



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Kansas**

**Application for 2009
Annual Report for 2007**



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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.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

//2009/ 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; expires May 31, 2009.

E. Public Input

//2009/ In order to solicit public review and comment as in [Section 505(a)(5)(F)], a notice requesting public input was posted on the Kansas Rural Health Information System, the public health information system with postings to all local health departments, hospitals, primary care clinics and other health care providers.

The February 28, 2008 Kansas Register contained a Notice of Hearing for the KDHE block grant programs: Maternal and Child Health Services Block Grant and the Preventive Health and Health Services Block Grant.

On Monday, March 17, 2008, the public hearing was held in the Statehouse before the House Appropriations Committee of the Kansas Legislature. The hearing included a presentation by KDHE on the federal requirements for each of the block grant programs, the services provided in Kansas, and the use of the federal funds.

No comments were received through these processes. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Needs Assessment Summary.

1. In order to determine state MCH priorities for the five year period 2006-2010, a formal MCH state needs assessment was conducted in 2004-2005. The needs assessment conformed to federal requirements to determine the state priorities for each of the three MCH population groups. This project and its products were called MCH2010. A final document was prepared and public input was solicited and incorporated. The final report was submitted to the MCHB in July of 2005 as part of the MCH Block Grant Application. The document is available to the public at <http://www.kdheks.gov/bcyf/>. Nine MCH state priorities were identified through the 5-Year MCH State Needs Assessment process.

Pregnant Women and Infants

Increase early/comprehensive health care before, during, and after pregnancy.

Reduce premature births and low birth weight.

Increase breastfeeding.

Children and Adolescents

Improve behavioral/mental health.

Reduce overweight.

Reduce injury and death.

Children with Special Health Care Needs

Increase care within a medical home.

Improve transitional service systems for CSHCN.

Decrease financial impact on CSHCN and their families.

//2009/ Since the submission of the last MCH Block Grant application there have been no changes in the Kansas State priority needs. An attachment to this Section provides an overview of recent activities addressing priority needs. //2009//

2. The MCH2010 process built on lessons learned in the previous two needs assessments. Quantitative and qualitative data were still used, but the process was organized around stakeholder involvement and decision-making. An MCH planning team consisted of the BCYF Director, Children & Families Section Director (representing both the pregnant women & infants and children & adolescents population groups), Children with Special Health Care Needs Section Director. In addition, two MCH epidemiologists, a contracted project manager, and the three facilitators (one internal to BCYF and two contracted facilitators), as well as a consultant from Johns Hopkins University Women's and Children's Health Policy Center (assistance in MCH capacity assessment) provided support to the project.

Three one-day meetings with over 70 stakeholders were held from June 2004 through October 2004. The stakeholders broadly represented MCH concerns in Kansas and included family representatives, adolescents, health care providers, and program staff as well as representatives from other state agencies, local health departments, universities, not-for-profit organizations, and advocacy groups.

Each of the meetings with stakeholders was structured to accomplish specific tasks in a sequence leading to identification of priorities. After a plenary session setting the objectives for the workday, stakeholders broke out into "panels of experts" to focus on one of the three MCH population groups. The first meeting provided an overview of the needs assessment process and stakeholders reviewed data indicators and identified data needed for the work in the second meeting. At the second meeting stakeholders reviewed data, selected priorities, and identified some possible strategies to address priorities. The focus of the third meeting was evaluation of MCH capacity to address priorities. The needs assessment process continues through the implementation of activities described in the State Performance Measures section of this application. Performance measures are assessed on an annual basis to track on progress in addressing the priorities. ***//2009/ An attachment to this Section provides current information relating to the needs assessment process adopted by Kansas. //2009//***

3. The needs assessment process has been invaluable in partnership building and collaboration with multiple stakeholders in the state. Many participants expressed appreciation for the opportunity to share their opinions and expertise. An important factor in the needs assessment process was consideration of the role of all stakeholders and of multiple and diverse partners in the broader state MCH system and their roles in addressing MCH priorities. As well, the process educated many stakeholders about the breadth and importance of the State MCH system and the role of the State MCH agency. ***//2009/ An attachment to this Section provides updated information about key stakeholders. //2009//***

4. The stakeholders themselves selected the State priority needs during the Kansas needs assessment process. They were given lists of indicators at the first meeting from which they selected the data they needed to review for the work of the second meeting. They were guided in their decision-making process by the quantitative data, but they were also encouraged to utilize their knowledge and backgrounds as expert panelists to select priorities. In general, as evidenced by the written feedback from stakeholders, the process was very satisfactory to all not only in selecting priorities but also in forging relationships to support MCH activities in the state.

//2009/ Please see the attachment for an update of information in this Section. //2009//

An attachment is included in this section.

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 (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 and west by Missouri and Colorado respectively. Hills, ridges and wooded river valleys in eastern and central Kansas give way to the flat, dry, treeless High Plains of the western part of the state.

With a 2000 Census total population of 2,688,418, Kansas ranks 32nd among the states, about 1% of the U.S. population. This represents an 8.5 percent increase over the 1990 Census. /2008/ Kansas increased in population from 2,735,502 residents in 2004 to 2,744,687 residents in 2005, a 0.3% increase. //2008// Geography, climate and economic resources combine to influence the population distribution of the state. The four most populous counties, Johnson, Sedgwick, Shawnee and Wyandotte, are located in the eastern and central parts of the state. The least populous counties are located in the western part of the state. In 2003 the population density of Kansas was 33.3 persons per square mile compared with 82.2 persons per square mile for the U.S. The county population density ranged from 1,040 persons per square mile in Wyandotte County in eastern Kansas, Kansas City area, to less than six persons per square mile in one far western county. Two counties in western Kansas had population densities of 1.8 persons per square mile. /2009/ **Based on the July 1, 2006 Census data, Kansas' population of 2,764,075 is 0.9% of the U.S. population. This is due to the slower growth rate for Kansas (0.6%) than for other States in the country, most notably the sunbelt States, e.g., Arizona at 3.6%. For comparison purposes, the overall growth rate for the U.S. for this period was 1.0%. //2009//**

Population Changes

Historically, Kansas has been predominantly rural. However, that trend is changing along with a similar trend for the U.S. The total population of all cities in Kansas is 2,211,271 or 81.2 percent of the total population (2003). /2008/ this was 81.4% in 2005. //2008// **/2009/ and 81.7% in 2006. //2009//** Of the 20 largest cities in Kansas, five have populations that exceed 100,000 including Wichita (354,617), Overland Park (160,368), Kansas City (145,757), Topeka (122,008), and Olathe (105,274). These cities are all located in the eastern half of the state. The western half of Kansas has five of the 20 largest cities in Kansas, including Salina (45,833), Garden City (27,216), Dodge City (25,568), Liberal (20,067), and Hays (19,915). **/2009/ Last year, 34.3 percent of the total population resided in rural areas and cities with populations of less than 5,000. //2009//**

In 2000 the population of the state was 86.1 percent white, 5.7 percent African American, 1.7 percent Asian, 0.9 percent American Indian or Alaska Native, some other race or mixed heritage 5.5%. /2008/ The 2005 population estimates put the percent white at 89.4 and Black at 5.9 percent. //2008// Native Hawaiians and other Pacific Islanders numbered 1,313. Seven percent (7%) of the population reported Hispanic ethnicity. Immigrants or foreign-born residents accounted for only 2.5 percent of Kansas' total population.

