics (KAAP) and the KDHE MCH staff convened a multi-agency task force to increase the number of children (ages 0-18) that receive mental health screening and appropriate mental health referral and treatment. Other agencies involved included: Kansas Health Policy Authority (KHPA) - Medicaid; Kansas Department of Social and Rehabilitation Services (SRS) - mental health and substance abuse designated agency and Kansas Health Solutions provider network; Association of Community Mental Health Centers of Kansas (ACMHCK) Community Mental Health Centers in Kansas; Private Mental Health Consultant of the Governor's Children's Mental Health Council; Kansas Behavioral Science Regulatory Board (KBSRB); Kansas Health Institute (KHI); and the Kansas Academy of Family Physicians (KAFP). The task force is patterned after the Assuring Better Child Health and Development (ABCD) project, a quality improvement initiative in primary care practice to improve developmental screening. .

The project developed a three-pronged approach. First, develop an easily accessible web-based resource list -- KidLink Resource Directory -- with contact information including a stratified level of care of all Kansas public and private mental health providers and therapists that serve the pediatric population. Second, develop and deliver education to healthcare providers in the use of evidence-based screening tools and appropriate early intervention resources to increase their competence level in diagnosis and treatment of childhood developmental and mental health disorders. Third, teach healthcare providers to navigate the KidLink Resource Directory of mental health providers in their geographical regions in Kansas with the ultimate goal to get children and adolescents into treatment interventions as soon as possible. Regional networking and collaboration between primary care providers, child/adolescent psychiatrists, and other mental health providers is essential to improving mental health in children.

Another example of work across agencies is the State Child Death Review Board (SCDRB). MCH represents the Kansas Department of Health and Environment on this board. The SCDRB was created by the Kansas Legislature in 1992 and is administered by the Kansas Attorney General's Office. The SCDRB ten-member multi-disciplinary panel whose appointments are defined by statute are comprised of medical, law and social service professionals. The purpose of the SCDRB is to "determine the number of Kansas children who die annually, describe trends and patterns of child deaths, identify risk factors . . . [and] develop prevention strategies in order to lower the number of child deaths."

A third example of partnership is school nursing services. MCH is responsible for guidance to local school district nurses. The 2010 Guidelines for Medication Administration in Kansas Schools is a revision of the 2001 guidelines providing guidance and resources for school personnel responsible for children with acute and chronic illnesses requiring medication during the school day. School districts must meet this need in the interest of facilitating school attendance and compliance with applicable state and federal laws, establishing policies and implementing procedures that meet all legal requirements for administration of medication required during school hours. Medication administration procedures must be consistent with standards of medical, nursing, and pharmacy practice guidelines. The revised expanded guidelines include sample forms, supporting documents, and links to resources and information facilitating safe and timely medication administration in the school setting.

Beginning in May of 2009, the Kansas MCH program was an integral partner in the agency

response to pandemic influenza. Nursing and epidemiology staff assumed additional responsibilities serving on the H1N1 Phone Bank assisting with calls from health providers and the general public, development of resource materials posted on the Kansas Department of Health and Environment (KDHE) Web site, and education of MCH staff in the local agencies. Other staff worked with the Center for Public Health Preparedness (CPHP) deploying supplies from stockpile warehouses out to Kansas providers. MCH served on the KDHE Community Mitigation Team. This team was charged with assisting with weekly statewide telephone conference calls with local health departments and providers and development of educational and resource materials.

The current public health leadership within the agency has pursued a course of greater public awareness of the importance of public health to the overall health of the population, the important roles and responsibilities of the state public health agency in achieving and maintaining a healthy population. The achievements in the 2010 legislative session are a testament to the positive impact of this approach with policy makers and the public. Whereas previously the focus was on insurance status and access to care, there has been a shift in public opinion to the merits of public health strategies.

In summary, the MCH role within the state Title V agency is to provide leadership to issues and concerns at the state and local levels affecting the health and wellbeing of Kansas mothers and children. This is manifest in many program and policy initiatives that are described here and elsewhere in this application. Overlaying all these initiatives and challenging many of our efforts, is the state's budget situation. The budget will remain the most significant issue for the state and for MCH in the foreseeable future. At the same time that budget pressures threaten program services, there is increased demand for services and supports by families impacted by the economic recession. Revenues remain unstable at both the state and local levels.

In addition, there are anticipated changes. Health care reform is slowly changing the face of the service system. A change in leadership in state government is expected during the coming year and along with this change, priorities and policy shifts may be expected. The agency including MCH is developing a public health agenda with these changes in mind. .

References:
1) Kansas Quick Facts, U.S Census Bureau 4/22/2010
http://quickfacts.census.gov/qfdstates/20000.html
2) Governor's Economic and Demographic Report, 2009-2010, Kansas Division of Budget, January 2010
3) Kansas Health Institute, April 2010 Reports www.khi.org
4) Kansas Annual Summary of Vital Statistics, 2008
5) KDHE Primary Care and Farmworker Health Programs.

/2012/ The 2000 to 2010 Census Results show a 6.1% increase in the Kansas population (2,688,418 to 2,853,118) compared to 9.7% for the U.S. Population density increased to 34.9 persons per square mile compared to 87.4% for the U.S. Kansas remains in the bottom quartile of states in terms of population density along with such states as Oregon and Utah.

Wichita, Overland Park, Kansas City, Topeka, and Olathe remain the most populous cities, although Kansas City showed a negative growth rate (-0.7%) from 2000 to 2010. Olathe, to the south of Kansas City, had a growth rate of 35.4%. This was the highest of any city in the state, followed by Shawnee a western suburb of Kansas City (29.6%) and Derby (24.4%) in the southeast Wichita metropolitan area.

County growth rates were strongest in Johnson County (20.6%) that in 2010 displaced Sedgwick County as the most populous county in the State. Johnson Co. includes Mission, Overland Park and Olathe. Geary County with its military base (23.0%) and Miami County (15.6%) located on

the southern border of Johnson County also had high growth rates. Wyandotte County, among the most populous counties, had a negative growth rate (- 0.2%) possibly due to out-migration into Johnson and Miami counties. Growth remains strongest in the eastern half of the state.

The state's population continues to become more diverse although not so diverse as the U.S. For Kansas, 83.8% reported white race compared to 72.4% for the U.S., 8.9% black (12.6% U.S.), 1.0% American Indian, Alaska Native (0.9% U.S.), Asian alone 2.4% compared to 4.8% U.S., other races and 2 or more races 6.9% compared to 9.1% U.S. Those reporting white race dropped from 88.7% in 2000 to 83.8% in 2010. Kansas population growth by race/ethnicity was significant for those of Hispanic/Latino ethnicity with a 59.4% increase from 2000 to 2010. In 2010 Hispanics comprised 10.5% of the state's population compared to 16.3% for the U.S.

Comparing 2008 and 2009 data, for the 0-24 age group population, the largest population increases occurred in the 1-4 and the 20-24 age groups. These increases held across white, black and Hispanic populations. For 2009 data for live births to women by age group, there were 36 births to women less than age 15 and 1,162 to women age 15-17. There was overrepresentation of young black women in births to women less than age 17. Seventeen percent (17%) of births to those less than age 15 were to young black women and 11% of births to those 15-17 were to young black women. There was also overrepresentation among Hispanics on this teen pregnancy indicator -- 47% of live births to those less than age 15 were to Hispanic women and 34% of live births to those women age 15-17 were to Hispanics.

There was an overall decrease in deaths to those in the MCH population (ages 0-24) from 2008 (767) to 2009 (686). There were declines in number of deaths for all age groups except for age 5-9 (slight increase) and 10-14 (relatively unchanged). The most dramatic decreases were for the white population. For the non-Hispanic population, declines were most evident for ages 1-4 and 20-24. For the Hispanic/Latino population, declines were evident in infant (0-1) and young adult (20-24) populations.

Miscellaneous data for enrollment of infants and children in various State programs (TANF, SCHIP, foster care, and WIC) appears relatively unchanged from 2008-2009 with the exception of Medicaid and Food Stamp (SNAP) programs. For these two programs there were substantial increases and increases are reflected across all racial/ethnic groups.

From 2008-2009, there were no major changes in numbers of children living in metro versus non-metro areas. No major changes in urban/rural residence for Kansas children. From 2008 to 2009, a slight decrease is evident for the Kansas population while increases were reported for percent population living in poverty: below 50% FPL-Federal Poverty Level (4.8 to 5.1%); 50-100% FPL (12.7 to 13.7%); 100-200% FPL (31.5 to 33.0%). From 2008-2009, with a slight increase in population from 0-19, there was very little change in the poverty status for those living below 50% FPL, 50-100% FPL, and those 100-200% FPL. As one would expect, Kansas children are more likely to live in poverty than the general population. Five percent (5.1%) of the general population live below 50% FPL but 6.1% of children ages 0-19; only 13.7 of the general population but 18.0% of children live 50-100% FPL; and 33% of the general population versus 40.9% of children live between 100-200% FPL.

In 2009, 7.3% of all Kansas live births were born weighing less than 2,500 grams; 5.6% of live singleton births weighed less than 2,500 grams. About 1.4% of live births were born very low birth weight at 1,500 grams. And 1.1% of live singleton births weighed less than 1,500 grams. These figures have remained relatively unchanged over the past 5 years.

In 2009, the death rate per 100,000 due to unintentional injuries among children ages 0-14 was 10.2 up from a low of 9.3 in 2008. Death rate per 100,000 for children ages 0-14 due to unintentional injuries related to motor vehicle crashes (MVCs) was 2.7 down from 3.6 in 2008. There has been a steady decline in the latter over the last five years with improved childhood seat belt legislation a possible contributing factor. There had been a steady decline in unintentional

injuries related to MVCs in 15-24 year olds from 28.9/100,000 in 2006 to 21.9 in 2009. The rate per 100,000 of nonfatal injuries among children ages 0-14 from hospital discharge data is 242.6. The rate per 100,000 of nonfatal injuries due to MVCs for children 0-14 was 13.8, for 15-24 year olds it was 87.6. In this latter category the decline is significant down from 135.6 in 2006.

Chlamydia rates per 1,000 for 15-19 year olds have been slightly variable over the last 5 years with the calendar year 2010 rate at 27.7, up from the 2006 low of 26.2. The 2010 rate for 20-44 year olds was 10.1/1.000 women, up from a low of 8.3 in 2006.

The rate for children hospitalized for asthma per 10,000 (ages 0-5) was 24.8 down from a high of 33.7 in 2006. The percent of Medicaid infant enrollees who received at least one initial periodic screen was 87% slightly down from a high of 89.4 in FFY 2007. The percent for SCHIP infant enrollees was 77.9 for the same time period. Kansas Kotelchuck Index (observed-expected prenatal visits) for 2009 was 79.0 slightly increased from 2006.

The percent of potentially Medicaid eligible children who have received a service was 83.1% down from a high of 95.7% in 2006. The percent of EPSDT eligible children ages 6-9 who have received any services during the year was 58.6% up from a low of 53% in 2006. There has been a steady progress from year to year in this area.

Fifteen percent of State SSI beneficiaries receive rehabilitation services through the CYSHCN program.

Disparities persist in health status for Medicaid recipients. 8.5% of Medicaid enrolled mothers have low birthweight babies compared to 6.7 for non-Medicaid. There are 9.4 infant deaths per 1,000 live births for Medicaid enrolled compared to 5.5% for non-Medicaid . 61.6% of women who deliver births covered by Medicaid received early prenatal care compared to 83.1% for non-Medicaid. 68% of Medicaid enrollees had appropriate observed to expected prenatal visits on the Kotelchuck index compared to 87% for non-Medicaid. Medicaid eligibility levels remain at federally required levels: 150% FPL for infants, 133% FPL for children ages 1-5, 100% for ages 6-18, and 150% for pregnant women. Eligibility levels for SCHIP were 241% FPL for children ages 0-18 and 200% for pregnant women.

Data capacity of Kansas to support MCH programs includes annual linkage of birth and infant death records, access to hospital discharge data, and annual birth defects reporting system. There is no annual linkage of birth records and Medicaid paid claims data, no annual linkage of birth records and WIC, no annual linkage of WIC-Medicaid, no annual linkage of birth records and newborn metabolic screening files, and no PRAMS. The Kansas State Department of Education (KSDE) and KDHE's Bureau of Health Promotion (BHP) in partnership with local school districts conduct the Youth Risk Behavior Survey. KDHE's BHP conducts the Youth Tobacco Survey. //2012//

/2013/ In 2010, the teen birth rate (ages 15-17) was 19.1 per1,000 females. This was 7.3% lower than 2009 (20.6). However, no statistically significant difference was observed. In 2010 (the most recent year preliminary national data for this age group is available), the birth rate for Kansas young teenagers 15-17 years was higher than the national rate (17.3 per 1,000). Teenage birth rates for ages 15-17 for white non-Hispanic and Hispanic decreased in 2010. The non-Hispanic black teen birth rate in 2010 (35.6) was significantly higher than the rate in 2009 (26.5). Hispanic teens had the highest rate (47.7) in 2010. Overall, there was a slightly decreasing trend observed over the 10 year period, 2001-2010. However, the APC (annual percent change) was not statistically significant.

The suicide rate among Kansas youth ages 15-19 was 13.7 per 100,000. This was 128.3% higher than 2009 (6.0). For the period 1999-2010, using rolling 3 year averages, overall, there was a stable trend in completed suicides by Kansas youth (15-19) during 1999-2001

and 2008-2010. The APC was not significant.

The mortality rate for children ages <= 14 as a result of unintentional injury--motor vehicle crash was 4.0/100,000 children, a 48.1% increase from 2009 (2.7). Overall, there is a significant decreasing trend observed over the 10 year period, 2001-2010. The APC was significant (-6.89). According to the 2011 Annual Report (2009 Data) of the Kansas State Child Death Review Board (SCDRB), in 2009, there was an 11% reduction in the number of child deaths from 2008. The Unintentional Injury - Motor Vehicle Crash (MVC) category showed a reduction of 25% from 2008. The Board attributes this drop to the Kansas Legislature enacting the booster seat and primary seat belt law for all children under age 17.

There were 689 deaths to children ages 0-24 with 253 of deaths to infants. As seen in previous years, the largest number of deaths were for infants. Based on the proportion of black or African-American children in the Kansas population, black children have proportionately greater numbers of deaths than other races. Black children comprise 9.0% of the States' children but 12.0% of the deaths to children, a slight decrease from 2009 (13.3%). Black infants comprise 10.2% of the States' infants but 13.4% of the deaths to infants, a decrease from 2009 (15.2%). Hispanic children comprise 15.7% of the States' children and 13.9% of the deaths to children. Hispanic infants comprise 19.8% of the States' infants and 7.3% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age.

The rate of asthma hospitalizations has decreased 7.8% from 24.8/10,000 in 2009 to 26.9/10,000 in 2008. The percent of Kansas women (15 through 44) with a birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index (adequate and adequate plus prenatal care) was 79.8% in 2010, significantly higher than the previous year (79.0%).

Medicaid paid for the delivery of 13,159 (32.8%) Kansas live births, a 16.7% increase from 2009 (28.1%). For Medicaid births, 8.8% were low birth weight compared to 6.2% for non-Medicaid births. About two-third (62.4%; n=1,720) of births to non-Hispanic black women were paid by Medicaid. More than one-third (36.0%; n=2,254) of births to Hispanic women were paid by Medicaid, followed by 29.4% (n=8,486) births to non-Hispanic white women were paid by Medicaid. The infant mortality rate was highest for the Medicaid service population (7.3 per 1,000 live births) and lowest for the non-Medicaid population (5.5). Only 61.4% of Kansas Medicaid infants were born to women receiving PNC in the 1st trimester of pregnancy. The eligibility level for pregnant women for Medicaid coverage in Kansas is 150% federal poverty level (FPL). Low-income undocumented women can qualify for Medicaid coverage under the Sixth Omnibus Budget Reduction Act (SOBRA). Both poverty status and undocumented status have been associated with delayed prenatal care.

Although the overall rates for Chlamydia in females aged 15-19 (29.5 cases per 1,000) and females aged 20-44 (11.2 cases per 1,000) have remained stable in Kansas over the last several years, a number of disparities exist for teenage and reproductive women in Kansas. Chlamydia rates are the highest for women aged 15-19 (29.5 cases per 1,000) followed by women aged 20-24 years (33.9 cases per 1,000). Chlamydia rates are two times higher for Hispanic women (19.1 cases per 1,000 women aged 15-19 and 8.7 cases per 1,000 women aged 20-44), and six times higher for non-Hispanic black women (62.5 cases per 1,000 women aged 15-19 and 27.1 cases per 1,000 women aged 20-44) compared to their respective non-Hispanic white peers (10.5 cases per 1,000 women aged 15-19 and 4.4 cases per 1,000 women aged 20-44).

Kansas's Supplemental Nutrition Assistance Program (SNAP) changed its policy in October 2011 to count the income of all members in a household, including illegal immigrants. Between October and November 2,006 children were closed in SNAP. The

majority of these children were American citizens of Hispanic descent.

Kansas's Temporary Assistance for Needy Families (TANF) began requiring eligibility staff to reference an employment verification service (The Work Number) to substantiate income for processing applications, performing a case review, and reviewing interim reports in May of 2011. No significant changes have been observed in the percent of denials or closed cases.

Juvenile crime in Kansas has declined by 30% over the last year. This decline can partially be explained by Kansas Bureau of Investigation following the FBI's decision to no longer collect data on runaways. In 2010, there were 1,413 reports of runaways in Kansas and accounted for 9.1 percent of all juvenile crime reports in that year.

Nearly one in four Kansas children live in households at or below 100% of the Federal Poverty Level (FPL). This is higher than the one out of seven individuals in Kansas households living at or below 100% FPL. In another analysis using the 2000 Decennial Census and the 2006-2010 American Community Survey indicated that high poverty census tracts of more than 30 percent of the population living in poverty increased from 25 census tracts areas in 2000 to 66 census tracts areas in 2010. The 2010 federal poverty level is $22,314 per year for a family of four. Of the 41 newly identified census tract areas, the most changes occurred in the metropolitan counties of Sedgwick (13 census tract areas), Wyandotte (11 census tract areas), and Shawnee (5 census tract areas).

On 1 May 2011, Healthwave (Kansas SCHIP) increased legibility for children from 200% to 238% of 2008 Federal Poverty Level. A number of significant changes were made in Medicaid policies in FY2011 that affect children. Kansas implemented express lane eligibility and allowed for passive renewal of Medicaid insurance for children. Beginning on 1 October 2010, all Medicaid eligible beneficiaries had hospice service limited to 210 days. On 1 July 2010, Kansas eliminated coverage for attendant care services in schools under the Medicaid School Based Services Program. To help prepare for an affordable care act requirement, Kansas Medicaid added concurrent care for children receiving hospice services.

Kansas has the data capacity to support MCH programs including annual linkage of birth and infant death records, access to hospital discharge data, and birth defects reporting system. Kansas has no PRAMS. In 2011 BEPHI and MCH launched a formal effort to annual create linked files of vital events data to other datasets. The latest matching initiative builds on initial linked birth, Medicaid, WIC (Pediatric and Pregnancy Nutrition Surveillance System - PedNSS and PNSS) methodology to probabilistically link de-identified hospital discharge data and Medicaid claims information for 2009 events. Linking 2010 data is scheduled to proceed in the summer of 2012. //2013//

B. Agency Capacity

This section addresses the capacity of the Kansas Title V Agency to promote and protect the health of all mothers and children, including CYSHCN. It describes Kansas' capacity to provide essential public health services for pregnant women and infants, children and adolescents, and children with special health care needs.

Kansas has established a vision, mission and goals for maternal and child health through a strategic planning process. Capacity assessment is included in the 5-Year MCH State Needs Assessment, MCH 2015. Through this process, Kansas has identified the priority health issues and desired population health outcomes for mothers and children. A review of the political, economic, and organizational environments for addressing the priority health issues is included in

the MCH Services Block Grant application that accompanies the needs assessment. All relevant information is utilized to set strategic directions for the Title V program in terms of identification and implementation of organizational strategies to achieve the desired outcomes for the maternal and child health population.

Also, Kansas uses the ten essential public health services to guide decision-making in all aspects of program operation. For the five year needs assessment, essential services were used as the basis of building logic models and work plans to address priority needs through 2015. Following is an overview of Kansas' Title V capacity in relation to each of the ten essential maternal and child health services.

Essential Service #1. Assess and monitor maternal and child health status to identify and address problems. Kansas uses public health data sets to prepare basic descriptive analyses related to priority health issues. Data from the Prenatal Nutrition Surveillance System (PNSS) and the Pediatric Nutrition Surveillance System (PedNSS) are available through the WIC program database. Data from the Behavior Risk Factor Surveillance System (BRFSS) is readily available and MCH has an opportunity each year to support additional modules on emergent issues in MCH/CYSHCN. Oral health and women's health modules have been funded in recent years. The Youth Risk Behavior Survey (YRBS) is conducted each year by the state department of education in partnership with local school districts. Previously, the data were not considered representative of the youth population due to non-participation of some school districts. Now, through the auspices of the CDC Coordinated School Health Program, the data are representative and useful to the Title V program in tracking youth health behaviors.

Vital statistics data of high quality are available to Title V through an approval process. Since 2005 hospitals submit records electronically to the state agency via a web-based system. The system implements the new NCHS standards. In 2007, MCH first received data from the new system. Any analysis of trend data now takes into consideration the timeframe for conversion to the new system. Entry into prenatal care, adequacy of prenatal care and birth defects reporting are some of the variables that were affected by the conversion. The new system expands the amount of data available and improves the ability of Title V to assess birth/death and birth risk data.

Changes to the Vital Statistics statutes during the 2010 session allow use of the system to survey recent mothers for purposes of maternal health surveillance. MCH is identifying resources to conduct Prenatal Risk Assessment Monitoring System (PRAMS). Local agencies have identified resources to conduct Fetal Infant Mortality Review (FIMR) at the community level.

Other data sets maintained by other bureaus within the department that are used for various analyses include: immunization, cancer registry, child care licensing, STDs, HIV, State laboratory, primary care, farm worker health, trauma registry, as well as BFH program services data systems (WIC, MCH, CYSHCN, Part C, Family Planning, Newborn Screening, Newborn Hearing Screening). Use of these data sets is outlined in relevant sections of this application.

Title V has access to data sets outside the state agency such as Medicaid data (MMIS & Clearinghouse), hospital discharge data, department of transportation data (motor vehicle accidents), Kansas Bureau of Investigation (intentional injuries), department of social services, education department (school lunch program, school injuries). The annual MCH Block Grant application includes a good representative sample of the types of data in use. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

BFH has two epidemiology positions. Additional epidemiological support would be beneficial. The epi's serve as data analysts and resource persons for: Kansas' five year needs assessment, KDHE Healthy Kansans 2020, analysis of the National CYSHCN Survey, National Child Health Survey, birth defects data, and numerous ad hoc projects throughout the year. There is not

sufficient capacity to conduct analyses of MCH data sets that go beyond descriptive statistics, although there has been some work in this area. BFH epidemiologists and other staff have compared health status measures across populations. The TVIS on the MCHB website is used often as a means of comparing health status measures for Kansas with those of other States.

The State has very limited capacity to generate and analyze primary data to address State and local knowledge gaps although there is some work in this area to generate CYSHCN data -- medical home, youth transition, and financial access. Information is needed beyond that available from the National CYSHCN Survey. Annual surveys are conducted to assess school nursing capacity. WIC conducts periodic family surveys. CYSHCN conducts regular surveys of family satisfaction with services.

Primary and secondary data are analyzed routinely and used in policy and program development across all BFH programs but the quality and consistency of the analyses varies based on staffing and other considerations. MCH grants to local agencies require local needs assessment to determine local priorities although capacity to provide training and technical assistance to the local agencies relating to the priorities is limited. Local agency epidemiological capacity ranges from highly sophisticated, primarily in urban areas, to very unsophisticated. Training of local staff to achieve some level of competence in use of data is ongoing. Training of State agency staff to achieve some basic level of competence across all BFH programs is ongoing as well. For the epidemiologists, specialized epidemiological training has been identified and completed. One such example is epidemiologist training in genetic epidemiology through the Sarah Lawrence College Public Health Genetics/Genomics certificate program.

Essential Service #2. Diagnose and investigate health problems and health hazards affecting women, children, and youth. BFH uses epidemiologic methods to respond to MCH issues and sentinel events. The Title V program engages in collaborative investigations and monitoring of environmental hazards (e.g., State schools for the deaf and blind, juvenile correction facilities, birthing centers) to identify threats to maternal and child health. The MCH epidemiologists participate in cross-bureau activities such as development of policies and procedures for cluster investigations to be observed by all programs.

The Title V program has been unsuccessful in applications to CDC for birth defects surveillance so the Title V program utilizes MCH Block Grant funds for some limited activities in this area. The Title V program continues to pursue federal funds to implement a law passed in the 2004 session giving the State agency statutory authority for birth defects surveillance. A formal request has been sent to CDC requesting on-site technical assistance to assess current efforts and to develop a plan and budget for future development efforts.

During the 2010 session, statutory authority to utilize birth certificate data to survey recent mothers was obtained largely through the efforts of the Blue Ribbon Panel on Infant Mortality. This legislation opens the way for Pregnancy Risk Assessment Monitoring System (PRAMS) and Fetal-Infant Mortality Review (FIMR) efforts in the state. Increasingly, the MCH epidemiologists serve as the State's expert resource for interpretation of data related to MCH issues. The Title V program is regularly consulted on MCH data issues and staffs participate as experts in planning processes. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the Kansas Perinatal Council. Title V serves on the state Child Death Review Board and serves as interface in information sharing for implementing community-based interventions. Through the MCH needs assessment process, Title V uses epidemiologic methods to forecast emerging MCH/CYSHCN threats that can be addressed through planning processes.

Essential Service #3. Inform and educate the public and families about maternal and child health issues. Title V has no health education plan per se and no dedicated health educators. These functions are incorporated into the job duties of all Title V staff. There is no dedicated funding for health education activities, such as for print or media campaigns, although this may change with new priorities of MCH 2015. The CYSHCN program incorporates information and education to

the public and to families about medical home, transition and other at specialty clinics as a routine part of its activities. Grants to local agencies and organizations encourage health education activities at the local level with the new focus on prevention/wellness, social determinants, life course perspective and health equity.

Title V engages in population based health information services, providing health information to broad audiences. Title V collaborated with Kansas Action for Children on a statewide media campaign to raise public awareness about the importance of oral health for pregnant women and children. MCH partnered with the March of Dimes on a public health education campaign on the importance of folic acid and also on prematurity. Title V partnered with early childhood programs on dissemination of information about text4baby, with WIC services on breastfeeding promotion. CYSHCN has expanded information resources available to families through the toll-free number and website.

The public information office of KDHE has new capacity and assists programs with public information through news releases, press events, print material development, website development, response to news reporters and related services.

Essential Service #4. Mobilize community partnerships with policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems. The Kansas Title V program is strong in this area, responding to community MCH concerns as they arise, regularly communicating with community organizations. Needs assessments and planning activities engage community audiences on state and local needs. The Title V program supports the office of health care information to produce issue- and population-specific reports that are distributed widely in the state. Informal mechanisms are utilized to obtain input into the Title V program on MCH/CYSHCN needs.

The 5-year state needs assessment process is a formal mechanism for obtaining community input into the program. Funding and technical assistance are provided to local providers for services that are determined locally through a community needs assessment process. No additional funding is available for local programs to establish community advisory boards but grants to local health departments and other community organizations encourage liaison with city and county policy makers, school officials, and other local groups. Kansas Title V supports coalition and stakeholder groups primarily through technical assistance, although as in the case of the State Early Childhood Comprehensive Systems (SECCS) grant, funding may also be provided for planning activities. For the implementation phase of SECCS, Title V has maintained both supportive and leadership roles. The SAMHSA LAUNCH initiative builds a local coalition in the Finney county area with a focus on early childhood systems.

Title V has been assigned responsibility for coordinating the Governor's Child Health Advisory Committee (CHAC) charged with developing recommendations relating to immunizations, newborn screening expansion, school health education, and physical fitness/nutrition. The President of the Kansas Chapter of the AAP, heads the group of 18 appointees. CHAC recommendations to the KDHE Secretary translate to policy and program initiatives.

Essential Service #5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families. Title V assembled a Panel of Experts for the state needs assessment, MCH 2015. Title V plays a major role in development and implementation of the State Early Childhood Comprehensive Systems strategic plan, Bioterrorism planning, Continuity of Operations Planning, H1N1 planning, and planning for the Healthy Kansas 2020 process to determine priorities for the State agency. MCH/CYSHCN routinely lead and/or participate in data-driven decision making and planning activities. The annual and five-year Title V grant application and needs assessment cycle assures a systematic review of progress on objectives. Title V actively promotes the use of scientific knowledge bases in the development, evaluation, and allocation of resources for policies, services, and programs. A project underway for the MCH epidemiologists is production

of the MCH Biennial Summary. The national and state performance measures serve as the basis for this report.

In 2009, the Secretary of KDHE convened a Blue Ribbon Panel on Infant Mortality to make recommendations on reducing Kansas' high infant mortality rate (2004-2006 MMWR Vo. 58, Number 17). Title V facilitated this effort. The Panel adopted a set of preliminary recommendations and agenda for the 2010 legislative session. Multiple organizations including March of Dimes and Kansas Action for Children advocated for these measures. The result was passage of amendments to the vital statistics statutes removing barriers to the use of birth certificates for MCH surveillance. Effective July 1, 2010, PRAMS or PRAMS-like surveys of recently delivered women will commence. The law will also facilitate access to data for FIMR projects in Kansas City and Wichita.

Formal advisory structures advise and assist KDHE on MCH/CYSHCN issues: the Kansas MCH Council, the CYSHCN Family and Youth Advisory Councils, and the Integrated Community Systems for CYSHCN grant council. Parents from Families Together, the State Affilliate Organization of Family Voices, participate. MCH/CYSHCN facilitates meetings of these groups throughout the year and solicits input on major issues impacting the health of mothers and children. MCH epidemiologists are available to support the deliberations of the groups.

Other groups convened are the Newborn Screening Advisory Council, the Sound Beginnings Advisory Council (newborn hearing screening), Genetics State Plan group, Nutrition and WIC Advisory Committee, Interagency Coordinating Council for special needs infants and toddlers, and the Family Planning Advisory Committee. Generally groups meet on a quarterly or as needed basis.

Kansas Title V regularly utilizes data available within the department as well as data from other agencies and organizations (state, local and/or national) to inform State MCH health objectives and planning. Recently, early childhood organizations requested MCH epidemiological support in developing the needs assessment for the Kansas application for federal home visiting funds. The annual MCH Block Grant utilizes a systematic process to produce an overview of the health of all mothers and children in the State.

Title V staffs are involved in multiple State-level advisory councils: Governor's Commission on Autism, Kansas Commission on Disability Concerns, Head Start, Kan-be-Healthy, Traumatic Brain Injury, Assistive Technology, and State Hunger Task Force. Routinely, staff partner with other agencies and programs listed in the collaboration section of this application. Title V has a number of formal interagency agreements for collaborative roles such as the agreement for the Individuals with Disabilities Education Act (IDEA) programs of Part C (located in the State health agency) and Part B (located in the State education agency); agreement with the Interagency Coordinating Council, agreement with KU's poison control center to assist in national certification efforts, KHPA/KDHE interagency agreement primarily focusing on Medicaid and SCHIP.

Title V has contributed to the planning processes of several State initiatives. Routinely, Title V staff are consulted by others needing guidance on MCH population services. Over time there has been a pattern of a gradual shift towards other programs developing independent capacity to address traditional MCH issues. Two examples of this shift are: hiring of a staff person within the Bioterrorism program to address MCH issues and development of programs to address needs of school aged population by chronic disease through the CDC Coordinated School Health grant. Still, Title V serves as the representative of the State health agency at key meetings such as public/legislative hearings relating to MCH/CYSHCN issues.

Essential Service #6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being. Title V has not coordinated a formal review of legislative and regulatory adequacy and consistency across all programs serving MCH populations for many years. Instead, there have been a number of

reviews of specific legislation or regulations due to emergent policy or program issues.

Title V participated with child care licensing and the Kansas Perinatal Council in a review of outdated birthing center regulations. The group recommended that the State adopt national standards for birthing centers. The regulations have been finalized and are soon to be adopted. This year, newborn screening and birth defects reporting regulations were amended to account for the expansion of newborn screening testing.

Title V staff routinely provide oral and written briefings to policy makers on maternal and child health issues. Examples of these activities include testimony in legislative hearings, issue papers, and briefs. Subject matter may be on a wide range of issues and advisory committee members from university and clinical areas may be called on to participate.

As part of the KDHE budget process, MCH puts forward proposals for legislation, budgetary or regulatory changes each summer. In late summer, proposals are reviewed by an internal executive team and selected as priorities for the State agency. These are incorporated into the budget that is submitted to the Governor in early Fall. A new development for 2010 is a June retreat for directors in the division of health that will be used to select key priorities for the 2011 session.

Title V staff are encouraged to participate in professional organizations and to engage with other State agencies in the development of licensure/certification processes. Title V provides leadership to the development of quality standards of care for women, infants and children in collaboration with other agencies and organizations such as Medicaid's EPSDT Advisory Board, Hearing Screening Guidelines and Vision Screening Guidelines, birthing center regulations. Specialty clinic standards are another standard setting activity. The Title V program has collaborated with Medicaid and SCHIP to incorporate MCH standards and outcomes such as the low birth weight Pregnancy Improvement Project with First Guard, adoption of the CYSHCN definition in managed care contracts, and use of the CYSHCN program for consultation regarding care. MCH promotes Bright Futures as the standard for local MCH agencies throughout the State. MCH/CYSHCN staffs have been involved in policy and legislative initiatives for child passenger safety seats, child care health consultation, regulations relating to community-based and faith-based organizations that serve pregnant women.

MCH conducts on-site reviews of local agencies and allocates staff resources to provide technical assistance. Training and technical assistance are increasingly provided through new technologies such as on-line training (KS-Train) and Go to Meeting. The MCH aid to local program has initiated a risk-based schedule for reviews of local agencies to improve efficiency.

Essential Service #7. Link women, children and youth to health and other community and family services and assure quality systems of care. The Kansas Title V program develops, publicizes and routinely updates its Make a Difference Information Network (MADIN) toll-free line. The program uses the State language assistance contract to obtain interpretation services as well as Spanish-speaking staff. There are plans to use print materials, website and other means to publicize the line. At all points of contact with women, children, and families the Title V program provides verbal information and/or print materials about publicly funded health services. The Title V program assists localities in developing and disseminating information and promoting awareness about local health services through such activities as community resource and referral lists that are maintained at each local service site. There has been no systematic effort to evaluate the effectiveness and appropriateness of efforts to link women and children with services.

Kansas Title V coordinates with managed care organizations (MCOs) on outreach and home visiting services for hard to reach populations. Innovative methods of providing services such as one stop shopping in Wyandotte County and CYSHCN involvement in Juniper Gardens have been encouraged although there has been no funding for these efforts. Technical assistance is

provided at conferences and during on-site visits to local agencies, also to providers in identifying and serving hard-to-reach populations. BFH disseminates information on best practices to local agencies, providers, and health plans across the State.

Tracking systems for universal, high risk and underserved populations have been utilized for newborn metabolic screening and newborn hearing screening follow-up. There has been some use of the birth defects statutes that permit program information and brochures to be mailed to parents of children with high risk conditions noted on the birth certificate.

MCH and CYSHCN link families with services. Partial support for direct services is provided only when not otherwise available. Examples of these services are: child health assessments for school entry through local health departments for uninsured and underinsured children and CYSHCN medical specialty clinic services.

Resources are provided to strengthen the cultural and linguistic competence of providers and to enhance their accessibility and effectiveness. CYSHCN and other staff routinely authorize interpreters at out-patient appointments for families who have English as a second language and also for those who phone for assistance. Interpretation services are available within KDHE through the public information office and the farm worker health program. All staff participate in cultural competency training as well as continuing education opportunities as these are available. The Title V program assures that local health departments and other local agencies interface with culturally representative community groups and prepare outreach materials and media messages targeted to specific groups. When there are vacant positions, there has been an effort within MCH to recruit persons of color and bilingual staff in partnership with Human Resources.

Despite a number of challenges to MCH-Medicaid collaboration due to organization changes, the staffs of Medicaid and MCH continue a close working relationship. The update of the KHPA/KDHE Interagency Agreement (Title V/Title XIX) was finally completed in Fall 2009. Staffs meet with foundations, professional organizations and other potential partners regarding established and new ventures. Interagency agreements are routinely reviewed for effectiveness and appropriateness. Kansas works with the Medicaid agency and its contractors, and public/private providers on enrollment screening procedures, tracking of new enrollee utilization of services, and consumer information.

MCH/CYSHCN provides leadership and resources for a statewide system of case management and coordination of services by convening community providers and health plan administrators to develop model programs and linkages. The Title V program distributes best practices information through conferences, website, and program-specific training. Kansas provides leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CYSHCN including: cross-agency review teams; developing and monitoring risk-appropriate standards of care; and, routine evaluation of systems.