Over the past decade, Kansas has seen an increase in the diversity of its population. From 1990 to 2000, the Hispanic population increased by 101% to 188,252 (or 7.0 percent). The Asian and Pacific Islander population increased 48,119 (51.6 percent). The American Indian and Alaska Native population increased 24,936 (13.5 percent). The African American population increased by 7.8 percent to 154,198. The increase for the white population over the same period was only 3.7 percent (2,231,986 to 2,313,944). /2008/ According to 2005 population estimates, the Hispanic population was 8.3% of Kansas' population. //2008// **/2009/ For 2006, this increased to 8.6%. Also for 2006, the African American population as a percent of total population was 6.0%. //2009//**

Approximately 8.7 percent of the Kansas population five years of age and older speak a language other than English at home according to the 2000 Census. Of these 3.9 percent speak English less than 'very well.' Between 1990 and 2000 there was a 66% increase in the population speaking a language other than English in the home. The Kansas percent increase was greater than the average increase for the Midwest (66% versus 43%) but considerably less than the increase for the South (62%).

Kansas has slightly fewer than 40,000 live births each year (39,353 in 2003). /2008/ 38,654 in 2004 and 39,701 in 2005 //2008// In 2003, the Kansas birth rate of 14.4 was 2.9 percent higher than the national rate of 14.0. Seward, Geary and Finney counties had the highest five-year county birth rates of 23.7, 22.3, and 21.2 births per 1,000 population respectively. In 2003, 27.1 percent of the population (736,901) were children ages 18 and younger. Women of reproductive age 15-44 accounted for 20.9 percent of the population (568,347).

During the period 2000 through 2003, 54% of births occurred in 5 urban counties with 77% (180) of Kansas obstetricians practicing in 5 counties. The remaining 100 Kansas counties account for 46% of all births where 23% (54) of the state's 234 obstetricians are in practice. Forty-two of 105 counties have no maternity services. Ten counties have no hospitals. /2008/ Six hospitals have over 100 NICU admissions per year. //2008// Thirty-seven (37) rural and frontier counties average fewer than 40 births per year.

Economic Considerations

Compared to the U.S. population (2003), a lower percentage of Kansans live in households with incomes below the federal poverty level (10.8% versus 12.5% for the U.S.) and a lower percentage of children under age 18 live in households with incomes below the federal poverty level (14.5% versus 17.6% for the U.S.). Twenty percent (20.1%) of Kansas' children living in poverty are of Hispanic ethnicity. Overall, the percent of Kansas' families living at or below the federal poverty level is 6.7%. Poverty is more common in Kansas' families headed by single females and those with children under the age of five in the household, regardless of race or ethnicity. Most Kansas children under age 18 living in poverty live in three population centers: Sedgwick Co. (Wichita), Wyandotte Co. (Kansas City, KS) and Shawnee Co. (Topeka).

/2008/ The population of school age children 5-19 years of age totaled 569,356 in 2005. This is a 10,307-person decrease, or -1.8 percent since 2004, and a 40,354-person decrease, or -7.1 percent since 2000. In 2000, school age children represented 22.7 percent of the Kansas population (21.2 in 2004, 20.7 in 2005, 21.1 in 2006). //2008//

Educational attainment for Kansans is favorable compared to the U.S. About 86.0% of Kansans age 25 and older are high school graduates compared to about 80.4% for the U.S. The percent of those ages 25 and older with college degrees is slightly higher for Kansas than for the U.S. (25.8% versus 24.4%).

Following the 2001 national economic downturn, Kansas' economic recovery has been more modest than the U.S. economic recovery. Even though the state experienced overall

employment growth in 2004, the economy is expected to continue modest growth below that of the U.S. in 2005. The monthly average unemployment rate for 2004 was 5.5%. ***//2009/ The unemployment rate for Kansas decreased from 4.3 percent in October 2006 to 3.4 percent in October 2007. //2009//***

Health Care Delivery Environment

In Kansas, total state health expenditures per capita for state fiscal year 2001 was slightly lower (\$3,275) than for the U.S. (\$3,590). The total includes both state-funded operating and capital spending. For state fiscal year 1999, Kansas state health care expenditures per capita was lower (\$698) than for the U.S. (\$872).

In 2005, there were eleven federally qualified health centers with sites in Kansas and 173 federally certified rural health clinics. There are 117 community hospitals of which 76 are Critical Access Hospitals. With 175 physicians per 100,000 population, Kansas was lower than the national ratio of 198 physicians per 100,000. Kansas ranked 31st among states in physicians per capita. There were 5,407 active patient care physicians in Kansas in 2003. Twenty-five percent of active patient care physicians are female (1,354).

The rate of registered nurses per 10,000 population in Kansas was slightly higher than the U.S. This was equal to 883.1 RNs per 100,000 population in Kansas in 2000 compared to 780.2 for the U.S. Registered nurses include advance practice nurses such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. There were 1,685 dentists, 2,020 dental hygienists, and 2,840 dental assistants practicing in Kansas in 2000. There were 62.6 dentists per 100,000 population in Kansas in 2000, slightly below the national rate of 63.6. The per capita ratios of dental hygienists and dental assistants were higher than their respective national rates. The number of dentists in Kansas increased 38% between 1991 and 2000 while the state's population grew 8%. The result was a 28% increase in dentists per capita compared to a 16% increase nationwide.

Overall, there were more than 126,000 people employed in the health sector in Kansas in 2000, 9.6% of Kansas' total workforce, higher than the national rate of 8.8%. Kansas ranked 13th among states in per capita health services employment. In 2000, Kansas ranked 8th among states in the number of hospital beds per 100,000 population.

According to the U.S. Census Bureau's Current Population Survey, in 2003, 11.0% of all Kansans had no insurance coverage. This compared favorably with data for the U.S. population at 15.6% uninsured. Eighty-nine percent (89.0%) of Kansans were covered by private or government health insurance, compared to 84.4% for the U.S. ***//2008/ Nationally, the number of people with health insurance coverage increased by 1.4 million in 2005 from 245 million in 2004, to 247 million in 2005. In the U.S., the total number of insured represents 84.1% of the U.S. population. For the same period 2004 to 2005, the number of Kansans covered by private or government health insurance increased from 2,372,000 (88.9% of the Kansas population) to 2,405,000 (89.2%). //2008//*** ***//2009/ In 2006, the U.S. Census put Kansas overall uninsurance rate at 12.3%. Eighty-seven percent (87.7%) of the Kansas population had public or private health insurance coverage. This compares favorably to U.S. rates for uninsurance at 15.8% and insured at 84.2%. //2009//***

According to the 2001 Kansas Health Insurance Study, children are disproportionately affected by lack of health insurance coverage with approximately 8% of Kansas' children age 18 and under uninsured. Over two thirds of Kansas children were covered by private insurance and fifteen percent were covered by public insurance. Similarly, women of reproductive age (15-44) are disproportionately affected by lack of health insurance coverage with 13.2% uninsured compared to 12% of the Kansas population. Of those with coverage, 82.6% were covered by private insurance and only 4.3% by public insurance.

The same study put the average annual growth of Medicaid enrolled at 5.6% in Kansas compared to 9.8% for the U.S. Fifty-two percent (52%) of Kansas Medicaid enrollees are age 18 or younger. Kansas maintains the eligibility level for the Medicaid program at the federally required minimum. See Form 18 for eligibility levels for Medicaid and State Children's Health Insurance Program (SCHIP), called the Health Wave program in Kansas.