Essential Service #8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. A link between the Title V program, the school of public health, and other professional schools to enhance state and local analytic capacity has been established. Internship/practicum students have been utilized. In 2009, a summer intern assisted with development of H1N1 and Pregnancy: FAQs that was posted on the KDHE Web site and utilized in training for Healthy Start Home Visitors during the fall regional training by MCH staff. For 2010, the CYSHCN program will have a summer intern for its Integrated Systems grant.

Academic partnerships, joint appointments, adjunct appointments, and sabbatical placements have been considered but not undertaken. Title V staff occasionally guest lecture at professional schools in the State such as the school of social welfare and the public health certificate program. MCH/CYSHCN collaborates with the primary care program to monitor changes in the public health workforce. Resource inventories of facilities and programs are also available through this

source. Geographic coverage and availability of services and providers are monitored. The 5-year State needs assessment addresses to some extent workforce issues and workforce gaps as these pertain to overall program planning. Examples of activities to address workforce shortages include: Title V coordination with Medicaid, the Kansas School Nurse Organization, the Kansas Association of Local Health Departments, and others to assure statewide fluoride varnish training for nurses. Another example is coordination with Head Start, Early Head Start and other early childhood providers to adopt a quality curriculum for home visitors in the State and assure consistent training for home visitors across all programs.

Kansas MCH/CYSHCN builds the competency of its workforce through support for continuing professional education for staff. All staffs maintain an Individual Professional Development Plan (IPDP). They participate in orientation and training and in ongoing in-service education. Title V staff are encouraged to log on to mchcom.com archived materials to obtain information on emergent issues. Staffs participate in UIC Leadership Conferences, the annual AMCHP meeting, and other in-state and out-of-state education opportunities. In-service meetings are held each month. Topics and speakers are drawn from suggestions of participants. All supervisors collaborate with State human resources office in establishing job competencies and qualifications. If relevant, Title V includes job qualifications in contract requirements with local agencies as, for instance, in requiring multidisciplinary teams for prenatal care coordination services, or nursing/social work for case managers.

Essential Service #9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services. MCH/CYSHCN evaluates outcomes of the services provided. This occurs through outcomes reporting and routine monitoring of all funded services. For some services such as Family Planning and Healthy Start home visiting, patient satisfaction with services is routinely assessed and there is a feedback loop with providers. For others there is submission of qualitative and quantitative data by local projects that is assessed and included in the grant application and the grant review. Some but not all require submission of an evaluation plan. For others such as the SAMHSA LAUNCH grant, a contract is secured with an outside evaluator in academia. Technical assistance may be provided to local agencies to design, analyze, and interpret their data depending on the program. State data is available to local agencies to facilitate implementation of their community assessments and evaluations through Kansas Information for Communities, Kansas Health Institute, and other data sources.

Consumer satisfaction is routinely assessed for all programs. Various mechanisms are used to assess satisfaction including mail-in postcards provided at the time of the service, phone surveys, family advocacy feedback, and focus groups. The Families Together contract includes a requirement for assessment of client satisfaction with services. Title V performs comparative analyses of programs and services when data are available across different populations or service arrangements such as for family planning or WIC. Special satisfaction surveys and focus groups have been conducted with families participating in CYSHCN and attending CYSHCN clinics. As requested, the results of monitoring and evaluation activities are reported to program managers, policy makers, communities and families/consumers. When there are deficiencies, corrective action is taken.

The Title V program disseminates relevant State and national data on "best practices." MCH plans quality improvement activities and communicates these to local agencies and other groups as needed. Information from evaluation and quality improvement activities does not necessarily translate into programs and practices. Interest groups outside the Title V agency are likely to influence program and policy development. Thus, there is a need for stakeholder involvement in all phases of planning, program development, operation, and evaluation.

The Title V program has not identified a core set of indicators for monitoring outcomes of private providers and is not currently at the table in discussions with insurance agencies, provider plans, and others about the use of MCH outcomes in their own assessment tools. An exception to this is the SECCS plan. MCH is a key partner in development of core indicators for early childhood

health.

Essential Service #10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems. The MCH program disseminates ZIPS, a monthly newsletter which abstracts current MCH research and reports to the readership. Staffs engage in research on a very limited basis. Examples of the types of research undertaken this year include an analysis of risk factors for newborn hearing screening loss to follow-up and loss to screening. An ongoing research project is that in partnership with Medicaid using hospital discharge data showing relative health status and health outcomes of women and children covered by public/private insurance plans. When research is undertaken, it is widely disseminated upon completion. MCH and KDHE are highly regarded for the availability of high quality data regarding many diverse health-related issues. Only very limited staffing resources are available for research, for local demonstration projects and special studies. Much of the research work is of a collaborative nature and done in consultation with other individuals inside and outside the agency.

/2012/ There have no major changes in agency capacity since last year's submission. //2012//

/2013/ There are no major changes in agency capacity since last year's submission. //2013//

C. Organizational Structure

The Secretary of the Kansas Department of Health and Environment (KDHE) is appointed by the Governor and serves on the Governor's Cabinet. The Secretary reports directly to the Governor. Previously four division diectors reported to the Secretary. In 2005, the four divisions were consolidated into two: Health and Environment. Health encompasses vital statistics and Environment now includes the state laboratory. The Director of Health, Jason Eberhart-Phillips, serves as the State Health Officer a position he has held since February of 2009. His background in chronic disease, epidemiology, and local health department management makes him uniquely qualified to serve in this role.

The Division of Health has eleven bureaus: Disease Control and Prevention (infectious disease); Bureau of Environmental Health (lead screening and abatement, radon, environmental tracking); Bureau of Family Health (maternal and child health); Bureau of Child Care Licensing and Health Facilities (child care & hospital regulation, credentialing); Bureau of Local and Rural Health (primary care, farmworker health); Bureau of Health Promotion (chronic disease); Bureau of Oral Health; Bureau of Public Health Preparedness; Bureau of Surveillance and Epidemiology; Bureau of Public Health Informatix; and the Bureau of Minority Health.

The Bureau of Family Health (BFH) administers the $4.7M MCH Services Block Grant. BFH has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services(MCH); and Children and Youth with Special Health Care Needs (CYSHCN). The organization charts for the agency, the BFH and the four sections are attached as PDF files. Also, refer to the website at www.kdheks.gov/bcyf.

Within the Bureau there are a number of cross-cutting initiatives such as nutrition, breastfeeding, oral health and epidemiology. The Bureau has two epidemiologists that serve as consultants to all programs. They interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. One epidemiologist serves as the State Systems Development Initiative project coordinator. Both epidemiologists coordinate all data analyses for the MCH/CSHCN needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH. Each of the Sections is attempting to build data capacity through staff training and education and rewrite of job descriptions to require data skills for new hires.

The Children & Families Section is responsible for: 1) Systems development activities for perinatal systems of care including coordination with Perinatal Association of Kansas; 2) Systems development for child, school and adolescent health care, in partnership with the Kansas Chapter of the American Academy of Pediatrics, Kansas School Nurse Association and others; 3) Maternal and Child Health grants to assist local communities to improve health outcomes for pregnant women and infants and for children and adolescents; 4) Women's Health Care and Family Planning - Systems of care and grants to communities to support the health of women in their reproductive years; 5) Other grants targeted to specific populations and needs - school nurse/public health nurse collaboration.

Children and Youth with Special Health Care Needs assumes the following responsibilities: 1) Systems development activities - promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized services and service coordination, quality assurance, and community field offices; 2) Make a Difference Information Network (MADIN) - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. MADIN serves as the MCH toll-free line; 3) State implementation grant for Integrated Community Systems for CSHCN; 4) Newborn Metabolic Screening - Assures identification and early intervention for infants with metabolic disorders.

The Children's Developmental Services Section includes the following programs: 1) Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delay and disorders through child find, services coordination (case management), resource referral and development, and direct service provision for eligible infants and toddlers and their families; 2) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants including a hearing aid loaner program for young children; 3) Interagency coordinating Council - advisory committee to Part C of IDEA. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members. http://www.kansasicc.org/

The Nutrition and WIC Services Section includes the following programs: 1) Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals; 2) the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Provides nutrition education, breast-feeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services; 3) Breastfeeding -- Peer Education Program - small grants to local agencies to assist with peer-to-peer education. This unit also supports the State Breastfeeding Coalition.

The State health agency is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. When funds are allocated to other programs outside the BFH, the Bureau maintains legal contracts for the use of the funds, or in the case of funds allocated to other programs within the KDHE MOUs clarify the nature of the work that is done in support of the MCH priorities.

Official and dated organizational charts that include all elements of the Title V Program and how it fits within the state agency, clearly depicted, are on file in the State Human Resources office and are available in the attachment.

/2012/ In January of 2011, Robert Moser MD was appointed by the new Governor to serve as both the Secretary of KDHE and the Director of Health. Dr. Moser graduated from the University of Kansas School of Medicine and served four years in a medically underserved rural area of the state after his residency. He then worked for 22 years as a family physician in a small western Kansas town in Greeley County.

Dr. Moser is Board Certified in Family Practice, a Fellow of the American Academy of Family Physicians, and holds Certificates of Added Qualifications from the American Board of Family Physicians in Sports Medicine and previously in Geriatrics. He is past President of the Kansas Academy of Family Physicians. Other service includes: Executive Board of Directors for the Kansas Practice-Based Research Network.; senior delegate for KAFP to the AAFP congress on delegates; rural health committee for AAFP; Commission on Government Advocacy; AAFP liaison to the American College of Obstetrics and Gynecology Committee on Professional Liability. Dr. Moser is on the American Hospital Association Committee for Small and Rural Hospitals; special assistant to the Executive Vice Chancellor, University of Kansas School of Medicine; Chairman for the coordinating committee of the Kansas Primary Care Collaborative.

Dr. Moser will head the Executive Reorganization Order (ERO 38) merger of two state agencies: KDHE (State MCH Agency) with the Kansas Health Policy Authority (State Medicaid Agency). Officially this merger will take place July 1, 2011. Some preliminary work has been accomplished in merging the agencies with twelve individuals moving to Curtis building from Landon. Also, contractors are being interviewed who will guide key agency staff through strategic planning relating to the merger. //2012//

/2013/ An Executive Reorganization No. 41 which consolidates the financing arm of Medicaid as the third division, (Division of Health Care Finance) within the Kansas Department of Health and Environment. The reorganization renames the Department on Aging as the Department for Aging and Disability Services and consolidates all disability waiver and mental health services from the Department o f Social and Rehabilitation Services into the Department for Aging and Disability Services. The reorganization renames the Department of Social and Rehabilitation Services as the Department for Children and Families.

Within the agency (KDHE), internal reorganization that includes merging the Bureau of Family Health and the Bureau of Child Care and Health Facilities takes effect July 1, 2012. Details of the process are fluid. The Acting Bureau Director of Child Care and Health Facilities, Rachel Berroth, will be the new Bureau Director. David Thomason, Acting Director of the Bureau of Family Health will be the new Deputy Bureau Director. An updated organizational chart is not available at this time.
//2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Describe the number of location of staff that works on Title V programs. Include those that provide planning, evaluation, and data analysis capabilities. Include qualifications in the form of a brief biography of senior level management employees in lead positions. Also include number and role of parents of special needs children on staff. In addition, provide other MCH workforce information that may be available, such as FTEs at State and local levels, tenure of the State MCH workforce, and projected changes to the MCH workforce in the coming year.

The BFH has 57.5 full-time equivalent (FTEs) positions. Four (4) FTEs including 2 epidemiologists are located in administration. CYSHCN has 11.5 FTEs plus 4 Newborn Metabolic screening. This includes three RNs. Children & Families Section has 11 FTEs including 5 RNs. Children's Developmental Services has 8 FTEs in Part C and 4 in Newborn Hearing Screening. This includes one audiologist. There are a total of 15 FTEs in Nutrition and WIC including 5 nutritionists. None of these positions are out-stationed in local or regional offices.

MCH Block Grant funds provide salaries for 22.5 FTEs or 40% of the staffing in the Bureau. This breaks out to 4.0 FTEs in Administration, 9.5 FTEs in CSHCN, 6.0 FTEs in C&F Section, 2.0 in CDS, and 1.0 in WIC.

Since 2000, Linda Kenney has served as Director of the bureau and Kansas Title V Director. From 1989-2000 she served as Director of the Children and Families Section in the Bureau. She served briefly as director of the state breast and cervical cancer screening program and director of a state mental hospital-community transition project, case management supervisor for a community disability organization, and director of a local family planning clinic. She has served on the Board of the Kansas Public Health Association (KPHA), and on a number of state and federal advisory groups relating to maternal and child health. She holds an MPH degree in Health Services Administration from the University of Pittsburgh, Pennsylvania and a bachelor's degree from Indiana University. In addition to the four Section Directors, three other staff report to her including the two epidemiologists. /2012/ The MCH/BFH Director retired in June 2011 after serving 25 years in state service. The position is vacant at the time of submission and a recruitment effrort is underway. The CYSHCN Director is serving as Acting MCH Director until a replacement is hired. //2012//

Marc Shiff serves as the State CYSHCN Director. He has a Master's of Public Administration degree from the University of Texas at Dallas with concentrations in Public Health and Resource Management. His Bachelor of Science degree in Management and Social Science is also from the University of Texas at Dallas. Prior to his current position, he served as Director of Operations and Services for the KDHE Bureau of Disease Control and Prevention and as Programs Manager for the University of Kansas Medical Center, Kansas City, providing medical, nursing, and allied health continuing education oversight. He was appointed to the Governor's Commission on Autism Task Force, and is a member of the Kansas Department of Social and Rehabilitation Services Traumatic Brain Injury advisory board, Kansas Developmental Disabilities Council, Kansas Families Together Advisory Council, and past State Co-Chair of the Kansas Community Planning Group. Shiff was selected to particpate in the MCH Leadership Development program. Fifteen CYSHCN/NBS Topeka staff report to him and he provides CYSHCN program support and guidance to 7 field contractor staff in Kansas City and Wichita. ***/2013/ Shiff is Region VII AMCHP Director and Chair of the AMCHP Governance Committee. //2013//***

Ileen Meyer is a professional registered nurse with experience in services to the pediatric and young adult populations during her 35 year career in public health. She holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 10 FTEs (5 nurses, 2 program planning and evaluation, 1 data entry and 2 clerical). ***/2013/ The Section Director of the Children and Families section retired in December 2011. The position is vacant at the time of this writing. //2013//***

The Section Director of the Children's Developmental Services section retired in April 2010 after serving 10 years in her position. The position is vacant at the time of this writing and a recruitment effort is underway. /2012/ In June of 2010, Sabra Shirrell was hired to fill this Section Director position. Sabra has a BS degree in Family and Child Development, Community Services from Kansas State University. She has a Masters degree in Early Childhood and also certifications in Early Childhood and Early Childhood Special Education. Prior to assuming her current position, Sabra worked with the Part C of IDEA program in KDHE as a health consultant. She worked as the coordinator of Successful Connections in Shawnee County through Southeast Kansas Education Service Center serving as staff to the local interagency coordinating council among other duties. She has worked as an early childhood special education teacher, and

Director of Children's Developmental Services at TARC, the Part C network in Shawnee County. //2012//

David Thomason is the Director of Nutrition and WIC services. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. Thomason has completed the Kansas Public Health Certificate Program. He has served as President of National Association of WIC Directors (NAWD).
Thomason manages a staff of 15 FTEs (5 nutritionists, 1 RN, 2 information systems, 4 program analysts, 3 clerical). BFH staffs have been appointed to a number of Governor's Initiatives: State Hunger Team, Blue Ribbon Task Force on Immunization, Bioterrorism Coordinating Council, and State Developmental Disabilities Council. ***/2013/ Thomason is the Acting Director of the Bureau of Family Health and Director of Nutrition and WIC Services. //2013//***

Other staff holds national offices: Sandy Perkins, WIC Nutritionist, is director of Association of State and Territorial Nutrition Directors; Jane Stueve is President of National Association of State School Nurse Consultants.

The only change to leadership in the BFH (the CDS Director) has been noted above.

The CYSHCN Family Advisory Council is comprised of parents and caregivers of children and youth with special health care needs. Efforts have been made to select families that represent geographical areas of the state, ethnic populations, and health categories supported by the state's training and information center for parents, Families Together Inc. The CYSHCN Family Advisory members are regarded as expert consumers as well as partners and their opinions are sought and incorporated on a variety of issues. Examples include the evaluation and implementation of the 5 year needs assessment, how to best disseminate/update information to families, and input on the design of the toll free information line and web-based companion. Family Advisory Council meetings occur in-person and via teleconferences throughout the year to maximize family's engagement.

The CYSHCN - HRSA D-70 Integrated Community Systems grant "Systems in Sinc" Advisory Council links families and youth with special health care needs with information and services for YSHCN. As members of the Advisory Council, parents of youth with special health care needs are able to provide feedback and input on project activities to ensure that identified objectives are met. Consumers are the central focus of these efforts. Parents are also represented on the Quality Improvement team that will meet in Washington, D.C. in June 2010 to ensure parent participation and involvement on all levels of the grant project. Family members participated in the 8 regional town hall meetings and provided feedback and input on a variety of topics related to transition and health for youth with special health care needs. A Youth Advisory Council is in development to ensure youth participation and input is central to the project. Parents of our youth advisory members are provided with trainings or opportunities to share information and discuss important issues and topics related to their youth's transition and development.

E. State Agency Coordination

Coordination within the State Health Agency

MCH and CYSHCN work with a number of program areas on public health issues. Office of Local and Rural Health (Primary Care Cooperative Agreement, district nurse consultants, community health assessment coordination, Farmworker Health, Refugee Health, Trauma Registry), Bioterrorism and Preparedness, Bureau of Child Care Licensing (standards for health and safety in out of home care, inspections of residential facilities, state schools for deaf and blind and birthing centers), Bureau of Consumer Health (childhood lead poisoning and environmental

tracking and birth defects), Bureau of Health Promotion (Breast & Cervical Cancer Screening, Injury/Disability Program, Youth Tobacco Prevention, Diabetes Control, Kansas LEAN, Arthritis, 5 A Day, Kansas LEAN 21), Bureau of Epidemiology and Disease Prevention (HIV/STDs, immunizations).

There is good coordination with the Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening), Neonatal Metabolic Screening. There is a close working relationship with Center for Health and Environmental Statistics (perinatal outcome data, adequacy of prenatal care, hospital discharge data, and data linkages with Medicaid).

Coordination with Other State Agencies

Education and Social Services are the two State Human Services Agencies with whom MCH/CYSHCN frequently has contact. MCH works with the State Department of Education on health related issues for preschool and school-age children including guidance for school nurses and administrators (see the BFH website). The school nurse role has been expanded to include preventive and primary health care at school for children and youth who are at risk including the underinsured and uninsured. Delegation of nursing tasks to unlicensed school personnel is an ongoing education issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration staff meetings. This collaboration has served to strengthen the health services components for special health care needs students in local school districts.

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children. "Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CYSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CYSHCN have been developed are also underway for early childhood education programs and child care providers. Others areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

Schools, health departments, and primary care providers are encouraged to use "School Nursing and Integrated Child Health Services: A Planning and Resource Guide" in tandem with Bright Futures as the standard for provision of public health services to children. Multiple professional development opportunities are provided utilizing the statewide Area Health Education Centers (AHECs) and local area education service centers as training sites. It is anticipated that a day long video conferencing format will become the norm with facilitators available at times and sites convenient for any school district.

MCH/CYSHCN staff have frequent contact with Medicaid and SCHIP (HealthWave). MCH/CYSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes standards of care, and assures provider training. Local MCH agency dollars expended on Maternal and Child Health services are utilized as match for federal Medicaid dollars to provide prenatal case management, nutrition and social work service for high risk women as well as newborn postpartum home visits. These and other collaborative arrangements are formalized in the Interagency Agreement (updated in 2009 to include HIPAA and data sharing). MCH/CYSHCN staffs meet monthly with Medicaid and HealthWave staff to discuss mutual concerns and to plan for identified service needs. Medicaid includes information about the WIC program in its notices to clients reminding them of immunizations due. Medicaid and Family Planning did considerable work on a family planning waiver request that was never forwarded to CMS.

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, has developed a Medicaid reimbursement fee for a service system of early intervention services (such as occupational

therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Training was provided to teach the Infant-Toddler Networks how to use their providership numbers to bill for these services. In 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Steps were implemented to add developmental intervention services as a Medicaid reimbursable service as well.

For the high-cost services to special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both Medicaid and CYSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CYSHCN staff has direct access to Medicaid information on children eligible for both Title V and Title XIX/XXI.

An interagency agreement delineates mutual responsibilities between Title V and SRS focusing on referral of Supplemental Security Income (SSI) children and youth between the two agencies. A third party, the Developmental Disabilities Center assists in design of materials to improve reporting of reliable information to make an accurate determination of eligibility for SSI benefits, and recruitment and expansion of the SSI provider pool for SSI consultative examinations. Another development is training for providers who give consultative evaluations. CYSHCN staff has a B agreement in place that allows increased access to SSA data.

Through the Farmworker Health Program and with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

Title V works with Employment Preparation Services in SRS on issues such as teen pregnancy prevention and public health assistance for indigents. Title V has worked with Alcohol and Drug Abuse Services on a number of substance abuse issues including prevention programs for youth, identification and intervention for pregnant women, and treatment facility standards for pregnant substance abusers. Title V has worked with Mental Health on a state plan for adolescent health, youth suicide and other issues. MCH serves on the State Developmental Disabilities Council located in SRS. KDHE's Child Care Licensing works with Foster Care regarding quality of child placements. CYSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CYSHCN collaborates include the following: Kansas Department of Insurance on issues of public and private insurance coverage for the maternal and child population. MCH works with the Kansas Department of Transportation (KDOT) and the Kansas Board of Emergency Medical Services through the Injury Prevention program on data and policy issues. MCH/CYSHCN has participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. MCH has assisted the Kansas Department of Corrections on health standards for youth facilities, finding providers of prenatal care for pregnant inmates.

Coordination with Other Agencies and Organizations

University and other collaborations include the following: University of Kansas; Bureau of Child Research/Center for Independent Living; Life Span Institute; University Affiliated Programs, Kansas University Center for Developmental Disabilities, Lawrence and Parsons; Developmental Disability Center/LEND Program; School of Medicine; School of Social Welfare; Preventive Medicine; Mid-America Poison Control Center; Area Health Education Center; Wichita State University; Kansas State University; Cooperative Extension Kansas Nutrition Network; University

of Kansas School of Medicine - Wichita, MPH Program; Heartland Regional Genetics Consortium (to develop State genetics plan).

MCH works with professional groups, private non-profit organizations and others such as: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Academy of Family Physicians; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Missouri D70 project; Kansas Head Start Collaboration Project.

There is an interdependent relationship between the state and local public health agencies. Kansas' 99 local health departments (LHDs) serve all 105 counties. The local health departments are organized under city and/or county government. They are mostly reliant on county mill levy funding, although some modest per capita state formula funds are provided to each county. Contracts and grants from the state health agency provide a third significant source of funding. The staffs of the Kansas Association of Local Health Departments assure coordination with KDHE programs. LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities: regional public health meetings that serve as a forum for updates; technical assistance to local health departments regarding administrative issues, including billing, grant writing, budget, human resources, information systems, policy/procedures, HIPAA; technical assistance to local health departments regarding public health practice issues, including public health performance standards and competencies, as well as the MCH Core Public Health Services; collaboration with Heartland Center for Public Health Preparedness and University of Kansas School of Medicine, Department of Preventive Medicine and Public Health, for training sessions on cultural competency and diversity, risk communication, informatics, and public health law, through Kansas Public Health Grand Rounds series; distribution of resource publications and information necessary to support practice, including Connections Newsletter, Kansas Rural Health Information Service (KRHIS), OLRH website, Public Health Nursing and Administrative Resources Manual, and Domestic Violence Manual. Public health nurses maintain ongoing partnerships to support education/training for public health with state and regional training partners, including: Heartland Center for Public Health Preparedness, St. Louis University School of Public Health, University of Kansas School of Medicine, KU Public Management Center, Professional Associations, and Kansas Association of Local Health Departments (KALHD). Ongoing training activities include the Kansas Public Health Certificate Program, and the Kansas Public Health Leadership Institute.

Newborn Screening staff work closely with Heartland Genetics and Newborn Screening Regional Collaborative funded by MCHB/HRSA. Staff serves on the Advisory Committee for the Heartland Collaborative and on the Newborn Screening committee. Heartland has provided funding for Kansas to complete a State Genetics Plan. Stakeholders participate in this planning process along with MCH/CYSHCN staff, Cancer Control and Prevention and Chronic Disease staff. The stakeholders have met for two face-to-face meetings and participated in conference calls. The plan will be finalized in 2010.

Coordination with other Kansas MCHB Grants

KDHE staff is involved in numerous ways with grants that are awarded by MCHB to the State of

Kansas. MCH coordinates with the Kansas City Healthy Start awarded to the MCH Coalition of Greater Kansas City and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department the Directors of these two programs serve on the state Blue Ribbon Panel on Infant Mortality. The Kansas University Affiliated Program at the University of Kansas Medical Center works closely with the CYSHCN program staff and contract staff actually share office space with the program. Currently MCH staff serves on the advisory board for the Traumatic Brain Injury Implementation grant and have served in the past with the Healthy Child Care Kansas grant. Staff within the bureau directly administers the State Early Childhood Comprehensive Systems and the Universal Newborn Hearing Screening. MCH works closely with the Bureau of Oral Health on its grants, Emergency Medical Services for Children (EMSC) Partnership and other grants.

Collaborative activities between newborn hearing screening (Sound Beginnings) and Part C of IDEA local agencies have decreased the loss to follow-up between diagnosis and early intervention. Collaboration with the KU Area Health Education Centers has facilitated ten regional trainings for over 150 nursing and laboratory staff who are involved in the collection of blood spot cards for newborn screening. Collaboration between SIDS Network of Kansas and Healthy Start Home Visitors has helped provide safe sleep environments for infants at risk of SIDS and other sleep related deaths. 'Cribs for Kids' were distributed through this joint effort. Collaboration with the data people in the state social service agency (SRS) has resulted in some program changes and explanation of the trends we see particularly for TANF. There has been ongoing sharing of data between SRS and KDHE and future meetings are planned with the possibility of MCH epidemiologists assisting with analysis of their data.

There has been strong collaboration among KDHE, KSDE, Kansas In-service Training System (KITS), local infant toddler networks and statewide school districts' Part B programs, to develop, implement, and provide user training for an outcomes web system that tracks a child's functional progress in three developmental outcomes.

CYSHCN and newborn screening have worked closely together during the expansion from four to 29 conditions. The newborn screening advisory council is a very strong group of specialty doctors, parents and staff that meet four times a year to assess program process and outcomes. Information about new conditions has been shared to assure families receive diagnoses and treatments for their infants. Collaboration with the federal Healthy Start projects in Kansas City and Wichita has helped bring the state up to date about the value of Fetal-Infant Mortality Review. Collaboration with the Perinatal Association of Kansas has enhanced multi-disciplinary expertise to the state agency's approach to perinatal care and education activities. Consultation is provided to the department to help improve state perinatal outcomes. The state MCH/CYSHCN agency and the Kansas Chapter of the AAP adopt strategies to improve child and adolescent health outcomes.

The Kansas Reconvene Team in which state health and education agencies obtained training through the National Alliance of State and Territorial AIDS Directors, National Coalition of STD Directors, and others was instrumental in advancing a plan for building capacity in the areas of disparities and peer education. The fatherhood summit was a collaborative activity in which JJA, Catholic Social Services, KPIRC, and others developed a common goal, shared resources, provided educational events for families and providers to help people better care for their children.

A strong ongoing collaboration is between family planning and the breast cancer program, Early Detection Works. These two programs work together to help low-income women get follow-up care on their abnormal Pap smears. The child care health consultation training was an important collaboration among a variety of organizations/experts, Wichita State University, and KDHE. The project was a direct result of the collaboration between MCH and all the signators to the Kansas Early Childhood Comprehensive Systems State Plan. Another collaboration worth mentioning is that formed with the conveners of the SECCS Plan. This resulted in training for MCH/CYSHCN

staff on Results-Based Accountability. A collaborative activity with K-State Research and Extension Department resulted in downsizing and redefining the activities of the Kansas Nutrition Network, the USDA State Nutrition Action Plan, and the annual MOU review and revision. The Kansas State Department of Education, Special Education Services and Children's Developmental Services have forged a close relationship attending each other's meetings. MCH participates in their annual Leadership Conference. Monthly meetings continue to build this important partnership.

Kansas business case for breastfeeding train the trainer grant has helped us build a coalition of partners committed to workplace reform and policies that better support families. The Medicaid/MCH Interagency Agreement defines collaborative activities between the two programs as required by law. In 2009, an update to the document helped to strengthen our relationship. These are among the numerous collaborative activities and practices engaged in by the Kansas Title V.

/2013/ There are no major changes in agency coordination since last year's submission. //2013//

F. Health Systems Capacity Indicators

Introduction

Kansas monitors trends in Health Systems Capacity Indicators and utilizes the data to answer the following questions:

what has influenced Kansas' ability to maintain or improve the data and the systems assessed;
what strategies are/could be used to improve capacity in these areas; and
what interpretations may be made from the data.

Also, for HSCI 09A, what is the link between the State Systems Development Initiative (SSDI) grant and improved access to data.

/2013/ Kansas Maternal and Child Health (MCH) is building data infrastructure, epidemiological capacity, and products of analysis in order to carry out core public health assessment functions. We continue to improve Kansas MCH data capacity by: 1) improving data linkages between birth records and other data sets such as infant death certificates, Medicaid eligibility and/or paid claims files, WIC eligibility files, and new born metabolic screening files; 2) improving access to hospital discharge data, Youth Risk Behavior Survey (YRBS) data, Birth Defects Surveillance System (BDSS) data, Pregnancy Risk Assessment Monitoring System (PRAM) data, and Children and Youth with Special Health Care Needs (CYSHCN) program data; and 3) assuring ongoing MCH state needs assessment and review of performance/outcome measures.

HSCI 1: In Kansas, the rate of asthma hospitalizations has decreased 7.3% from 24.8/10,000 in 2009 to 23.0/10,000 in 2010. For the years 2001-2010, Joinpoint regression analysis showed a slight decreasing trend (APC=-0.79, not significant) over the interval 2001-2007 followed by a significant decreasing trend from 2007-2010 (APC=-11.64).

The disparity between black non-Hispanic children, white non-Hispanic children, and Hispanic children is of continuing concern. The hospitalization rate for black non-Hispanic children (57.3) is more than three times that of white non-Hispanic (18.6) or Hispanic children (15.3), which may indicate poor access to medical homes, the need for better quality of care for children diagnosed with asthma, poverty and living conditions, or other factors.

The Office of Health Promotion, KDHE (OHP) applied for a CDC grant in April 2009, but was not funded. If they were to get funded, they will revisit the Kansas Asthma Program (KAP) Work Plan and address these topics: 1) An operative statewide organization will define and guide Kansas asthma initiatives; 2) Regional and state level asthma data for Kansas

will be collected, analyzed, and disseminated; 3) a comprehensive evaluation plan will be designed and implemented; 4) reduce disparities among populations disproportionately affected by asthma; 5) reduce state asthma hospitalization rate; and 6) increase the proportion of people with current asthma who report that they have received selfmanagement education. More information can be found on the internet at http://www.kdheks.gov/bhp/download/Asthma_burden.pdf and http://www.kdheks.gov/bhp/download/Addressing_Asthma_in_Kansas.pdf.

HSCI 4: The percent of Kansas women (15 through 44) with a birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index (adequate and adequate plus prenatal care) was 79.8% in 2010, significantly higher than the previous year (79.0%). Over the 10 year period (2001-2010), Joinpoint regression analysis showed a significantly decreasing trend over the interval 2001-2008 (Annual Percent Change (APC) = -0.76) followed by an increasing trend from 2008-2010 (APC=1.53).

HSCI 5A: Selected demographic characteristics of Medicaid and non-Medicaid births

According to 2010 live birth certificate data, where payment source was known, Medicaid paid for the delivery of 13,159 (32.8%) Kansas live births, a 16.7% increase from 2009 (28.1%). There is some indication that this number/percent may be too low. The payer may be classified as self pay at the time the birth certificate data is collected and later designated Medicaid (SOBRA). The payer was known in 99.1% of live births.

Live birth certificate data (2010) indicates 7.1% of Kansas births were low birthweight. For Medicaid births, 8.8% were low birth weight compared to 6.2% for non-Medicaid births. The difference was statistically significant at the 95% level.

In 2010, in Kansas, where payment source was known:
Race and Ethnicity: About two-third (62.4%; n=1,720) of births to non-Hispanic black women were paid by Medicaid. More than one-third (36.0%; n=2,254) of births to Hispanic women were paid by Medicaid, followed by 29.4% (n=8,486) births to non-Hispanic white women were paid by Medicaid.

Maternal age: Among births to women aged 17 and less, 61.0% (n=682) were paid by Medicaid compared to 39.0% (n=436) of non-Medicaid recipients. About two-thirds of births to women ages 18 to 19 were paid by Medicaid (66.6%; n=1,794) compared to non-Medicaid recipients (33.4%; n=899). The proportion of births to Medicaid recipients ages 20 to 24 was 51.4% (n=5,481) compared to 48.6% (n=5,181) among non-Medicaid recipients. Among births to women ages 25 to 34, 21.6% (n=4,578) were paid by Medicaid compared to 78.4% (n=16,655) among non-Medicaid recipients. Among births to women ages 35 and older, 14.3% (n=624) were paid by Medicaid. Eighty-eight percent (85.7%; n=3,736) of births among women ages 35 and older were among non-Medicaid recipients.

Maternal education level: About 56.5% (n=3,747) of births to women with less than a high school was paid by Medicaid. Approximately 52.8% (n=4,918) of births to women with a high school education were reimbursed by Medicaid. Less than one-sixth (18.5%; n=4,428) of births to women with more than a high school education were paid by Medicaid.

Maternal marital status: More than half (62.5%; n=9,416) of births to unmarried women were paid by Medicaid compared to 14.9% (n=3,731) of births to married women were paid by Medicaid.

Studies show that income status impacts both health status and access to care. Medicaid data for Kansas support this. Medicaid enrolled women are least likely to have positive birth outcomes possibly due to greater likelihood of poor preconception health,

preconception and prenatal risk behaviors, limited access to early prenatal care and social supports, as well as possible greater exposure to prenatal stress.

MCH provides medical prenatal care at a few local sites and prenatal care coordination services to low-income and high risk women. Healthy Start home visitors link women and their families with community services and supports

HSCI 5B: Refer to HSCI 5A on selected demographic characteristics of Medicaid and non-Medicaid births.

In 2010, in Kansas, where payment source was known, the infant mortality rate was highest for the Medicaid service population (7.3 per 1,000 live births) and lowest for the non-Medicaid population (5.5). The overall infant mortality rate for Kansas was 6.2.

The MCH program has collaborated with the Kansas City federal Healthy Start Program to conduct Fetal-Infant Mortality Review (FIMR) recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) as a best practice strategy in helping communities identify the systems issues that need to be addressed to prevent infant deaths.

Direct source funding from the CDC, Sedgwick County Health Department (SCHD) Healthy Babies is able to continue funding the development and implementation of the FIMR project. In April, 2010, SCHD and KDHE, Bureau of Epidemiology and Public Health Informatics, entered into a contract that will allow the 2 agencies to work together to continue the SC FIMR thru 2012. The role of SCHD will be to carry out the functions of a local FIMR (including chart abstractions and the work of the Case Review Team (CRT) and Community Action Team (CAT); the role of KDHE will be to provide notification of death when an infant death occurs, provide technical assistance and data analysis support.

In May, 2010, SCHD Healthy Babies hired a part-time chart abstractor. In early, 2010, SIDS Network of Kansas committed to conducting the FIMR maternal interviews with the capacity to conduct 40-60 interviews per year. The part time FIMR chart abstractor was hired as the full-time SC FIMR Coordinator. The SC FIMR project was approved by the KDHE IRB. SC FIMR organized with state stakeholders a state infant mortality awareness campaign with the Office of Minority Health and Tonya Lewis Lee. SC FIMR Coordinator works closely with the Kansas Blue Ribbon Panel on Infant Mortality on state IM logic models. The SC FIMR CRT membership has grown to 60 community/medical members. SC FIMR 2010 FIMR data was shared with the CRT. In fall of 2011, SC FIMR presents the FIMR model at the KPHA state conference. In 2012, Kansas Health Foundation funds Basinet for SC, a web based data program to collect local FIMR data. In 2012, SC FIMR, Project Imprint, presents at the NHSA conference in Washington, D.C. In 2012, Working closely with KU School of Medicine in Wichita, SC FIMR completes first evaluation of the CRT. Project Imprint is making community changes with the initiatives from the four task forces from the Community Action Team. Project Imprint's first annual report will be released. Project Imprint is collaborating with KDHE on local PPOR data and to be shared with CRT. Project Imprint is working closely with counties throughout Kansas to develop new FIMR projects with partners, KAC, KHF, and United Health Ministry Fund.

HSCI 5C: Refer to HSCI 5A on selected demographic characteristics of Medicaid and non-Medicaid births.

In 2010, 75.1% of Kansas infants were born to women receiving prenatal care (PNC) beginning in the first trimester of pregnancy. Only 61.4% of Kansas Medicaid infants were born to women receiving PNC in the 1st trimester of pregnancy. Those not participating in Medicaid had the best access to early prenatal care at 82.0% (where payment source was known).

The eligibility level for pregnant women for Medicaid coverage in Kansas is 150% federal poverty level (FPL). Low-income undocumented women can qualify for Medicaid coverage under the Sixth Omnibus Budget Reduction Act (SOBRA). Both poverty status and undocumented status have been associated with delayed prenatal care.

HSCI 5D: In 2010, 79.8% of all live births were to women with adequate or adequate plus prenatal care. For Medicaid-enrolled women, 70.4% had adequate or adequate plus prenatal care, compared to 84.7% for non-Medicaid live births (where payment source was known).

Medicaid status is an indicator of poverty. Medicaid births include those covered by Sixth Omnibus Budget Reduction Act (SOBRA) for labor and delivery of undocumented women who meet the income eligibility requirements. Both poverty status and undocumented status have been shown to be associated with delayed prenatal care.

HSCI 6A, 6B, 6C: On 1 May 2011, Healthwave (Kansas SCHIP) increased legibility for children from 200% to 238% of 2008 Federal Poverty Level.

A number of significant changes were made in Medicaid policies in FY2011 that affect children. Kansas implemented express lane eligibility and allowed for passive renewal of Medicaid insurance for children. Beginning on 1 October 2010, all Medicaid eligible beneficiaries had hospice service limited to 210 days. On 1 July 2010, Kansas eliminated coverage for attendant care services in schools under the Medicaid School Based Services Program. To help prepare for an affordable care act requirement, Kansas Medicaid added concurrent care for children receiving hospice services.

HSCI 7A: Please note that for 2007-2010, the numerator and denominator are entered in reverse (because the percentage cannot equal 100%). The number of Medicaid-enrolled children receiving at least one service increased from 257147 (117.7%) in 2009 to 298994 (127.6%) in 2010.

Numerator: # of unduplicated consumers
Denominator: # of unduplicated Medicaid beneficiaries

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2009 can be paid in 2010, and services in 2010 can be paid in 2011.

Beginning with SFY 2007, Kansas Department of Social and Rehabilitation Services (SRS) implemented a PIHP (Prepaid Inpatient Health Plan) and PAHP (Prepaid Ambulatory Health Plan) waiver for substance abuse treatment and mental health services. With those waivers, all Medicaid persons not in a nursing home or incarcerated are now enrolled in a managed care organization for these services and a capitation payment is made for each person, each month. The timely filling requirements and the newer waiver payments may help explain why consumer counts are higher than beneficiary counts.

For timely data, claims are best reported on a "date of payment' basis, instead of a "date of service' basis. Medicaid timely filing rules allow for a claim to be submitted for payment up to 12 months after the date of service. This timing often creates situations where consumer counts are higher than beneficiary counts for a given month.

HSCI 9A: Kansas has the data capacity to support MCH programs including annual linkage of birth and infant death records, access to hospital discharge data, and birth defects reporting system. Kansas has no PRAMS. Currently, MCH is collaborating with Bureau of

Epidemiology and Public Health Informatics (BEPHI) to create an annual linked birth, Medicaid, WIC (Pediatric and Pregnancy Nutrition Surveilance System - PedNSS and PNSS) and hospital discharge dataset. The 2009 events were linked to conduct special studies and also to use to the vital statistics quality improvement activities.

Birth records are maintained within BEPHI. BEPHI is a continuing partner with MCH programs and provides limited analytic support. Resources limit the number of projects BEPHI and MCH/SSDI pursue. Both programs continue to pursue external grants to study the linked files, and have begun to solicit interest from academic researchers to perform secondary data analysis. Approximately 98% of all birth records in Kansas are submitted to BEPHI by a web-based electronic birth registration system (EBRS) and are uploaded directly into the birth record's database. The remaining 2% are submitted to BEPHI in hard copy, then keyed into the database. In 2011, BEPHI entered its seventh year of operation of a new Vital Statistics system that is composed of a web-based vital record registration system including a fully implemented electronic birth registration. In 2009, BEPHI created a position to focus on electronic quality assurance programming to identify and correct illogical and other data anomalies in the birth certificate data. In 2009, BEPHI implemented electronic death registration for physicians and continues to train physicians in this new system. In 2011 BEPHI strengthened the partnership on MCH evaluation by assigning a bureau Health Officer to oversee the two MCH epidemiologist positions. BEPHI continues to improve the MCH data on its web-based data dissemination site Kansas Information for Communities (http://kic.kdhe.state.ks.us/kic/index.html) to enhance the policy making potential of Kansas MCH data. BEPHI has also submitted multi-year trend data for eight natality indicators being tracked at the Kansas Health Matters community health needs assessment/community health improvement planning web site (http://www.kansashealthmatters.org/index.php) started by the Kansas Partnership for Improving Community Health.

Birth records and infant death: BEPHI links all deaths to Kansas residents, including infants, to the Kansas live birth certificate. BEPHI staff using the EBRS application and SAS programs have linked birth and infant death files (1994-2009). The 2009 match rate was 99.7%. Linking capacity was piloted in birth/WIC/Medicaid linking projects using 1999 and 2000 data. Network-shared, linked birth-infant death cohort files are used by agency epidemiologists for MCH research. Linked birth and infant death files are used for Perinatal Periods of Risk (PPOR) analysis. The linked birth and infant death information now is now in its third year of providing information for the Sedgwick County Health Department's Fetal and Infant Mortality Review (FIMR) project. The linked birth and infant death data has been used to support maternal and child health initiatives in a two county area surrounding a U.S. military base with high infant mortality. MCH and BEPHI continue to pursue opportunities for producing special analyses of these data.

Birth records and Medicaid / WIC: Medicaid eligibility or paid claim files were linked for 1999 and 2000 were linked in a pilot project. BEPHI completed the project matching birth records with both the mother's and the child's Medicaid eligibility files, as well as with the Medicaid paid claims files. The final report, "WIC-Medicaid-Vital Statistics Birth Records Matching" was completed in November 2003. These data were also provided to an academic researcher/medical epidemiologist who remains as an adjunct consultant to BEPHI. In 2011 BEPHI and MCH launched a formal effort to annual create linked files of vital events data to other datasets. The latest matching initiative builds on initial linked birth, Medicaid, WIC (Pediatric and Pregnancy Nutrition Surveillance System - PedNSS and PNSS) methodology to probabilistically link de-identified hospital discharge data and Medicaid claims information for 2009 events. In 2011 the Kansas Department of Health and Environment because the state's Medicaid funding agency, assuming responsibilities formerly held by the Kansas Department of Social and Rehabilitation Services and later by the Kansas Health Policy Authority (KPHA). KPHA is now a division of KDHE - Division of Health Care Finance (DHCF). This division administers the medical portion of the Kansas

Medicaid program, as well as the state Children's Health Insurance Program (CHIP, also known as "HealthWave"); MediKan, which provides coverage for certain low-income, disabled Kansans; the State Employee Health Program; and the State Self-Insurance Fund. This has resulted better access to Medicaid data. BEPHI now has access to eligibility and claims data.

Birth records and Newborn Screening: An electronic process has been developed that allows the hospital birth clerks or designated laboratory technician the ability to enter newborn screening data into their electronic birth records database. Some of the unique data fields include the newborn screening laboratory tracking/kit number, the collection date, the collection time and the current weight of the infant. These files are then transferred into the KHEL Laboratory Information Management System (LIMS). Fields from the newborn screening collection card/kit have been designed and beta testing is in process. The Newborn Screening Program (NBS) has met with the University of Kansas Medical Center, one of the state's largest birthing facility with a Neonatal Intensive Care Unit. KU Med is serving as one of the beta test sites that will be entering the NBS data into the electronic birth records.The bets testing is scheduled to begin June 1, 2012. The process of linking and updating the newborn screening primary care physician file (PCP) with hearing screening's PCP file has been completed. KDHE Information Technology (IT) and KDHE Newborn Screening staff matched and merged the two files so there will only be one file to update and keep current. This PCP file is needed to accurately report out testing results to the newborns' physicians. Newborn metabolic screening data are compiled annually and included in the National Newborn Screening Report to the National Newborn Screening Information System (NNSIS). MCH/NBS, KHEL, BEPHI and IT will continue to identify resources to improve data quality as well as linkage percentages for birth records and newborn screening files. Currently the work plan can be scored as a 3 with significant progress being made in the development of this new electronic link. The MCH/NBS, KHEL, BEPHI and IT staff will collaborate on this work plan to complete the data linkage project. A plan will be developed to train newborn screening collection facilities on the new process. IT staff has created a program in the current laboratory database that will accept the BEPHI download. The data will be used for: 1) fraud detection, 2) Medicaid claims reimbursement to the KHEL, 3) Electronic download of newborn demographic information from BEPHI directly to the laboratory database, and 4) verifying every newborn has been screened and obtains appropriate follow-up. The current link between these data sources is inefficient, requiring many manual steps between initial data entry and production of final reports. The previous data linkage has been discontinued due to lack of funding and personnel. MCH/NBS will continue to collaborate with KHEL, BEPHI and IT to resurrect this process and to improve data quality. The goal is to have an electronic link between the two systems by the end of the 2012 calendar year. This link will provide newborn demographic information directly from BEPHI to the laboratory database eliminating missing information, manual data entry, and tracking every newborn screened.

Hospital discharge data: Currently, BEPHI has an agreement with the DHCF for acquisition of Medicaid claims data and will continue to work for access to other data that are relevant to MCH programs. Presently, BEPHI has access to 2006 through 2012 Medicaid data. Annual updates will be requested for MCH use. Presently, BEPHI has 2000-2008 Kansas Health Insurance Information System (KHIIS) data, which are private sector health insurance data for MCH decision-support. Access to 2009 and 2010 KHIIS data has been requested. Annual updates will be requested from the Kansas Insurance Department.

HSCI 9B: The Kansas State Department of Education (KSDE) and KDHE's Bureau of Health Promotion (BHP) in partnership with local school districts conduct the Youth Risk Behavior Survey (YRBS). KDHE's BHP conducts the Youth Tobacco Survey (YTS).

YRBS: The YRBS is part of a biennial national effort led by CDC and is conducted by the

Kansas State Department of Education (KSDE) and KDHE in partnership with local school districts. The YRBS monitors health risks and behaviors in six categories, which are related to the leading causes of mortality and morbidity among both youth and adults. Data is collected on behaviors that contribute to physical activity, nutrition, tobacco use, alcohol and other drug use, violence and injuries, and sexual behaviors. The YRBS has been conducted in Kansas four times: in the spring of 2005, 2007, 2009 and 2011. A weighted high school sample was achieved each year from 41 to 51 high schools and 1,652 to 2,026 high school students in grades 9-12. A YRBS middle school (grades 6-8) sample was attempted for the first time in 2011, but did not garner sufficient sample for weighted data.

The YRBS results provide useful information that can be used to make important inferences about 9th through 12th grade students statewide due to the rigorous, multi-state random sampling methodology used to gather the data. Compiled results from the 2005, 2007, 2009 and 2011 Kansas YRBS can be found on the Healthy Kansas Schools Program website at www.kshealthykids.org, or on CDC's Youth Online website at http://apps.nccd.cdc.gov/youthonline/App/Default.aspx.

Healthy Kansas Schools (HKS) is a section of the Bureau of Health Promotion (BHP) at KDHE and is a shared program with KSDE. HKS will be conducting the YRBS in Kansas high schools and middle schools for the 2013-2014 school year. HKS will continue to share and promote the use of the data received with partners across the state. Reports are being developed for the dissemination of YRBS trend reports to public health partners and schools across the state.

Previously, the data was not considered representative of the youth population due to non-participation of some school districts. For the last four survey sessions, through joint work by HKS, KSDE and KDHE, Kansas has been able to collect quality, weighted data that is representative of the health behaviors of all students in the state. The data is also useful to the Title V program in tracking youth health behaviors. The Bureau of Health Promotion will continue to work through Health Kansas Schools in partnership with local school districts to maintain this level of participation.

YTS: The purpose of the Kansas Youth Tobacco Survey (YTS) is to monitor the prevalence, attitudes and knowledge, and other aspects of tobacco use, physical activity, and nutrition among adolescents in grades 6 to 12. The Kansas YTS is conducted once every two school years. The Kansas YTS was conducted in 2000, 2002, 2006, 2008, 2010 and 2012. Community-specific Kansas YTS were conducted in 9 communities in 2000, in 7 communities in 2002, in 4 communities in 2004, and in 17 communities in 2006 and 2008. The 2010 Kansas YTS was conducted at the state-level only and achieved a weighted sample. The surveys have been analyzed, and the associated reports and fact sheets are provided to county partners. The 2012 Kansas YTS was conducted at the state level and in two counties. The results of the 2012 YTS are being compiled by CDC and should be available in summer 2012. //2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

In Kansas, high standards of accountability apply to all maternal and child programs. This is due to scarcity of resources at the federal, state and local levels and through other funding sources such as foundations. Legislators and others require regular reports on best practices, performance and outcomes. Increasingly data is linked to funding decisions, mostly to achieve efficiencies but also to improve outcomes for certain target populations. The State budget including the BFH budget is based on performance and outcome measures linked to the spending plan. The Legislature requires strict accountability through annual reports and special reviews. An example of a special review is the Legislative Post Audit study on KDHE programs that address low birthweight. Other funding sources such as the Children's Cabinet which provides oversight of Tobacco Settlement funds requires each recipient of funds to provide an annual program evaluation summary including performance and outcome data.

Since 1999 BFH has included performance plans and performance information in its federal MCH budget submission. BFH submits annual reports to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) on the actual performance achieved compared to that proposed in the performance plan. This Section of the Kansas MCH Services Block Grant Application describes how the State-Local partnership will implement the federally-required performance reporting requirements.

The MCH Block Grant Performance Measurement System is an approach utilized by Kansas that begins with the state/local needs assessment and identification of priorities. Evidence-based strategies are identified to address each priority. The strategy(ies) selected are formalized in logic models and workplans. This culminates in improved outcomes for the maternal and child population.

After Kansas establishes its priority needs for the five-year statewide needs assessment, programs are developed based on best practices, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure-building activities. Since there is flexibility available to Kansas in implementing programs to address priority needs, the program activities or the role that MCH plays in the implementation of each performance measure may be different from that of other states. Kansas tracks its individual progress on up to ten unique State performance measures and Kansas tracks its progress on all national performance measures. Kansas compares its performance with the performance of other states using the Maternal and Child Health Bureau's Title V Information System.

Accountability in BFH programs is determined in three ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by budgeting and expending dollars in each of the four recognized MCH services: direct health care, enabling services, population-based activities, and infrastructure-building activities; and (3) by having a positive impact on the outcome measures.

While improvement in outcome measures is the long-term goal, more immediate success may be realized by positive impact on the performance measures. These are measures of short term and intermediate term change, and they are precursors of long term change in outcome measures. It is important to note the change in performance measures because there may be other significant factors outside BFH control affecting the outcomes.

/2013/ There are no major changes since last year's submission. //2013//

B. State Priorities

The Kansas comprehensive needs assessment, MCH 2015, was completed in 2009-2010. In all, ten priority needs were identified, four for pregnant women and infants and three each for children and adolescents and children/youth with special health care needs.

These are the resulting goals for each population group and the ten Kansas priority needs for 2011-2015:

Pregnant Women and Infants
Goal: Enhance the health of Kansas women and infants across the lifespan.

- All women receive early and comprehensive care before, during and after pregnancy
- Improve mental health and behavioral health of pregnant women and new mothers
- Reduce preterm births (including low birth weight and infant mortality)
- Increase initiation, duration and exclusivity of breastfeeding

Children and Adolescents
Goal: Enhance the health of Kansas children and adolescents across the lifespan.

- All children and youth receive health care through medical homes
- Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs (ATOD)
- All children and youth achieve and maintain healthy weight

Children and Youth with Special Health Care Needs (CYSHCN)
Goal: Enhance the health of all Kansas children and youth with special health care needs across the lifespan.

- All CYSHCN receive coordinated, comprehensive care within a medical home
- Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence
- Financing for CYSHCN services minimizes financial hardship for their families

This narrative will describe each priority need, Kansas capacity and resources to address each need, and relation of each to the national and state performance measures.

PREGNANT WOMEN AND INFANTS

1. Kansas women need early and comprehensive health care before, during and after pregnancy.

This priority need was originally selected for MCH 2010 based on state and regional Perinatal Periods of Risk (PPOR) analysis. PPOR was used as a tool to identify excess mortality and to suggest reasons for excess mortality. It suggested which community interventions were most likely to result in improved health outcomes. Kansas data pointed to a need to target the area of Maternal Health/Prematurity and corresponding preconception health, health behaviors, and perinatal care.

MCH 2015 needs assessment stakeholders reviewed the data and concluded that more needs to be done in this area. MCH needs to redirect resources to health education and health promotion activities at both the state and local levels. In addition, through partnerships with stakeholders such as private physicians, March of Dimes, Medicaid, other programs, MCH can help guide policy decision-making relating to health care reform and coordinates public health efforts in support of positive changes in the health care system.

NPMs 8, 15, 18 and NOMs 1, 2, and 3 relate to this priority need.

2. The mental health and behavioral health needs of pregnant women and new mothers should

be addressed.

This priority need was selected based on data showing that Kansas women have higher than average rates of cigarette smoking and other stress-related behaviors before, during and after pregnancy. Information needs to be readily available to the public and to women about the value of early/comprehensive health care for women of reproductive age and assimilated. There is a need to change the approach to women's health to a lifecourse perspective.

NPMs 8, 15, 18 and NOMs 1, 2, 3 relate to this priority need.

3. Kansas preterm births, low birthweight and infant mortality should be reduced.

This priority need was selected based on data that show continuing high rates of preterm birth, low birthweight and infant mortality for Kansas. MCH 2015 stakeholders concurred that all three are important and were unable to select from among the three.

Kansas has the capacity to address this priority through prenatal smoking cessation, improved nutritional status, and community-based prenatal case management and care coordination for low-income and high risk women. As well, through its wide array of stakeholder groups MCH can mobilize advocacy for policy changes needed to improve outcomes.

NPMs 8, 15, 18 and NOMs 1-3 relate to this priority.

4. Kansas women need support to increase initiation, duration, and exclusivity of breastfeeding.

The positive benefits of breastfeeding both for the mother and infant are provided in the discussions for NPM 11 and SPM 3. Kansas capacity to address this priority is significant due to partnerships forged across programs including WIC and women's health, due to the low cost of interventions and high yield in health benefits, and finally, due to a change in public attitudes and policy supporting breastfeeding mothers in the community and in the workplace. Kansas has devoted resources to peer education, health promotion and health education efforts, plus public information and education to address this priority.

NPMs 11, 15 and NOMs 1-3 relate to this priority.

CHILDREN AND ADOLESCENTS

5. All Kansas children and youth should receive health care through medical homes

This priority was held over from the last five year needs assessment due to data showing that the number of uninsured children is rising and that the problem of underinsured may be greater than uninsured. There was concern that more needs to be done in this area with the advent of national health care reform. MCH is in a unique position to support families and providers. MCH needs to engage in activities to educate families about the importance of care within a medical home. MCH needs to enlist the support of community partners to increase enrollment in Medicaid and Health/Wave for eligible children.

NPMs 7, 13, and 14 and NOMs 1 and 2 relate to this priority.

6. Child and adolescent risk behaviors relating to alcohol, tobacco, and other drugs should be reduced.

Youth Risk Behavior trend data show that Kansas youth continue to report higher than average use of alcohol, tobacco and other drugs. These priority health risk behaviors are major contributors to morbidity and mortality trends including motor vehicle crashes, unintended pregnancy, HIV/STDs, and other. More effective school health programs and other policy and

programmatic interventions are needed to reduce risk and improve health outcomes among youth. In particular, the state needs an Adolescent Health Plan that focuses on the needs of youth from a health perspective. MCH has the capacity to convene a group of stakeholders to address this need.

NPM 10, 16, and NOM 6 relate to this priority need.

7. Kansas children and youth need to achieve and maintain healthy weights.

This priority will be continued from MCH 2010. There is an increasing trend toward overweight even among very young Kansans and there is a strong association between overweight and health status. Many current efforts in the state focus on the needs of school-age and adult nutrition and physical activity. Kansas MCH not only joins in those efforts but also is in position through its public/private partnerships especially in the early childhood areas to address this priority. The Kansas breastfeeding priority also relates to this priority since breastfeeding has been linked with healthy weight in childhood.

NPMs 11 and 14 relate to this priority.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

8. All CYSHCN should receive coordinated, comprehensive care within a medical home.

This state performance measure holds for all children but in particular for CSHCN. Kansas capacity in this area is expanding to include development of data collection (new application form and survey systems), tracking systems (new CSHCN data system linked to Immunization Registry), parent/provider education about the medical home concept and practice, and linkages to other programs (Newborn Hearing Screening Learning Collaborative).

NPM 3 relates to this Kansas priority although NPM3 is broader and encompasses two concepts: family partnering in decision-making and care within a medical home. Kansas is developing interventions to address both and is developing capacity to track progress.

9. Kansas CYSHCN need early transition planning and services necessary to achieve maximum potential in all aspects of adult life, including health care, work and independence.

Kansas capacity in this area has improved considerably with the realignment of staff duties to include a focus on transition systems. This has resulted in new and enhanced partnerships with organizations in the disability community and a refocusing of state efforts on the needs of youth with special health care needs (YSHCN) as they transition to adult medical care.

NPMs 2-6 relate to this state priority.

10. Financing for CYSHCN services should minimize financial hardship for their families.

Kansas capacity in this area is enhanced through close working relationships with public programs (such as WIC and Farmworker Health) and public insurance (Medicaid and SCHIP). Direct financing of services through CYSHCN dollars has become more restrictive due to dwindling state and federal dollars and rising costs. Hospitals, labs and private providers continue to work with CYSHCN despite reductions in amount of coverage available. Private insurance coverage may only partially offset financial burden to the family or not at all. Rising numbers of uninsured and underinsured add to the ongoing challenge for the program. CYSHCN continues to engage in policy decisions to ration limited dollars.

NPMs 2-6 relate to this State of Kansas priority.

/2013/ There are no major changes since last year's submission. //2013//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	45	61	57	59	78
Denominator	45	61	57	59	78
Data Source		Kansas Newborn Screening data	Kansas Newborn Screening data, 2009	Kansas Newborn Screening data, 2010	Kansas Newborn Screening data, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
DATASOURCE:
*NOTE: Data for 2010 is not available at the time of this application. 2009 data was used to pre-populate this peformance measure. Data will be available by 1 September 2011.

Notes - 2009
DATA SOURCE:
KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2009 .

a. Last Year's Accomplishments
Direct Services:

Medical consultation for children with genetic/metabolic conditions was available statewide through the CYSHCN contractual process. CYSHCN purchased metabolic formula and food products for individuals with phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD)

along with treatment products for conditions identified through the newborn screening (NBS) program. CYSHCN continued to use a sliding fee scale with all families with children identified through the NBS process including those with cystic fibrosis.

NBS follow-up staff works closely with CYSHCN staff to assure diagnostic testing is available for patients identified by the NBS program.

Kansas has transitioned to IRT/DNA testing for Cystic Fibrosis (CF) and this allows for identification of CF Carriers. Referral to accredited CF centers allows for diagnosis, consultation and counseling.

Enabling Services:

Newborn Screening (NBS) staff participate in the Heartland Genetics and Newborn Screening Collaborative on both the advisory committee and standing committees. Heartland encourages states in the region to share knowledge.

Last year the NBS program developed its first annual report and a quarterly newsletter to be sent to collection facilities.

Population-Based Services:

Kansas hospital and birthing center personnel, as well as midwives, collected blood spot specimens from infants, usually between 24 to 48 hours of age. Specimens were sent to the Kansas Health and Environmental Laboratory (KHEL) for processing. Lab staff notified the NBS follow-up program of abnormal screening results. The NBS follow-up staff notified the primary care physician (PCP) of the abnormal screening test results. Also, the PCP was informed of consultation and referrals available through the CYSHCN program. Parents were notified by letter of the need for follow-up with the PCP regarding abnormal screening results, if the infant was not a patient in a neonatal intensive care unit. The PCP which is listed on the blood spot card is reported in the letter to the families. The family is asked to notify the NBS follow-up program if the PCP listed is not their child's PCP. The NBS follow-up program provided case management services to assure that all infants had appropriate testing, diagnosis, referral and treatment services.

As mentioned under Direct Services, Kansas has transitioned to IRT/DNA testing for CF. This has dramatically decreased the number of false positives screens related to CF. Educational materials for parents have been updated to include discussion of possible carrier status.

Infrastructure Building Services:

KDHE screened for 29 of the 30 conditions on the core panel recommended by the American College of Medical Genetics (ACMG). NBS staff provided updates and information to the NBS Advisory Council related to possible implementation of SCID, which was added to the core panel for screening in May 2010. The NBS Advisory Council deferred implementation due to the costs for the additional testing but are keeping track of new technology and information; they will continue to consider the addition of SCID to the Kansas panel of conditions.

Kansas requested technical assistance from National Newborn Screening and Genetics Resource Center to assist with development of a proposed fee for NBS in Kansas. Kansas is one of 3 states in the nation that does not charge a fee for NBS. The final report is available on our website.

Staff from the NBS follow-up program meet regulary with laboratory staff to coordinate activities and troubleshoot issues.Training is provided to staff from both KHEL and follow-up have when needs are identified.

The webpage section "Information for Parents" is available in both English and Spanish. Parent letters and information sheets had also been translated and used with parent mailings regarding abnormal or unsatisfactory specimens.

Because the current data system has no method to verify that each infant in the state is receiving a newborn screen and numerous data systems are used to manage information, Envisage has been contracted to evaluate the data system needs of the program.

Staff continued to monitor unsatisfactory rates for NBS specimens in the state. Contacts were identified at various hospitals with resulting decrease in unsatisfactory rates at those facilities. NBS staff follow up with physicians and parents of infants with unsatisfactory newborn screening specimens helping to assure that babies return for repeat screens.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide nursing case management to families that have infants with abnormal newborn screens		X		
2. Assure that contracts provide statewide coverage for consultations on NBS conditions				X
3. Purchase and distribute treatment products to eligible individuals	X			
4. Arrange transportation, as needed, for follow-up services		X		
5. Manage data collection and reporting systems for NBS follow-up and birth defects information				X
6. Provide information to policy makers on laboratory and follow-up procedures				X
7. Notify parents and medical providers about abnormal lab results and follow-up recommendations		X		
8. Provide educations materials such as pamphlets, handouts, DVD and website address to parents and medical providers		X		
9. Participate in the newborn screening advisory committee to include QA activities				X
10.				

b. Current Activities

Enabling Services:

The second annual report was issued that compared the current and last fiscal years. On a regular basis, a quarterly newsletter is sent to collection facilities and highlights conditions screened, describes the testing process and provides diagnosis and treatment information.

NBS program worked in conjunction with the Kansas D-70 grant in order to place parent advocates in 2 genetic clinics (PKU and Hematology) in the Wichita area. The parent advocate worked with families seen at the clinic to increase compliance and lost to follow-up rates.

Population-Based Services:

NBS staff continue to monitor the addition of SCID and CCHD screening to the newborn screening panel.

Infrastructure Building Services:

KHEL has undergone the development of a new LIMS which will not connect with the follow-up program directly but will provide web access for reports. Specimens will also be linked by patient versus specimen driven. NBS staff have continued to work on data linkages with Vital Statistics and LIMS.

The NBS advisory council has updated its charter and now meets biannually instead of quarterly. More information is shared via email with council members. Members now have 3 year terms and can agree to serve an additional 3 year term or be replaced on the council. A new chair and vice chair were elected.

NBS staff provided the advisory council with information regarding Critical Cyanotic Heart Disease (CCHD), the newest condition to be added to the NBS core panel.

c. Plan for the Coming Year

Direct Services:

Continue screening and following up with 28 metabolic conditions on the newborn screening panel.

Enabling Services:

NBS staff will work on expanding the e-mail list for the quarterly newsletter to encompass private physician office staff.

Evaluation of the D-70 parent support liaison project will begin.

Population-Based Services:

Continue last year's services. NBS staff will develop a parent survey for parents of children who had abnormal NBS results.

Infrastructure Building Services:

NBS follow-up staff will continue regular coordination meetings with the KHEL. Biannual meetings of the legislatively-mandated NBS Advisory Council will continue to ensure coordination between the public and private sectors and to evaluate the program. The NBS Advisory Council will continue to address whether Kansas will add the new ACMG Core Panel conditions, SCID and CCHD, to the Kansas screening panel.

Kansas plans to add a field on the Kansas Birth Certificate for the infant's NBS bloodspot card number, date and time of collection, as well as other information regarding NICU infants. Training will take place and this information should provide for better tracking of NBS specimens for Kansas infants.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**41580**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	41252	99.2	9	2	2	100.0
Congenital Hypothyroidism (Classical)	41252	99.2	47	27	27	100.0
Galactosemia (Classical)	41252	99.2	2	0	0	
Sickle Cell Disease	41252	99.2	11	9	9	100.0
Biotinidase Deficiency	41252	99.2	1	0	0	
Cystic Fibrosis	41252	99.2	127	12	12	100.0
Homocystinuria	41252	99.2	18	0	0	
Maple Syrup Urine Disease	41252	99.2	18	0	0	
Tyrosinemia Type I	41252	99.2	14	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	41252	99.2	5	0	0	
Citrullinemia	41252	99.2	1	0	0	
Isovaleric Acidemia	41252	99.2	7	0	0	
Carnitine Uptake Defect	41252	99.2	16	3	3	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	41252	99.2	21	1	1	100.0
Glutaric Acidemia Type I	41252	99.2	2	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	41252	99.2	88	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	41252	99.2	13	2	2	100.0

Methylmalonic Acidemia (Mutase Deficiency)	41252	99.2	3	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	65	70	70	67	66
Annual Indicator	65.6	65.6	65.6	65.6	72.6
Numerator					
Denominator					
Data Source		National CSHCN 2005-2006. Estimate KS.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	73	73	74	74	75

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. The wording of the two questions used to evaluate this outcome remained the same between 2001 and 2005-2006 National Children with Special Health Care Needs Survey and are therefore, comparable.

a. Last Year's Accomplishments
A parent partner project, aptly named the Parent Support Liaison (PSL) project, to provide care coordination, follow-up, and support services to families and clinic staff in select Children and Youth with Special Health Care Needs (CYSHCN) clinics began. A parent survey for families of CYSHCN was developed and implemented to identify gaps and barriers to services in relation to the CYSHCN three priority areas. These projects support all four service areas.

DHC: CYSHCN Family and Youth Advisory Council (FAC and YAC) members are paid a stipend, travel and child-care costs (if applicable) for participation in meetings. Family input is sought when the CYSHCN health care plan for families in the CYSHCN Specialty Clinics and recipients of CYSHCN funding. Family partners were also included in the D-70 Integrated Community Systems (D-70 ICS) grant project.

ES: The Make a Difference Information Network (MADIN) underwent changes to enhance resources and increase community awareness. MADIN was renamed the KS Resource Guide (KRG) to better reflect the nature of the program. A searchable resource directory was added to the existing website to provide a comprehensive, multi-system approach to providing resources. The directory houses resources of all major systems impacting children and families, as well as the disability community.

Through a partnership with the Families Together, the State Affiliate Organization of Family Voices and the KS Family-to-Family Health Information Center (F2F-HIC), health care information notebooks are disseminated to families as a tool to help them organize their child's health records/needs and to engage providers and the health care team in a more effective, efficient partnership.

PBS: Bilingual staff within the CYSHCN program allowed Spanish speaking families to be more engaged and assist in an effective and culturally competent, effective, and patient-centered manner. CYSHCN Advisory Councils have a particular focus to ensure families from various cultural and geographical areas of KS are represented. CYSHCN materials and resources were developed in both English and Spanish and made available to families through community outreach efforts and partnerships with other organizations and agencies dedicated to supporting CYSHCN.

IB: Engagement of family and youth partners continued through CYSHCN Advisory Councils. The councils are available to support families and youth to ensure the consumer voice is addressed and to provide opportunities for families and youth to become advocates for themselves or their loved ones. FAC members offer guidance and feedback related to the three CYSHCN state priority objectives. Additionally, the YAC provides an opportunity to learn about

transition issues from the youth perspective.

Continued communication with providers to support family engagement in health care plans and activities. Mallory Cyr, National Health Care Transition Center, visited Kansas and participated in a three-part webinar series on youth empowerment for families, youth and providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CYSHCN staff meet with families at each multi-disciplinary clinic visit to assess and address family needs.	X		X	
2. Treatment plans are reviewed with youth and families to assure understanding and agreement.	X	X		
3. Families and youth are engaged and active participants of the CYSHCN Family and Youth Advisory Councils.	X	X	X	X
4. Families and youth are financially supported to serve on advisory councils.	X	X	X	X
5. Parent partners are engaged through the Parent Support Liaison project to provide care coordination, follow-up and support services to patients and families in select CYSHCN specialty clinics.	X	X	X	X
6. Parent survey to identify gaps and barriers to health care to support future program activities.	X	X	X	X
7. Expansion of resources through the KS Resource Guide and related activities.		X		X
8. Cultural diversity is addressed through accessible, bi-lingual materials and bi-lingual services in clinics.		X	X	
9. Partnership with Families Together, Inc. to support the use of personal health care notebooks and provision of trainings for parents and families.		X	X	X
10. Development and implementation of a course for graduate-level health care professionals at the University of Kansas-Medical Center.				X

b. Current Activities

Continued previous program activities. Completed the development of the PSL project and concluding the first year pilot of this project. Completed and analyzed data from the family/parent survey -- the 2011 CYSHCN Family Survey Executive Summary was completed in May 2012 and will be available on the CYSHCN website and is attached under the "Other Program Activities" section in the State Narrative menu.

DHC: Continued support for the FAC and YAC. The CYSHCN nurse continues to coordinate and engage families the development of CYSHCN health care plans.

ES: The CYSHCN program continued to support the Kansas Resource Guide (KRG) to assist consumers and professionals in finding appropriate resources in Kansas. As a result of a targeted marketing effort the number of providers increased by 30% in the last year.

PBS: Reduction in CYSHCN bilingual staff occurred this year causing a gap in providing bilingual services in house. A translation service was utilized to provide culturally competent services. Efforts to ensure diversity in all CYSHCN Advisory Councils continue.

IB: Parent consultants were supported in attending the D-70 ICS Evaluation Training in Baltimore, the Health Care Transition conference in Houston, and the AMCHP conference in Washington,

D.C.

A partnership with the CDC-funded Disability and Health Program developed a 2-hour elective course for the graduate nursing and allied health programs at the University of Kansas-Medical Center.

c. Plan for the Coming Year
Continue previous and current program activities.

Continue the Parent Support Liaison (PSL) project with a focus on evaluation to support sustainability. Plans to change the name of this initiative to Parent Support Navigator to align with national efforts and potential support from insurers and health providers are being considered. Partner with Families Together to identify funding, supports and future expansion opportunities for the project.

Utilize data from 2011 CYSHCN Family Survey to support future project activities related to family advocacy and shared-decision making. Data from this and the 2009/10 National Survey will be used to assist in planning future CYSHCN FAC-led activities/initiatives.

DHC: Continue support of FAC and YAC. Support transition of the YAC to a stronger leadership development program with opportunities to expand education on transition, advocacy, and self-determination for youth across Kansas.

ES: Complete the KRG marketing campaign utilizing social media and online advertisements. Continue the targeted marketing efforts to recruit community providers for inclusion in the directory. Dissemination of the medical home, transition, and community resource tools developed by the CYSHCN FAC. The CYSHCN FAC will develop new initiatives or activities related to CYSHCN state priorities and block grant measures.

PBS: The program will attempt to gain public input from outlying areas while implementing the above mentioned activities. Diversity will continue to be a focus of recruitment for all advisory councils. Future staffing opportunities within the program will include hiring of a Bilingual staff member and materials and resources will continue to be available in English and Spanish.

KRG project staff identified a tool to provide the searchable directory resources and services in languages other than English. The contracted vendor for the directory service is currently testing this tool. This translation option for the KS Resource Guide will be made available as soon as possible an option to diverse cultures.

IB: Recently, the CYSHCN and Disability and Health Programs at KDHE partnered to develop a 2-hour elective course in the graduate nursing and allied health programs at the University of Kansas-Medical Center. The course was piloted during the Spring 2012 semester and evaluation activities are currently underway. This course educates health professionals on how to effectively care for persons with disabilities in health care or public health settings. Course topics included: effective communication and partnership with people with disabilities; disability civil rights; advocacy and independent living; health promotion and chronic disease considerations; medical home; transition; mental health; education; employment and more. Future plans include modifying the existing curriculum to develop a series of online continuing education modules for health care and public health professionals.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	60	60	60	60
Annual Indicator	55.3	55.3	55.3	55.3	49.4
Numerator					
Denominator					
Data Source		National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	51	52	53	54

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

Notes - 2009

DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial additions, wording changes, and skip revisions between 2001 and 2005-2006 National Children with Special Health Care Needs Survey have occurred. This indicator is not comparable with pre 2005 data.

a. Last Year's Accomplishments

DHC: CYSHCN specialty clinic contracts include a requirement that specialty evaluations and recommendations are sent to the primary care physician within two weeks of the clinic appointment in support of the medical home team approach. Contract language continues to support medical home and care coordination.