//2009/ A Kansas Health Institute study published in February of 2008 updated the health insurance data for the State using the March 2007 Current Population Survey. Key findings of the report are the following: the percent of children covered by private insurance declined from 66.6 percent in 2004-05 to 63.0 percent in 2005-06. Children's enrollment in Medicaid and the SCHIP program declined in SFY 07 after steady increases for several years, possibly due to new citizenship documentation. The percent of all Kansans who are uninsured increased from 10.5 to 11.3 percent from 2004-05 to 2005-06, following 5 years of relative stability. The overall percent of children uninsured showed a slight increase from 6.5 to 7 percent, although the finding was not statistically significant. The percent of adult Kansans uninsured increased significantly from a six-year low of 13.5 to 15.5 percent. Poverty is on the rise in Kansas with the number of uninsured Kansans living in poverty increasing significantly to 95,140 in 2005-06 up from 68,602 in 2000-01. //2009//

Among Kansas Medicaid enrollees, 55.3% are enrolled in managed care compared to 58.3% for the U.S. The percentage of Medicaid spending on children under age 18 (15%) in Kansas is the same as for the U.S. However, long-term care (fee-for-service) Medicaid spending is higher (53%) compared to the U.S. (38%). The number of births financed by Medicaid in Kansas rose from 7,718 (23% of Kansas live births) in 1999 to over one third in 2002. Joint application was allowed for children's Medicaid and SCHIP-funded separate programs starting in 2002. Kansas is one of 18 states in the U.S. with 12-month continuous eligibility for Medicaid eligible children. Due to budget shortfalls, Kansas has followed the lead of other states in implementing cost-sharing requirements for the Kansas SCHIP program but not decreasing benefit levels. Kansas has not applied for a waiver to expand eligibility for Medicaid services to women from the existing 60 days postpartum to 2-5 years as has been done in several other states.

Kansas has no laws requiring coverage of all FDA-approved prescription contraceptives by all health insurance policies written in the State that provide prescription coverage. There is no mandated coverage for infertility diagnosis and treatment. However, there is mandated direct access to OB/GYN limited to one visit per year from an in-network OB/GYN. OB/GYNs are not mandated as primary care providers. Kansas law mandates benefits for breast and cervical cancer screening. Kansas laws also require insurers to provide coverage for diabetic supplies, equipment, and/or out-patient management training. Insurance coverage of newborn metabolic and newborn hearing screening is not mandated.

Even though insurance coverage and financing mechanisms dominate policy discussions about the health of Kansans, there is a strong role for public health in prevention and early intervention, health promotion, and basic gap filling services. The state health agency operates within a framework of legislative authority. In partnership with 99 local health departments operating in 105 counties, the state health agency carries out its public health mandate.

State Health Agency's Current Priorities or Initiatives & Title V Role

//2009/ Going into the 2008 legislative session, the Kansas Department of Health and Environment (KDHE) health priorities and initiatives included the following: enhanced funding for the Part C Infant Toddler Program, Primary Care Safety Net Clinics funding, Coordinated School Health Program, and support for the Kansas Health Policy Authority (KHPA) 21-point health care reform agenda.

The health care reform agenda (www.khpa.ks.gov) was a major agenda for the Governor,

the KHPA, and KDHE going into the 2008 session. Agency administration and the Director of Health were involved in the formulation of the agenda which included various components of the Healthy Kansans prevention plan. Among the provisions of the agenda were the following: define medical home in statute/regulation; increase provider reimbursement; implement statewide community health record; promote insurance card standardization for public insurance programs; increase tobacco user fees; statewide ban on smoking in public places; expand health and wellness programs in partnership with community organizations; add Commissioner of Education on KHPA Board; statewide surveillance system for obesity of school children; promotion of healthy food choices in schools; increase in physical activity in schools; wellness grant program for small business; promote healthier food options for State employees; dental care for pregnant women enrolled in Medicaid; expansion of cancer screening through State breast cancer program; improve enrollment of children in HealthWave (Medicaid/SCHIP), allow parents to keep young adults on their family insurance plans through age 25, and develop inexpensive young adult policies; premium assistance program for adults in poverty (>100% FPL); assistance to small businesses for affordable coverage. Total cost for the 21-point package was \$159.88 million with \$86 million from State funds.

The following provisions had been adopted by the close of the 2008 legislative session: medical home definition; Commissioner of Education on KHPA Board; study of young adult insurance policies; studies of small employer policies; transfer of cafeteria plan from Dept of Commerce to KHPA; funding for continuation of Comprehensive School Health Program at \$550,000 per year. There was no action on tobacco use fees or statewide ban on smoking. The following provisions passed with no appropriation: insurance card standardization; statewide community health record; dental coverage and tobacco cessation for pregnant women enrolled in Medicaid; improved access to public insurance for children and young adults; and improved access to cancer screening.

An additional \$1 million tobacco settlement funds was appropriated for the Part C (tiny-K) program that serves children ages birth to two years of age with disabilities and their families. The program located within the Bureau of Family Health complements the program serving 3-5 year olds (Part B Special Education program) in the Kansas State Department of Education.

The agency requested \$154,000 for primary care safety net clinics to assist them with the rising costs of providing services in underserved communities. The Kansas Association for the Medically Underserved (KAMU) proposed a separate plan estimated to cost between \$6.1 and \$8.6 million, to accommodate a 10-20 percent increase in patient visits for uninsured persons; provide additional outreach for enrolling eligible individuals in Medicaid and SCHIP; allow for increased recruitment of physicians and dentists; and other. Primary Care Safety Net Clinics received additional funding of \$2.5 million to serve the uninsured after the legislature rejected many of the Medicaid and SCHIP expansion provisions of the KHPA health care reform plan. The legislature appropriated an additional \$1,645,000 for primary clinics plus an additional \$855,000 for capital expenditures.

Since the \$500,000/year 5-year CDC grant, Coordinated School Health, was set to expire in 2008, KDHE supported an extension using state general funds. The program was a joint effort between KDHE and the State Department of Education focusing on increased physical activity, nutrition, decreased tobacco use, and obesity prevention and reduction. The legislature appropriated tobacco settlement funds at \$550,000 to continue the effort.

The State Agency also supported expansion of the newborn screening program to the core panel of 29 conditions recommended by the ACMG. This received early approval in the session with appropriation of an additional \$1.3 million for the KDHE Public Health Laboratory and \$336,000 for follow-up and treatment through the Bureau of Family Health,

all through tobacco settlement funds. The legislature specified a start-up date of July 1, 2008.

The Agency continued to resist efforts by interest groups to dilute health and safety portions of the child care licensing program. Child care labor unions are also emergent as a force in the State bringing another constituency into the arena of child care licensing and regulation. Many bills were introduced to restrict state-funded services to immigrants, penalize employers who hire immigrants, and the Agency provided numerous briefings to legislative committees. None of the bills passed. //2009//

The KDHE continues to work towards an integrated public health data system in partnership with local agencies. As such, the new databases for MCH and CSHCN interface with the web-based Immunization Registry. Plans are underway to develop additional interfaces with WIC, birth defects surveillance, and other programs within the department. These efforts, in turn, link with the development of public health performance measures as a prelude to advancement of a Public Health Standards/Accreditation process for the State.

Meanwhile, the State Early Childhood Comprehensive Systems (SECCS) grant stakeholders incorporated into their state plan the components from the Governor's school financing plan relating to young children including all day kindergarten, increased support for 4 year old at-risk programs, and funding for evaluation of Parents as Teachers. In turn, the Governor endorsed the SECCS plan and staffers are participating in the implementation process.

/2007/ The 2006 legislature passed a 3-year education spending bill which fell short of increases recommended by both a private consulting firm and the research wing of the legislature, Legislative Post Audit, but there were no tax increases. The spending bill included funding for the Governor's recommended pre-K pilot projects. The legislature did not consider funding for universal pre-K and all day kindergarten. *//2007//* */2008/* The 2007 Kansas Legislature appropriated \$500,000 to improve access to child care for infants and toddlers, plus \$10.5 million for child care subsidies for low-income working parents, \$1.6 million for expansion of Early Head Start to 70 counties, \$3 million for expansion of the pre-K pilots, and \$400,000 for after school programs. The most significant development of the session relating to early childhood issues, was near passage of a bill to create a separate Office of Early Childhood through a reorganization of programs servicing the 0-5 age group into one entity. This bill stalled out but a study group was named to make recommendations to the 2008 Legislature. Other developments included selection of Kansas as one of 18 states to work on the ABCD Screening Academy, a Commonwealth Fund and NASHP effort. Kansas was selected as one of 10 states for a \$10,000 grant from the NGA for an Early Childhood Summit. *//2008//*

The second most important policy agenda was expanding eligibility while at the same time holding down health insurance costs. The Governor's Office proposed creation of a health authority within the Office of Administration that would combine Medicaid, SCHIP, and the State Employees Health Insurance programs to obtain greater purchasing power, and lower prescription drug and administrative costs. During the 2005 legislative session, the proposal was reworked by the majority party and passed. The legislators maintained the key points of combining programs/purchasing power. The plan diverged by establishing a separate State agency more answerable to the legislature while at the same time appropriating no funding for a separate state agency.