Planning for the Parent Support Liaison (PSL) project in select CYSHCN specialty clinics began in May 2011 as an effort to provide care coordination and parent/peer supports to families attending four CYSHCN-sponsored clinics. This project was developed as an opportunity to better assist families in partnering with their doctor to support improved quality health care and coordination with increased cost-efficiencies.

ES: Through a strong partnership with Families Together, a medical home presentation was developed to educate families on the medical home concept and provide information on how families can begin building a medical home for their families. This presentation was made available at multiple Families Together local and state-wide conferences. This presentation supports family and young adult skill-building in developing effective partnerships and active participation within the medical home. Articles addressing family and youth empowerment, medical home and engaging the youth/parent in decision making were included in the CYSHCN Magazine made available for waiting rooms and conferences.

As the State's Medical Home Initiative lead by the KS Health Policy Authority has continued to remain unfunded and efforts have not been reestablished, the D-70 Integrated Community Systems (D-70 ICS) grant project began a partnership with the KS Academy of Family Physicians (KAFP) -- the lead organization in a three year grant-funded pilot project titled the Patient-Centered Medical Home Initiative. This effort began in January 2011 and immediately began planning for eight KS provider groups in both the pediatric and family medicine disciplines to begin working toward meaningful use and establishing a true medical home for the practice, based upon the Trans4Med medical home model.

PBS: Printed materials were provided to consumers in requested languages and accommodations. CYSHCN staff participated in the Heartland Genetics Regional Collaborative Medical Home work group, which began discussion opportunities to engage genetic providers as team members for persons with metabolic conditions within a Medical Home. The work group began meeting monthly via conference calls and identified the need for a white paper related to the geneticists' role within the medical home.

IB: The D-70 ICS grant began the shift from addressing transition and medical home as separate activities to a focus on transition and life course within the medical home and how youth, families and providers can be effective partners in this model. This model incorporates a variety of components related to transition, with a focus on how providers and support successful transition as part of the medical home. Through the D-70 ICS grant "JumpStart" Quality Improvement project, a health care transition youth self-assessment was developed to support medical home providers in supporting transition for their youth patients.

The KS and MO D-70 ICS grants co-presented at the Heartland Regional Genetic Collaborative 2010 Fall Conference on the newly formed partnerships in the collaborative related to medical

home. The CYSHCN Family Advisory Council began a work group on medical home to address the needs and services for CYSHCN and families in KS. Medical home was embedded as an underlying concept through the Caring for People with Disabilities course at KU Medical Center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Clinic reports are provided to the PCP and other providers identified by the family.	X			X
2. The contracting PCP can access the state-wide immunization registry.		X		X
3. CYSHCN tracks medical home status of clients seen in specialty clinics and assists families to obtain a primary care provider, if needed.	X	X	X	X
4. Infants identified with a positive Newborn Screening test are referred to the CYSHCN program and follow-up services are explained to families.		X	X	
5. Develop information & disseminate information about medical home for youth, families and professionals.		X		X
6. Conduct trainings for providers on medical home and how to partner with families.		X		X
7. Continue to expand the KS Resource Guide to provide additional medical home resources, tools and materials for youth, families and professionals.		X		X
8. Participate in the Heartland Genetics Collaborative medical home work group and related activities.		X	X	X
9. Support Family Advisory Council work group on medical home to support family leadership and advocacy.	X	X	X	X
10.				

b. Current Activities
Prior year activities continued.

DHC: Contract language continues to support medical home and care coordination. Two Parent Support Liaisons were hired to provide care coordination and support services in select CYSHCN specialty clinics. The PSL's have worked to connect families to needed community-based services, increase attendance and family preparedness for clinic appointments, developed a newsletter for families within a clinic, providing ongoing support for families in these clinics and much more.

ES: The partnership with the KS F2F grantee continues to educate families on medical home components and partnerships. CYSHCN staff continues to be engaged in the KAFP medical home initiative as part of their engagement coalition and partially funded the 2011 PCMH Summit.

PBS: CYSHCN staff continues to participate in the development of the Heartland Genetics white paper related to the medical home. The intent of this paper is to improve engagement of genetic providers as part of the medical home team across Kansas and other states in the Heartland region.

IB: The D-70 ICS grant and the CYSHCN Family Advisory Council developed tools/resources for families and providers on effective partnerships among families and providers. Medical home was the underlying concept through the Caring for People with Disabilities course at KU Medical Center and one week was devoted specifically to the medical home concept and how to

effectively partner with patients within the medical home.

c. Plan for the Coming Year
Continue current medical home initiatives.

Through blended funding from the D-70 ICS grant, Title V, and Families Together Phase 2 of the Parent Support Liaison project will occur. Phase 2 will focus on evaluation to support sustainability and includes plans to change the name of this initiative to Parent Support Navigator to align with national efforts and potential support from insurers and health providers.

DHC: All CYSHCN contracts will continue to include language that supports medical home and care coordination for families served by the Title V program.

ES: The Family Advisory Council (FAC) work group will continue to work on medical home as one of the priorities. The FAC has identified provider and family training as a priority for the coming year, including medical home as one of the trainings to develop. There is interest in making these trainings available in a variety of formats including in-person and live/archived webinars. Another priority of the FAC is dissemination of the Medical Home informational "rack" card developed this past year.

PBS: Materials and products will continue to be developed to address the diverse needs of rural, underserved and ethnically/demographically diverse families in KS. Materials will continue to be provided in requested languages. Provide medical home resources and educational materials to local parties involved in the CYSHCN Decentralization effort to provide more community-based services to families served by the program.

IB: KDHE will continue to partner with the KS Academy of Family Physicians (KAFP) and participate in the engagement coalition to ensure CYSHCN needs are addressed throughout the initiative. KDHE and partners have been invited to present at the PCMH Summit on medical home, health transition, and the PSL project. KAFP is continuing to include feedback from families of CYSHCN as part of the PCMH summit agenda by contracting with Brad Thompson to present on the family's role in the medical home.

The Medical Home will continue to be a focus of "Caring for People with Disabilities" course, both at the University of Kansas-Medical Center and in the online continuing education modules for health care and public health professionals.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	70	64	64	64	65
Annual Indicator	62.9	62.9	62.9	62.9	60
Numerator					
Denominator					
Data Source		National CSCHN	National CSCHN	National CSCHN	National CSHCN

		2005-2006. Estimate KS	2005-2006. KS Estimate.	2005-2006. KS Estimate.	2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	61	61	62	62	63

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Indicators are comparable because no changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey.

a. Last Year's Accomplishments
DHC: Adults with eligible genetic conditions can be seen in CYSHCN supported specialty clinics and qualify for financial assistance based upon family income and a sliding fee scale. CYSHCN administrative and field office staff continued to direct those in need to apply for public assistance (ie: HealthWave, SSDI, etc). Families were directed to safety-net clinics if other options were not available.

ES: The CYSHCN consumer application was updated and made electronic. Families can apply

online and submit applications electronically to the program. Families who are unable to complete an online application can still access the application online or receive applications by fax or mail. Applications continue to be sent to those referred to the program or whose newborn had a positive screening result.

The KS Equipment Exchange Program is utilized frequently by families of CYSHCN specialty clinics. This program provides an opportunity to "recycle" durable medical equipment when a child no longer has a need for it (or has outgrown the current equipment). Families continued to be referred to this program as appropriate.

PBS: Kansas has experienced an economic downturn similar to many other states. Many jobs have been lost and increased persons/families are uninsured or underinsured. Families of CYSHCN have experienced similar hardships and coverage for necessary services continues to be an issue. The CYSHCN program continues to support medically and financially eligible CYSHCN from all areas throughout the state. The CYSHCN program applications are available in both English and Spanish and two bi-lingual staff persons are available to assist families.

IB: HealthWave coverage and Health Care Reform legislative advocacy was a key activity of many of our stakeholders. CYSHCN partnered with professional organizations (AAP, KAFP) and family partners (Families Together) to educate families and young adults about components of the Health Care Reform/Affordable Care Act (physical and mental health) that may impact their ability to maintain, gain, or expand insurance coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor Federal and State leadership efforts to provide affordable health care coverage.				X
2. Educate families and providers on specific elements of the Health Care Reform Bill that may impact access to services, and coverage.		X		X
3. Coordinate with SCHIP/Medicaid on eligibility determinations.	X	X		
4. Route metabolic formula orders through CYSHCN for discounted rate to reduce out of pocket expenses.	X		X	
5. Authorize eligible services with contracted providers that take CYSHCN's negotiated rates to avoid/minimize family's liability.	X			
6. Assist families in identifying and connecting with private non-profit organization to fund medically necessary treatments and equipment not otherwise covered.		X		
7. The Parent Support Liaison will assist families in identifying available financial supports and connecting with necessary services.	X	X	X	X
8. Family Advisory Council Transition Work Group will provide feedback and guidance on insurance and financial impact for families of CYSHCN.		X		X
9. Transition website to assist families of YSCHN in understanding state and national financial supports available.		X	X	X
10.				

b. Current Activities

DHC: Continuation of previous year activities. Expanded oral health services in select CYSHCN clinics to provide these services to families who are unable to obtain dental care due to lack of insurance or funding. The Parent Support Liaison project also addressed the financial needs of

families and assisted in connecting families with appropriate opportunities. Clinic services continued to be provided for patients and families and not be billed for services.

ES: Vendor contracts were modified to support improved data collection. Reporting was enhanced to provide additional information and more accurate data on clinic patients and provide opportunity to analyze financial impact of CYSHCN on families.

PBS: Initial discussions with local health departments have occurred to identify the potential for establishing satellite offices for the CYSHCN program in communities across Kansas in an effort to provide a more community-based approach and local entry point into the program. This will provide a local point of contact for the CYSHCN program and an opportunity to educate more families about the services available through the CYSHCN program.

IB: The FAC Financial Impact Work Group created a Community Resource Brochure -- a quick reference guide for families on common state and community resources. Dissemination of this brochure began in March 2012 and has been well received by both consumers and providers.

c. Plan for the Coming Year

Continuation of previous and current activities.

Efforts to "decentralize" the CYSHCN program and launch satellite offices across Kansas have been ongoing. Beginning July 2012, offices in Garden City, Hays, Salina and Wichita will be available to families in the Western half of the state. Plans for the Eastern half will begin this year (Emporia, Kansas City, Pittsburg, and Topeka) with an implementation date of July 2013. Training and ongoing technical assistance will be available to the satellite offices. This underlies our plans to enhance a more community-based approach to providing CYSHCN services in each of the four service areas within western Kansas, and utilize "lessons learned" for implementation in eastern Kansas in July, 2013.

DHC: Continue support of CYSHCN-sponsored specialty care clinics and PSL project. Enhanced Wichita CYSHCN field office data linkage with KUSM/Wesley Medical Center is planned to expand pediatric screening and treatment services in Sedgwick and surrounding counties.

ES: An ongoing emphasis on the importance of prevention/wellness, health maintenance and promotion, and life course will be embedded into program activities and initiatives developed by the Family Advisory Council.

PBS: The newborn screening program (lab and follow-up) will secure a stable funding mechanism with the signing of Bill that dedicates funding for NBS.

IB: Work with CYSHCN advisory councils and external stakeholders for input into a navigational toolkit to assist families in navigating and identifying available healthcare funding opportunities. Additionally, the CYSHCN FAC is interested in developing trainings for community and medical providers related to the three state priority measures, including financial impact on families of YSHCN. Plans for these trainings is being developed, however the interest in educating community providers on the needs of CYSHCN and their families will support more effective and efficient service provision. It is anticipated that this will also provide opportunities for increased linkages to needed financial support services.

A website related to transition for YSHCN and their families will be launched. This website includes information for families on how to navigate the transition to adulthood, including financial resources and explanations of state and national financial supports. This website will be shared with stakeholders and links placed on the KRG and CYSHCN website. The website will be housed within the KU CCHD for sustainability.

A data extract from the KDHE Health Informatics Bureau to the CYSHCN web-based data system is being tested and plans are to move to production approximately July, 2013. This enhanced data capacity will allow for searching of all Kansas newborns to ensure coordination, outreach, eligibility, and enrollment within CYSHCN the web-based portal.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	95	95	99	93
Annual Indicator	92.5	92.5	92.5	92.5	66.8
Numerator					
Denominator					
Data Source		National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2009/2010. Estimate KS.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	67	68	68	69	69

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

*The Annual Performance Objective of 99 is unrealistic and should be revised to 93 for 2010.

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Significant changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey in placement, phrasing, and ordering of this question. Thus, this indicator is not comparable with pre 2005 data.

a. Last Year's Accomplishments
DHC: CYSHCN funded a total of 20 specialty clinics in Kansas City and Wichita. From these clinics, approximately 6,206 patients were seen throughout the year. A dental hygienist was available to provide screening and preventative services to patients in the cerebral palsy, cleft lip/cleft palate, and spinal cord clinics in Wichita, KS and the cerebral palsy, cleft lip/cleft palate, and spina bifida clinics in Kansas City.

Local resources are identified in the annual CYSHCN generated health care plan and are provided to the family, primary care provider, and authorized service providers along with community resources.

ES: Through previous D-70 ICS grant listening tour meetings, families identified that they were unable to find the resources and services they needed in a timely fashion. Based upon this feedback, it was determined the most effective way to address this was through the development of a comprehensive resource guide and navigational tool kit. The Kansas Resource Guide was developed to provide a comprehensive, multi-system approach to providing resources. The directory will house resources of all major systems impacting children and families, as well as the disability community. This guide is intended to serve as a "one-stop-shop" for resources so families and professionals can find the resources and services they need in a more time-effective manner. The online directory launched in April 2011.

PBS: Interpretation services are provided to families for those who are not English-speaking and upon request. The KS Early Intervention, "tiny-K" program, continues to provide services in a natural setting (home or child care center) and collaborates with the CYSHCN for eligible services. Follow-up screenings are provided to those who screen positively in the two newborn screening programs in KS (Sound Beginnings/Hearing and Genetic conditions). Primary, specialty, dental and mental health services continue to be sparse in rural communities in KS and families continue to struggle with accessing these services.

IB: CYSHCN and D-70 ICS grant staff participated in a number of advisory councils and work groups to support collaboration and partnerships with the various community-based service systems. These include: Oral Health, Sound Beginnings, EPSD, Newborn Screening Advisory Councils; Shawnee County Transition Council; Working Healthy Advisory Council; Research and Training for Centers for Independent Living Access to Health Care Work Group; Heartland Genetics Transition and Medical Home Work Groups; and serves on the Kansas Commission on

Disability Concerns as the Secretary of Health's designee. Through participation in these meetings we can assure that the CYSHCN population is included in state policy and practices and that this population's voice does not go unheard. Additionally, these meetings provide opportunities for education, provision of information and networking to ensure our service systems are complimenting, not duplicating, each others services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Special needs outreach clinics are held in underserved areas of the state based on consumer need and staff capacity. Special clinics offered to local school systems, upon request.	X		X	
2. CSHCN (age 0-3) are referred to Part C Early Intervention networks that serve their community.	X	X	X	X
3. Interpreter services provided for visits with local and specialty providers, as needed.	X	X	X	
4. Transportation support is provided via EPSDT benefits or are authorized by CYSHCN if over 50 miles one way.	X	X		
5. Provide care coordination and system support through the Parent Support Liaison	X	X	X	X
6. Expand the KS Resource Guide to provide additional medical home resources, tools and materials for youth, families and professionals.		X		X
7. Serve and represent the CYSHCN population and their families at local, regional state level meetings and activities.				X
8.				
9.				
10.				

b. Current Activities
Prior year activities continued.

DHC: Continued prior year activities. Local resources are identified in the annual CYSHCN generated health care plan and are provided to the family, primary care provider, and authorized service providers along with community resources. Parent Support Liaisons placed in select CYSHCN clinics have created additional opportunities to connect families with community-based services and resources based upon their individual child/family needs.

ES: Promotion of the Kansas Resource Guide began to share with families, providers, and consumers about the online, comprehensive, multi-system directory of community-based resources. Efforts to expand the number of providers in the KS Resource Guide have occurred since implementation. A stronger focus on provider recruitment has resulted in a 30% increase. A formal marketing campaign, including Google and Facebook advertisements is currently underway.

PBS: Continued prior year activities. KRG project staff identified a tool to provide the searchable directory resources and services in languages other than English and the contracted vendor for the directory service is testing this tool. This translation option for the KS Resource Guide will be pursued and will be made available as an option to diverse cultures.

IB: Continued to serve and represent CYSHCN on stakeholder and organizational groups. Feedback from these groups was presented to the families serving on the CYSHCN advisory

council.

c. Plan for the Coming Year
Continue current initiatives to provide community-based services and resources to families in KS in a way families can easily identify and access these services.

DHC: Continue providing specialty and outreach clinics, including dental hygienist services in select specialty clinics. Support Phase 2 of the Parent Support Liaison project to continue connecting families with community-based services and resources based upon their individual child/family needs. Enlist assistance from the Parent Support Liaisons in the KS Resource Guide marketing efforts, to ensure resources provided to families through the PSL are included in the KS Resource Guide.

ES: Continue to expand the KS Resource Guide through recruitment of providers to be included in the searchable resource directory and disseminating information to families about the resource guide and website. Increase marketing efforts through cost-effective methods and utilizing social media. Coordinate social medial efforts with the KDHE Communications Team.

Now that the online directory has been established, efforts to develop a navigational tool kit to assist families in navigating and understanding the various service systems in KS will be pursued. The CYSHCN Advisory Councils and interested stakeholders will be engaged to ensure the needs are being addressed appropriately. Other state agencies will be asked for input regarding agency/program-specific information to ensure accurate information is provided to families.

PBS: Continue working towards expansion of the KS Resource Guide to ensure rural and underserved populations are being reached, as well as the resources available to various ethnic populations. Pursue the possibility of reaching out to rural KS through other organizations and webinars. Recruitment from underserved areas will continue to be a focus for all advisory councils and input for program activities to ensure access, promote health equity, and knowledge of community-based systems is being addressed for these populations. Continue providing interpretation services.

IB: Continue to serve and represent CYSHCN on stakeholder and organizational groups. Provide feedback from these groups to the families and consumers serving on the CYSHCN advisory councils to assist in future program planning.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6.3	53	53	55	53
Annual Indicator	50.3	50.3	50.3	50.3	52.7
Numerator					
Denominator					
Data Source		National CSHCN 2005-2006.	National CSHCN 2005-2006.	National CSHCN 2005-2006.	National CSHCN 2009/2010.

		Estimate KS	KS Estimate.	KS Estimate.	KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	53	54	54	55	55

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Data for 2010 is not available. The 2009/2010 National Survey of CSHCN will be available in October 2011.

* The 2010 Annual Performance Objective of 55 is unrealistic and should be revised to 53.

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial alterations, additions, and difference in skip pattern have occurred between 2001 and 2005-2006 National Children with Special Health Care in these questions. Thus, this indicator is not comparable with pre 2005 data.

a. Last Year's Accomplishments
One of the main focuses of the D-70 Integrated Community Systems (D-70 ICS) grant is on transition to adulthood and addresses all four service area types. Through partnership with the University of Kansas Center on Developmental Disabilities (KUCDD), Kansas has increased consumer awareness of health care transition, worked with medical providers to develop tools for transition and strengthened the capacity of the state, and their partners, to provide transition services for YSHCN in KS.

DHC: Four CYSHCN specialty clinics (Cleft Lip/Palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics) provide transition clinics for older youth. Adults with eligible genetic conditions are able to continue to be seen in the adult specialty clinics.

The KS Family-to-Family Health Information Center families and youth are being trained on the development and use of the personal healthcare notebook. Through the D-70 ICS grant and partnership with KUCDD, an online curriculum for youth with special health care needs and disabilities has been developed. The curriculum is intended to be used by youth to independence and provide opportunities for skill-building, self-determination and support in becoming an empowered patient. Youth will also learn how to communicate with peers, parents and health care providers. The curriculum consists of the following six modules: About Me, Taking Charge, Staying Healthy, Empowered Patient, Taking Care of Myself and After High School. Each module consists of an overview of what will be learned in that section, the youth's personal learning goal, a table of contents, a status check to see if the youth met their goal and a "VIP" section that describes the "Very Important Points" in each section. The curriculum is progressive and each module will build on skills and information learned in the prior modules. Each module is interactive in that the youth will fill out the information online and then the system will save this to their account/file for the youth to look back on and to help drive future modules. Development of the curriculum content was completed and made available for an initial field test the following fall.

ES: CYSHCN staff participated in transition resource fairs to learn and share community connections to assist in transitioning not only to adult health care providers but to address other aspects of work and community living. The Youth Advisory Council continued to work with youth to become self-advocates and active members of the community to support successful transition. The Family Advisory Council work group on transition began development of a series of transition checklists for parents of children 0-6, pre-teens and teenagers age 7-13, and youth and young adults ages 14-19. These booklets cover a variety of topics, including health, education, employment, community living, and more.

PBS: Through a partnership with Families Together, regional transition conferences were provided to educators and parents/families about common issues with transition for YSHCN. These conferences continue to have an expanded focus to address health care transition as well as education transition. A three-part online learning series on health care transition, a workshop on health care transition and a three-part webinar series for youth, parents and professionals on youth independence was available for consumers, families, and providers.

IB: CYSHCN contract language was included to ensure partners and vendors are addressing transition to adulthood for YSHCN. CYSHCN staff and partners continue to serve on councils and committees that address youth issues and disability concerns. The D-70 ICS grant sponsored youth to attend the Youth Empowerment Academy's week long Youth Leadership Forum held on the Washburn University campus. The CYSHCN Youth Advisory Council continued to build capacity for the state by ensuring the youth voice is addressed. The family survey through the specialty clinics began and included questions related to transition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition clinics for Cystic Fibrosis, Cerebral Palsy, Cleft Lip/Palate and Spinal Cord are held regularly for the older youth.	X			
2. Coordinate with family and education partners' transition workshops.		X		X
3. CYSHCN staff participate in local, regional, state and national workshops to promote inclusion and increase awareness of the needs of YSHCN.			X	X
4. Family Advisory Council Transition Work Group will provide feedback and guidance on state transition efforts.				X
5. The Parent Support Liaison project will assist in providing transition services to families within the pilot clinics.	X	X	X	X
6. Development of a youth-focused model for health care transition that includes a care coordination, provider policy development, system integration, partnerships, and resources/tools for youth, families and providers.		X	X	X
7. Expansion of the Kansas Resource Guide with the development of a transition navigational tool kit.		X		X
8.				
9.				
10.				

b. Current Activities
Continued all previous clinic activities.

DHC: The self-determination curriculum was field tested to gain youth and educator's feedback, adjustments were made and the curriculum is currently being piloted in the school system and evaluation will begin in June 2012.

ES: The YAC continues to enable youth to become self-advocates and active members of the community. The FAC transition checklists were completed and dissemination began March 2012.

A website dedicated to families to navigating transition is being developed in partnership with the KU Center for Child Health and Development (CCHD). The website will include resources, tools and stories to aid families in supporting youth transition.

PBS: The FAC transition tools are being distributed through Families Together to all families who request a medical care notebook. This tool is currently being translated in Spanish, as are all of the other CYSHCN FAC tools developed.

IB: The D-70 ICS grant began the shift from addressing transition and medical home as separate activities to a focus on transition and life course within the medical home and how youth, families and providers can be effective partners in this model. This model incorporates a variety of components to support capacity and infrastructure building in Kansas, including: the Parent Support Liaison project; the JumpStart project; a self-determination curriculum; partnership with the Heartland Genetics Collaborative; and individualized healthcare plans.

c. Plan for the Coming Year
Continue current and previous transition-related activities. In partnership with KUCDD, coordinate multiple submissions for poster and oral presentations related to the various innovative transition initiatives that have occurred.

DHC: Continue CYSHCN specialty transition clinics. Complete evaluation and final revisions to the KUCDD self-determination curriculum. Promote the use of the curriculum to various stakeholders, particularly health providers to share with their transitioning youth patients.

ES: Continue expansion of the KS Resource Guide. Resource staff will work with multiple stakeholders, including the Family Advisory Council, in the development of the navigational tool kit.

Launch the Kansas Transition website, a website dedicated to families to navigating transition. The website will include resources, tools and stories to aid families in supporting youth transition related to the following six transition-related topics: Life in the Community; Your Home; Work; School; Health; and Circle of Support. The website will be housed at the CCHD for ongoing technical support and sustainability.

PBS: A link to the new transition website will be placed on the CYSHCN home page and the KS Resource Guide. Continued focus on transition across Kansas and materials provided to those in requested languages. Upon completion of the model, it is anticipated that tools and resources will be available in both English and Spanish.

The FAC has identified provider and family training as a priority for the coming year, including transition as one of the trainings to develop -- particularly as it relates to the need for early transition planning (at time of diagnosis) and use of the transition tools developed through the CYSHCN FAC and D-70 ICS grant. There is interest in making these trainings available in a variety of formats including in-person and live/archived webinars.

IB: The D-70 ICS grant project, through a no-cost extension, will finalize the model for transition within the medical home. Webinars and online trainings will be developed to share the model and disseminate information to families, consumers, and providers. This information will be incorporated in stakeholder trainings and conferences. Local, state, and national presentations will be pursued.

The CYSHCN YAC will undergo a transition with a stronger focus on youth leadership. The group will transition to a youth leadership committee, which will be responsible for developing a structure for the committee and planning additional youth-outreach activities across the state to empower other youth and support leadership and growth through coordinating multiple community-wide youth outreach activities to engage more youth across the state. These additional activities will be planned, coordinated, and hosted by the youth leadership committee, with support and assistance from KYEA and KDHE.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	89	90	90	79	79
Annual Indicator	83.3	76.7	80.5	82.1	82.1
Numerator					
Denominator					

Data Source		CDC National Immunization Survey 2008, KS	CDC National Immunization Survey 2009, KS	CDC National Immunization Survey 2010,KS	CDC National Immunization Survey 2010,KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	83	83	83	84	84

Notes - 2011
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2010-Q4/2010. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/10/tab02_antigen_iap.xls

Data is not available for 2011, so 2010 was used to populate this field. Data for 2011 will be available November 2012.

Note** indicator was changed. Prior to 2008, National Immunization Survey rates for DTaP(4): Polio(3):MMR(1) combination were reported. Due to the changes in the National Immunization Survey, data for 2008 reports the rates for DTP(4): Polio(3): MMR(1): Hib (3): HepB (3): Varicella (1) combination. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age. For school year 2010-2011, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 10.

Notes - 2010
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2010-Q4/2010. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/10/tab02_antigen_iap.xls

Note** indicator was changed. Prior to 2008, National Immunization Survey rates for DTaP(4): Polio(3):MMR(1) combination were reported. Due to the changes in the National Immunization Survey, data for 2010 reports the rates for DTP(4): Polio(3): MMR(1): Hib (0): HepB (3): Varicella (1) combination. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry

but is required for public preschools or school operated child care for children under five years of age. For school year 2010-2011, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 10.

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2009-Q4/2009. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/09/tab02_antigen_iap.xls

According to the National Immunization Survey, 2009, the percentage of Kansas's children 19-35 months old for 4:3:1:3 (DTP4: Polio3: MMR1: HepB3) is 77.0 ±7.4 percent.

The Retrospective Immunization Coverage Survey, 2005-2006 Results (School Year 2009-2010) reports statewide coverage rate for the 4-3-1-3-3 series (DTap4, Polio3, MMR1, Hib3, HepB3) for children by 24 months of age increased by more than 6.5 percentage points to 70%, but still below HP2010 goal of at least 80%.

School entry vaccines required are DTaP5, Polio4, MMR2, HepB3, and Varicella 2. HIB3, Pneumococcal conjugate (PCV)4 and HepA2 required for children less than 5 years of age in early childhood programs and daycare. The Kindergarten Immunization Coverage Survey (2010) reports statewide coverage rates for all vaccines required for school entry (DTaP5, Polio4, MMR2, Var2, HepB3) were above 80%, with HepB3 having the highest coverage at 96%, meeting the HP2010 goal of at least 95% coverage rates of immunizations for kindergartners.

Note** indicator was changed. Prior to 2008, National Immunization Survey rates for DTP(4): Polio(3):MMR(1) combination were reported. Due to the changes in the National Immunization Survey, data for 2008 reports the rates for DTP(4): Polio(3): MMR(1): Hib (3): HepB (3): Varicella (1) combination. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age. For school year 2009-2010, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 10.

a. Last Year's Accomplishments
The program has undertaken several initiatives in place to increase immunization rates in children less than 2 years of age. Immunize and Win a Prize gives a small prize to a family each time their child comes in for vaccine and when the child has completed their primary infant vaccination series, are entered into a raffle for a $400 prize. From 2003 to 2010, immunization rates for Health Connect Kansas, Medicaid and Healthwave-21(SCHIP) children have increased 78%. The Maximizing Office Based Immunizations (MOBI) trained 22 health providers to improve vaccine practices, administration, and storage for their practices.

During the national infant immunization week, the BEEWISE and the immunization visited 9 counties and 10 different Health Department Offices in 5 days. Approximately 201,500 vaccines were entered into KSWebIZ for children under 3 years of age during the week of Aril 24th to May 1st, 2010

The immunization coverage for the 4-3-1-3-3 series for children enrolled in the retrospective survey from 2007-2010 has been increasing every year. In 2010, the Kansas Certificates of Immunizations (KCIs) and other immunization records for children enrolled in a kindergarten class in Kansas public and private schools during the 2010-2011 school years were evaluated for immunization coverage levels. Children born between September 2, 2004 and September 1, 2005 were included in this study, and their immunization coverage levels at 24 months of age, which corresponds to September 2, 2006 and September 1, 2007, were analyzed. In total, there were 792 schools, 690 public and 102 private, included in the analysis, which consisted of a

representative sample of 12,912 children from both public and private schools.

The statewide coverage level for the 4-3-1-3-3 series (DTaP4, Polio3, MMR1, Hib3, and HepB3) for children by 24 months of age was 71.5%(95% confidence interval of 70.3-72.8) and did not increase, compared to the 2009-2010 Retrospective Study, and remains below the Healthy People 2010 goal of at least 80%. Of the children missing one or more series of the 4-3-1-3-3 at 24 months of age, 58.7% (16.7% of total population studied) needed to complete one immunization series (DTaP4, Polio3, MMR1, Hib3, or HepB3). If these children had received the missing immunization series, the coverage levels for 4-3-1-3-3 would have increased from 71.5% to 88.2% well above the Healthy People 2010 goal. Among children who needed one immunization series, the majority (50.2%) needed DTaP4. Of children not up-to-date at 24 months of age, 8.6% (2.5% of total population studied) were not up-to-date on any of the vaccination series (DTaP4, Polio3, MMR1, HepB3 and Hib3).

The coverage level for the 4-3-1-3-3 series is lower in the 2010-11 Retrospective Survey (71.5 [95% CI 70.3 -- 72.8]) when compared to the Kansas National Immunization Survey (NIS) 24 month milestone (78.4 [95% CI 72.6-84.2]); however, the coverage levels are not statistically different. Additionally, NIS results for Kansas are not significantly different from the national NIS 4-3-1-3-3 coverage level (76.4 [95% CI 75.3-77.5]).

In 2010, the 4-3-1-3-3 series remains more than seven percentage points from meeting the HP2010 goal of 80% coverage. This retrospective study report as well as those from previous years is available at http://www.kdheks.gov/immunize/retro_survey.html.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor, evaluate and communicate provider vaccine management performance to reduce wasted, spoiled, expired or unaccounted-for vaccines			X	X
2. Conduct compliance site visits				X
3. Update and maintain list of participating health providers				X
4. Monitor and assess completeness and timeliness of case reporting to CDC for vaccine preventable conditions			X	X
5. Monitor and assess the accuracy, timeliness, and series completeness of vaccinations in children			X	X
6. Increase the number of health providers providing information to the immunization registry				X
7. Continue MOBI-KS project that has physician trainers educate and train providers on site at about immunization policies		X		X
8. Continue and expand the providers and families participating in 'Immunize and Win Prize' initiative		X	X	
9. Continue to assess immunization coverage for the 4-3-1-3-3 series for children enrolled in kindergarten using the retrospective immunization survey				X
10.				

b. Current Activities

The Kansas Immunization Program (KIP) continues to make improvements to the services offered to health professionals. The program is developing an online vaccine-ordering module to help professionals quickly and easily order vaccines. An existing interface allows State Women Infant and Children (WIC) staff to view the vaccination status of children served by their clinics. The program is also in the process of developing a data exchange with the State Medicaid billing

system.

KIP is continuing to expand the user base for the registry. Immunization staffs are working with numerous vendors to develop interfaces that will allow providers to access and exchange information with the registry. Over the past few years, the registry has expanded enrollment to include non Vaccine for Children providers and clinics.

KIP recently completed a survey on the interest and capacity of local health departments and other partners to bill for vaccine services. The program is also evaluating the pilot Dare to Be a Champion that fostered peer-to-peer discussions in the offices of health providers about missed opportunities, avoiding invalid doses and implementing an effective reminder/recall system.

The immunization program will develop and maintain initiatives designed to promote and enhance immunization rate in young children. These initiatives include Immunize and Win a Prize, MOBI, and Governor's Birth card.

c. Plan for the Coming Year

1) KSWebIZ will continue to expand its versatility and user base through data exchanges and direct entry immunization data.
2) VFC will continue to expand to more Kansas providers in order to reach the eligible population.
3) The Kansas Immunization Program (KIP) will continue to collaborate with community and internal partners to collaborate and share knowledge about immunizations in Kansas.
4) The KIP will continue to assist communities to improve immunization coverage for all ages to reduce the incidence of vaccine-preventable disease.
5) MCH will Partner with KIP to provide links to educate health providers about new Vaccine Tracking System (VTrckS) and updates to Immunization Information System interface.
6 KIP will conduct a retrospective survey of kindergartner children who were born between September 2, 2006 and September 1, 2007 regarding their immunization coverage levels at 24 months of age, which corresponds to September 2, 2008 and September 1, 2009. This report is expected to be posted for public access on July 1, 2013.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	18	18	20	20	20
Annual Indicator	21.7	22.0	20.6	19.1	19.1
Numerator	1273	1261	1162	1106	1106
Denominator	58780	57321	56277	57952	57952
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18	18	18	18	18

Notes - 2011
The 2011 column is populated with 2010 data. 2010 data will be available Fall 2012.

Notes - 2010
Data Source:
Numerator = Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census; 2010 data are actual Census counts, not estimates.

Notes - 2009
Data Source:
Numerator = Birth certificate (resident) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2009

a. Last Year's Accomplishments
In Kansas, 2010, the teen birth rate (ages 15-17) was 19.1 per 1,000 females. This was 7.3% lower than 2009 (20.6). However, no statistically significant difference was observed. In 2010 (the most recent year preliminary national data for this age group is available), the birth rate for Kansas young teenagers 15-17 years was higher than the national rate (17.3 per 1,000).

Teenage birth rates for ages 15-17 for white non-Hispanic and Hispanic decreased in 2010. The non-Hispanic black teen birth rate in 2010 (35.6) was significantly higher than the rate in 2009 (26.5). Hispanic teens had the highest rate (47.7) in 2010.

There was a slightly decreasing trend observed over the 10 year period, 2001-2010. The APC (annual percent change) was not statistically significant (i.e., non-significant change).

The overall rates for Chlamydia, which is an indication for sexual activity, in females aged 15-19 (29.5 infections per 1,000) have remained stable in Kansas over the last several years, a number of disparities exist for teenage in Kansas. Chlamydia rates are the highest for women aged 15-19 (29.5 infections per 1,000) in Kansas. Chlamydia rates are two times higher for Hispanic women (19.1 infections per 1,000 women aged 15-19, and six times higher for non-Hispanic black women (62.5 infections per 1,000 women aged 15-19 compared to their respective non-Hispanic white peers (10.5 infections per 1,000 women aged 15-19. (Source Kansas STD Program).

Direct Services:

None.

Enabling Services:

Teen Pregnancy Targeted Case Management (TPTCM) was funded with state general funds. It

support pregnant and parenting adolescents up to age 21 in order to reduce negative pregnancy outcomes and delay future pregnancies.

Kansas received Section 510 Abstinence Education of Title V funding. The targets of the grant funds are children in foster care ages 10-18. The goal of the grant is to use of positive youth development principles to teach them how to make responsible choices. The KAEP information is added to the initial foster care curricula and foster parents are given incentives to teach KAEP information to the foster children.
Kansas received a Personal Responsibility Education Program (PREP) grant that has a goal to educate and empower adolescents to make informed, healthy decisions about their sexual health in order to reduce unplanned pregnancy and transmission and acquisition of sexually transmitted diseases, including HIV. PREP targets four counties which contain about 48 percent of the state population.
KDHE will continue to support evidence based teen pregnancy prevention program sand STD Program efforts to reduce teen pregnancy and STDs.

Population-Based Services

MCH adolescent health staff collaborated with KSDE and seven states to provide educational conference on HIV/AIDS/STDs. There were 186 participants at the conference.

MCH continued to partner with KDHE's STD Prevention Program to identify early and treat cases of chlamydia. Disparate populations continue to be the target of teaching and intervention efforts though the schools and health fairs.

Infrastructure Building:

MCH staff continued collaboration with the Title X Family Planning staff to assure that contraceptive services and counseling were accessible to teens in all geographic areas across Kansas.

MCH staff provided TA to grantees on grant writing and provided support to secure funding to sustain teen pregnancy prevention efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide family planning and STD prevention/treatment services to adolescents.	X	X	X	
2. Continue to develop and promote evidence based teen pregnancy prevention programs using principles		X	X	X
3. Collaborate with Positive Youth Development team to provide training that encourages teen to develop goals and avoid unhealthy decisions.		X	X	X
4. Promote the prevention of Fetal Alcohol Spectrum Disorder (FASD) in teen's children though education and participation in FASD prevention campaigns.		X		X
5. Serve on a SRS Kansas Child Welfare Quality Improvement Committee to improve the permanency of teens in the foster care systems that are pregnant or parenting.				X
6. Actively look for opportunities to address teen pregnancy disparity issues such as speaking opportunities and program committee involvement.		X	X	X

7. Serve on committee with SRS to provide education & support male involvement programs and resources.		X	X	X
8. Plan and participate with KSDE and surrounding states to offer a regional training on HIV/STD/AIDs prevention conference.		X	X	X
9.				
10.				

b. Current Activities
Direct Services:

None.

Enabling Services:

MCH and Kansas Title X Family Planning (FP) program has contractual relationships with 58 FP agencies located in Kansas. Focus is on STD screening for all women 24 years of age or younger.

The KDHE STD Section staff report chlamydia rates are increasing because of increased availability of testing and perhaps more disease and the current level of funding for STD treatment is not sufficient for universal partner intervention.

MCH partnered with KSDE to provide AIDS/HIV/STD education for teachers and nurses, topics included the technical world of teen sexuality, current trends in adolescent sexual behavior, HIV prevention for incarcerated youth, and literature's impact on human sexuality.

The KDHE STD Section continues use of MySpace, Facebook, and Twitter providing relevant STD information available to teens.

Population Based Services:

Information on STDs and wellness are sent to all MCH sites and around 600 school nurses to provide awareness and prevention messages.

Infrastructure Building

KDHE continues to partner with KSDE, and all departments within KDHE to maximize resources and assure access to information and resource.

c. Plan for the Coming Year
Direct Services:

None.

Enabling Services:

KDHE staff will continue to support evidence based TPP programs and FP and STD Program efforts to reduce teen pregnancy and STDs.

Population Based Services:

MCH will continue collaborations with KSDE to provide training on adolescent health issues and continue to provide school nurse/MCH education and treatment.

KDHE staff will provide Fetal Alcohol Spectrum Disorder (FASD) training to teens and groups that work with teens on how to prevent FASD in the children of adolescents. MCH staff received a grant from the FASD Foundation for MRFASTC Midwest Regional Fetal Alcohol Syndrome Training.

PREP grant will continue to provide training to target high population areas in Kansas using proven effective curricula.

KAEP will continue to provide foster parent education to help teen make responsible choices.

Infrastructure Building:

KDHE will continue to collaborate with all State agencies to maximize funds. KDHE will continue to look for and apply to new funding sources for teen pregnancy prevention programs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	37	40	40	40	40
Annual Indicator	38.2	38.2	38.2	38.2	35.7
Numerator	13176	13176	13176	13176	
Denominator	34506	34506	34506	34506	
Data Source		KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	41	41	42	42	42

Notes - 2011
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

Notes - 2010
Data Source: KDHE. Office of Oral Health. Smiles Across Kansas: 2007 Update - unpublished weighted data.

Data for 2010 is not available. 2007 data was used to pre-populate this performance measure. A report of 2009 data will be released in September 2011.

Notes - 2009
Data Source: KDHE. Office of Oral Health. Smiles Across Kansas: 2007 Update - unpublished weighted data.

Data for 2009 is not available. 2007 data was used to pre-populate this performance measure.

a. Last Year's Accomplishments
Enabling Services:
Oral Health Education/Outreach
1) Collaboration with the Primary Care Association -- Bureau provides the Primary Care Association with assistance on educating their dental providers about pediatric and special needs patients. We also collaborate on dental recruitment and workforce issues.
2) An updated Online Module "Kansas Oral Health Screening Initiative Calibration/Training Course" was posted in 2011 on kstrain.org
3) Conducted the third "Smiles Across Kansas" survey in the fall of 2011, screening over 2,000 3rd grade children in 65 elementary schools. Report will be completed and published by the end of summer 2012.

Support Services:
1) The Bureau partners with a safety net clinic to provide an access point for dental care for patients with special needs who require sedation services. Funding provided by the Bureau's MCH Targeted Oral Health Service Systems grant funds a special needs day at the clinic.
2) The Bureau has contracted with 16 clinics or programs to create and maintain school sealant programs. The Bureau provides funding and technical assistance. During the 2010-11 school year sealants were placed on over 1400 children.

Population Based Services:
Oral health screening-Kansas law requires each child to have a yearly oral health screening. The Bureau of Oral Health assists schools in complying with this statute. Bureau staff train screeners and help schools organize screening dates. Screening data is collected and housed at the Bureau. In the 2010-11 school year over 124,000 children were screened.

Infrastructure Building Services:
Sealant Site Grantee meeting was held in July 2011 for administrative and technical support for the Kansas School Sealant Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide fluoride varnish training and oral health education to non-dental professionals		X		X
2. Establish school oral health screenings and referrals		X	X	X
3. Provide consultation and technical assistance to school based dental sealant projects		X		X
4. Provide support and technical assistance to the Medicaid Agency on dental matters				X
5. Provide leadership to the Oral Health Kansas Coalition				X

6. Provide leadership to the Kansas Public Health Association Board Oral Health Section				X
7. Provide education and dental access to Children and Youth with Special Health Care Needs		X		X
8. Provide a forum for discussion of Dental Workforce policy, the Dental Workforce Cabinet				X
9. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations				X
10. Targeted education and outreach to families to improve the oral health of children across Kansas		X	X	X

b. Current Activities

Population Based Services:

The school based screening initiative will screen over 120,000 children in the 2011-12 school year. The data will be available in the fall of 2012. Other activities the bureau plans to continue are:

1) educating medical providers about caries risk assessment and providing oral health screenings, especially during Kansas KanBE Healthy Examinations (EPSDT) in young children on Medicaid and Healthwave through educational presentations at medical conferences and online training.

2) providing dentists with educational materials, continuing education sessions (live and online) and technical support to increase their willingness to provide a dental home for children age zero to five (Head Start children in particular) and pregnant women

3) collaborating with Kansas Head Start Association to provide annual updates on the oral health of children in Kansas Head Start.

4) expanding the number of schools that comply with the Kansas Dental Screening Law and provide data to the Bureau of Oral Health about children's oral health.

c. Plan for the Coming Year

Continue to recruit volunteer screeners to expand the number of children offered screenings in school.

Collect data from the 16 sealant sites on services performed in the 2012-13 school year and evaluate programs to increase program sustainability.

Population Based Services:

Thorough 2014, continue to inform medical providers about how to apply fluoride varnish and bill Medicaid for the procedure with both an online training program and in-office hands on demonstrations.

Through August of 2014, Provide dentists with educational materials, continuing education sessions (live and online) and technical support to increase their willingness to provide a dental home for children age zero to five (Head Start children in particular) and pregnant women.

Through 2014, expand the number of children that have access to school based oral health services including topical fluoride, sealants and restorative care.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**

Annual Performance Objective	5.5	3.8	3.6	3.6	2.5
Annual Indicator	3.7	3.6	2.7	4.0	4.0
Numerator	21	21	16	24	24
Denominator	575333	582572	588523	606823	606823
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3.6	3.5	3.4	3.3	3.2

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source:
Numerator = Death certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census; 2010 data are actual Census counts, not estimates.

Notes - 2009
Data Source:
Numerator = Death certificate (resident) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2009

a. Last Year's Accomplishments
In 2010, the mortality rate for children ages <= 14 as a result of unintentional injury--motor vehicle crash was 4.0/100,000 children, a 48.1% increase from 2009 (2.7).

Overall, there is a significant decreasing trend observed over the 10 year period, 2001-2010. The APC (annual percent change) was significant (-6.89).

According to the 2011 Annual Report (2009 Data) of the Kansas State Child Death Review Board (SCDRB), in 2009, there was an 11% reduction in the number of child deaths from 2008. The Unintentional Injury - Motor Vehicle Crash (MVC) category showed a reduction of 25% from 2008. The Board attributes this drop to the Kansas Legislature enacting the booster seat and primary seat belt law for all children under age 17.

Direct Services:

The child safety seats installation/inspection continues with additional training offered by Kansas Traffic Safety Resource Office (KSTRO). SAFE KIDS Kansas, Inc., a nonprofit coalition consisting of statewide local MCH programs/partners, is dedicated to preventing accidental injuries to Kansas children ages 0-14 and is affiliated with SAFE KIDS Worldwide. Yearly SAFE KIDS adopts a platform to prevent accidental injuries to Kansas children; in 2010 it included booster seat use for children.

Enabling Services:

SAFE KIDS networks serve 78% of Kansas children ages 0-14. State MCH staff served on the SAFE KIDS Advisory Committee, KDHE's Emergency Medical Services for Children (KEMS) Coalition and the State Child Death Review Board identifying trends in child death.

Population Based Services:

KDHE partnered with SAFE KIDS to support legislation for the primary seat belt law and restricting cell phone use by teen legislation to improve the MVC rates. Both of these laws passed and appear to make an impact on decreasing the MVC rates by ticketing front seat passengers not wearing a seat belt and restricting youth less than 18 years old from using cell phones while driving.

Safe Routs to School program was successful and is continuing in many schools.

Infrastructure Building Services

MCH staff worked with SAFE KIDS to provided mini grants to local communities for Safe Routes to School.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Title V staff collaborates with SAFE KIDS Advisory Council and the Emergency Medical Services for Children Coalition to coordinate delivery of motor vehicle injury/death prevention information and resources.		X	X	X
2. State Child Death Review Board analyzes of deaths of children ages 0-18 that are involved in motor vehicle crashes.			X	
3. Link local health departments' to data resources that provide information of motor vehicle unintentional injury to facilitate development of regional/ community strategies targeting specific populations/injuries/deaths.			X	X
4. Local MCH staff provides education and instruction to families with infants and young children on importance of proper Child Passenger Safety, graduated driver's licensing, and new laws for primary seat belt use and banning cell phone use.		X	X	X
5. Encourage community collaboration to seek out resources to assist in injury prevention programs such as Cycle Smart, Walk This Way, Spot the Tot and Safe Routes to School.			X	X
6. MCH provides education/resources for developing/ delivering targeted MCH services for specific populations through annual orientation session for new MCH staff, the monthly MCH newsletter, and participation on statewide coalitions/committees.			X	X

7.				
8.				
9.				
10.				

b. Current Activities
Direct Services:

Child safety seats installation/inspection continue with additional training offered by KSTRO.

Enabling Services:

SAFE KIDS has 28 local coalitions covering 74% of Kansas children age 0-14. State MCH staff serves on the SAFE KDIS Advisory Committee, KDHE's Emergency Medical Services for Children (KMSD) Coalition and the State Child Death Review Board identifying trends in child death.

Population-Based Services:

KDHE staff support and promotes the above-mentioned coalitions training and prevention programs. MCH staff continues to write prevention articles for publication.

Infrastructure Building Services:

KDOT and SAFE KIDS continue to provide mini grants to communities with SAFE Routes to School, booster seats, and other pedestrian bicycle/motorized vehicle safety programs.

c. Plan for the Coming Year
Direct Services:

Child safety seats instillation/inspection will continue with additional training offered by KSTRO.

The MCH programs will continue to collaborate with outside sources and develop objectives to decrease accidental morbidity caused by motor vehicle crashes.

Enabling Services:

KDHE will continue to serve on the SAFE KIDS Advisory Committee, Emergency Medical Services for Children Coalition and look for other organizations with missions to improve child safety.

Population-Based Services:

MCH works with KSTRO and the Kansas Highway Patrol, local law enforcement, the Kansas Drivers Safety Education Association, AAA, Kansas Safe Kids Coalitions, the Kansas Family Partnership, Students Against Destructive Decisions (SADD) and others to provide an assortment of traffic safety education through newsletters, web mail, education programs and public service announcements.

Infrastructure Building Services

BFH staff collaborated with the above-mentioned coalitions and agencies to support legislation to protect children locked in cars.

Additional Child Passenger Safety (CPS) Technicians are continuing to be trained through coordinated efforts with KSTRO across the state, focusing on each region of the state. Registered CPS inspection stations will receive periodic disbursements of car seats from KDOT to provide the families at no cost.

Safe Kids Kansas, through a grant from KDOT, provides funds to participating local networks to support CPS efforts, including training costs, media expenses, check lane supplies, and car seats. KEMS continues to work with emergency medical personnel to update ambulance equipment and provide training for care of infants, toddlers and small children.
Safe Kids Kansas received a grant from Safe Kids USA for an initiative to "Never Leave Your Child Alone in a Car" targeting the dangers of hyperthermia in vehicles. A partnership with Radio Disney in the Kansas City area will run PSAs and distributing flyers at public events.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	23	24	45	45	50
Annual Indicator	42.1	43.8	47.4	41	41
Numerator					
Denominator					
Data Source		National Immunization Survey, 2006 birth cohort	National Immunization Survey, 2007 birth cohort	National Immunization Survey, 2008 births	National Immunization Survey, 2008 births
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	42	43	44	45	46

Notes - 2011
The 2011 column is populated with 2010 data (provisional data, 2008 births). Data will be available in 2013.

Notes - 2010
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Breastfeeding Report Card - United States, 2011
http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf

Notes - 2009
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Provisional geographic-specific breastfeeding rates among children born in 2007, CDC's Breastfeeding National Immunization Data: Any by States: 2007.

http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm

a. Last Year's Accomplishments
In the 2011 Breastfeeding Report Card, 41.0% of Kansas children born in 2008 (provisional) were breastfed at least 6 months, 13.5% lower than children born in 2007 (provisional, 47.4%). This compares to 44.3% for U.S children born in 2008 (provisional). This estimate remains below the national Health People 2020 objective (60.6%). Over the 8 year period (2000-2008), there was a significantly increasing trend in the proportion of Kansas infants breastfed at 6 months of age. A similar trend was observed at the national level. The survey also shows that low income mothers are less likely to breastfeed than their higher income counterparts.

According to the 2010 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 17.3% of Kansas WIC infants were breastfed at least 6 months, 17.2% lower than in 2009 (20.9%). This was 31.1% lower than the percent for U.S. WIC infants (25.1%). This is well below the Health People 2020 objective (60.6%). In recent years (2004-2010), the prevalence of Kansas WIC infants breastfed at 6 months of age has declined, while the US prevalence continue to increase.

Enabling Services:

Kansas Breastfeeding Coalition in partnership with KDHE conducted 3 Business Case for Breastfeeding workshops and offered assistance on support of working breastfeeding mothers to businesses throughout Kansas

Population Based Services:

Supported Breastfeeding Peer Counselor Programs in 41 Kansas counties. Peer counseling was a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Coordinated a public awareness campaign for World Breastfeeding Week in August 2011 where Kansas families submitted their breastfeeding stories. Four selected families received a professional photo shoot an 8x12 family photo and their picture on a billboard advertising the Breastfeeding Let's Talk about it Campaign.

Infrastructure Building Services:

Supported evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets included a newsletter and breastfeeding resources which can be shared with other health professionals in communities.

Supported Certified Breastfeeding Educator Training in October 2010, August and September 2011.
.
Provided financial support to the Kansas LaLeche League 2010 fall conference for all health professionals.

Provided financial support to assist 10 candidates to prepare for the IBCLC exam. Eight of which successfully completed all requirements and passed the exam.

Provided financial support to encourage LHD staff to attend trainings on breastfeeding promotion and support.

Approximately 250 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2011. The conference featured a breakout session on "Breastfeeding in the African American Community."

Adapted the "Using Loving Support to Grow & Glow in WIC" breastfeeding training for all new WIC employees that is held twice a year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support state agencies, LHD and private businesses to implement new or enhance existing breastfeeding friendly worksite policies.				X
2. Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.		X		
3. Provide or support evidence-based continuing education on breastfeeding promotion and support.				X
4. Support breastfeeding credentialing efforts of LHD staff for both MCH and WIC programs.				X
5. Sustain a statewide public awareness campaign that supports breastfeeding.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Ongoing training and partnerships including the Business Case for Breastfeeding to support working breastfeeding mothers.

Foster the development of local breastfeeding support groups for minority populations.

Population Based Services:

Kansas WIC expanded their peer counseling program to cover 46 of the 105 counties in the state.

Assess breastfeeing duration statistics to compare counties with peer counseling program vs. counties without peer counseling program.

Sponsor a breastfeeding promotion and support billboard campaign.

Active participation with a planning and implementation workgroup for "High 5 for Mom and Baby" hospital education campaign to improve Kansas breastfeeding statistics through policy and practices changes.
Infrastructure Building Services:

Provide financial support to the Kansas LaLeche League 2012 spring conference for all health professionals.

Provide financial support to encourage LHD staff to attend trainings on breastfeeding promotion and support.

Approximately 270 local and state health department staff attended the Seventh annual Governor's Public Health Conference in April 2011. The conference featured a breakout session on "The Business Case for Breastfeeding"

Support evidenced-based breastfeeding related training of researchers and practitioners with a bi monthly electronic newsletter.

Support Certified Breastfeeding Educator Training.

Twice a year breastfeeding training for all new WIC employees.

c. Plan for the Coming Year
Enabling Services:

Work with local Breastfeeding Coalitions, the LaLeche and other interested parties to promote breastfeeding friendly employee policies.

Fostering the development of local breastfeeding coalitions

Fostering the development of local breastfeeding support groups for minority populations.

Population Based Services:

Sustain Breastfeeding Peer Counselor programs in existing counties.

Support World Breastfeeding Week activities.

Support evidenced-based breastfeeding related training of researchers and practitioners with a bi monthly electronic newsletter and newsletter articles promoting breastfeeding newsletters letters for partner organizations.

Infrastructure Building Services:

Work with LHD to improve staff competencies related to breastfeeding by providing financial

support for staff to attend trainings.

Provide financial and in kind support to organizations organizing education on breastfeeding promotion and support to health professionals and the general public.

Twice a year breastfeeding training for all new WIC employees, other LHD employees invited to attend as space allows.

Collaborate with federally funded nutrition programs and community organizations to identify opportunities for coordination to promote and support breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	98	98	98	98.2	98.2
Annual Indicator	90.5	89.5	98.0	98.5	98.6
Numerator	38355	37661	41645	40962	39891
Denominator	42376	42060	42515	41593	40454
Data Source		KDHE. Kansas Newborn Screening program, 2008	KDHE. Kansas Newborn Screening program, 2009	KDHE. Kansas Newborn Screening program, 2010	KDHE. Kansas Newborn Screening program, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99	99	99	99	99

Notes - 2011
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2011.
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

Notes - 2010
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2010.
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

Notes - 2009
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2009 .
Denominator= KDHE. BEPHI. Kansas Live Birth by Occurrences for Hospitals.

Data Prior to 2009 is not comparable.

a. Last Year's Accomplishments
Kansas has continued to screen at 98% or better since 2009. The percent of newborns screened before hospital discharge in 2010 has an increase of 2.2% since 2007. Out of Hospital Birth hearing screening rates have increased from 21% in 2010 to 34% for 2011. The percent of infants who are Lost to Follow-Up/Loss to Documentation (LFU/LTD) is 42% for 2010. This is a decrease of 42% since 2008. In 2008 Kansas' Newborn Hearing Screening Program reported that 84% of the infants were who failed the newborn hearing screen never completed the hearing screening process and/or it was not reported to the state.

SoundBeginnings (SB) developed and distributed surveys to known midwives, birthing babies in Kansas, requesting their interest and knowledge of the state mandated hearing screen, who was performing the hearing screenings, their needs/wants for hearing screening equipment and their interest in educational trainings. A survey was also distributed to all 105 County Health Departments requesting hearing screening information performed at their facility, if any, and their need/want for hearing screening equipment. Research has indicated that 75% of infants known as LFU (not having completed the hearing screening process) are being seen at local health departments for other services (WIC and Immunizations). These researching states have been able to resolve up to 30% of their LFU cases. From the information collected from the surveys, SB has been able to understand where the breaks were occurring in the hearing screening process, areas that need further education and implementations that will continue to reduce the overall LFU in all stages of the hearing screening process.

Population Based Services:
The screening is implemented at the local level by hospitals, birthing centers or other obstetrical/newborn services licensed facilities. SB administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance.

Enabling Services:
Collaboration and funding was provided for assistance with parent-to-parent support, and continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization. SB staff, parent representatives attended an EHDI Family Support National Meeting to assist with development family support infrastructure and services for children and their families. Information resources to outpatient and diagnostic Audiology Providers were provided. Enhancement of the current SB database allowing hospitals and audiologist to manually enter hearing screening data was implemented. It is felt that this enhancement will continue to decrease the state's rate of LFU and documentation.

Infrastructure Building:
The SB Advisory Committee continued to meet quarterly and establish goals for each year to support the program and stakeholders.

SB visited 4 birthing hospitals (Sumner Regional Medical Center, Via Christi-St. Joseph, Citizen's Medical Center, St. Catherine Hospital) and 3 Part C Infant Toddler networks (Arrowhead West, Reno County Infant Toddler Services, Shawnee County Infant Toddler Services) to retrain and re-educate the coordinators and hearing screeners. Funding was provided for 5 birthing hospitals/clinics (Sumner Regional Medical Center, Midwives of KC, Newbirth Company, Minneola District Hospital, Cushing Memorial Hospital) and 5 selected Health Departments (Sumner, Finney, Sedgwick, Wyandotte, Johnson) to receive Otoacoustic Emission screening equipment. An Auditory Brainstem Response machine was also purchased for the 2 of the state's largest birthing facility (Wesley Medical Center and Via Christi-St. Joseph) and 1 Early Intervention Network Pediatric Audiologist (NE Kansas Infant Toddler Services-Greenbush) to help reduce their LFU rate which will provide diagnostic testing without sedation on the birth to three years of age population.

Presentations provided by Liz Abbey, SB Coordinator/Audiologist at the Kansas Academy of Family Physicians, Kansas Chapter AAP, Sound START Train the Trainer conference, Kansas Speech Language Hearing Association, Academy of Audiology Association and the 2011 Annual National Early Hearing Detection and Intervention conference.

Liz Abbey developed training curriculum for Parents as Teachers (PAT) Otoacoustic Emission hearing screenings The PAT networks are to be trained and have the hearing screening protocols in place by 2014.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data submission through the web-based birth certificate (VRV) reporting system.				X
2. Continue quarterly meetings of the SoundBeginnings Advisory Committee				X
3. Continue the education training to professionals on early intervention				X
4. Collaborate to assist Kansas Hands and Voices chapter enabling parental input and parent to parent support			X	
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc				X
6. Support to hospitals to enhance screening equipment				X
7. Family and Audiologist Consultants to assist reduce loss to follow-up				X
8. Formalization of a regional program to assist newly identified families at first contact.				X
9. Continued attendance at EHDI, parent support and deaf education focused meetings				X
10.				

b. Current Activities

Population Based Services:

The screening is implemented at the local level by birthing facilities. SoundBeginnings administers the statewide system for EHDI including a data management tracking and surveillance system.

Enabling Services:

Continued collaboration and funding for Kansas Hands & Voices parent-driven family support

organization.

Infrastructure Building:
SoundBeginnings will continue with Advisory Committee meetings and dissemination of brochures.

Continued submission of screening and diagnostic evaluation results through direct database input, fax, mail and email. Follow-up is completed on missed, NICU, and failed screens by staff and by EHDI Coordinator for confirmed hearing loss to medical home providers, Part C local networks and families.

Site visits are made to hospitals and Audiologists. Information and technical assistance is provided to all stakeholders on program via phone and email.

Support through grants to assist with reducing refer rate to include Automated Auditory Brainstem Response equipment has been provided to Level III NICU Hospitals.

Continued work with support through grants is ongoing for reducing loss to follow-up and loss to documentation and tracking, surveillance and integration.

c. Plan for the Coming Year
Population Based Services:
Maintain and make improvements to statewide data management tracking and surveillance system.

Enabling Services:
Continued assistance with the Kansas Hands and Voices Chapter family support organization group specifically for families of children who are deaf or hard of hearing to promote Parent-to-Parent program services to families, assist with a family support activities and assist parent consultants. Collaboration with Early Head Start and Parents as Teachers with continued trainings and data sharing. Collaboration with county health departments providing training and funding for the purchase of hearing screening equipment. Continue assistance and education with midwives and out of hospital births.

Infrastructure Building:
Continued submission of hearing screening results through the web-based birth certificate system and the SoundBeginnings database to accept the required Healthy People 2010 data fields including race, ethnicity, language spoken in the home, birth defects, and transferring hospital.

Support through CDC grant working towards enhancements to the SoundBeginnings web-based data system, Auris, allowing birthing facilities and Audiologist to directly access their patient's record and input hearing screen reports. It is felt that this will help in the reduction of the Loss to Follow-up and Loss to Documentation cases.

Collaborate with the Kansas School for the Deaf, Infant Toddler Services, University of Kansas Deaf Education program, tiny-k networks, Hartley Family Center and the St. Joseph Institute for the Deaf to provide assistance and training for personnel at tiny-k networks working with families of children identified with hearing loss and develop a regional program to assist in first contacts with families.

Continued technical assistance provided to hospital personnel, Audiologists, Early

Interventionists, Medical Home and other stakeholders of newborn hearing screening and intervention services. Audiologist Consultants and Family Consultants will be contracted to assist local communities in reducing loss to follow-up and/or documentation.

SoundBeginnings Newborn Hearing Screening Program Advisory Committee continues to meet quarterly. The committee has established goals for the Advisory year which begins in January including parent communication and family concerns; focus on education to all members involved in early intervention and including the focus of the family perspective; and information sharing of legislative issues or advocacy from the Kansas Commission of the Deaf and Hard of Hearing or other organizations that are related to early hearing detection and intervention.

Support will be provided to two hospitals that have a Level II or III NICU to purchase Automated Auditory Brainstem Response (AABR) equipment.

Staff, parents, and Pediatric Audiologists continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6.5	7	7	10.5	8
Annual Indicator	7.7	11	8.1	7.5	7.5
Numerator					
Denominator					
Data Source		US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HI05
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.5	7.3	7.3	7.3	7.3

Notes - 2011

DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at
http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm

Data for 2011 is not available. 2010 data was used to pre-populate this performance measure. Data for 2011 will be available October 2012.

Notes - 2010
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2010. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm

Notes - 2009
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2009. Addition information can be found at
http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm

a. Last Year's Accomplishments
Across Kansas there is a high rate of children growing up without health insurance which means they have less access to routine and preventive care that helps ensure their healthy development and manages any chronic care conditions. The lack of access to early intervention means children without health insurance are more likely to access costly care in emergency rooms for acute conditions such as asthma attack, sore throat, fever, or stomach pain. This type of care equates to a growing medical debt for many Kansas families and increases the burden of uncompensated care for community hospitals in Kansas.

According to the U.S. Census Bureau's Current Population Survey, 7.6% of Kansas children under 18 did not have health insurance coverage during 2010. This was not significantly lower than 9.8% of children under 18 nationally. This year data suggest that health insurance coverage for Kansas children has stabilized. The percent of children in Kansas without insurance coverage has decreased since 2008 from 11% to 7.6% in 2010. This increase in public insurance coverage may be due to easier application process and a more expedite renewal process for children.

In another survey conducted by the U.S. Census Bureau (the American Community Survey), several disparities were identified for Kansas children without health insurance between 2008 and 2010. In Kansas, a higher percentage of:

•children aged 6-17 years old were without health insurance (9.1%) compared to children less than 6 years old (6.7%)
•children without disabilities were without health insurance (8.3%) compared to children with disabilities (6.7%)
•American Indian/Alaskan Native children (15.1%), Hispanic children (15.8%), or children of some other race (20.3%) were without health insurance compared to non-Hispanic whites (7.5%)

Direct Services:

MCH clinics provided immunizations, well child checks and Healthy Start Home Visitor Services on a sliding fee scale to families unable to afford care at full price.

Enabling Services:

HealthWave-21 and Medicaid reduced their backlog of Medicaid applications using Centers of Medicaid Services (CMS) grant money to increase their workforce and streamline the application process.

The safety net health care in Kansas consisted of 42 Kansas Association for the Medically Underserved (KAMU) members, including 14 Federally Qualified Health Centers (FQHC), which includes the Kansa Statewide Farmworker Health Program, one FQHC Look-Alike, 27 Primary Care Clinics, and 1 other member who does not provide direct care but supports the mission. In addition to the 40 main clinic sites, services were provided at 33 additional satellite sites for a total of 73 access points.

Population Based Services:

Medicaid/ HealthWave enrollment activities were conducted in community settings. Kansas Healthy Start Home Visitors provided outreach to at risk pregnant women, families and new infants to assist in their enrollment in Medicaid and HealthWave. All MCH clinics worked to enroll clients in their clinic into a Medical Home as required by their MCH grants.

Infrastructure Building Services:

An electronic online HealthWave/Medicaid was successfully launched using grant funding provided by Health Resources Services Administration (HRSA). Local health departments, FQHCs, physician offices, and other providers can easily access the applications and assist the uninsured in completing the applications on line.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide information to MCH programs related to location and services available in safety net clinics.		X	X	X
2. Provide MCH clinics with Medicaid/HealthWave Program information and application assistance.		X	X	X
3. Assist families with Medicaid/HealthWave in establishing of a medical home.	X	X	X	
4. Link students with Medicaid/HealthWave coverage through school health services.		X		X
5. Promote local coordination and collaboration between agencies to link hard-to-reach and disparate populations to Medicaid/HealthWave Programs.				X
6. Assist local health agencies to create a community plan for linking families to safety net clinics/dental hubs and in providing care for those uninsured children who remain ineligible for Medicaid/HealthWave Programs.		X	X	X
7. Develop strategies to inform the public of implications of health reform and Patient Protection and Affordable Care Act.		X	X	X
8.				
9.				
10.				

b. Current Activities

Direct Services:

State general funds are provided to assist in the development and operation of clinics that focus on improving access to health care with an emphasis on community-based services and reducing health disparities for underserved populations. The clinics serve as "safety net" clinics in their communities. Clinics provide services regardless of ability to pay and have a discounted fee schedule.

Enabling Services:

MCH continues to work with state/local partners to assist MCH staff in locating insurance coverage and access to care for children.

Population Based Services:
MCH supports/promotes outreach /enrollment activities in local agencies and schools for Medicaid-eligible women/children encouraging health services in medical home and referring ineligible families to safety net clinics.

Infrastructure Building Services:

Medicaid and the Children's Health Insurance Program (CHIP) are now part of KDHE and part of the Kansas Medical Assistance Program (KMAP). Their new website is comprised of applications and eligibility requirements for different categories of eligibility, including fact sheets. On the KMAP webpage is a link for providers to be able to check current eligibility for their patients.

KMAP held forums across the State to gather information on quality assurance and improvement. Comments like longer clinic hours and prescription pharmacy availability will be address in the KMAP strategic plan.

c. Plan for the Coming Year
Direct Services:

The Kansas Statewide Farmworker Health Program will coordinate a state-wide case management system for migratory/seasonal farm workers. Covered health services vouchers from state-funded access point agencies made payable to primary care clinics or local health departments will be used by regional case managers to assist clients in obtaining needed services and assist clients in applying for Medicaid/HealthWave coverage or to secure private insurance.

Enabling Services:

MCH will continue to work with state/local partners to assist families in locating insurance coverage and access to care for children.

Population Based Services:

MCH will continue to support and promote outreach/enrollment activities in local agencies and schools for Medicaid-eligible women/children encouraging health services in a medial home or safety net clinic.

Infrastructure Building Services:

KMAP will continue to improve their application access making modifications, eliminating language barriers, and developing a strategic plan.

KMAP, as an agency within KDHE, will establish more communication and coordination of activities to improve health services to Kansas families.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	29	29	28	28
Annual Indicator	30.1	30.0	29.8	28.7	28.4
Numerator	9474	10306	11013	10860	10657
Denominator	31476	34352	36956	37838	37524
Data Source		Kansas PedNSS, 2008	Kansas PedNSS, 2009	Kansas PedNSS, 2010	Kansas PedNSS, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	28	27	27	27	26

Notes - 2011
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2011(Kansas WIC database).

Notes - 2010
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2010 (Kansas WIC database).

Notes - 2009
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2009 (Kansas WIC database).

a. Last Year's Accomplishments
According to the 2011 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 28.4% of low-income children ages 24-59 months in Kansas were overweight (at or above 85%) or obese (above 95%). In 2010 (the most recent year national data is available), Kansas prevalence (28.7%) was significantly lower than the prevalence nationally (30.5%). Over the 10-year period (2002-2011), there was a significant increasing trend during 2002-2004, since 2004 the trend has decreased significantly. For both periods, the annual percent changes (APCs) were significant (8.15, -1.17, respectively).

Infrastructure Building:

Training websites and resources that promote good nutrition and physical activity were published in the resources and events section of the Zero to age 21: Information for Promoting for Public

Health Professionals working with Kansas Kids (ZIPS) newsletter throughout the year.

Specific ideas in identifying funding sources, writing proposals guidelines, and following the proposal to successful delivery of a grant were presented in a breakout session at the June 2011 HIV/AIDS/STDs and Human Sexuality Education Regional Conference. Many local staff responsible for writing grants for obesity funding attended this conference.

Worked with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to use to address healthy eating and physical activity. In total, Kansas received almost $350,000 in grants.

Two state staff attended the 2011 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

School nurses were surveyed to assess if school age children are being weighed, measured and referred, as appropriate. For the 2010-2011 school year, approximately 25% of nurses who responded to the survey reported assessing BMIs. The nurses reported screening BMIs on 33,777 students of which 11,686 (34.6%) were = 85% BMI/age but only 2,159 (4.5%) were referred to a health care professional.

Population Based Services:

Approximately 250 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2011. The conference featured breakout sessions on "Supporting Healthy Food and Active Living Environments in Kansas" and "Obesity Prevention: Connecting the Dots."

Enabling Services:

Participated at the Kansas Governor's Council on Fitness meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				X
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:

Publicize existing or develop new training opportunities for state and LCH staff on healthy eating and physical activity.

Assist LHDs in identifying funding mechanisms and partnerships to support initiatives at the community level.

Survey school nurses to assess if children are being weighed, measured and referred, as appropriate.

In November 2011 the MCH Nutrition Consultant earned a Certificate in Pediatric and Adolescent Weight Management.

Population Based Services:

Participate in the development of a targeted media campaign aimed at reducing sugary drinks in the diet of tweens in Shawnee County. Initial results are positive.

Approximately 270 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2011. The conference featured a keynote presentation on "Healthy People 2020."

Enabling Services:

Participate on the Kansas Governor's Council on Fitness

Participate in planning and promoting a 2012 Statewide Obesity Summit.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Enhance or expand existing partnerships with federally funded nutrition programs for coordination to meet the overall maternal and child health nutrition goals.

c. Plan for the Coming Year

Infrastructure Building:

Advocate for policies and environmental changes that support daily physical activity opportunities in all settings.

Engage child care providers in modeling health education and physical activity for young children and their families.

Utilize and improve data systems to measure the development and impact of community-based policy and program interventions at the individual, organizational and community level.

Inventory existing partnerships related to healthy eating, nutrition and physical activity.

Work with federally funded nutrition programs to identify opportunities for coordination to meet the overall maternal and child health nutrition goals.

Survey school nurses to assess if school-aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters and referring to the health care provider will be covered in newsletters and trainings.

Population Based Services:

Work with the BHP and other stakeholders to design and promote consistent and culturally appropriate nutrition and physical activity messages.

Support continuing education opportunities on nutrition and physical activity from credentialing organizations, member associations, academic institutions and other groups.

Enabling Services:

Participate on the Kansas Governor's Council on Fitness

Model health education and physical activity for 3rd grade students in Kansas, by working with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	13.5	13.5	13	13	12.5
Annual Indicator	13.8	13.8	12.7	12.7	12.7
Numerator	5729	5720	5246	5005	5005
Denominator	41664	41570	41210	39409	39409
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.5	12.4	12.4	12.2	12.2

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

Notes - 2009
Data Source: Birth certificate (resident) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE

Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

a. Last Year's Accomplishments
Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. In 2010, 12.7% (5,005) of women reported smoking during the last three months of pregnancy, no change from 2009 (12.7%). Over the six year period (2005-2010), there was a statistically significant decreasing trend detected. The annual percent change was significant (APC=-2.46). Among women who reported smoking during the last three months of pregnancy, 68.1% reported Medicaid as principal source of payment for this delivery. This is a 17.0% increase from 2009 (58.2%).