The timeline for the current plan (House Substitute for Senate Bill 272) is as follows: July 1, 2005 Kansas Health Policy Authority established; July 1, 2005 transfer programs from Kansas Department of Social and Rehabilitation Services (SRS) to Dept of Administration, Division of Health Policy and Finance; January 1, 2006 Assumption of Responsibilities by Authority; March 1, 2006 Authority Plan Submitted to Legislature; July 1, 2006 Transfer programs to the Authority; Beginning of 2007 Legislative Session - Plan submitted for transfer of additional Medicaid funded programs to the Authority (could include mental health services, Home and Community-Based

Services waivers, nursing facilities, substance abuse prevention and treatment and the state hospitals); Beginning of 2008 Legislative Session - Plan submitted to legislature for assuming responsibility for purchase of health care services for Dept. of Aging, Dept. of Corrections, Juvenile Justice Authority, Dept of Education - Local Education Agencies (LEAs).

/2007/ July 1, 2006 is the date for completion of the transfer from Executive branch control to control by a governing body appointed by both legislative and executive branches. Also, the directorship of the HPA is unclear as the executive director will serve at the pleasure of the governing body. //2007//

At least one area of KDHE will be impacted by this major reorganization, the Center for Health and Vital Statistics (CHES). The administration of the Health Care Data Governing Board and staff to that board currently reside in the CHES Office of Health Care Information. Administration and staffing are expected to transfer to the new state agency in January of 2006. The impact of this transfer on access to hospital discharge and other data by state health department programs cannot be determined at this time. //2007// /2008/ SB 11 of the 2007 session directs the KHPA to develop a plan to move to universal coverage. The plan will be presented to the 2008 session. Meanwhile, the bill provides assistance to families with incomes below 100% FPL to purchase private coverage. It provides grants and loans to small businesses to form group plans. There are loans to safety net clinics. //2008//

Federal legislation requires coordination between Title V and Title XIX of the Social Security Act (MCH and Medicaid). The SRS/KDHE Interagency Agreement spells out the relationship between the state Medicaid agency and the state MCH agency in Kansas. It is certain that the interagency agreement will need to be reviewed in light of these recent changes in Kansas. Meanwhile, MCH/CSHCN acts in an advisory capacity to the state Medicaid agency relating to services for pregnant women and children. Another advisory role is to the state insurance agency and to the legislature in insurance matters relating to pregnant women and children.

Although it has not received funding, the health promotion portion of the Governor's health plan, based on a similar plan in the state of Arkansas, has been implemented through the Office of Health Promotion in KDHE. The focus is on nutrition and physical activity in the work place and in the community with school-age, adult and elderly populations. School age efforts are coordinated with the Department of Education through CDC's Coordinated School Health grant to Kansas. Maternal and Child Health staffs participate in the state advisory group for the Coordinated School Health project and provide an important link to school nursing services in the state. The Coordinated School Health program links with health education and physical education teachers and the school nutrition services mandated by the Child Nutrition Act.

In the Spring of 2005, Healthy Kansans 2010 was launched by the Office of Health Promotion within KDHE. PowerPoint data presentations with recommendations were provided by individuals from within and outside KDHE relating to Healthy People 2010 priorities. At the final meeting of the consensus group, the participants were asked to vote on the key priorities for KDHE for the next 5 years, keeping in mind the presentations and the 10 leading health indicators. Following are the three priority areas selected by participants: 1) Health & Disease Disparities; 2) Early identification and interventions (women and children); 3) Systems interventions to deal with Social Determinants of Health. Workgroups were formed around each of the three priority areas and each recommended strategies in the following areas: improved communications regarding health and public health; ongoing workforce development; surveillance and data needs; coordination and collaboration of programs. MCH/CSHCN continues to participate in this effort to establish a linkage with other planning efforts such as MCH 2010 and SECCS.

/2007/ Highlights of Kansas' legislative activity in 2006 relating to maternal and child health included: three year school finance plan; passage of the child passenger safety seat referred to elsewhere in this document under injury prevention; continued discussion but no passage of

emergency contraception education by public health; supplemental appropriation for CSHCN for treatment products; HB 2284 right to breastfeed as needed in a public place and jury duty deferment when breastfeeding; mental health parity; school vending machines and nutritious food in schools; requiring liability insurance for day care; domestic violence-battery; services for undocumented individuals; cord blood bank education; establishment of dental residency program in Wichita; amendments to laws concerning the state trauma program; new requirement of meningitis vaccine for incoming college students.

Appropriations highlights for the session relating to maternal and child health included: PKU treatment supplemental of \$100,000 state funds for SFY 06 and \$208,000 Tobacco Settlement funds for PKU in SFY 07; \$110,000 SGF for the Wichita cerebral palsy seating posture seating program; \$1,850,000 increase for the Part C Infant-Toddler program; \$415,000 for Dentistry Residency Training program; \$50,000 additional funds for SIDS Network of Kansas; \$200,000 increase for Pregnancy Maintenance Initiative; \$50,000 for Newborn Hearing Loaner Program; \$380,000 for Cord Blood Bank education; \$225,000 for Domestic Violence Training; and \$250,000 for Youth Mentoring program. There was a great deal of discussion about funding for expansion of the Kansas newborn screening program to 29 tests recommended by the American College of Medical Genetics and a \$2 million proposal was not passed. At the same time federal reductions in recent years from Maternal and Child Health Block Grant and Preventive Health Block Grant necessitated a 6.59% across the board reduction to local MCH agencies. CSHCN continues to tighten its belt due to pharmaceutical and other cost increases plus increasing caseload. //2007//

/2008/ Legislative successes relating to child care subsidies, Early Head Start, and After school Programs funding were mentioned earlier. Other successes included expansion of the state's primary seat belt law to teens. SB 211 allows officers to stop and ticket occupants ages 17 and under not wearing seat belts with an increase in the fine from \$10 to \$60. There is new funding of \$200,000 for expansion of immunization outreach through the WIC clinics. The final budget included \$800,000 start up funds for expansion of newborn screening. //2008//

/2009/ Internally, the State Agency uses an issue paper process to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery including current and emergent issues. Bureaus within the division of health write issue papers relating to legislative and budget issues. These are reviewed by a group of peers and they are forwarded to a management team for review and prioritization. A final review by the Governor's team will determine which State Agency legislative and budgetary issues will be put forward in the next session. Policy issues that are of consequence only within the KDHE may be put forward at the same time. These may be considered and handled separately from those sent forward to the Governor.

Externally, Title V program staff engage in a number of stakeholder groups that put forward various agendas impacting the health care delivery environment. These are discussed in the coordination and collaboration section of this application. //2009//

The 5-Year State Needs Assessment continues to guide Bureau decision-making for MCH and CSHCN. ***/2009/ More information about this process can be found in the needs assessment section of this application. //2009//***

B. Agency Capacity

This section addresses the capacity of the Kansas MCH Title V Agency to promote and protect the health of all mothers and children, including CSHCN. 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.

Although the Kansas program has not completed a Capacity Assessment for State Title V (CAST-V) Programs, it has addressed core components. The program has established a vision, mission and goals for the maternal and child health population through a strategic planning process. Capacity assessment is a key part of the 5-Year MCH State Needs Assessment called MCH 2010 (www.kdheks/BFH). Through the Title V needs assessment 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 was included in the needs assessment process. All relevant information was 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, the basis for the CAST-V assessment, to guide decision-making in all aspects of program operation. 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 Behavior Risk Factor Surveillance System (BRFSS) that is conducted within the Office of Health Promotion is readily available and MCH has an opportunity each year to support additional modules relevant to emergent issues within MCH/CSHCN. Oral health and women's health modules have been supported 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 will be representative and useful to the Title V program in tracking youth health behaviors.

//2009/ Vital statistics data of high quality are available, through an approval process, to the Title V program for assessment purposes. //2009// As of January 1, 2005, a new web-based electronic system is in place that implements the new national standards for vital records. ***//2008/*** In 2007, MCH received the first Vital Statistics data from the new system based on new NCHS standards. At this time, we are evaluating the impact of new categories on our trend data. In particular, entry into and adequacy of prenatal care and birth defects reporting categories appear to be affected. ***//2008//*** Additional new data elements will improve the ability of the MCH/CSHCN programs to assess birth/death and birth risk data. Other data sets maintained by other bureaus within the department that the Title V program uses 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, CSHCN, Part C, Family Planning, Newborn Screening, Newborn Hearing Screening). ***//2009/ Use of these various data sets is outlined in various sections of this application. //2009//***

Title V has access to data sets outside the BFH and the Department. Some examples of the type of data that are routinely accessed are 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 submission includes a good representative sample of the types of data accessible to Title V. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

MCH has shifted resources to two epidemiology positions for which orientation has been completed and training is ongoing. ***//2009/ One position is vacant as of this writing. //2009//*** The epidemiologists serve as data analysts and resource persons for MCH2010, the Kansas 5-year MCH State needs assessment, for the KDHE Healthy Kansans 2010, for the analysis of the National CSHCN Survey, National Child Health Survey, and birth defects data, and numerous

other 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. The open mouth survey of Kansas third graders and the analysis of poison control center data are good examples of the latter. Increasingly, BFH epidemiologists and other staff have compared health status measures across populations. The Title V Information System (TVIS) on the Maternal and Child Health Bureau (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-specific knowledge base gaps although there will need to be some work in this area particularly as this relates to CSHCN priority needs (medical home, youth transition, and financial access) since these will need information beyond that available from the National CSHCN Survey. ***/2009/ Annual surveys are used to assess school nursing capacity in the State. New surveys this year are the survey of WIC participants' food preferences and family satisfaction with CSHCN clinic services. Both the WIC survey and the CSHCN survey will be used to improve program services. //2009//***

Primary and secondary data are routinely analyzed and used in policy and program development across all BFH programs but the quality and consistency of the analyses varies based on staffing considerations. MCH grants to local agencies require local needs assessment to set local priorities although capacity to provide training and technical assistance to the local agencies is limited. Local agency epidemiological capacity ranges from highly sophisticated, primarily in urban areas, to very unsophisticated, mostly the case in rural areas. Training of local staff to achieve consistency across all local agencies is needed. Training of State agency staff to achieve consistency across all BFH programs is needed as well. */2008/ One MCH epidemiologist received training in genetic epidemiology this year as part of the Sarah Lawrence College Public Health Genetics/Genomics certificate program. //2008//*

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. Recent examples of these activities are: the linkage of lead screening data with Medicaid EPSDT data; review of low birth weight data in response to legislative concerns; gastroschisis cluster study in response to physician concerns; review of lead screening data for pregnant women in cooperation with the pediatric toxicologist at the Mid-America Poison Control Center and the perinatologist from the Kansas Perinatal Council. Through these and other efforts, 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. */2008/ The MCH epidemiologist is assisting in developing Agency policies and procedures for chronic disease cluster investigations, e.g., cancer. //2008//*

/2007/ Last year, the Title V program was unsuccessful in its application to CDC for birth defects surveillance funds. The Title V program continues to seek federal funds to implement a law passed in the 2004 session giving the State agency statutory authority for a birth defects surveillance system. An analysis of the State's current activities in this surveillance area shows many gaps in meeting CDC standards for a birth defects surveillance system. //2007//

/2007/ Another interest for the Title V program is developing a prenatal surveillance system. This year, the Title V program was unsuccessful in its application to the CDC for PRAMS, Prenatal Risk Assessment Monitoring System funds. //2007//

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 requiring analyses. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the Kansas Perinatal Council. The program has limited contact with the State child death review board as the representative and information conduit is vital statistics. Through the MCH needs assessment

process, Title V uses epidemiologic methods to forecast emerging MCH/CSHCN threats that are 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 there are no Title V health education staffs per se. Health education functions are incorporated into the job duties of all Title V staff. There is no designated funding at the state level for health education activities, such as for print or media campaigns. Title V does not routinely assess priorities for health education services and appropriate audiences for those services. The exception to this is Healthy Start Home Visitor services. Home visitors provide individual-based health education for which there is a formal annual assessment. Visitors receive training in need/deficit areas. The oral health program is another exception. The oral health website has a wealth of information for parents and families, for providers and others on oral health. Health education is a significant part of the emergent Office of Oral Health. The CSHCN program incorporates transition information and education at specialty clinics. Grants to local organizations do not require particular individual-based health education activities. There is some general agreement that this area requires further review.

Even though there is no routine mechanism for identifying existing and emerging population-based health information needs, Title V has engaged in population based health information services, providing health information to broad audiences. There is no state or federal funding set aside for public awareness campaigns on specific MCH issues, so that foundation or other support is the usual source of financing for media campaigns. 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 usage. Nutrition and WIC services have expanded breastfeeding promotion and health education through all local health departments. Abstinence Education utilizes the services of a contractor to assist with its media campaign and health education activities. The CSHCN program is in the process of expanding the toll-free resources to the internet. Each of these activities was generated independently rather than in response to an overall review of state needs. With the addition of staff, the public information office of KDHE has new capacity to assist programs with websites, print materials, news releases, and other health education services. During the past year Title V has received assistance in framing messages relating to MCH. ***//2009/ Through the auspices of the KDHE Office of Public Information, MCH has developed new print materials this year for birth defects surveillance and expansion of NBS (posters and pamphlets). //2009//***

Essential Service #4. Mobilize community partnerships between 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 MCH status 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/CSHCN 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 community organizations such as the comprehensive school health services and disparity initiatives require local advisory boards and specify composition. Kansas Title V supports coalition and stakeholder groups primarily through technical assistance, although as in the case of the State Early Childhood Comprehensive Systems grant, funding may also be provided for planning activities. ***//2009/ For the implementation phase of SECCS, Title V has maintained both supportive and leadership roles. //2009// //2007/*** MCH has been assigned responsibility for coordinating the Governor's Child Health Advisory Committee (CHAC) that has been charged with developing recommendations relating to immunizations, newborn screening expansion, school health

education, and physical fitness/nutrition. Dr. Dennis Cooley Past President of the Kansas Chapter of the AAP has been appointed to head the group of 18 appointed individuals who are very broadly representative of the topical areas. //2007// /2008/ During the past year, CHAC has made recommendations to the KDHE Secretary relating to: 1) health care access for all children 0-18; 2) physical activity and nutrition to reduce obesity; and 3) expansion of the state newborn screening program. For more information go to: www.datacounts.net/CHAC. //2008// **/2009/ Recommendations regarding breastfeeding support in the workplace and emergency medical services for children were completed during the past year. //2009//**