Direct Services:

Pregnant women referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services were provided tobacco cessation assistance. The Kansas Tobacco Use Prevention Program (Kansas TUPP) manages the Quitline to help smokers in Kansas to quit using tobacco products.

Enabling Services:

Prenatal providers and MCH local agencies are given relevant tobacco cessation information/resources through newsletter articles, involvement with the Kansas TUPP and routine communications with MCH staff. Referrals to the Quitline and local cessation services are provided and local agency staff is encouraged to screen, educate and refer pregnant women to appropriate resources.

Population Based Services:

Kansas is participating as a State partner in the text4baby free text messaging program for pregnant women and new moms. Health messages discouraging smoking during pregnancy and around children are some of the messages provided. Currently, there are 18 actively participating partners in the Kansas Text4baby Partnership. The partnership meets via telephone conference call annually or as needed to promote text4baby in Kansas to healthcare and social service professionals and communities statewide.

Infrastructure Building Services:

Birth outcomes and smoking rates are monitored ongoing in relation to local agency efforts in prenatal smoking prevention and cessation.

Kansas TUPP and MCH staff encourages local agencies to use the Quitline and other materials to aid in smoking cessation efforts.
MCH grantees and prenatal providers are encouraged to use CDC and March of Dimes tobacco cessation web resources and to participate in the promotion of the text4baby program to support the pregnant women and new mothers they serve.
The Kansas TUPP and MCH staff provides support and technical assistance to local grantees.
Kansas Clean Indoor Air Act has been in law since 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. . MCH encourages LHD staff and local perinatal healthcare providers to attend tobacco cessation trainings when available to help decrease the number of pregnant women that smoke tobacco.			X	X
2. . MCH encourages LHD staff and local perinatal healthcare providers to refer pregnant women to Quitline and local tobacco cessation services to help decrease the number of pregnant women that smoke tobacco.	X		X	X
3. MCH and the Kansas TUPP coordinate referrals with LHD programs and local perinatal healthcare providers to provide a linkage for pregnant women to tobacco cessation services.		X		X
4. LHD and local perinatal healthcare staff trained in the use of the 5 A's counseling approach to smoking cessation provide brief interventions to assist pregnant women to quit smoking.	X			
5. MCH staff link LHD and local perinatal healthcare staff to web resources provided by the CDC and the March of Dimes.		X		X
6. MCH staff provides LHD and local perinatal healthcare staff with other relevant tobacco cessation resources via the Web, educational conferences, newsletter articles and through routine communications.		X		X
7. MCH staff educates LHD and local perinatal healthcare staff to screen pregnant women for smoking behaviors and tobacco use and provides information on the risks associated with continued smoking and to refer to local smoking/tobacco cessation service		X		
8. MCH staff in collaboration with the Kansas TUPP and partnering tobacco-free coalitions will continue to monitor for changes in local and state-wide smoking/tobacco cessation ordinances/legislation.				X
9. Kansas Clean Air Act in place since 2010.				X
10. Kansas participates as state-level text4baby partner with 18 current member organizations.			X	

b. Current Activities
Direct Services:

Pregnant women are referred to the Kansas Quitline and local tobacco cessation services for tobacco cessation assistance. Local activities are provided by community coalitions and youth organizations.

Enabling Services:

MCH staff provides prenatal care providers and MCH local agencies relevant tobacco cessation

resources through newsletter articles, involvement with the Kansas TUPP and routine communications with MCH staff. Local agency staff is encouraged to screen, educate and refer pregnant women to appropriate resources like the Kansas Quitline and local cessation services.

Population Based Services:

KDHE serves as a State partner in the text4baby free text messaging program for pregnant women and new moms. Health messages discouraging smoking during pregnancy and around children are some of the messages provided. There are currently 18 participating organizations in the Kansas text4baby partnership.

Infrastructure Building Services:

Kansas TUPP and MCH staff encourages local agencies to use the Quitline and evidence-based strategies to reduce smoking during pregnancy.
MCH grantees and prenatal care providers are encouraged to use CDC and March of Dimes tobacco cessation web resources.
The Kansas TUPP and MCH staff provides support and technical assistance to local grantees.
2010 Kansas Clean Indoor Air Act

c. Plan for the Coming Year
Direct Services:

Kansas TUPP and MCH Programs will continue to promote evidence-based 5 A's counseling approach to tobacco cessation for use with pregnant women and use of the Quitline.

Enabling Services:

Local MCH grantees in the Kansas TUPP will participate in system enhancement activities inclusive of: building and sustaining capacity; expanding existing activities; and implementing comprehensive best practice programs.
Grantees will be asked to place an emphasis on identifying and eliminating disparities among different population groups in regard to tobacco use in an effort to reduce infant mortality resulting from pregnant women smoking and/or being exposed to second-hand smoke.
Screening, referral and counseling services will be provided by local MCH grantees and local prenatal care providers where available.
MCH staff will provide tobacco cessation resources via Web links, newsletter articles and routine communications to local agencies and prenatal care providers.
Kansas home visitation staff will provide outreach services to pregnant women and their families including linking them to smoking cessation resources and referrals to the Quitline and local smoking cessation services where available.
Medicaid pays for the Zyban and Chantix patches, but does not pay for nicotine gum, sprays, inhalers, or lozenges nor does it pay for smoking cessation counseling.

Population Based Services:

Work with existing programs in communities with high rates of pregnant women that smoke by providing them with messages focusing on the health benefits of smoking cessation and suggest implementation of a reporting mechanism to measure success.
MCH local grantees will be encouraged to utilize existing smoking cessation resources for pregnant women and women of childbearing age such as the Quitline and information from the CDC and March of Dimes websites.

Infrastructure Building Services:

MCH staff in collaboration with Kansas TUPP will monitor for any changes in local and State policy changes related to smoking cessation.
MCH staff will participate with existing advisory councils on implementing strategies to decrease smoking in pregnant women in women of childbearing age.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.5	9.4	9.3	11	9
Annual Indicator	10.1	11.1	9.1	10.1	10.1
Numerator	61	67	55	61	61
Denominator	606239	604131	602256	604262	604262
Data Source		Kansas Vital Statistics, 2006-2008	Kansas Vital Statistics, 2007-2009	Kansas Vital Statistics, 2008-2010	Kansas Vital Statistics, 2008-2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10	9.9	9.8	9.7	9.6

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source:
Numerator = Death certificate (resident) data, 2008-2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: U03, X60-X84, Y87.0.

Denominator =U.S. Bureau of the Census
2008-2009 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

Notes - 2009
Data Source:
Numerator = Death certificate (resident) data, 2007-2009, Bureau of Epidemiology and Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: X60-X84,Y870.

Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2007-2009

a. Last Year's Accomplishments
In 2010, the suicide rate among Kansas youth ages 15-19 was 13.7 per 100,000. This was 128.3% higher than 2009 (6.0). For the period 1999-2010, using rolling 3 year averages, overall, there was a stable trend in completed suicides by Kansas youth (15-19) during 1999-2001 and 2008-2010. The annual percent change (APC) was not significant.

According to the WISQUARS Leading Causes of Death Reports, for 2007-2009 (the most recent year national data for the 15-19 age group are available), the suicide rate for Kansas youth ages 15-19 (10.1) was 38.4% higher than the U.S. rate (7.3); youth suicide was the third cause of death in Kansas 15-19 year olds and for the U.S. the third cause of death.

According to the 2011 Kansas Youth Risk Behavior Survey (YRBS)
•11.8% of students had seriously considered attempting suicide during the past 12 months before the survey, a decrease of 6.3% from 2009 (12.6%).
•9.9% of students had made a plan about how they would attempt suicide during the past 12 months before the survey, a slight increase from 2009 (9.5%).
•Hispanic/Latino (11.4%), multiple race (10.7%), and white non-Hispanic (9.2%) than black non-Hispanic (7.5%) students. There were no statistically significant differences between the racial/ethnicity groups.
•5.9% of students had actually attempted suicide one or more times during the 12 months before the survey, a decrease from 2009 (6.1%).
•2.5% of students had made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse, an increase from 2009 (1.8%).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the Governor's Mental Health Services Planning Council and SPS to promote statewide suicide prevention strategic plan.		X	X	X
2. Work with the SPS to develop culturally appropriate, effective suicide prevention strategies for adolescent populations in Kansas.				X
3. Develop infrastructure and provide awareness of mental health/suicide specialist so referral sources will be available when needed.		X		X
4. Assist making linkages from Kansas schools to regional mental health centers for counseling and mental health services to decrease suicide ideology.		X		X
5. Ask school nurses for feedback if they are implementing a suicide prevention program in their schools through a school nurse survey to evaluate program implementation.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct Health Care Services

Kansas schools continue to connect to the Telemedicine network, their regional mental health centers, and KU to provide mental health services to rural areas of KS.

According to school nurse survey data, in 08-09 school year, 42% of the nurses report a school suicide prevention program within their school. In 10-11 that number increased to 44%.

Enabling Services

Technical assistance was available to Kansas School Nurses on how to develop a Yellow Ribbon Suicide Prevention Program in their schools and communities.

Population Based Services

Article on suicide awareness and prevention are in MCH newsletters to local health department and school nurse staff.

Grass roots suicide prevention coalitions are starting across KS. One such coalition is in Harvey County with a focus team that contacts any suicide related caller to make sure the person has support and a referral to mental health. Douglas County is starting a group that is inviting community discussion and forming a survivor support group in an effort to increase awareness and begin activities.

Infrastructure Building Services

MCH continues to work with all agencies to maximize resources to reduce adolescent suicides in KS and assure best practice information is available.

c. Plan for the Coming Year
Direct Services

School nurses will continue to provide suicide prevention interventions in the school setting and are encouraging school administration to have a suicide action plan and trained staff to prevent suicide from occurring and/or dealing with the survivors.

Enabling Services

Suicide prevention will be addressed at the annual school nurse conference in order to continue the upward trend of schools that have a suicide prevention program.

Suicide prevention articles will continue in MCH and school nurse newsletters. MCH staff will actively seek opportunities for Kansans' to improve suicide prevention skills and interventions. With updates to the KDHE network, suicide prevention links will be added to the Children & Families Section.

Population Based Services

School nurses will be encouraged to continue initiation of a suicide prevention program in their schools.

MCH staff will promote information to youth regarding a new Facebook page for those in crisis. SAMHSA and the National Suicide Prevention Lifeline are collaborating with Facebook to help those in crisis. The service enables Facebook users to report a suicidal comment they see posted by a friend to Facebook using the report links found on the site. The person that posted the suicide comment will receive an email from Facebook encouraging them to call the National Suicide Prevention Lifeline or click on a link to begin a chat session with a crisis worker.

KDHE will support efforts through consortiums to reduce access to lethal means and methods of self-harm. This will include supporting Safe Kids initiatives to enact stricter gun laws in Kansas.

Infrastructure Building Services

MCH will continue to promote the goals & strategies of the KS Suicide Prevention plan.

The SPS will continue to work to secure sustainable funding for the suicide prevention efforts in KS.

The SPS will continue to pursue changes to the KS Board of Healing Arts asking for general practitioners to have additional training in mental health in order to treat suicidal patients more effectively in a small community. SPS is asking the Behavioral Sciences Regulatory Board to increase certification requirements for professionals specialized in suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	85	85	86	86	87
Annual Indicator	82.8	78.9	80.8	82.3	82.3
Numerator	434	412	437	377	377
Denominator	524	522	541	458	458
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	87	87	87	87	87

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source: Birth certificate (resident instate births) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Kansas's level III hospitals are Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), Via Christi-St Joseph and Wesley Medical Center (Wichita).

Notes - 2009
Data Source: Birth certificate (resident instate births) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE

Kansas's level III hospitals are Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), Via Christi-St Joseph and Wesley Medical Center (Wichita).

Source: Kansas Annual Summary of Vital Statistics, 2009
Peer Groups - For various demographic studies, it is useful to consider groups of counties with similar characteristics. "Peer Groups" of counties, as used in here, are defined as those with similar populations density based on their 2000 actual census counts. Frontier counties are defined as those with less than 6.0 persons per square mile; Rural counties are those with 6.0-19.9 persons per square mile; Densely-Settled Rural counties as those with 20.0-39.9 persons per square mile; Semi-Urban counties as those with 40.0-149.9 persons per square mile; and Urban counties as those with 150.0 or more persons per square mile. These definitions originated with the Kansas Department of Health and Environment, Office of Local and Rural Health, and should not be confused with the USCB definitions of urban and rural areas. Sources for calculation of population densities are population figures from the 2000 U.S. Census and land areas from the 2000 U.S. Census.

a. Last Year's Accomplishments
In 2010, the percent of very low birth weight (VLBW) infants delivered in subspecialty perinatal care facilities was 82.3%, a 1.9% increase from 2009 (80.8%). This increase was statistically significant. Over the ten year period (2001-2010), there was a stable trend in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates.
According to current data, less densely populated counties in Kansas have a smaller percentage of VLBW babies born at hospitals with Level III NICU's. KDHE is exploring strategies to address/implement an increase in the number of babies (VLBW) delivered in hospitals with Level III NICU's and in improving the quality and number of prenatal/preterm risk assessments. The Healthy People 2020 goal of VLBW infants born in hospitals with Level III NICU's is 90 percent.

Direct Services:
Services were provided in subspecialty perinatal care facilities in the Wichita, Topeka and Kansas City metropolitan areas.
Enabling Services:
Obstetrical providers in the public and private sectors utilized a variety of methods to identify women at risk for preterm delivery or other complications that potentially lead to the delivery of very low birthweight infants.

Population-Based Services:

MCH staff instructed and provided resources to local grantees to educate pregnant women on the signs and symptoms of preterm labor along with instructions of what to do if they experience these signs and symptoms.
The Kansas Maternal Child Health Council (KMCHC) provided multidisciplinary expertise in the area of perinatal health in a forum that discussed issues associated with VLBW infants being delivered in Level III NICU's involving the March of Dimes (MOD), the Perinatal Association of Kansas (PAK), MCH and a variety of stakeholders representing various levels and associations of health care providers in Kansas.

Infrastructure Building Services

Kansas has maintained its system of provider-driven referrals to facilitate access to consultation across various jurisdictions for consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system includes several hospitals that are self-designated subspecialty perinatal care centers that provide both in-patient and out-patient high risk obstetrical/fetal and neonatal services. All of the subspecialty perinatal care centers are located in Wichita, Kansas City and Topeka.
The University of Kansas Hospital in the Kansas City area and Wesley Medical Center in Wichita both have neonatal transportation services available for high-risk obstetrical cases in outlying areas.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide workforce educational opportunities in partnership with PAK, KHA, hospitals and other health care providers and a plan to develop and disseminate website and educational materials.		X		X
2. Perinatal outcome data is provided in an electronic format to delivering hospitals who request data about their hospital or hospital group.		X		X
3. Develop protocols for obstetrical case management of maternal transfer and improvement of pre-/interconception health with PAK, hospitals and KHA.		X	X	X
4. Develop map of perinatal care system.				X
5. Provide information to health care providers concerning levels of perinatal health care services available in obstetric care facilities.				X
6. MCH serves as lead partner for text4baby program in Kansas to get healthy text messages out to pregnant women and new moms.		X	X	X
7. MCH supports “High Five for Mom and Baby” hospital initiative				X
8.				
9.				
10.				

b. Current Activities
Direct Services:

Subspecialty perinatal care services are provided in Wichita, Kansas City and Topeka.

Enabling Services:

Local obstetrical care providers use a variety of strategies to identify women with high-risk pregnancies to help prevent premature births and LBW or VLBW infants.
The KMCHC met to discuss perinatal health issues including: a fee structure to support newborn screening; legislation concerning health and social service budgets; disease surveillance related to providing immunizations to protect mothers and newborns; updates from the Kansas Blue Ribbon Panel on Infant Mortality, childhood obesity, implementation of the "Becoming A Mom" curriculum in select communities' prenatal education programs and development of maternal health homes.

Population Based Services:

MCH worked with PAK and KMCHC on advocating for the delivery of VLBW infants in subspecialty perinatal care facilities to obstetrical care providers through professional education and consultation.
MCH staff and PAK staff share perinatal education web resources and links for interested stakeholders.

Infrastructure Building Services:

Kansas participates as a lead state partner in the national Healthy Mothers, Healthy Babies text4baby free text messaging initiative.
MCH tracks hospitals with Level III NICU's and use of maternal/infant transport.
MCH continues to work on a map of the perinatal system.
KDHE provides perinatal data to hospitals on request with additional resources being developed.

c. Plan for the Coming Year
Direct Services:

Subspecialty perinatal care services will be provided at Level III NICU's in Wichita, Kansas City and Topeka.

Enabling Services:

Healthy Start Home Visitors in the MCH Program will provide outreach, support and education on the signs and symptoms of premature labor and other pertinent topics as well as referral to appropriate social and health care services using a culturally-relevant approach to women of childbearing age and their families in local communities.

Population Based Services

MCH will work on website resources related to healthy pregnancy and conditions related to pregnancy and childbirth.
MCH will assist PAK in making a concerted effort to provide professional education and consultation to obstetrical delivery facilities and advocate for delivery of very low birthweight infants in subspecialty perinatal care facilities.
MCH will continue partnership with text4baby program to provide healthy messages to pregnant women and new moms.

Infrastructure Building Services:

The KMCHC will meet to provide expertise to seek improvements in health for women of reproductive age and pregnant women and their infants.

MCH will support the position of the Kansas Hospital Association to improve perinatal outcomes by promoting the "High Five for Mom and Baby" initiative.
MCH will work with the KMCHC to update a list of delivering hospitals with levels of NICU as part of Kansas' developing system of hospitals' self-designation of perinatal health services.
MCH plans to continue work on data dissemination methods and related policies and procedures to better serve its internal and external customers.
KDHE will provide perinatal health information to hospitals electronically upon request.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	78	78	79	79	80
Annual Indicator	72.4	73.1	74.1	75.1	75.1
Numerator	28677	29089	29244	29552	29552
Denominator	39597	39776	39481	39362	39362
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	80	80	80	80

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE

Notes - 2009
Data Source: Birth certificate (resident) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE

a. Last Year's Accomplishments

In 2010, 75.1% of infants were born to pregnant women receiving prenatal care in the first trimester, a slight increase from 2009 (74.1%). The U.S. data for 2009 (the latest data available) on this measure was 72.1%. Kansas exceeded the U.S. on this measure by 2.8% in 2009 (74.1%). However, this was below the Healthy People 2020 goal of 77.9%. During 2005-2010, Joinpoint regression analysis showed a significantly decreasing trend over the interval 2005-2007 followed by a significantly increasing trend from 2007-2010. Kansas 2010 data shows that Hispanic and non-Hispanic black mothers are most likely to enter prenatal care late. Older mothers are most likely to begin prenatal care early regardless of race and ethnicity. In general, women in rural areas are less likely to get prenatal care.

Direct Services:

In 2011, a total of 84 MCH grants were awarded to local agencies/organizations providing services for 8,958 women and infants plus 10,313 infants given immunizations in almost all of Kansas' 105 counties. Six agencies continued to provide medical prenatal care due to lack of available providers in their communities (Lyon, Sedgwick, Reno, Ford, Seward and Johnson counties).

Enabling Services:

In 2011, Healthy Start Home Visitors (HSHV) received professional education on health literacy, identification and treatment of Fetal Alcohol Spectrum Disorders and breastfeeding to use in their work with families in a variety of settings. Local MCH grantee staff linked clients to services on the online Kansas Resource Guide and to the state hotline number.
Funding continued from the Kansas Medicaid program for providers in high-risk communities for "Healthy Babies Initiatives" that provide extra case management and care coordination for pregnant women enrolled in Medicaid.
Outreach and services to a primarily Hispanic migrant population, speaking Low German and Spanish, were provided services in collaboration with the Kansas Farm Worker Health Program.
Local MCH grantees provided prenatal care services to women at risk for no prenatal care or late entry into prenatal care using community-specific approaches adapted from national evidence-based programs (e.g., Centering Pregnancy Model and Family Nurse Partnership, Olds Model, and others).

Population Based Services:
MCH grantees provided SIDS education and supportive services and provided linkages to local prenatal care services.

Infrastructure Building Services:
At the Seventh Annual Governor's Conference on Public Health MCH staff provided professional staff development on: development of MCH Service Plans (based on community needs assessment); data reporting process and procedures; community health assessment and the improvement process; strategic planning and quality improvement; the on-going state collaboration on health care issues. MCH staff assisted in planning educational conferences with partners from a variety of organizations in the health care sector that are involved in caring for pregnant women and stressing the importance of early and comprehensive prenatal care. Some of the events are as follows: Perinatal Association of Kansas annual educational conference; Kansas Public Health Association Bi-annual Conferences; Kansas Chapter of the American Academy of Pediatrics Spring Continuing Medical Education Conference; Governor's Conference on the Prevention of Child Abuse and Neglect.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Provide Prenatal Care/Care Coordination Services.	X		X	
2. Identify women at risk for late entry or no prenatal care.		X	X	
3. Grantees using evidence-based prenatal care models		X		
4. Utilize prenatal, delivery and postnatal provider resources.		X		X
5. Provide/encourage use of Kansas Resource Guide		X		
6. Encourage greater use of readily available data systems (e.g., KIC, Kansas Health Matters, etc.,).				X
7. Promote early and comprehensive prenatal health care through all available means.		X	X	X
8. Promote optimal health during the interconception period.			X	X
9. Support/encourage local efforts to overcome disparities in the provision of prenatal care and incidence of low birth weight.		X		
10. Work with KDHE Center for Health Disparities on messaging related to healthy pregnancy information to various cultures in Kansas.			X	X

b. Current Activities
Direct Services:

Local MCH agencies use care coordination and case management models to provide prenatal services. Another agency transitioned from direct care services to care coordination.

Enabling Services:

Local health departments, Federally Qualified Health Centers, hospitals and local obstetrical and perinatal health care providers make up systems of comprehensive prenatal care coordination.

Population Based Services:

The Kansas text4baby Partnership now includes 18 organizations from across the state. There are 5,596 participants from Kansas, as of May, 2012, in text4baby.
Family Planning, WIC and MCH Programs coordinate prenatal care outreach and help clients with system navigation and paperwork.
MCH staff participated in the Region VII Office of Minority Health's Men's Conference that provided men with information about health, parenting, fatherhood and community resources for men.

Infrastructure Building Services:

The Kansas Fatherhood Coalition are in the process of updating their strategic plan.
Participated on panel presentation on fatherhood at annual Parent Leadership Conference
Working with KDHE Center for Health Disparities to develop and disseminate best practice information, work force development opportunities and special events to improve health of women in disparate communities.
Participated in tour of Kansas by Tonya Lewis Lee spokeswoman for "A Healthy Baby Begins with You" as part of a state-wide education effort on infant mortality and healthy pregnancies.

c. Plan for the Coming Year
Direct Services:

Care coordination of comprehensive prenatal care and case management services will be used in local MCH grantee agencies. Where service gaps exist, local agencies will provide direct

prenatal medical services.

Enabling Services:

MCH staff provides professional education and technical assistance to its grantees in moving toward systems of comprehensive prenatal care coordination and case management services. Continued development of KDHE's Kansas Health Matters website that contains county, regional and state health indicators. The site provides tools and resources for community health assessment and community health improvement activities.

Population Based Services:
MCH will encourage Kansas text4baby partners to promote the program using materials from the national Healthy Mothers, Healthy Babies Coalition and to more actively participate in this year's national enrollment event.
MCH will help facilitate Family Planning and WIC to coordinate prenatal outreach to clients offering assistance in navigating the health care system and filling out paperwork.
Continue on-going process of working with KDHE Center for Health Disparities to develop and disseminate best practice information, work force development opportunities and special events to improve health of women in disparate communities.
Incorporate fatherhood concepts into programming, professional education activities, technical assistance to MCH grantees and outcome measures.

Infrastructure Building Services:

MCH collaboration with KMCHC, March of Dimes, PAK and other stakeholders in identifying/promoting best practice strategies for perinatal care.
MCH will support local grantees working on accreditation activities with information and technical assistance in facilitating local groups, promoting community health assessment and health improvement.
MCH will promote use of the Kansas Resource Guide for local grantees, perinatal care providers and other community members for information on access to local services.
MCH will facilitate the Kansas Fatherhood Coalition in becoming more active in promoting evidence-based information on fatherhood, fatherhood activities and events state-wide.

D. State Performance Measures

State Performance Measure 1: *The percent of women who receive prenatal care beginning in the first trimester of pregnancy with health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					76.6
Annual Indicator		75.8	76.5	77.1	77.1
Numerator		27332	27416	27900	27900
Denominator		36074	35823	36207	36207
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Is the Data				Final	Provisional

Provisional or Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	78	79	80	81	82

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which date of first prenatal visits are not reported are excluded from the computation of percentages.

Notes - 2009
Data Source: Birth certificate (resident) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which date of first prenatal visits are not reported are excluded from the computation of percentages.

a. Last Year's Accomplishments
Elimination of health risks and comprehensive management of disease prior to pregnancy increase the likelihood of a pregnant woman delivering a healthy infant. Access to health services before, during and after pregnancy often depends on whether a person has health insurance.
In 2010, 75.1% of infants were born to pregnant women receiving prenatal care in the first trimester, a slight increase from 2009 (74.1%). However, this was below the Healthy People 2020 goal of 77.9%. In 2010, the percent of women who receive prenatal care beginning in the first trimester of pregnancy with health insurance was 77.1%, a slight increase from 76.5% in 2009. In 2010, the percent of Medicaid women receiving first trimester prenatal care was 61.4%, 28.3% lower than non-Medicaid women (85.6%). This difference was statistically significant. During 2005-2010, Joinpoint regression analysis showed a significantly decreasing trend over the interval 2005-2007 followed by a significantly increasing trend from 2007-2010.Overall, from 2005 to 2009, there was a slightly decreasing trend detected. The annual percent change (APC) was not significant (-0.58). Further, the percentage appears to decrease until 2007 and then increases slightly again in 2008 and 2009 (APC: -2.02 and 0.87, respectively).

Direct Services:

Women were provided assistance in filling out Medicaid/HealthWave applications by local grantee program staff and linked to available local health care services.

Enabling Services:

The Kansas Statewide Farmer Worker Health Program provided outreach and assistance with access to health care for a primarily Hispanic Spanish- and Low German- speaking population of migrant farm workers.

Healthy Start Home Visitors linked pregnant women and families to local resources and in filling out related paperwork.

Population Based Services:

Unicare offered, Maternicall, a free telephone service led by a team of specially trained Registered Nurses that allows pregnant women access to medically accurate prenatal care information to promote healthy pregnancies and birth outcomes.

Infrastructure Building Services:

KDHE and its partners tracked whether or not pregnant women have health care insurance during the first trimester of pregnancy.
Participated in Region VII Office of Minority Health's Men's Conference that provided education on health care, parenting and fatherhood for interested men and service providers.
Participated in updating the strategic plan for the Kansas Fatherhood Coalition that provides leadership in supporting fathers and local fatherhood organizations by providing education, activities and technical assistance on fatherhood topics.
MCH staff provided leadership in the Kansas text4baby Partnership that promotes use of this free text messaging service that provides relevant and timely health care information to pregnant women and new moms.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate information on the availability of Medicaid/HealthWave coverage for pregnant women		X	X	X
2. Promote the importance of preventive health care, comprehensive chronic disease management, and early prenatal care for women in the preconception period.		X	X	X
3. Increase efforts to assist uninsured women to enroll in Medicaid/HealthWave.	X	X	X	X
4. Teach the importance of reducing risk behaviors of smoking, drinking and other physically harmful lifestyles prior to pregnancy.			X	X
5. Provide outreach and peer support to young women in disparate populations			X	X
6. Promote health insurance coverage availability for pregnant women in the State.				X
7. Use text4baby and other social media to provide outreach to women in disparate populations.		X	X	X
8. MCH partner with agency programs to work on common health outcomes.				X
9. . Implementation of KanCare as new Medicaid program in Kansas				X
10.				

b. Current Activities
Direct Services:

Women receive assistance with filling out application forms for Medicaid and HealthWave (SCHIP) by local MCH staff and community partners.

Enabling Services:

The Kansas Statewide Farmer Worker Health Program provides outreach and assistance with access to health care for a primarily Spanish- and Low German-speaking Hispanic population of migrant farm workers.
Healthy Start Home Visitors link pregnant women and families to local services and provide them support and health and safety education.

Population Based Services:

Unicare offers a free telephone service led by a team of specially trained Registered Nurses that

allow pregnant women access to medically accurate prenatal care information to promote healthy pregnancies and birth outcomes.

Infrastructure Building Services:

KDHE and its partners track whether pregnant women have health care insurance during the first trimester and provide annual reports.
Participation by MCH staff in updating Kansas Fatherhood Coalition's strategic plan to include educating and encouraging fathers to take a more active role in their children's lives.
Text4baby and other social media used to reach pregnant women in hard-to-reach, disparate populations with health messages pertaining to access, prenatal care, avoidance of alcohol and other substances especially during pregnancy and infant care.

c. Plan for the Coming Year
Direct Services:

Local program staff will assist women with filling out Medicaid and HealthWave insurance applications.
Local program staff will assist women in signing up for/link them to text4baby that provides free text messages on health issues and child care topics.

Enabling Services:

The Kansas Statewide Farm Worker Program will provide outreach and assist the population of migrant farm workers in Kansas with access to health care.
Healthy Start Home Visitors will provide outreach to pregnant women and families and link them to local services.

Population Based Services:

KanCare, the newest version of the Medicaid program in Kansas, is anticipated to create efficiencies in the health care system as well as create financial stability over time and supports the idea of medical homes and maternal health homes.
Local partners in the text4baby program and other perinatal care providers that use social media will provide outreach to pregnant women on the promotion of healthy pregnancy and availability of health care insurance and services.

Infrastructure Building Services:

Expand current network of partners that utilize text4baby and other social media to reach pregnant women.
Partner with other agency programs, where possible, in finding ways to support and strengthen current projects by working toward common health outcome goals.
Partner with March of Dimes and KDHE's Center for Health Disparities using a peer-to-peer support model to educate and support college-age women on health and reproductive issues.

State Performance Measure 2: *The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011

Performance Data					
Annual Performance Objective					14.4
Annual Indicator		12.7	14.5	14	14
Numerator					
Denominator					
Data Source		Kansas BRFSS, 2008	Kansas BRFSS, 2009	Kansas BRFSS, 2010	Kansas BRFSS, 2010
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	13.5	13	12.5	12	11.5

Notes - 2011
The 2011 column is populated with 2010 data. 2011 data will be available Fall 2012.

Notes - 2010
Data Source: Kansas BRFSS 2010

Notes - 2009
Data Source: Kansas BRFSS 2009

a. Last Year's Accomplishments
According to the Kansas BRFSS, in 2010, 14.0% of women ages 18-44 years old reported consuming four or more alcoholic drinks (i.e., excessively) on an occasion in the past 30 days. It was a slightly decrease from 2009 (14.5%). White women ages 18-44 years old reported the highest levels of excessive drinking (15.0%), compared to Black women (12.2%) and Hispanic women of all races (11.4%).
Healthy People 2020 recommends that all pregnant women, as well as women who may become pregnant, completely abstain from alcohol. Healthy People 2020 Objectives MICH -- 11.1 and 11.2 propose to increase abstinence from alcohol among pregnant women to 98.3% and from binge drinking to 100%.

Direct Services:

The treatment of pregnant women is prioritized in Community Mental Health Centers and through local alcohol and drug treatment facilities is on a priority basis.

Enabling Services:

Parts of a voluntary, incentive-based program to help pregnant women stay off alcohol and drugs were maintained in local Department of Social and Rehabilitation Services programs.

Population Based Services:

MCH participated in a panel on fatherhood issues and education in the Parent Leadership Conference with one of the messages about how fathers can support their wives abstain from alcohol and other substances during pregnancy.

Infrastructure Building Services:

KDHE tracked Behavioral Risk Factor Surveillance System (BRFSS) data on binge drinking of reproductive age women (18-44 years old).

MCH staff promoted the efforts of local grantees in a panel discussion about successful collaborations, one of which provided education on alcohol-exposed pregnancies to a local university and involved interested community partners.
The Kansas Chapter of the American Academy of Pediatrics made application for becoming a National Organization of Fetal Alcohol Spectrum Disorders (NOFAS) chapter.
MCH tracked the incidence of FAS through the birth defects information system. KDHE also received technical assistance from CDC on the birth defects information system.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide local health care providers and MCH grantee staff with professional education on the effects of alcohol during pregnancy.		X		X
2. Develop, disseminate and promote use of evidence-based information on reducing alcohol consumption in the perinatal health population using web links and raising awareness of the need to abstain from alcohol during pregnancy.		X		X
3. Partner with Kansas Fatherhood Coalition in promoting no safe amount of alcohol use during pregnancy and how fathers can support this goal.		X	X	X
4. KDHE will report data on the occurrence of binge drinking during pregnancy from the BRFSS.			X	X
5. MCH will facilitate discussion of strategies to approach binge drinking during pregnancy with Kansas Partnership to Prevent Underage Drinking, Mental Health and Alcohol and Prevention Services in SRS, KCSL and with other interested stakeholders.				X
6. KDHE tracks number of FAS cases through the birth defects information system.				X
7. Kansas Leadership to Keep Children Alcohol Free present facts on underage drinking impacts to legislators.				X
8. “No safe amount of alcohol during pregnancy” message and other alcohol prevention messages promoted by MCH and other stakeholders			X	
9.				
10.				

b. Current Activities
Direct Services:

Pregnant women's treatment is prioritized in Community Mental Health Centers and in local alcohol and drug treatment facilities.

Enabling Services:

Department of Social and Rehabilitation Services incentive-based alcohol abstinence programs were maintained.
MCH grantees educate the pregnant women and women of reproductive age they serve with messages to abstain from alcohol and other substances during pregnancy and if breastfeeding.

Population Based Services:

MRFASTC trained staff provided professional education on the prevention of FASD to MCH

grantees, health care providers and other interested stakeholders.
Local MCH staff provide outreach, education and evidenced-based resources from the Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and Fetal Alcohol Syndrome Community Resource Center web sites to women served.

Infrastructure Building Services:

MCH provides leadership in helping bring awareness to the topic of alcohol-exposed pregnancies through education, participation in National Association of FASD State Coordinators meetings and activities; and promoting FASD Awareness Day activities statewide.
KDHE tracks Behavioral Risk Factor Surveillance System (BRFSS) data on binge drinking of reproductive age women (18-44 years old).
MCH reports the incidence of FAS through the birth defects information system.

c. Plan for the Coming Year
Direct Services:

Pregnant women will continue receiving services in Community Mental Health Centers and in local alcohol and drug treatment facilities on a priority basis.

Enabling Services:

MRFASTC trained MCH staff will continue to provide at least two annual trainings on the identification, diagnosis and treatment of FASD's in Kansas.
Pregnant women will continue to be referred to local services to assist them in maintaining abstinence from alcohol and other substances during pregnancy.
MCH grantees will continue providing education and resources to pregnant women and women of reproductive age to abstain from alcohol and other substances during pregnancy and if breastfeeding.

Population Based Services:

MCH provides access to evidence-based research, FASD awareness and prevention resources from the FASD Center for Excellence and Fetal Alcohol Syndrome Community Resource Center websites.

Infrastructure Building Services:

MCH promotes awareness for the prevention of FASD statewide in a variety of settings with stakeholders.
MCH staff will develop annual Kansas FASD awareness and prevention plan written in cooperation with the Substance Abuse and Mental Health Services Administration's Building FASD State Systems program.
An additional MCH staff will receive the MRFASTC training.
MCH will facilitate an FASD Awareness Day event for September 9, 2012 to elevate awareness of FASD to enlist more support for statewide prevention efforts.
MCH participates with Kansas Family Partnership's Kansas Leadership to Keep Children Alcohol Free Committee in promoting prevention efforts in schools and other settings and in presenting briefs to legislators of the impacts of underage drinking.
KDHE reports FAS in its birth defects information system with ongoing improvements being made to the system.
MCH tracks BRFSS data on binge drinking in pregnant women and women of reproductive age.

State Performance Measure 3: *The percent of live births that are born preterm less than 37 weeks of gestation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					9.1
Annual Indicator		9.3	9.2	8.8	8.8
Numerator		3873	3804	3534	3534
Denominator		41747	41313	40381	40381
Data Source		Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8.6	8.4	8.2	8	7.8

Notes - 2011
The 2010 column is populated with 2009 data. 2010 data will be available Fall 2011.

Notes - 2010
Data Source: Birth certificate (resident) data, 2010, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

Notes - 2009
Data Source: Birth certificate (resident) data, 2009, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

a. Last Year's Accomplishments
Reducing premature births is a Kansas MCH priority in MCH 2015; the 5-year State MCH needs assessment. In 2010, the rate for preterm births, those occurring before 37 weeks gestational age, has been lower in Kansas than the U.S. [8.75% and 11.99% (preliminary), respectively]. The Kansas prematurity rate met the Healthy People 2020 goal of 11.4%. Among racial/ethnic groups, the black non-Hispanic prematurity rate was 41.9% higher than the white non-Hispanic rate (12.2% and 8.6%, respectively). Hispanic premature births (7.5%) were lower than the State average. During 2001-2010, Poisson Joinpoint regression analysis showed a statistically significant increasing trend over the interval 2001-2004 (APC=4.31) followed by a statistically significant decreasing trend from 2004-2010 (APC=1.29).
APC = Annual Percent Change

Direct Services:

Focus was maintained in providing pregnant women referrals to the Kansas Tobacco Quitline (Quitline) and to available tobacco cessation clinical provider services.