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 five-year State MCH needs assessment, MCH 2010, played a major role in development of the State Early Childhood strategic plan, and participated in the Healthy Kansas 2010 process to determine priorities for the State agency. MCH/CSHCN routinely leads and/or participates in data-driven decision making and planning activities. The annual and five-year Title V grant application and needs assessment cycle serves as the cycle for 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 a bi-annual MCH State Summary. The national and state performance measures will serve as the basis of the data in the report. The format for the annual publication, Reportable Diseases in Kansas, will be used to generate the MCH Annual Summary. /2007/ The report was published and disseminated in the summer of 2006. //2007// **/2009/ The annual summary is almost complete for 2008. //2009//**

MCH/CSHCN uses three formal advisory structures to advise Title V and KDHE: the Kansas Perinatal Council, the Kansas Child and Adolescent Health Council, and Families Together. Each of these groups holds quarterly meetings. Title V has input into the agendas to assure that key issues facing the State Title V agency are addressed. MCH epidemiologists are available to support the deliberations of the groups. 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. These efforts are most evident in the annual MCH Block Grant submission which utilizes a systematic process to produce an overview of the health of all mothers and children in the State. /2008/ In 2007, Judy Gallagher facilitated the Kansas Perinatal Council in developing a strategic plan. The group has decided to focus on expansion of Medicaid coverage to women of reproductive age. //2008//

MCH/CSHCN 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 as 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 KU's poison control center to assist in national certification efforts; SRS/KDHE interagency agreement primarily focusing on Medicaid and SCHIP collaborative efforts, among others. This latter agreement will need to be reassessed given the reorganization of the Medicaid and SCHIP programs to a newly established State agency that is described in the State Overview section. This will likely be done after the July 1, 2006 final reorganization. **/2009/ This has not yet been completed. //2009//** The Title V program has contributed to the planning processes of several State initiatives and implementation of a joint State initiative. 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 (BFH) issues. Two examples of this shift are as follows: 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, the BFH serves as the representative of the State health agency at key meetings such as public/legislative hearings relating to MCH/CSHCN 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. BFH has the responsibility for assuring legislative and regulatory adequacy for MCH/CSHCN. Title V has not coordinated a formal review of adequacy and consistencies of legislative/regulatory mandates across all programs serving MCH populations for a number of years. There have been a number of reviews of specific legislation or regulations due to emergent policy or program issues. Recently, Title V participated with child care licensing and the Kansas Perinatal Council in a review of outdated birthing center regulations. KPC recommended that the State adopt national standards for birthing centers. /2007/ This year, newborn screening statutes and regulations were updated relating to treatment formula.//2007//

Title V staff routinely attend legislative hearings related to maternal and child health issues and provide testimony. Examples of these activities are hearings on fluoride in public drinking water and impact on the oral health of children, and the importance of community/workplace support for breastfeeding. /2007/ In the 2006 Legislature, a law was passed supporting a women's right to breastfeed in a public place and granting deferrals from jury duty for breastfeeding women. //2007// The Title V program engages in strategies for informing elected officials about legislative/regulatory needs for maternal and child health such as when the oral health survey report was provided to legislators and others in policy making positions to fill knowledge gaps relating to the oral health of Kansas children. As part of the KDHE budgetary process, BFH puts forward proposals for legislation, budgetary or regulatory changes each summer. Proposals are reviewed by an internal executive team and prioritized in terms of the overall needs of the agency. The budget is submitted to the Governor in early Fall.

Title V staff are encouraged to participate in professional organizations and to engage with other State agencies in the development of licensure/certification processes. Kansas Public Health Association and Kansas State Nurses Association are examples of participation. 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. See birthing center regulations as in #5 above. 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 CSHCN definition in managed care contracts, and use of the CSHCN program for consultation regarding care. MCH promotes Bright Futures as the standard for local MCH agencies throughout the State. MCH routinely conducts record and site reviews of local agencies and allocates staff resources to provide technical assistance. The MCH aid to local program has initiated a risk-based schedule for reviews of local agencies to improve allocation of technical assistance. /2007/ During the past year, MCH/CSHCN staff have been involved in policy and legislative issues relating to child passenger safety seats, child care health consultation, birthing center regulations, regulations relating to community-based and faith-based organizations that serve pregnant women through "Pregnancy Maintenance Initiative" State dollars. //2007//

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. There are plans to use website, TV, radio, and print advertisements 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 (e.g., family planning, WIC sites). 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 CSHCN involvement in Juniper Gardens have been encouraged although there has been no funding for these efforts. Technical assistance is provided at conferences and at 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 are developed and routinely evaluated such as the evaluation of newborn metabolic screening and follow-up system in preparation for the application to CDC for birth defects surveillance system funding. In collaboration with partners, CSHCN is implementing new outreach through vital records data. Program information and brochures will be mailed to parents of children with high risk conditions noted on the birth certificate. MCH and CSHCN provide or pay for direct services not otherwise available. Examples of these services are: child health assessments for school entry through local health departments for uninsured and underinsured children; and CSHCN medical specialty clinic services.

Resources are provided to strengthen the cultural and linguistic competence of providers and to enhance their accessibility and effectiveness. CSHCN and other staff routinely authorize interpreters at out-patient appointments for families who have English as a second language and phone for assistance. Interpretation services are available within KDHE through the public information office and the farm worker health program. All BFH staff has participated 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 the BFH to recruit persons of color and bilingual staff in partnership with Human Resources.

This year, monthly meetings with Medicaid staff were suspended following the exit of one key individual. Proposals for Medicaid waivers and other collaborative activities were dropped as Medicaid staff were shifted to new responsibilities and inundated with legislative inquiries about a proposed major State reorganization. /2007/ despite a number of challenges to MCH-Medicaid collaboration due to reorganization, the staffs of Medicaid and MCH continue a close working relationship. //2007// **/2009/ Working relationships with Medicaid are back on track following the reorganization, although the update of the Title V/Title XIX Interagency Agreement has not been accomplished. //2009//** Staff meets 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 Insurance Commission as appropriate on enrollment screening procedures, tracking of new enrollees' utilization of services and consumer information.

MCH/CSHCN 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 throughout the State via its website, at conferences, and through program-specific training. Kansas provides leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CSHCN 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 not been established. Internship/practicum students have not been used to

any great extent. ***//2009/ An intern was secured this year to assist with development of Child Care Health Consultation training for Healthy Start Home Visitors. Also, the intern assisted Child Care Licensing with update of health and immunization forms for child care providers. //2009//*** Academic partnerships, joint appointments, adjunct appointments, MOUs with academia, and sabbatical placements have likewise not been considered. 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/CSHCN 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 continually monitored. The 5-year State needs assessment addresses workforce issues and workforce gaps are considered in 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 BFH 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/CSHCN builds the competency of its workforce through support for continuing professional education for staff. All staff 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. Staff participate in Leadership Conferences, the annual AMCHP meeting, and other in-state and out-of-state education opportunities. BFH in-service meetings are held on the first Monday of each month. Topics and speakers are drawn from suggestions of participants. All BFH 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 services for case managers. ***//2008/ In Spring of 2007, the Governor's Public Health Conference had a specific MCH focus and preconception health was a featured topic. //2008//***

Essential Service #9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services. Routine monitoring is assured for all MCH/CSHCN state-funded services. Neither MCH nor CSHCN has routinely evaluated outcomes of the services provided. All Title V issued grants require that projects will participate in routine monitoring. All require reporting submission of qualitative and quantitative data. Some but not all require submission of an evaluation plan. For others such as teen pregnancy prevention, a contract is secured with an outside evaluator as from 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 and other data sources. This year as part of an evaluation process, the BFH organized a review of lead screens completed during the EPSDT visit for children participating in the State Early Head Start program.