Enabling Services:

The Kansas Tobacco Use Prevention Program (TUPP) continued a partnership with local MCH grantee agencies to screen and make referrals to locally available tobacco cessation services for

pregnant women and women of reproductive age.
The Quitline, local tobacco cessation services and activities of local community coalitions helped assure education and support to help women quit using tobacco.
Kansas home visitation staff will provide outreach services to pregnant women and their families offering support, smoking cessation resources and referrals.
KDHE's Center for Health Disparities along with other stakeholders sponsored a three city tour by Tonya Lewis Lee on infant mortality awareness through her use of "A Healthy Baby Begins with You" educational campaign.
MCH supported the March of Dimes promotion of the National Birth Defects Prevention Network's campaign to increase use of folic acid.
MCH facilitated awareness day activities for folic acid use by women of reproductive age.

Population Based Services:

MCH staff provided leadership in the area of using social media as an outreach strategy to women in hard-to-reach communities.
KDHE Center for Health Disparities supported the 2011 MCH Governor's Conference on Public Health: Reducing Health Disparities: Partnerships for Progress in an effort to educate the public health work force in life course development and social determinants of health with presentations featuring the Prevention Institute.

Infrastructure Building Services:

MCH staff provided prenatal risk assessment tools for local programs use during technical assistance site visits.
MCH, in collaboration with the Kansas TUPP and partnering tobacco-free coalitions, monitored local and state-wide smoking/tobacco cessation ordinances/legislation.
KDHE supported the March of Dimes on-going Prematurity Awareness Campaign.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A's tobacco use prevention method and Quitline services.	X			
2. MCH grantee agencies and local prenatal care providers will provide screening, counseling and referral services for pregnant women and women of reproductive age.		X		
3. Kansas will promote text4baby free healthy text messaging service for outreach to high-risk populations.		X		
4. Public will be provided information and education about contributing factors leading to preterm birth, low birthweight, and infant mortality		X		
5. MCH will partner with March of Dimes and other organizations in the Kansas Prematurity Coalition to prevent prematurity.		X		
6. MCH participates with the KDHE Center for Health Disparities in efforts to target and work with disparate populations in Kansas where prematurity is an issue.			X	X
7. MCH works with and supports the work of the Kansas Prematurity Coalition.				X
8. MCH staff and partners will provide the local nursing and social worker staff with tools on prenatal risk assessment for women of childbearing age.				X

9. Kansas' Clean Air Act of 2010				X
10.				

b. Current Activities
Direct Services:

Pregnant women are referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services.

Enabling Services:

Kansas, as a partner of the national Healthy Mothers, Healthy Babies text4baby program, has a total of 18 local partners bringing about 5,600 pregnant women and new moms messages regarding personal health and child health and safety.

Population Based Services:

MCH participates with the KDHE Center for Health Disparities in efforts to target and work with disparate populations in Kansas where prematurity is an issue.

Infrastructure Building Activities:

MCH staff participated in efforts with local communities working on infant mortality issues using PPOR and FIMR methodologies.
MCH supports the work of the March of Dimes, Kansas Blue Ribbon Panel on Infant Mortality and Center for Health Disparities in raising awareness of issues of prematurity in Kansas.
March of Dimes Prematurity Coalition provides advocacy and awareness of prematurity.
KDHE's Kansas Health Matters and other data resources with data for community assessment activities.

c. Plan for the Coming Year
Direct Services:

Pregnant women will continue to be referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services.

Enabling Services:

Local MCH grantees and health care providers will screen and refer women for tobacco use to the Quitline or local tobacco cessation services.
MCH will promote the text4baby program to physicians and other local health care practitioners and participate in national enrollment contest.

Population Based Services:

MCH will continue website updates to include more comprehensive and user-friendly information and tools for government agencies, health care providers, the public and other stakeholders interested in reducing prematurity.
Work with Center for Health Disparities, KDHE in working with communities with high rates of low birth weight and infant mortality to provide them support by using a peer-to-peer mentoring for young women.

Infrastructure Building Services:

MCH will remain an active partner in the Kansas Prematurity Coalition with the March of Dimes, the Kansas Chapter of the American Academy of Pediatrics, the Perinatal Association of Kansas and other stakeholder groups in an effort to prevent prematurity.
MCH staff will participate with the Kansas TUPP on strategies to increase smoking cessation in the pregnant and women of childbearing age populations.
MCH will partner with Kansas Fatherhood Coalition in promoting the message that there is "no safe amount of alcohol use during pregnancy," and other appropriate health-related messages and how fathers can support the women in their lives in making and sticking to healthy behaviors before, during and after pregnancy.

State Performance Measure 4: *The percent of infants exclusively breastfed at 6 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					20
Annual Indicator		17.1	18.5	10.6	10.6
Numerator					
Denominator					
Data Source		National Immunization Survey, 2006 birth cohort	National Immunization Survey, 2007 birth cohort	National Immunization Survey, 2008 births	National Immunization Survey, 2008 births
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	20	20	20	20	20

Notes - 2011
The 2011 column is populated with 2010 data (provisional, 2008 births). Data will be available in 2013.

Notes - 2010
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Breastfeeding Report Card - United States, 2011
http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf

Notes - 2009
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Provisional geographic-specific breastfeeding rates among children born in 2007, CDC's Breastfeeding National Immunization Data: Any by States: 2007.

http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm

a. Last Year's Accomplishments
In National Immunization Survey, 18.5% of Kansas children born in 2007 (provisional) were exclusively breastfed at 6 months, 8.2% higher than children born in 2006 (17.1%). This compares to 13.3% for U.S children born in 2007. Over the 4 year period (2004-2007), there was a significantly increasing trend in the proportion of Kansas infants exclusively breastfed at 6 months of age. A similar trend was observed at the national level. The survey also shows that low income mothers are less likely to breastfeed than their higher income counterparts.

According to the 2009 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 3.1% of Kansas WIC infants were exclusively breastfed at 6 months, slightly higher than in 2008 (2.9%). This was 4.2% lower than the percent for U.S. WIC infants (5.3%). In recent years (2006-2009), the prevalence of Kansas WIC infants exclusively breastfed at 6 months of age has declined..

Enabling Services:

Kansas Breastfeeding Coalition in partnership with KDHE conducted 3 Business Case for Breastfeeding workshops and offered assistance on support of working breastfeeding mothers to businesses throughout Kansas

Population Based Services:

Supported Breastfeeding Peer Counselor Programs in 41 Kansas counties. Peer counseling was a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Coordinated a public awareness campaign for World Breastfeeding Week in August 2011 where Kansas families submitted their breastfeeding stories. Four selected families received a professional photo shoot an 8x12 family photo and their picture on a billboard advertising the Breastfeeding Let's Talk about it Campaign.

Infrastructure Building Services:

Supported evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets included a newsletter and breastfeeding resources which can be shared with other health professionals in communities.

Supported Certified Breastfeeding Educator Training in October 2010, August and September 2011.
.
Provided financial support to the Kansas LaLeche League 2010 fall conference for all health professionals.

Provided financial support to assist 10 candidates to prepare for the IBCLC exam. Eight of which successfully completed all requirements and passed the exam.

Provided financial support to encourage LHD staff to attend trainings on breastfeeding promotion and support.

Approximately 250 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2011. The conference featured a breakout session on "Breastfeeding in the African American Community."

Adapted the "Using Loving Support to Grow & Glow in WIC" breastfeeding training for all new WIC employees that is held twice a year.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support state agencies, LHD and private businesses to implement new or enhance existing breastfeeding friendly worksite policies.				X
2. Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.		X		
3. Provide or support evidence-based continuing education on breastfeeding promotion and support.				X
4. Support breastfeeding credentialing efforts of LHD staff for both MCH and WIC programs.				X
5. Sustain a statewide public awareness campaign that supports breastfeeding.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Ongoing training and partnerships including the Business Case for Breastfeeding to support working breastfeeding mothers.

Foster the development of local breastfeeding support groups for minority populations.

Population Based Services:

Kansas WIC expanded their peer counseling program to cover 46 of the 105 counties in the state.

Sponsor a breastfeeding promotion and support billboard campaign.
.
Active participation with a planning and implementation workgroup for "High 5 for Mom and Baby" hospital education campaign to improve Kansas breastfeeding statistics through policy and practices changes.
Infrastructure Building Services:

Provide financial support to the Kansas LaLeche League 2012 spring conference for all health professionals.

Provide financial support to encourage LHD staff to attend trainings on breastfeeding promotion and support.

Approximately 270 local and state health department staff attended the Seventh annual Governor's Public Health Conference in April 2011. The conference featured a breakout session on "The Business Case for Breastfeeding"

Support evidenced-based breastfeeding related training of researchers and practitioners with a bi monthly electronic newsletter.

Support Certified Breastfeeding Educator Training.

Twice a year breastfeeding training for all new WIC employees.

c. Plan for the Coming Year
Enabling Services:

Work with local Breastfeeding Coalitions, the LaLeche and other interested parties to promote breastfeeding friendly employee policies.

Fostering the development of local breastfeeding coalitions

Fostering the development of local breastfeeding support groups for minority populations.

Population Based Services:

Sustain Breastfeeding Peer Counselor programs in existing counties.

Support World Breastfeeding Week activities.

Support evidenced-based breastfeeding related training of researchers and practitioners with a bi monthly electronic newsletter and newsletter articles promoting breastfeeding newsletters letters for partner organizations.

Infrastructure Building Services:

Work with LHD to improve staff competencies related to breastfeeding by providing financial support for staff to attend trainings.

Provide financial and in kind support to organizations organizing education on breastfeeding promotion and support to health professionals and the general public.

Twice a year breastfeeding training for all new WIC employees, other LHD employees invited to attend as space allows.

Collaborate with federally funded nutrition programs and community organizations to identify opportunities for coordination to promote and support breastfeeding.

State Performance Measure 5: *The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual					63

Performance Objective					
Annual Indicator		61.3	61.3	61.3	61.3
Numerator				415393	415393
Denominator				677778	677778
Data Source		National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	63	65	65	65	66

Notes - 2011
DATA SOURCE:
National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Data for 2011 is not availabe so 2007 data was used to pre-populate this field. A 2011 update of the survey will be available in September of 2013.

Notes - 2010
DATA SOURCE:
National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Data for 2010 is not availabe so 2007 data was used to pre-populate this field.

a. Last Year's Accomplishments
Last Year's Accomplishments:

Last Year's Accomplishments:

Per recommendations from last year's Block Grant review, a review of similar national and state performance measures was undertaken to determine the need for multiple measures related to medical home.
State Performance Measure #5 (SPM5): The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home and State Performance Measure #8 (SPM8): The percent of children with special health care needs (CSHCN) who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home are similar in nature and potentially a duplication of effort. The data source used for these SPM's was the same, but different populations were used in the analysis. In addition, activities for SPM8 are identical to National Performance Measure #3 (NPM3): The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. It was decided to continue with SPM5 and to inactivate SPM8.

In the 2007 data release from the National Survey of Children's Health, Kansas data shows 61.3% of children meet the AAP's definition of medical home. This is the first time that this measure was added to the national survey. The next anticipated time data from this survey will be updated is 2012 or 2013.

Direct Services:

Enabling Services:

MCH grantees linked clients to local mental health, medical, dental and social services through use of Healthy Start Home Visitors and other health department outreach activities.
MCH staff assisted local grantee agencies to measure medical home as an objective as part of their grant reporting process.
MCH staff provided local agencies with technical assistance in working with the medical home objective in the grant process.

Population Based Services:

Two annual Basic Home Visitation trainings were provided by the Kansas Head Start Association to train Healthy Start Home Visitors (HSHV) and other State home visitation program staff on the importance of medical home and the facilitation of linkages and referrals to local services for their clients.

Infrastructure Building Services:

MCH staff was involved with stakeholders in advisory councils and in various partnership meetings discussing evidence-based medical homes.
Kansas was in the process of reinventing its Medicaid program that will be called KanCare with the goal of improving health outcomes and establishing financial sustainability. The concepts of medical homes and maternal health homes have been mentioned in this process.
MCH staff collected data that served as a proxy measure for medical home in their WebMCH and Children and Families Section data systems.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adapt resources within KDHE to measure medical home				X
2. Promote the importance of preventive health care, comprehensive chronic disease management, and early prenatal care for women in the preconception period.		X	X	X
3. Increase efforts to assist uninsured women to enroll in Medicaid/HealthWave.	X	X	X	X
4. Kansas has current legislation (KSA 75-7429) that defines medical home.			X	X
5. Provide outreach and education to hard to reach populations and disparate populations			X	X
6. Promote health insurance coverage availability for pregnant women in the State.				X
7. Outreach to pregnant women in disparate, hard-to-reach populations with text4baby and other social media		X	X	X
8. MCH facilitate agency programs work on achievement of common health outcomes measurements.				X
9. Work with Medicaid toward achieving earlier access into prenatal care for pregnant women.				X
10.				

b. Current Activities

Direct Services:

Enabling Services:

MCH grantees' Healthy Start Home Visitors work with clients to gain an understanding of the health care system and in gaining access to health care services.
MCH staff assists local grantees to work on the objective of medical home for grant reporting and progress in this area.

Population Based Services:

Basic Home Visitation trainings are provided by the Kansas Head Start Association to train Healthy Start Home Visitors (HSHV) and other State home visitation program staff on the importance of medical home and the facilitation of linkages and referrals to local services for their clients.

Infrastructure Building Services:

Kansas is still in the process of revamping its Medicaid program into what will be KanCare.
Kansas has legislation (KSA 75-7429) that defines medical home that became effective July 1, 2008.
MCH collects proxy medical home data in its Children and Family Section's data system and through WebMCH a module of the Kansas Immunization Registry.

c. Plan for the Coming Year
Direct Services:

Enabling Services:

MCH staff will continue to provide technical assistance to local grantees in working toward a medical home objective as part of their grant activities.
Local MCH grantees will assist clients in filling out Medicaid/HealthWave applications forms.
MCH staff provides technical assistance and professional education on the importance of access to medical homes to local MCH grantees and health care providers.

Population Based Services:

KanCare is anticipated to roll out in July, 2012 as the newly reformed Kansas Medicaid program.
Local partners in education will provide information to parents on Medicaid/HealthWave services during Kindergarten round-up and school enrollment.

Infrastructure Building Services:

MCH staff will measure responses from the Kansas School Nurse Survey on the existence of local policies to provide information on medical homes and responses from the National Survey of Children's Health on medical homes.
MCH staff will facilitate meetings with various statewide partners including representatives from the local health department association, school nursing, child care provider organizations, faith-based and other community-level organizations to provide outreach, identification and referral services to increase enrollment of eligible children in Medicaid/HealthWave.

State Performance Measure 6: *The percent of high school students who had at least one drink of alcohol during the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					37
Annual Indicator				38.7	38.7
Numerator					
Denominator					
Data Source				CDC. YRBS, 2009.	CDC. YRBS, 2009.
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	37	36	36	36	36

Notes - 2011
DATA SOURCE:
CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2009.
http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.
Data for 2011 is not available. Data from 2009 was used to populate this field. 2011 Data will be available in October 2012.

Notes - 2010
DATA SOURCE:
CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2009.
http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS

a. Last Year's Accomplishments
According data from the 2009 Youth Risk Behavior Survey (YRBS), 38.7 percent of Kansas high school students reported having at least one drink of alcohol in the past month prior to taking the survey. This compares similarly to the national average of 41.8 percent. A non-significant, decrease percentage of Kansas students reported having alcohol within past month prior to taking the survey in 2009 (38.7 percent) compared to 2005 (43.9 percent). A similar decrease in alcohol use was observed nationally. The 2009 YRBS found for Kansas high school students:

•A higher percentage of male students (40.1 percent) reported having alcohol in the last month than female students (37.4 percent)
•A lower percentage of black students (28.8 percent) reported having alcohol in the last month than white (39.2 percent) or Hispanic students (43.2 percent).
•As the grade level increased, a higher percentage of students reported having alcohol in the past month. Reports of having alcohol were highest among 12th graders (46.3 percent) and lowest among 9th graders (29.2 percent).
•One out of four students (25.5 percents) reported having five or more alcoholic drinks within a couple of hours apart during the past month.
•3.2 percent of students reported having at least one alcoholic drink on school property in the past month.
•One out of five students (21.1 percent) reported having alcohol (other than a few sips) for the first time before they were 13 years of age.

Direct Services:

None.

Enabling Services:

KDHE staff partnered with Kansas Family Partnerships (KFP) in training for Students Against Destructive Decisions (SADD) and their sponsors on the use of alcohol and the effects on the adolescent brain development.
KFP provided position statements supporting legislation to increase excise taxes on beer and/or liquor and establishment of a fund to support substance abuse prevention and treatment. KFP also provided position statements on supporting: maintaining the minimum legal drinking age of 21; increased regulation on advertising of alcohol marketed to youth; continued public education and increase awareness of social hosting laws prohibiting alcohol consumption by minors on the property of adults (not legal guardians or parents of the minors and; increased funding for education about underage drinking; and support for Fetal Alcohol Spectrum Disorder awareness.

Population-Based Services:

At the annual Kansas School Nurse Conference a breakout session was provided on the affects of alcohol and binge drinking on a developing fetus and a developing adolescent brain.

Article on alcohol consumption and risky behavior appeared in the KDHE/MCH newsletter that was set to MCH and school health personnel.

Infrastructure Building:

KDHE supports Kansas Family Partnership coalition and Kansas Leadership to Keep Children Alcohol Free Committee in their efforts to address youth access to alcohol, harmful effects of alcohol and law enforcement efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase stakeholder knowledge of adolescent health issues related to alcohol consumption and risky behavior.		X	X	X
2. Participate in Kansas Family Partnership (KFP) to maximize limited funding to detour alcohol use.		X	X	X
3. Work with SADD leaders to increase their knowledge and leadership abilities to remain alcohol free and be peer role models.		X	X	X
4. Provide education for school nurses and MCH grantees on identifying alcohol use and referral resources.				X
5. Provide information on effects of alcohol on the developing adolescent brain to parent organizations and SADD organizations.			X	X
6. Prepare information for distribution on training school/community members on how to establish Students Against Destructive Decisions (SADD) organizations in their schools.		X	X	X
7. Actively seek partners to prevent alcohol consumption among teens so existing strengths and resources can be combined and utilized.				X
8.				
9.				
10.				

b. Current Activities
Direct Services:
None.

Enabling Services:

Articles on alcohol use and preventative services available in Kansas are provided to school nurses, MCH grantees and teachers through articles in newsletter articles.

Population-Based Services:

SADD students and their sponsors received one day training on becoming leaders in their schools and communities. The training included capacity building, refusal skills, peer mentoring, using media to promote positive youth development principles, and Kansas laws.

KDHE staff partner with Kansas State Department of Education (KSDE) to present at the summer HIV/AIDS/STD Regional Conference on alcohol use and related risky behavior.

Infrastructure Building Services:

KDHE staff participate in the KFP coalition consisting of members from Kansas Highway Patrol, Kansas Department of Education, Kansas Sheriff's Association, State SADD Agency, Kansas Nurses Association, Kansas Legislature, American Indian Tribal Council, AAA of Kansas, Kansas Funeral Home Directors, Prevention and Recovery Services, Local school districts and drug and alcohol treatment centers.

c. Plan for the Coming Year
Direct Services:

None

Enabling Services:

KDHE will continue to partner with FHP, SADD, Leadership to Keep Children Alcohol Free, KSDE, and other agencies and organizations with the goal of reducing alcohol use among youth. Health education on alcohol prevention and the effects on adolescent development will be provided to requesting organizations, including United Way and Healthy Start Home Visitors. MCH staff in local health departments will continue to receive health education on referral resources and support services relating to alcohol cessation.

Population-Based Services

MCH staff will collaborate with KSDE to provide training on alcohol related adolescent health issues and continue to provide school nurses and health departments with educational materials and updates on trends in alcohol use through articles in the MCH monthly newsletter.

KDHE staff will provide Fetal Alcohol Spectrum Disorder (FASD) training to teens and groups that work with teens on how to prevent FASD in the children of adolescents. KDHE will train additional staff to present on FASD and the effect of alcohol on the adolescent brain.

Infrastructure Building Services:

KDHE will increase staff alcohol cessation knowledge by attending National training on Fetal Alcohol Spectrum Disorder (FASD), how to identify FASD in the school child and adolescent

population and how to make the appropriate referrals.

Continue support of KFP coalition, SADD chapters, KSDE and other organizations with a goal to decrease alcohol use among youth.

State Performance Measure 7: *The Percent of children who are obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					13.1
Annual Indicator		13.3	13.2	13.0	12.8
Numerator			4878	4919	4803
Denominator			36956	37838	37523
Data Source		Kansas PeNSS, 2008	Kansas PeNSS, 2009	Kansas PeNSS, 2010	Kansas PeNSS, 2011
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.6	12.4	12.2	12	11.8

Notes - 2011
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2012(Kansas WIC database).

Notes - 2010
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2010(Kansas WIC database).

Notes - 2009
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2009 (Kansas WIC database).

a. Last Year's Accomplishments
According to the 2011 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 28.4% of low-income children ages 24-59 months in Kansas were overweight (at or above 85%) or obese (above 95%). In 2010 (the most recent year national data is available), Kansas prevalence (28.7%) was significantly lower than the prevalence nationally (30.5%). Over the 10-year period (2002-2011), there was a significant increasing trend during 2002-2004, since 2004 the trend has decreased significantly. For both periods, the annual percent changes (APCs) were significant (8.15, -1.17, respectively).

Infrastructure Building:

Training websites and resources that promote good nutrition and physical activity were published in the resources and events section of the Zero to age 21: Information for Promoting for Public Health Professionals working with Kansas Kids (ZIPS) newsletter throughout the year.

Specific ideas in identifying funding sources, writing proposals guidelines, and following the proposal to successful delivery of a grant were presented in a breakout session at the June 2011 HIV/AIDS/STDs and Human Sexuality Education Regional Conference. Many local staff

responsible for writing grants for obesity funding attended this conference.

Worked with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to use to address healthy eating and physical activity. In total, Kansas received almost $350,000 in grants.

Two state staff attended the 2011 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

School nurses were surveyed to assess if school age children are being weighed, measured and referred, as appropriate. For the 2010-2011 school year, approximately 25% of nurses who responded to the survey reported assessing BMIs. The nurses reported screening BMIs on 33,777 students of which 11,686 (34.6%) were = 85% BMI/age but only 2,159 (4.5%) were referred to a health care professional.

Population Based Services:

Approximately 250 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2011. The conference featured breakout sessions on "Supporting Healthy Food and Active Living Environments in Kansas" and "Obesity Prevention: Connecting the Dots."

Enabling Services:

Participated at the Kansas Governor's Council on Fitness meetings.

With the Bureau of Health Promotion (BHP) promoted the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was May 20, 2011. Nearly half of all third graders in the state of Kansas participate each year.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:

Publicize existing or develop new training opportunities for state and LCH staff on healthy eating and physical activity.

Assist LHDs in identifying funding mechanisms and partnerships to support initiatives at the community level.

Survey school nurses to assess if children are being weighed, measured and referred, as appropriate.

In November 2011 the MCH Nutrition Consultant earned a Certificate in Pediatric and Adolescent Weight Management.

Population Based Services:

Participate in the development of a targeted media campaign aimed at reducing sugary drinks in the diet of tweens in Shawnee County. Initial results are positive.

Approximately 270 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2011. The conference featured a keynote presentation on "Healthy People 2020."

Enabling Services:

Participate on the Kansas Governor's Council on Fitness

Participate in planning and promoting a 2012 Statewide Obesity Summit.

Work with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was held on May 4, 2012.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Enhance or expand existing partnerships with federally funded nutrition programs for coordination to meet the overall maternal and child health nutrition goals.

c. Plan for the Coming Year

Infrastructure Building:

Advocate for policies and environmental changes that support daily physical activity opportunities in all settings.

Engage child care providers in modeling health education and physical activity for young children and their families.

Utilize and improve data systems to measure the development and impact of community-based policy and program interventions at the individual, organizational and community level.

Inventory existing partnerships related to healthy eating, nutrition and physical activity.

Work with federally funded nutrition programs to identify opportunities for coordination to meet the overall maternal and child health nutrition goals.

Survey school nurses to assess if school-aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters and referring to the health

care provider will be covered in newsletters and trainings.

Population Based Services:

Work with the BHP and other stakeholders to design and promote consistent and culturally appropriate nutrition and physical activity messages.

Support continuing education opportunities on nutrition and physical activity from credentialing organizations, member associations, academic institutions and other groups.

Enabling Services:

Participate on the Kansas Governor's Council on Fitness

Model health education and physical activity for 3rd grade students in Kansas, by working with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

State Performance Measure 8: *The percent of children with special health care needs (CSHCN) who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					50
Annual Indicator				49.4	49.4
Numerator				195	195
Denominator				395	395
Data Source				National Survey of Children's Health, 2007.	National Survey of Children's Health, 2007.
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	50	51	51	52

Notes - 2011
DATA SOURCE:
National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Data for 2011 is not availabe so 2007 data was used to pre-populate this field. A 2011 update of the survey will be available in September of 2013.

Notes - 2010

DATA SOURCE:
National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

Data for 2010 is not availabe, so 2007 data was used to pre-populate this field.

a. Last Year's Accomplishments
DHC: CYSHCN specialty clinic contracts include a requirement that specialty evaluations and recommendations are sent to the primary care physician within two weeks of the clinic appointment in support of the medical home team approach. Contract language continues to support medical home and care coordination.

Planning for the Parent Support Liaison (PSL) project in select CYSHCN specialty clinics began in May 2011 as an effort to provide care coordination and parent/peer supports to families attending four CYSHCN-sponsored clinics. This project was developed as an opportunity to better assist families in partnering with their doctor to support improved quality health care and coordination with increased cost-efficiencies.

ES: Through a strong partnership with Families Together, a medical home presentation was developed to educate families on the medical home concept and provide information on how families can begin building a medical home for their families. This presentation was made available at multiple Families Together local and state-wide conferences. This presentation supports family and young adult skill-building in developing effective partnerships and active participation within the medical home. Articles addressing family and youth empowerment, medical home and engaging the youth/parent in decision making were included in the CYSHCN Magazine made available for waiting rooms and conferences.

As the State's Medical Home Initiative lead by the KS Health Policy Authority has continued to remain unfunded and efforts have not been reestablished, the D-70 Integrated Community Systems (D-70 ICS) grant project began a partnership with the KS Academy of Family Physicians (KAFP) -- the lead organization in a three year grant-funded pilot project titled the Patient-Centered Medical Home Initiative. This effort began in January 2011 and immediately began planning for eight KS provider groups in both the pediatric and family medicine disciplines to begin working toward meaningful use and establishing a true medical home for the practice, based upon the Trans4Med medical home model.

PBS: Printed materials were provided to consumers in requested languages and accommodations. CYSHCN staff participated in the Heartland Genetics Regional Collaborative Medical Home work group, which began discussion opportunities to engage genetic providers as team members for persons with metabolic conditions within a Medical Home. The work group began meeting monthly via conference calls and identified the need for a white paper related to the geneticists' role within the medical home.

IB: The D-70 ICS grant began the shift from addressing transition and medical home as separate activities to a focus on transition and life course within the medical home and how youth, families and providers can be effective partners in this model. This model incorporates a variety of components related to transition, with a focus on how providers and support successful transition as part of the medical home. Through the D-70 ICS grant "JumpStart" Quality Improvement project, a health care transition youth self-assessment was developed to support medical home providers in supporting transition for their youth patients.

The KS and MO D-70 ICS grants co-presented at the Heartland Regional Genetic Collaborative 2010 Fall Conference on the newly formed partnerships in the collaborative related to medical home. The CYSHCN Family Advisory Council began a work group on medical home to address the needs and services for CYSHCN and families in KS. Medical home was embedded as an

underlying concept through the Caring for People with Disabilities course at KU Medical Center.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Clinic reports are provided to the PCP and other providers identified by the family.	X			X
2. The contracting PCP can access the state-wide immunization registry.		X		X
3. CYSHCN tracks medical home status of clients seen in specialty clinics and assists families to obtain a primary care provider, if needed.	X	X	X	X
4. Infants identified with a positive Newborn Screening test are referred to the CYSHCN program and follow-up services are explained to families.		X	X	
5. Develop information & disseminate information about medical home for youth, families and professionals.		X		X
6. Conduct trainings for providers on medical home and how to partner with families.		X		X
7. Continue to expand the KS Resource Guide to provide additional medical home resources, tools and materials for youth, families and professionals.		X		X
8. Participate in the Heartland Genetics Collaborative medical home work group and related activities.		X	X	X
9. Support Family Advisory Council work group on medical home to support family leadership and advocacy.	X	X	X	X
10.				

b. Current Activities
Prior year activities continued

DHC: Contract language continues to support medical home and care coordination. Two Parent Support Liaisons were hired to provide care coordination and support services in select CYSHCN specialty clinics. The PSL's have worked to connect families to needed community-based services, increase attendance and family preparedness for clinic appointments, developed a newsletter for families within a clinic, providing ongoing support for families in these clinics and much more.

ES: The partnership with the KS F2F grantee continues to educate families on medical home components and partnerships. CYSHCN staff continues to be engaged in the KAFP medical home initiative as part of their engagement coalition and partially funded the 2011 PCMH Summit.

PBS: CYSHCN staff continues to participate in the development of the Heartland Genetics white paper related to the medical home. The intent of this paper is to improve engagement of genetic providers as part of the medical home team across Kansas and other states in the Heartland region.

IB: The D-70 ICS grant and the CYSHCN Family Advisory Council developed tools/resources for families and providers on effective partnerships among families and providers. Medical home was the underlying concept through the Caring for People with Disabilities course at KU Medical Center and one week was devoted specifically to the medical home concept and how to effectively partner with patients within the medical home.

c. Plan for the Coming Year
Per recommendations from the FY12 Block Grant review, a review of similar national and state performance measures was completed to determine the need for multiple measures related to medical home.

Upon review, it has been determined that State Performance Measures #5 (SPM5): The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home and State Performance Measure #8 (SPM8): The percent of children with special health care needs (CSHCN) who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home were similar in nature and potentially a duplication of effort. The data source used for these SPM's was also similar in that they came from the same data source, however different populations were used in the analysis.

Additionally, activities for SPM8 are identical to National Performance Measure #3 (NPM3): The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. It was determined that SPM8 and NPM3 although identical in reporting utilized different data sources. Upon review of these data sources, the data source used for NPM3 was felt to be more representative of the CYSHCN population.

Therefore, SPM8 will be deactivated for future reporting periods and SPM 5 will continue reporting on state medical home initiatives, as related to ALL children and not only CYSHCN. NPM3 will continue to be the primary reporting for medical home initiatives for the CYSHCN population. The data sources for these measures will remain the same as in previous years. State activities related to medical home will not be reduced or impacted by these changes in reporting.

State Performance Measure 9: *The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					84
Annual Indicator				84.0	83.6
Numerator				299	291
Denominator				356	348
Data Source				National Survey of CSHCN, 2005/2006	National Survey of CSHCN, 2009/2010
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	84	85	85	85	86

Notes - 2011
DATA SOURCE:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

Notes - 2010

DATA SOURCE:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2005/06. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.

a. Last Year's Accomplishments
One of the main focuses of the D-70 Integrated Community Systems (D-70 ICS) grant is on transition to adulthood and addresses all four service area types. Through partnership with the University of Kansas Center on Developmental Disabilities (KUCDD), Kansas has increased consumer awareness of health care transition, worked with medical providers to develop tools for transition and strengthened the capacity of the state, and their partners, to provide transition services for YSHCN in KS.

DHC: Four CYSHCN specialty clinics (Cleft Lip/Palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics) provide transition clinics for older youth. Adults with eligible genetic conditions are able to continue to be seen in the adult specialty clinics.

The KS Family-to-Family Health Information Center families and youth are being trained on the development and use of the personal healthcare notebook. Through the D-70 ICS grant and partnership with KUCDD, an online curriculum for youth with special health care needs and disabilities has been developed. The curriculum is intended to be used by youth to independence and provide opportunities for skill-building, self-determination and support in becoming an empowered patient. Youth will also learn how to communicate with peers, parents and health care providers. The curriculum consists of the following six modules: About Me, Taking Charge, Staying Healthy, Empowered Patient, Taking Care of Myself and After High School. Each module consists of an overview of what will be learned in that section, the youth's personal learning goal, a table of contents, a status check to see if the youth met their goal and a "VIP" section that describes the "Very Important Points" in each section. The curriculum is progressive and each module will build on skills and information learned in the prior modules. Each module is interactive in that the youth will fill out the information online and then the system will save this to their account/file for the youth to look back on and to help drive future modules. Development of the curriculum content was completed and made available for an initial field test the following fall.

ES: CYSHCN staff participated in transition resource fairs to learn and share community connections to assist in transitioning not only to adult health care providers but to address other aspects of work and community living. The Youth Advisory Council continued to work with youth to become self-advocates and active members of the community to support successful transition. The Family Advisory Council work group on transition began development of a series of transition checklists for parents of children 0-6, pre-teens and teenagers age 7-13, and youth and young adults ages 14-19. These booklets cover a variety of topics, including health, education, employment, community living, and more.

PBS: Through a partnership with Families Together, regional transition conferences were provided to educators and parents/families about common issues with transition for YSHCN. These conferences continue to have an expanded focus to address health care transition as well as education transition. A three-part online learning series on health care transition, a workshop on health care transition and a three-part webinar series for youth, parents and professionals on youth independence was available for consumers, families, and providers.

IB: CYSHCN contract language was included to ensure partners and vendors are addressing transition to adulthood for YSHCN. CYSHCN staff and partners continue to serve on councils and committees that address youth issues and disability concerns. The D-70 ICS grant sponsored youth to attend the Youth Empowerment Academy's week long Youth Leadership Forum held on the Washburn University campus. The CYSHCN Youth Advisory Council continued to build capacity for the state by ensuring the youth voice is addressed. The family survey through the

specialty clinics began and included questions related to transition.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition clinics for Cystic Fibrosis, Cerebral Palsy, Cleft Lip/Palate and Spinal Cord are held regularly for the older youth.	X			
2. Coordinate with family and education partners' transition workshops.		X		X
3. CYSHCN staff participate in local, regional, state and national workshops to promote inclusion and increase awareness of the needs of YSHCN.			X	X
4. Family Advisory Council Transition Work Group will provide feedback and guidance on state transition efforts.				X
5. The Parent Support Liaison project will assist in providing transition services to families within the pilot clinics.	X	X	X	X
6. Development of a youth-focused model for health care transition that includes a care coordination, provider policy development, system integration, partnerships, and resources/tools for youth, families and providers.		X	X	X
7. Expansion of the Kansas Resource Guide with the development of a transition navigational tool kit.		X		X
8.				
9.				
10.				

b. Current Activities
Continued all previous clinic activities.

DHC: The self-determination curriculum was field tested to gain youth and educator's feedback, adjustments were made and the curriculum is currently being piloted in the school system and evaluation will begin in June 2012.

ES: The YAC continues to enable youth to become self-advocates and active members of the community. The FAC transition checklists were completed and dissemination began March 2012.

A website dedicated to families to navigating transition is being developed in partnership with the KU Center for Child Health and Development (CCHD). The website will include resources, tools and stories to aid families in supporting youth transition.

PBS: The FAC transition tools are being distributed through Families Together to all families who request a medical care notebook. This tool is currently being translated in Spanish, as are all of the other CYSHCN FAC tools developed.

IB: The D-70 ICS grant began the shift from addressing transition and medical home as separate activities to a focus on transition and life course within the medical home and how youth, families and providers can be effective partners in this model. This model incorporates a variety of components to support capacity and infrastructure building in Kansas, including: the Parent Support Liaison project; the JumpStart project; a self-determination curriculum; partnership with the Heartland Genetics Collaborative; and individualized healthcare plans.

c. Plan for the Coming Year
Continue current and previous transition-related activities. In partnership with KUCDD, coordinate multiple submissions for poster and oral presentations related to the various innovative transition initiatives that have occurred.

DHC: Continue CYSHCN specialty transition clinics. Complete evaluation and final revisions to the KUCDD self-determination curriculum. Promote the use of the curriculum to various stakeholders, particularly health providers to share with their transitioning youth patients.

ES: Continue expansion of the KS Resource Guide. Resource staff will work with multiple stakeholders, including the Family Advisory Council, in the development of the navigational tool kit.

Launch the Kansas Transition website, a website dedicated to families to navigating transition. The website will include resources, tools and stories to aid families in supporting youth transition related to the following six transition-related topics: Life in the Community; Your Home; Work; School; Health; and Circle of Support. The website will be housed at the CCHD for ongoing technical support and sustainability.