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. BFH performs comparative analyses of programs and services when data are available across different populations or service arrangements such as for family planning or WIC. ***//2009/ In 2007 and again in 2008, special satisfaction surveys have been conducted with families participating in CSHCN and attending CSHCN clinics. The results of surveys are used by staff to improve clinic services, especially family satisfaction with services. //2009//***

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 more 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 "at the table" in discussions with insurance agencies, provider plans, and others about the use of MCH outcomes in their own assessment tools. *//2009/ An exception to this is the SECCS plan. MCH his still at the table with early childhood providers and advocates. In late 2008, an invitation-only retreat will be held to examine and refine the early childhood indicators for the State. A set of key indicators will be developed that are more in line with those recommended by national groups such as Project Thrive. //2009//*

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. BFH staffs engage in research on a limited basis. When research is undertaken, it is widely disseminated upon completion. The BFH 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 our staff rather than directed by our staff. For instance, BFH is collaborating with the Bureau of Epidemiology and Disease Prevention in a research project to determine immunization status of pregnant women.

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. Prior to the Spring of 2005, there were four divisions under the KDHE Secretary: Health, Environment, State Laboratory, and Center for Health & Environmental Statistics. A reorganization in 2004 consolidated these to three divisions. The Center for Health and Environmental Statistics was moved under the Division of Health so that the Center Director reports to the Director of Health. *//2009/ Another reorganization consolidated the State Public Health Laboratory under the Division of Environment. //2009//* The Director of Health serves as the State Health Officer.

The Division of Health has five Bureaus: Bureau of Family Health (maternal and child health); Bureau of Child Care Licensing and Health Facilities (child care & hospital regulation, credentialing); Bureau of Consumer Health (lead program; food service inspections); Bureau of Epidemiology and Disease Prevention (infectious disease, bioterrorism); and the Bureau for Health and Environmental Statistics. There are three Offices: Office of Local and Rural Health (manpower, primary care, migrant health, hospital bioterrorism); Office of Health Promotion (chronic disease); and Office of Oral Health. An effort is underway to establish a fourth Office of Minority Health. *//2007/ This Office was formally established in 2006. //2007// //2009/ In 2008, a legislative initiative moved restaurant and food service inspections to the Department of Agriculture. //2009//*

The Bureau for Children, Youth and Families (BCYF) now the Bureau of Family Health (BFH)

administers the MCH Services Block Grant. It has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services; and Children with Special Health Care Needs. The organization chart for the BFH and the four sections is attached as a PDF file. Also, refer to the BFH organizational structure and staffing on the BFH website at www.kdhe.state.ks.us/bcyf. /2008/ The Bureau for Children, Youth and Families was officially renamed the Bureau of Family Health in the Spring of 2007. //2008//

Within the Bureau there are a number of cross-cutting initiatives such as oral health and epidemiology. In April, 2002, the BFH hired a registered dental hygienist to build oral health capacity in the agency, to integrate oral health education and health promotion into all maternal and child health programs and to serve as an agency link with emergent oral health coalition efforts in the state. This position has since been integrated as Deputy Director into the new Office of Oral Health. Recruitment of a Director (dentist) is underway. /2007/ A Director was hired in 2006. //2007// The Deputy Director continues to provide consultation, technical assistance, assessment (oral health survey), policy development (coalition-building), and assurance (fluoride varnish training). She serves as consultant to all Bureau programs including MCH/CSHCN and WIC. 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 Envisage Consulting. Both conduct assessments and evaluations of MCH programs, conduct original MCH research, and address epidemiologic needs of the Bureau. 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 newly hired employees.

The Children & Families Section includes the following responsibilities: 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 - teen pregnancy prevention; adolescent health disparities; abstinence education, comprehensive school health clinics.

Children 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.

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 Metabolic Screening - Assures early identification and intervention for infants with PKU, galactosemia, hypothyroidism and sickle cell; 3) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants. /2007/ NBHS includes follow-up and interventions. Starting in SFY 07, \$50,000 was appropriated for a hearing aid loaner program for young children. //2007// /2008/ A proposal to move the Infant-Toddler program to another State Agency (SRS) was put on hold pending creation of an Office of Early Childhood. Two additional staff will be hired for this Section in mid-2007 to begin start-up work on expanded newborn screening. //2008// **/2009/ The proposal to move the Infant-Toddler program to another**

State Agency (SRS) is still on hold pending review of the creation of a State Office of Early Childhood. Two additional staff were hired this year to support the expansion of newborn metabolic screening program. As well, newborn metabolic screening and newborn hearing screening staffs were merged to form the Newborn Screening Unit within the CDS. //2009//

Federal law requires that Part C (KDHE) and Part B of IDEA (State Education Agency) maintain an advisory committee. The Kansas Coordinating Council on Early Childhood Developmental Services serves in this capacity and the staffers for this council have their offices in the BFH. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members.

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) Commodity Supplemental Food Program (CSFP) - Improves the nutritional status of eligible women, infants, children, and the elderly over age 60 through supplemental foods and nutrition education. /2007/ WIC completed the transfer of the CSFP program to the Kansas Department of Social and Rehabilitation Services (SRS). This had been initiated a couple of years ago due to a change in the service population from pregnant women and children to the elderly. //2007//

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. All programs funded by the Federal-State Block Grant Partnership budget total (Form 2, Line 8) are included.

Official and dated organizational charts that include all elements of the Title V Program, clearly depicted, are on file in the State Human Resources office and are available upon request at the time of the Block Grant Review. Also, please see attachments.

D. Other MCH Capacity

The BFH has 57 full-time equivalent (FTEs) positions: 5 FTEs including 2 epidemiologists are located in administration, 10 FTEs in CSHCN Section, 12 FTEs in Children & Families Section, 15 FTEs in Children's Developmental Services, and 15 FTEs in WIC. None of these positions are out-stationed in local or regional offices. The MCH Block Grant is used for 21.25 FTEs or 40% of the staffing in the Bureau. This breaks out to 3.75 FTEs in Administration, 10.0 FTEs in CSHCN, 7.0 FTEs in C&F Section, 3.0 in CDS, and 0.25 in WIC. /2007/ Four new FTEs were obtained in the 2006 session including a genetics counselor and health educator to implement provisions of a cord blood bank bill. //2007// All non-clerical staff position descriptions have been re-written to require planning, evaluation and data analysis capabilities. The qualifications, in terms of a brief biography, of senior level management employees in lead positions are as follows. /2009/ ***Prior to the 2008 session, the BFH received two new positions for newborn screening follow-up. These positions have been filled. In addition, another vacancy in the bureau was allocated to meet the staffing requirements of the expansion. //2009//***

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,

primarily responsible for services to pregnant women and infants, children and adolescents, and women's health. She has held positions as director of a state breast and cervical cancer screening program, 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, four other staff report to her (2 epidemiologists, dental hygienist (transitioning to Office of Oral Health), 1 fiscal, 1 clerical). **//2009/ The establishment of the Office of Oral Health is complete and the dental hygienist has moved to that Office. //2009//**

Jamey Kendall serves as the State CSHCN Director. She has a Bachelor of Science degree in Nursing from Wichita State University. Since 1997 she has served as Director of CSHCN. Prior to 1997, she worked as a CSHCN nurse consultant (1989-1997), pediatric staff nurse at Stormont-Vail Regional Medical Center in Topeka, case manager for a Visiting Nurse Service in Fort Wayne, Indiana, and home visitor for high risk infants and families with the Wichita health department. Jamey is involved with the Kansas Commission on Disability Concerns, the Kansas Chapter of American Academy of Pediatrics Subcommittee for Children with Special Health Care Needs, Assistive Technology for Kansas Advisory Board, Kansas Asthma Coalition, Head Start Collaboration, and Governor's Commission on Autism. Nine staff report to her (2 nurse case managers, 1 social worker (toll-free line), 1 fiscal, and 5 clerical). **//2009/ This year Kendall resigned to accept a position with newborn metabolic screening. A search is underway to find a replacement. Kenney will serve as interim director until a replacement can be found. //2009//** The CSHCN program has a contract with the Developmental Disabilities Center at University of Kansas Medical Center (KUMC) and another contract with the University of Kansas School of Medicine in Wichita (UKMC-W). The staff in these two regional CSHCN offices are not included in the FTE count for the BCYF.