PBS: A link to the new transition website will be placed on the CYSHCN home page and the KS Resource Guide. Continued focus on transition across Kansas and materials provided to those in requested languages. Upon completion of the model, it is anticipated that tools and resources will be available in both English and Spanish.

The FAC has identified provider and family training as a priority for the coming year, including transition as one of the trainings to develop -- particularly as it relates to the need for early transition planning (at time of diagnosis) and use of the transition tools developed through the CYSHCN FAC and D-70 ICS grant. There is interest in making these trainings available in a variety of formats including in-person and live/archived webinars.

IB: The D-70 ICS grant project, through a no-cost extension, will finalize the model for transition within the medical home. Webinars and online trainings will be developed to share the model and disseminate information to families, consumers, and providers. This information will be incorporated in stakeholder trainings and conferences. Local, state, and national presentations will be pursued.

The CYSHCN YAC will undergo a transition with a stronger focus on youth leadership. The group will transition to a youth leadership committee, which will be responsible for developing a structure for the committee and planning additional youth-outreach activities across the state to empower other youth and support leadership and growth through coordinating multiple community-wide youth outreach activities to engage more youth across the state. These additional activities will be planned, coordinated, and hosted by the youth leadership committee, with support and assistance from KYEA and KDHE.

State Performance Measure 10: *The percent of children with special health care needs (CSHCN) families that experience financial problems due to the child's health needs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	20	20	20	20	20

Annual Indicator	21.4	21.4	21.4	21.4	26.3
Numerator				152	205
Denominator				710	780
Data Source		National CSHCN 2005-2006. est KS	National CSHCN 2005-2006. est KS	National CSHCN 2005-2006. est KS	National CSHCN 2009-2010. est KS
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	21	21	21	20	20

Notes - 2011
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2009/2010. Percentage of CSHCN whose conditions cause financial problems for the family.

Notes - 2010
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN whose conditions cause financial problems for the family.

Data for 2010 is not available. 2005-2006 data was used to pre-populate this performance measure. This indicator is comparable between 2005-2006 and 2001 National Children with Special Health Care Needs Survey.

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN whose conditions cause financial problems for the family.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. This indicator is comparable between 2005-2006 and 2001 National Children with Special Health Care Needs Survey.

a. Last Year's Accomplishments
DHC: Adults with eligible genetic conditions can be seen in CYSHCN supported specialty clinics and qualify for financial assistance based upon family income and a sliding fee scale. CYSHCN administrative and field office staff continued to direct those in need to apply for public assistance (ie: HealthWave, SSDI, etc). Families were directed to safety-net clinics if other options were not available.

ES: The CYSHCN consumer application was updated and made electronic. Families can apply online and submit applications electronically to the program. Families who are unable to complete an online application can still access the application online or receive applications by fax or mail. Applications continue to be sent to those referred to the program or whose newborn had a positive screening result.

The KS Equipment Exchange Program is utilized frequently by families of CYSHCN specialty clinics. This program provides an opportunity to "recycle" durable medical equipment when a child no longer has a need for it (or has outgrown the current equipment). Families continued to be referred to this program as appropriate.

PBS: Kansas has experienced an economic downturn similar to many other states. Many jobs have been lost and increased persons/families are uninsured or underinsured. Families of CYSHCN have experienced similar hardships and coverage for necessary services continues to be an issue. The CYSHCN program continues to support medically and financially eligible CYSHCN from all areas throughout the state. The CYSHCN program applications are available in both English and Spanish and two bi-lingual staff persons are available to assist families.

IB: CYSHCN partnered with professional organizations (the American Academy of Pediatrics, Kansas Chapter, the Kansas Academy of Family Physicians, the National Association for Mental Illness, and the University of Kansas Medical Center Research Institute) and family partners (Families Together and Keys for Networking) to educate families and young adults about components of the Health Care Reform/Affordable Care Act that may impact their ability to maintain, gain, or expand insurance coverage. The goal was to educate families and other community members so they had the knowledge to advocate for their needs

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor Federal and State leadership efforts to provide affordable health care coverage.				X
2. Educate families and providers on specific elements of the Health Care Reform Bill that may impact access to services, and coverage.		X		X
3. Coordinate with SCHIP/Medicaid on eligibility determinations.	X	X		
4. Route metabolic formula orders through CYSHCN for discounted rate to reduce out of pocket expenses.	X		X	
5. Authorize eligible services with contracted providers that take CYSHCN's negotiated rates to avoid/minimize family's liability.	X			
6. Assist families in identifying and connecting with private non-profit organization to fund medically necessary treatments and equipment not otherwise covered.		X		
7. The Parent Support Liaison will assist families in identifying available financial supports and connecting with necessary services.	X	X	X	X
8. Family Advisory Council Transition Work Group will provide feedback and guidance on insurance and financial impact for families of CYSHCN.		X		X
9.				
10.				

b. Current Activities

DHC: Continuation of previous year activities. Expanded oral health services in select CYSHCN clinics to provide these services to families who are unable to obtain dental care due to lack of insurance or funding. The Parent Support Liaison project also addressed the financial needs of families and assisted in connecting families with appropriate opportunities. Clinic services continued to be provided for patients and families and not be billed for services.

ES: Vendor contracts were modified to support improved data collection. Reporting was enhanced to provide additional information and more accurate data on clinic patients and provide opportunity to analyze financial impact of CYSHCN on families.

PBS: Initial discussions with local health departments have occurred to identify the potential for establishing satellite offices for the CYSHCN program in communities across Kansas in an effort to provide a more community-based approach and local entry point into the program. This will

provide a local point of contact for the CYSHCN program and an opportunity to educate more families about the services available through the CYSHCN program.

IB: The FAC Financial Impact Work Group created a Community Resource Brochure -- a quick reference guide for families on common state and community resources. Dissemination of this brochure began in March 2012 and has been well received by both consumers and providers.

c. Plan for the Coming Year
Continuation of previous and current activities.

Efforts to "decentralize" the CYSHCN program and launch satellite offices across Kansas have been ongoing. Beginning July 2012, offices in Garden City, Hays, Salina and Wichita will be available to families in the Western half of the state. Plans for the Eastern half will begin this year (Emporia, Kansas City, Pittsburg, and Topeka) with an implementation date of July 2013. Training and ongoing technical assistance will be available to the satellite offices. This underlies our plans to enhance a more community-based approach to providing CYSHCN services in each of the four service areas within western Kansas, and utilize "lessons learned" for implementation in eastern Kansas in July, 2013.

DHC: Continue support of CYSHCN-sponsored specialty care clinics and PSL project. Enhanced Wichita CYSHCN field office data linkage with KUSM/Wesley Medical Center is planned to expand pediatric screening and treatment services in Sedgwick and surrounding counties.

ES: An ongoing emphasis on the importance of prevention/wellness, health maintenance and promotion, and life course will be embedded into program activities and initiatives developed by the Family Advisory Council.

PBS: The newborn screening program (lab and follow-up) will secure a stable funding mechanism with the signing of Bill that dedicates funding for NBS.

IB: Work with CYSHCN advisory councils and external stakeholders for input into the navigational toolkit to assist families in navigating and identifying available healthcare funding opportunities.

A data extract from the KDHE Health Informatics Bureau to the CYSHCN web-based data system is being tested and plans are to move to production approximately July, 2013. This enhanced data capacity will allow for searching of all Kansas newborns to ensure coordination, outreach, eligibility, and enrollment within CYSHCN the web-based portal.

E. Health Status Indicators

Introduction
Annual tracking on health status indicators contributes to Kansas' ability to: provide information on the State's residents; direct public health efforts; conduct surveillance and monitoring of health issues; and, evaluate the impact of interventions. Data for health status indicators 1-5 are routinely provided to policymakers as, for example, when considering appropriations for prenatal smoking cessation

/2013/ HSI1A: Reducing births with low birth weight (LBW) is a Kansas MCH priority in the MCH 2015, the 5-Year State MCH Needs Assessment. In Kansas, the 2010 rate of LBW was 7.09 percent, significantly lower than the 2009 rate (7.30 percent). Kansas' LBW rate has been lower than the national average (7.09% and 8.15% (preliminary), respectively, in 2010)

and is lower than the Healthy People 2020 goal of 7.8%, but still needs a lot of improvement. Over the ten year period (2001-2010), Joinpoint regression analysis showed an increasing trend over the interval 2000-2003 followed by a stable trend from 2003-2010, without significant increase or decrease.

Regardless of maternal race and ethnicity, LBW is associated with a small percentage of live births but a disproportionate large percentage of infant deaths. In 2010, among the infant deaths where birth weight was known, 66.4% (166) of infants who died were LBW. This compares to 7.1% for all live births at LBW. Black non-Hispanic women are more likely than white non-Hispanic women to give birth to a LBW infant (13.5% and 6.5%, respectively, in 2010). Hispanics had the lowest LBW percentage (6.3%). In 2010, 67.9% of infants who died who were born to black non-Hispanic mothers were LBW, compared with 65.6% of infants of white non-Hispanic mothers.

Recent trends in LBW are influenced by the multiple birth rate. Twins and higher order multiples are much more likely to be born LBW than singletons. In 2010, 57.4% of all plural births in Kansas were LBW.

In 2010, anytime during pregnancy, the risk of LBW was greater for smokers than for nonsmokers (10.9% versus 6.4%), creating an excess LBW risk of 4.5% associated with smoking. Other risk factors for LBW live births include low socioeconomic status, inadequate weight gain during the pregnancy, history of infertility problems, close inter-pregnancy spacing and age of mother.

HSI1B: This health indicator removes the impact of multiple births on the low birth weight rate. Over the ten year period (2001-2010), the ongoing trend is relatively stable, without significant increase or decrease. In Kansas for 2010, the percent of singleton LBW births (5.5%) slightly decreased from 2009 (5.6%). For 2009, the most recent year national birth data (final) are available, the percent of Kansas singleton births with LBW is 5.64% lower than for the U.S. (6.36%).

HSI2A: Kansas' VLBW rate was 1.2% in 2010, slightly decreased from 2009 (1.4%). Over the ten year period (2001-2010), the ongoing trend is fairly stable, without significant increase or decrease. In 2010, 82.3% of VLBW infants were born at facilities for high-risk deliveries and neonates a 1.9% decrease from 2009 (80.8%). For 2010, the most recent year U.S. birth data (preliminary) are available; the percent of Kansas live births with VLBW is lower than the U.S. (1.45%).

HSI2B: This health indicator removes the impact of multiple births on the VLBW percent. In Kansas for 2010, 0.9% of live singleton births were VLBW, slightly decreased from 2009 (1.1%). Over the ten year period (2001-2010), there was an increasing trend observed, but was not significant. For 2009, the most recent year U.S. birth data (final) are available, the percent of Kansas singleton live births with VLBW is lower than for the U.S. (1.10%).

HSI3A: In 2010, the death rate for children due to unintentional injuries was 10.9 per 100,000, an increase from 2009 (10.2). Over the ten year period (2001-2010), there was a significant decreasing trend detected in the rate of deaths due to unintentional injuries among children aged 14 and younger. The annual percentage change (APC) was significant (-2.62). For the period 1999-2009, the most recent year for which the U.S. data are available (WISQARS Injury Mortality Report), Kansas unintentional injury death rates (ages 0-14) have been consistently higher than for the U.S.

To prevent mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level.

HSI3B: In 2010, the death rate for children due to motor vehicle crashes was 4.0 per 100,000, increased 48.1% from 2.7 per 100,000 in 2009. Over the ten year period (2001-2010), there was a significant decreasing trend detected with an annual percentage change (APC) of -6.93. For the period 1999-2009, the most recent year for which the U.S. data are available, Kansas motor vehicle crash death rates (ages 0-14) have been consistently higher than for the U.S.

HSI3C: In 2010, the death rate for youth in this age group due to motor vehicle crashes was 27.9 per 100,000, up 27.4% from 2009 (21.9). Over the ten year period (2001-2010), there was a significant decreasing trend detected with an annual percentage change (APC) of -4.93. For the period 1999-2009, the most recent year for which the U.S. data are available, Kansas motor vehicle crash death rates (ages 15-24) have been consistently higher than for the U.S., except in 2007, when Kansas rate was slightly lower.

HSI4A: In 2010, the rate of all nonfatal injuries among children ages 14 and younger was 215.4 per 100,000, decreased 12.6% from 2009 (242.6). After a period of increase (APC=7.11, not statistically significant), there was a significant decreasing trend detected during 2004-2010 (APC=-3.96).

The most common cause of unintentional injury hospitalizations in this age-group is falls followed by poisonings. To prevent morbidity and mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level.

HSI4B: In 2010, injuries from motor vehicle crashes were the third leading cause of unintentional injury hospitalization for this age group. After a period of increase in the rate of nonfatal injuries due to motor vehicle crash, there was a significant decreasing trend detected during 2003-2010 (APC=-17.24). This decrease in hospitalizations caused by MVCs can be attributed to the injury prevention efforts of MCH partners such as SAFE Kids and Kansas Department of Transportation.

HSI4C: Injuries from motor vehicle crashes are the leading cause of injury hospitalization among youth in this age group. In 2010, the rate was lower among 15-19 year olds (79.0) than among older age group, 20-24 (90.0). During 2001-2010, there was a significant decreasing trend detected (APC=-9.27). This decrease in hospitalizations caused by motor vehicle crashes can be attributed to the injury prevention efforts of MCH grantees and partners such as the Injury and Disability Program section in the Office of Health Promotion and the Kansas Department of Transportation. These groups have worked to increase seat belt usage in the 15-19 age group. They advocated for "graduated drivers' licensing" legislation that provides teens with the opportunity to gain more experience under safer conditions before they become fully-licensed drivers.

HSI 5Aand B: Although the overall rates for Chlamydia in females aged 15-19 (29.5 cases per 1,000) and females aged 20-44 (11.2 cases per 1,000) have remained stable in Kansas over the last several years, a number of disparities exist for teenage and reproductive women in Kansas. Chlamydia rates are the highest for women aged 15-19 (29.5 cases per 1,000) followed by women aged 20-24 years (33.9 cases per 1,000). Chlamydia rates are two times higher for Hispanic women (19.1 cases per 1,000 women aged 15-19 and 8.7 cases per 1,000 women aged 20-44), and six times higher for non-Hispanic black women (62.5 cases per 1,000 women aged 15-19 and 27.1 cases per 1,000 women aged 20-44) compared to their respective non-Hispanic white peers (10.5 cases per 1,000 women aged 15-19 and 4.4 cases per 1,000 women aged 20-44).

HSI 7A and B: In 2010, 98.0% of births were to women who only selected one race, while 2.0% selected two or more races, increased by 11.1 percentage points from 2009 (1.8%). White race alone was selected for 81.9% of live births, black race was 7.0% of live births, Asian 2.8% of live births, Native American 0.6% of live births, native Hawaiian or other Pacific Islander 0.1%, other race 5.4%, and race was unknown 0.2% of live births. Women of Hispanic ethnicity accounted for 15.8% of live births, a slight decrease from 2009 (16.4%). As seen in previous years and as might be expected, the majority of births (79.6%) occurred to women between the ages of 20 and 34, across all racial and ethnic categories. Women age 35 or older had the second highest number of births, accouning for 10.9%. Young women ages 10-19 (teenage women) made up the remaining 9.6% of the births. Of the births to teenage women, 72.9% were to white, and 11.6% to black, and 26.9% to Hispanic of any race.

HSI 8A and B: In 2010, there were 689 deaths to children ages 0-24 with 253 of deaths to infants. As seen in previous years, the largest number of deaths were for infants. Based on the proportion of black or African-American children in the Kansas population, black children have proportionately greater numbers of deaths than other races. Black children comprise 9.0% of the States' children but 12.0% of the deaths to children, a slight decrease from 2009 (13.3%). Black infants comprise 10.2% of the States' infants but 13.4% of the deaths to infants, a decrease from 2009 (15.2%). Hispanic children comprise 15.7% of the States' children and 13.9% of the deaths to children. Hispanic infants comprise 19.8% of the States' infants and 7.3% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age.

HSI 9A and B: Kansas's Supplemental Nutrition Assistance Program (SNAP) changed its policy in October 2011 to count the income of all members in a household, including illegal immigrants. Between October and November 2,006 children were closed in SNAP. The majority of these children were American citizens of Hispanic descent.

Kansas's Temporary Assistance for Needy Families (TANF) began requiring eligibility staff to reference an employment verification service (The Work Number) to substantiate income for processing applications, performing a case review, and reviewing interim reports in May of 2011. No significant changes have been observed in the percent of denials or closed cases.

Juvenile crime in Kansas has declined by 30% over the last year. This decline can partially be explained by Kansas Bureau of Investigation following the FBI's decision to no longer collect data on runaways. In 2010, there were 1,413 reports of runaways in Kansas and accounted for 9.1 percent of all juvenile crime reports in that year.

Nearly one in four Kansas children live in households at or below 100% of the Federal Poverty Level (FPL). This is higher than the one out of seven individuals in Kansas households living at or below 100% FPL. In another analysis using the 2000 Decennial Census and the 2006-2010 American Community Survey indicated that high poverty census tracts of more than 30 percent of the population living in poverty increased from 25 census tracts areas in 2000 to 66 census tracts areas in 2010. The 2010 federal poverty level is $22,314 per year for a family of four. Of the 41 newly identified census tract areas, the most changes occurred in the metropolitan counties of Sedgwick (13 census tract areas), Wyandotte (11 census tract areas), and Shawnee (5 census tract areas). //2013//

F. Other Program Activities

State MCH program activities have considerable breadth. Many fall outside the parameters of priority needs and National and State performance measures. Some make significant contributions to the health and well-being of mothers and infants, children, and CYSHCN.

/2012/ Special Efforts made to address Health Disparities

MCH in collaboration with the Director of the Center for Health Equity and community stakeholders such as KC and Wichita Healthy Start Programs, SIDS Network of Kansas, sponsored a State Campaign in which Tanya Lewis Lee did a State tour, promoting preconception health for women to reduce infant mortality. The Tour got a lot of press in the communities and helped support local FIMR efforts to target limited resources.

Maternal, Infant, and Early Childhood Home Visiting

MCH coordinated the efforts of a workgroup to submit a federal grant application, complete a state home visiting needs assessment, and coordinate the efforts of many programs to achieve high quality, comprehensive, and coordinated care for high risk families.

Online Medication Safety Training Course

The Kansas Chapter of the American Academy of Pediatrics (KAAP) was awarded a competitive grant to develop and train child care providers and health professionals in safe medication administration to improve the health and safety of children in early education and child care settings in Kansas using the Healthy Futures: Improving Health Outcomes for Young Children, Medication Administration Curriculum. The application was collaboration between the KAAP and the Bureau of Family Health. In addition to presenting at conferences and conducting face to face training, the five module curriculum was adapted as Web based training to be utilized by child care providers. A sixth module was developed to train professional registered nurses who conduct face to face training. The training is available on KS-TRAIN and includes narrated presentations by a pediatrician and nurse consultant, pre- and post-tests, reviews with each module, and resources to be utilized in training, as well as practice settings. The Web based training is approved for continuing education hours for both child care providers and nurses.

Clinical Site for Public Health Leadership Practicum

BFH served as a clinical practicum site for a graduate-level public health nursing student with BFH staff serving as preceptor. Learning experiences included home visitation grant, visits to two local health departments with different home visiting models. The student had an opportunity to follow legislation related to child safety, to attend the Governor's public health conference with a poster presentation , and contribute an article to the ZIPS newsletter.

Kansas Health Institute (KHI) Leadership Practicum

BFH participated in a leadership practicum at the Kansas Health Institute, a non-partisan policy/research institute. BFH contributed to a publication, "Children's Health in all Policies: A Workbook" a cross-sector policy approach to child health. BFH also contributed to the segment on Children and Youth with Special Health Care Needs providing insight, resources, and evidence-informed examples for Kansas. //2012//

Medicaid Reimbursement Cuts

The KHPA reached an agreement with a group of durable medical equipment suppliers after an approximate 2 month service disruption. The agreement will allow Medicaid beneficiaries who need wheelchairs to continue receiving the equipment that is vital to their health, mobility, and independence.

/2013/
Safe Haven for Newborns Public Awareness Campaign

A Safe Haven for Newborns in Kansas public awareness campaign has been launched across the state. The United Way 2-1-1 Call Center in Kansas City and Wichita are prepared to answer questions. "A Safe Haven for Newborns(r)" sign has been presented to all 105 county health departments in Kansas. Collaboration with the Safe Haven for Newborns Coalition of Greater Kansas City, KDHE Bureau of Family Health and United Way of the Plains, Wichita, provides the safe haven for newborns message across Kansas. The goal is to raise community awareness about the Safe Haven laws and at the same time, help prevent a tragedy. We can help prevent child abuse and neglect by strengthening families and communities.

Toll-Free Hotline: The Kansas Resource Guide

The Kansas Resource Guide (KRG) continues to be a collaborative effort among the Kansas Department of Health and Environment and the Kansas State Department of Education, and Oral Health Kansas. This guide is an informational service designed to connect Kansans and service providers with resources for women, infants, children, youth, families, and people with disabilities. We strive to provide a central point of entry for resources, reducing time spent in searching for needed services and resources. The website (www.kansasresourceguide.org) serves as a navigational tool for both consumers and providers and includes a directory of resources that can be searched based upon geographical location and/or specific services. Consumers and providers can find resources and service providers addressing the following topics: advocacy, adult and aging services, disability services, education, employment, health care services, independent and community living, nutrition and wellness, women and children's services, and youth services (age 14-25). The toll-free line, 1- 800-332-6262 (in Kansas only), continues to be staffed 8 - 5 Monday through Friday.

Parent Support Liaison Project

The Parent Support Liaison (PSL) project was developed to provide care coordination, follow-up, and support services to families and clinic staff in select CYSHCN-Specialty clinics. The PSL's are parents or family members of children with special health care needs who are knowledgeable about resources, supports, and services in Kansas. They are experienced in navigating the service delivery system in our state and use their knowledge and training to assist families in accessing community resources. Currently there is a PSL located in the Cerebral Palsy and Spina Bifida clinic in Kansas City and the PKU and Hemoglobinopathies clinics in Wichita. The project has been well received by both families and providers in the clinic and both CYSHCN and Families Together are looking forward to the possibility of an extension upon the completion of the original pilot project.

CYSHCN Family Survey

To meet the needs of patients served by the program and fulfill goals set by stakeholders at the Maternal and Child Health 2015 Needs Assessment, a survey was conducted at clinics sponsored by CYSCHN. Individuals were asked 20 questions about unmet medical needs and services, financial impact, care coordination, and concerns about patient's skills/abilities. Individuals were asked to complete the survey during their specialty clinic appointments between April and July of 2011. Two hundred and thirty-three individuals (overall response rate of 18.5%) answered the 2011 Family Survey. The gaps and barriers identified by individuals in this survey will be included in the planning of future CYSHCN efforts and in partner discussions. //2013//
An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

Infant Mortality Reduction

In 2009, Kansas requested and received technical assistance on infant mortality reduction with an emphasis on black infant mortality. Rosemary Fournier from Michigan FIMR presented to the Kansas Blue Ribbon Panel on Infant Mortality, a subcommittee of the Governor's Child Health Advisory Committee. She provided an overview of how data from PRAMS and FIMR have guided Michigan with good examples from Detroit. Then she facilitated a discussion with panelists about next steps. The panel adopted a number of recommendations which are posted on this website -- http://www.datacounts.net/infant_mortality/

During the 2010 session, they focused on changing the Vital statutes that have prohibited use of birth certificates for "follow-back" that is, for PRAMS and FIMR. The result is this law http://www.kslegislature.org/bills/2010/2454.pdf Hooray for our Panel members (especially Kansas Action for Children and March of Dimes). They worked hard to get this bill through the legislature. And there were many ups and downs. We are very grateful to them and for the technical assistance that helped moved this process along.

Birth Defects Information System

For the coming year, Kansas is requesting technical assistance from CDC. Senate Bill 418 passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects surveillance system. The statutory language is similar to that of model statutes for the State of Ohio. BCYF submitted an application to the CDC for funding of a birth defects surveillance system. The application was approved but not funded. Resources are not available to establish a surveillance system at this time. Some very limited components of a system such as a database are maintained using MCH federal funds. BFH needs CDC technical assistance to review current efforts and to make recommendations about next steps. /2012/ Two consultants from CDC visited Kansas. They reviewed existing systems with staff and senior management. They have provided Kansas with a document that outlines the steps needed to achieve a quality system for Kansas. Within funding constraints, Kansas MCH is implementing recommended steps. //2012//

/2012/ MCH/Medicaid Intragency Coordination/Collaboration

As indicated earlier in this document, ERO 38 introduced in the 2011 Legislative Session, mandates the merger of the KDHE (Title V MCH State Agency) and the Kansas Health Policy Authority (The State Medicaid Agency). Consultation with a national expert is needed to take advantage of the opportunities and to meet new challenges to MCH posed by this merger. No specific consultant has been suggested. //2012//

/2013/ Technical Assistance is requested from CDC to evaluate our current birth defects information system and to make recommendations: Vital Statistics was reengineered and we are analyzing our birth defects database and staffing needs for data collection and reporting.

Technical Assistance is requested from from CDC to evaluate our current MCH/NBS information system and to make recommendations: Database and staffing needs for data collection and reporting. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4718608	3637101	4710420		4670131	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	4462639	3408049	3972344		3972344	
4. Local MCH Funds *(Line4, Form 2)*	4374000	3854940	4710220		4190160	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	13555247	10900090	13392984		12832635	
8. Other Federal Funds *(Line10, Form 2)*	72444016	70032836	70032836		70032836	
9. Total *(Line11, Form 2)*	85999263	80932926	83425820		82865471	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2774634	2119509	2674119		2550360	
b. Infants < 1 year old	2774635	2119510	2674120		2550360	
c. Children 1 to 22 years old	5456728	4880853	5375059		5076243	
d. Children with	2179250	1577209	2329686		2320672	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	370000	203009	340000		335000	
g. SUBTOTAL	13555247	10900090	13392984		12832635	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		97260		97260	
c. CISS	132000		135813		135813	
d. Abstinence Education	0		359879		359879	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	62000000		60000000		60000000	
h. AIDS	0		0		0	
i. CDC	100000		100000		100000	
j. Education	4030759		4030759		4030759	
k. Home Visiting	0		0		0	
k. Other						
Family Planning	2300000		2300000		2300000	
Other	3786613		3009125		3009125	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1086334	879161	1180342		1179092	
II. Enabling Services	6901877	5582047	7258507		6929242	
III. Population-Based Services	4254786	3462004	3827857		3629085	
IV. Infrastructure Building Services	1312250	976878	1126278		1095216	
V. Federal-State Title V Block Grant Partnership Total	13555247	10900090	13392984		12832635	

A. Expenditures

/2012/ Form 3 - SFY 10 Block Grant partnership expenditures were as follows: $4,164,028 federal; $3,880,903 state; and $4,598,337 local. In comparison, for FFY 09, Block Grant partnership expenditures were: $4,718,608 federal; $4,512,530 state; and $4,782,085 local match. So, from SFY 09 to SFY 10 there were decreases in all three expenditures categories.

In SFY 10, Kansas spent federal dollars within the amount available and also compatible with the priority needs identified in the State Needs Assessment.

In SFY 10, federal MCH funding to support MCH/CYSHCN initiatives was expended within the department as follows: Office of Health Assessment $23,085; Office of Local and Rural Health $39,999; Child Care Licensing and Registration $146,775. Within the Bureau of Family Health (the MCH unit within KDHE) $475,784 in federal MCH funds was spent for staff and operating

costs working in programs for Pregnant Women & Infants, and for Children & Adolescents. Staff, operating costs, and CYSHCN contracts and supplies were $1,001,064. Nutrition consultation through the WIC program was $1,800. Aid to Local agencies and contracts with providers for MCH services totaled $1,806,306.

Newborn screening follow-up expenditures (2 salaries) were $90,868. Salary and operating for one epidemiologist, the director and assistant were $203,366 while indirect costs totaled $334,907.

Federal MCH dollars have declined over the past 17 years from $5,004,067 in FFY 94 to $4,710,420 in FY 10. While this decline appears small, taking into account inflation, the Kansas federal MCH grant has lost almost half of its spending value. What cost $5 million in FFY 94, would cost $7.4 million today. To a great extent increased costs for MCH/CYSHCN have shifted to state and local governments. MCH dollars have been directed towards priority work with accountability for work performed.

For FY 10, no State dollars were expended for Pregnancy Maintenance Initiative. This funding accounts for much of the variability from year to year in state expenditures. It is routinely cut by executive branch and then some or all is restored by the legislature or vice versa. This is also the case for Teen Pregnancy Prevention.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements. However, most provide a dollar for dollar match or greater. A very few local health departments have had difficulties meeting minimal local matching requirements. We continue to monitor this situation as local budgets tighten.

Form 4 - Two other items relating to expenditures should be noted here: 1) When considering federal MCH funds only, the state meets its federal obligation of 30-30 that is, equity in funding for each of the three population groups. When considering all Block Grant partnership expenditures, the Children and Adolescent (C&A) services funding is three times the funding for CYSHCN, and 2.5 times that for Pregnant Women & Infants (P&I). The reason for this is twofold. First, CYSHCN contracts require no local matching dollars. Second, MCH grants to local communities do not require services for CYSHCN. Various solutions to address this have been proposed such as requiring CYSHCN contractors to provide a match, or require that local MCH agencies serve children with special health care needs, and/or a combination of these. Such changes are not likely to take place in the near future.

Another item worth noting is that the funding paradigm has shifted in the MCH grants to local agencies. Previously, services were weighted towards pregnant women and infants through such programs as M&I and Healthy Start Home Visitor. After consolidation of these two grants with the Child Health grants to make one MCH grant, the instruction to local agencies was to allocate resources 50% to pregnant women and infants, and 50% to children and adolescents. Since there were already other aid to local grants focusing on youth services (e.g., teen pregnancy, disparity, school health) the effect of this change was a slight over-allocation of resources to the C&A population group.

Form 5 - Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 50% of the overall budget with population-based at 31% and core public health at 10% each. Over the past five years of this program, there has been a shift away from expenditures for direct services towards other levels of the pyramid.

With State expenditures of $3,880,903 in FY 10, the State of Kansas is well within its required maintenance of effort requirement of $2,352,511.

Kansas meets its 75% matching requirement through use of State funds. The increase in state

and local fiscal responsibility for the program has continued over the past several years.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet. //2012//

/2013/

Form 3. SFY 11 Block Grant partnership expenditures were: $3,637,101 federal; #3,408,049 state, and $3,854,940 local. There were decreases in all 3 expenditure areas from SFY 10 to SFY 11.

In SFY 11, federal spending to support MCH/CYSHCN initiatives expended within the department were: $22, 595 Office of Health Assessment, $28,534 Office of Local and Rural Health, $156,112 Office of Child Care Licensing and Registration. Within the Bureau of Family Health (MCH Section) $392,790 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $975,801. Aid to Local agencies and contracts with providers for MCH services totaled $1,675,505.

Newborn screening follow-up expenditures (2 salaries) were $77,395. Salary and operating for one epidemiologist, director and assistant were $86,309. Indirect costs totaled $203,009.

Federal MCH dollars have declined over the past 18 years. To an increasing extent, costs for MCH/CYSHCN have shifted to state and local governments. This shift is increasingly more difficult to sustain.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements. We continue to monitor this as local budgets tighten.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Including all Block Grant partnership expenditures, the Children & Adolescent services funding is 3 times the funding for CYSHCN and 2.5 times the funding for Pregnant Women & Infants. CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 51% of the overall budget. Population based services are 31%, and core public health at 10%. The shift of expenditures from direct services toward other pyramid levels continues.

The State Kansas is well within its required maintenance of effort of $2,352,311 with expenditures of $3,408,049 in SFY 11.

Kansas meets its matching requirement of $3 state/$4 federal through the use of State funds. Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached spreadsheet.

//2013//

An attachment is included in this section. VA - Expenditures

B. Budget

/2012/

Form 2 - The Kansas budget for MCH federal dollars is $4,710,420. This is the full amount of the anticipated federal Title V award. There is an additional $70 million other federal dollars budgeted and $6.3 million other state dollars.

For FFY 12, the Block Grant partnership budget is: $4,710,420 federal; $3,880,903 state match; and $4,598,337 local. Overall Kansas Maternal and Child Health Services' funding is about one-third federal, one-third state, and one-third local. Kansas meets the 75% match for the federal dollars. Local agencies who receive MCH funds report all local funds used for MCH services.

Comparing the budgeted amounts of MCH dollars for FFY 11 and FFY 12 there is a small reduction in funds for Child Care Licensing ($8,188) that corresponds to the estimated amount of the federal reduction at the time of the submission. Child Care Licensing has gone to a fee-funded operation due to passage of Lexie's Law.

Form 2 - Amounts of funding allocated to children and adolescents and CYSHCN meet the 30-30 allocation requirement with $1,539,884 (33%) of the federal grant allocated to children and adolescents and $1,491,017 (32%) allocated to children with special health care needs.

Form 3 - Kansas' budget for FFY 12 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of 75% is achieved through projected State matching funds of $3,972,344. Kansas also anticipates local reporting of expenditures of $4,710,220.

Form 4 - Of its overall MCH budget (fed, state and local), Kansas allocates about $2.7 million to services for pregnant women and $2.7 for infants. Another $5.4 million is allocated to children and adolescents and $2.3 million for CYSHCN.

Form 5 - Considering the overall MCH budget, about $1.2 million (9%) is allocated to direct services, $7.3 million (54%) to enabling services such as case management and transportation. $3.8 million and $1.2 million are allocated respectively to population-based services and to core public health infrastructure services.

The indirect cost rate for KDHE is 21%. For Kansas, administrative costs are defined as indirect costs charged to the MCH Title V grant. As such they are within the 10% limit set forth in federal Title V law.

At this time, Kansas is in compliance with all requirements of the law.

Detailed information about the FFY 12 budget is provided in the attached Excel spreadsheets.

The State of Kansas assures that the MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, into the state budget, and into the process of prioritizing programs for MCH resources based on the State MCH needs assessment.

The Children & Families Section administers MCH grant funding for local agencies relating to: perinatal and reproductive health services, and child and adolescent health services. The contracts for this section include: MCH-- 85 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 58 contracts with local health departments and other local agencies for coverage of all counties. In addition there are contracts with providers of teen pregnancy case management services, pregnancy maintenance initiative services, SIDS outreach and education.

Following is the list of MCH contracts with local agencies for SFY 12 -- totaling $4,095,403
Barber Co Health Dept $4,413

Barton Co Health Dept (multi county) $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $76,997
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept B $3,115
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept - $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,303
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK (multi county) $92,645
Nemaha Co Health Dept $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036

Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,629
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK (multi county) $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Dept $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
CHC of SE Kansas $54,571
Hays Area Children's Center $18,156
Mercy Hospital $63,245

Teen Pregnancy Case Management Contracts for SFY 12 -- $338,846 (plus Medicaid match)

School-Public Health Nurse Collaboratives -- not funded in SFY 12

Pregnancy Maintenance Initiative for SFY 12 -- funding restored to $338,846

SIDS Network of Kansas contract for SFY 12 -- reduction from $75,000 in SFY 11 to $71,374 in SFY 12

Women's Right to Know budget for SFY 12 --no budget

//2012//

/2013/

Form 2. The Kansas federal budget for MCH dollars is $4,670,131. There is an additional $70 million other federal dollars budgeted and $6.3 million other state dollars.

The SFY 13 Block Grant parntership is: $4,670,131 federal; $3,972,344 state match; and $4,190,150 local. Overall, Kansas' MCH Services funding is approximately 36% federal, 31% state, and 33% local.

The amounts of funding allocated to Children and Adolescents (C&A) and CYSHCN meet the 30-30 allocation requirement. Children and Adolescents (C&A) with $1,527,101 (33%) and CYSHCN with $1,482,002 (32%).

Form 3. The Kansas budget for SFY 13 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of $3 state/$4 federal is achieved through projected State matching funds of $3,972,344. Kansas anticipates local match of $4,190,160.

Form 4. Kansas allocates approximately $2.5 million to services for pregnant women and $2.5 million for infants. An additional approximate $5.1 mlllion is allocated to C&A and $2.3 million for CYSHCN.

Form 5. Approximately $1.1 million (9%) is allocated to Direct Health services. Approximately $6.8 million (53%) is allocated to Enabling services. Approximately $3.5 million (28%) is allocated to Population Based services. Approximately $1.1 million (9%) is allocated to Core Public Health/Infrastructure services.

The indirect cost rate for KDHE is 21.4%. Administrative costs are indirect costs charged to the MCH Title V Grant. They are within the 10% limit set forth in federal Title V law.

Kansas is in compliance with all requirements of the law.

Kansas MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based upon the State MCH Needs Assessment.

Following is the list of MCH contracts with local agencies for SFY 13 -- totaling $4,095,403.00

Barber Co Health Dept $4,413
Barton Co Health Dept $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $77,000
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept $3,115
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306

Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,300
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK Multi- Co Health Dept $92,645
Neosho Co Health Dept $18,925
Nemaha Co Health Services $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,629
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK Multi-Co Health Dept $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Agency $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
Community Health Center $54,571
Hays Area Children's Center $18,156
Mercy Health System of KS $63,245

//2013//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.