Ileen Meyer is a professional registered nurse experienced in serving the pediatric and young adult population throughout her 35 year career in public health. Along with her nursing background 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 11 FTEs (4 nurses, 4 program planning and evaluation, 1 data entry and 2 clerical).

Carolyn Nelson has served as the Director of Children's Developmental Services since 2001. From 1999 to 2001, she coordinated services for the Infant-Toddler (Part C) Program at KDHE. Prior to 1999, she worked as Director of Children's Developmental Services at Arrowhead West, Inc. in Southwest Kansas and as a speech-language pathologist in Arkansas. Carolyn holds a degree in Speech-Language Communication and English from Henderson State University in Arkansas. She represents KDHE on the Kansas Division of Early Childhood Board and the Kansas Coordinating Council on Early Childhood Developmental Services. She is also involved in the Head Start Collaboration Council and Advisory Board, Early Childhood Stakeholders, the National Part C Coordinators' Association, School Readiness Task Force, Child Care and Early Education Advisory Committee, and the National Council for Exceptional Children. Nelson manages a staff of 14 (2 nurses for newborn screening, 1 medical technologist, 2 audiologists for newborn hearing screening, 1 early childhood, 1 fiscal, 4 program planning and evaluation, 3 clerical).

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. The WIC program implemented an automated WIC system for Kansas. The new WIC system will allow local agency staff to spend more time on mission oriented educational activities and less time on administrative duties. Thomason manages a staff of 14 FTEs (4 nutritionists, 2 information systems, 4 program analysts, 4 clerical).

The one change to leadership within the BFH (the CSHCN Director) has been noted above. BFH staff 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. Both Carolyn Nelson and David Thomason have completed the Kansas Public Health Certificate Program. /2007/ David Thomason was elected as Vice President of National Association of WIC Directors (NAWD). //2007// /2008/ He served a term as NAWD President this year. //2008//

E. State Agency Coordination

Coordination within the State Health Agency

MCH and CSHCN work with a number of program areas on public health issues. Office of Local and Rural Health: Primary Care Cooperative Agreement; District Nursing Consultants; Community Health Assessment Coordination; Farmworker Health; Refugee Health; Trauma Registry; Bioterrorism Hospital Preparedness. Bureau of Child Care Licensing: standards for health and safety in out of home care; inspections of residential facilities; inspections for state schools for deaf and blind; inspections of birthing centers. Bureau of Consumer Health: Childhood Lead Poisoning and Prevention. Bureau of Health Promotion: Breast & Cervical Cancer Screening Program; Office of Injury/Disability Program; Youth Tobacco Prevention Program; Diabetes Control Program; Kansas LEAN Program; Arthritis Program; 5 A Day; Kansas LEAN 21. Bureau of Epidemiology and Disease Prevention: HIV/STDs Program; and Immunization Program.

Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening); Neonatal Metabolic Screening. Center for Health and Environmental Statistics, Vital Statistics: Perinatal Outcome Data, Adequacy of Prenatal Care Utilization Index (APNCU); 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/CSHCN 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 BCYF website --- http://www.kdhe.state.ks.us/bcyf/c-f/school_resources_docs.html). There are ongoing efforts to expand the school nurse role to include preventive and primary health care at school for children and youth who are at risk including the underinsured and uninsured school population. Delegation of nursing tasks to unlicensed school personnel is an ongoing 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 CSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CSHCN are also underway for early childhood education programs and child care providers. Other 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.

The Social Service Agency (SRS) programs with which MCH/CSHCN has most frequent contact are Medicaid and SCHIP (HealthWave). MCH/CSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes standards of care, assures provider training, among others. 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 KDHE/SRS Interagency Agreement (updated in 2002 to include HIPAA and data sharing). MCH/CSHCN staff 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. Currently Medicaid and Family Planning are working on a waiver to extend the mother's eligibility after birth from 6 weeks to 2-5 years. /2007/ This effort has been postponed due to reorganization within the Medicaid state agency. //2007//

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, have 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. Preliminary steps were implemented to add developmental intervention services as a Medicaid reimbursable service which was added in 2002.

For the high-cost services for 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 CSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CSHCN staff have 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. CSHCN staff have 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. CSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CSHCN 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/CSHCN have participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. The Kansas Advisory Committee on Hispanic Affairs provides assistance with finding translators. 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 are as follows: 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 the following: March of Dimes; American Academy of Pediatrics - Kansas Chapter; 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; 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 staffer for the Kansas Association of Local Health Departments assures coordination with KDHE. LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities such as: regional public health meetings which 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 Pyramid of 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.

Coordination with other Kansas MCHB Grants

KDHE staff are involved in numerous ways with grants that are awarded by MCHB to the State of Kansas. The BCYF is a partner agency in the on-going collaborative efforts between the Kansas Title V agency and the Kansas City Healthy Start (KCHS) and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department. The Kansas University Affiliated Program at the University of Kansas Medical Center works closely with the CSHCN program staff and contract staff actually share office space with the program. BCYF staff currently serve 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 administer community project funding for the Section 510 Abstinence Education Grant, Community Integrated Service Systems (CISS) -- State Early Childhood Comprehensive Systems planning and implementation grant, and the Universal Newborn Hearing Screening. MCH works with the Health Systems Development in Child Care, Emergency Medical Services for Children (EMSC) Partnership and Bioterrorism grants.

F. Health Systems Capacity Indicators

Introduction

Kansas MCH monitors trends in Health Systems Capacity Indicators to determine what can be done from a policy or program perspective to maintain or improve the HSCIs. The MCH epidemiologists and the program staff confer to interpret the data. In partnership with other State Agencies, families and communities, the State MCH agency may develop new strategies for meeting the HSCIs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 35.1 | 33.5 | 31.3 | 33.4 | 33.4 |
| Numerator | 665 | 632 | 588 | 649 | 649 |
| Denominator | 189267 | 188782 | 187949 | 194100 | 194100 |
| 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 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public.

Only discharges with asthma as a primary diagnosis were included.

Data Source: Center for Health and Environmental Statistics, Kansas Hospital Association.

Notes - 2005

Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public.

Only discharges with asthma as a primary diagnosis were included.

Data Source: Center for Health and Environmental Statistics, Kansas Hospital Association.

Narrative:

//2009/ In Kansas, the rate of asthma hospitalizations has increased 6.9% from 31.3/10,000 in 2005 to 33.4/10,000 in 2006. For the years 2002-2006, asthma hospitalizations has fluctuated from a high of 35.3/10,000 in 2003 to a low of 31.3/10,000 in 2005.

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 is approximately two times that of white non-Hispanic or Hispanic children (all races), 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 KDHE has initiated public health surveillance of this condition in children through the BRFSS and participation in the State Environmental Health Indicators Collaborative (SEHIC). The SEHIC developed standardized measures for adoption by States which Kansas has piloted with feedback to SEHIC. These indicators address: 1) chronic lower respiratory disease (CLRD) and asthma mortality; and, 2) asthma hospitalization. Also, there are developmental indicators exploring the use of emergency department (outpatient) visit data and medication dispensing as well as other measures of the burden of asthma. A workgroup has been convened to explore the development of a document that will reflect the burden of asthma in Kansas with the anticipated coordination of asthma surveillance in Kansas. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 81.0 | 88.4 | 87.6 | 88.7 | 89.4 |
| Numerator | 13610 | 15765 | 16457 | 16834 | 17140 |
| Denominator | 16807 | 17841 | 18778 | 18968 | 19177 |
| 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 |

Notes - 2007

Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Total eligibles receiving at least one initial or periodic screen.

Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2006

Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report, report period: 10/1/2005-09/30/2006 (FFY 2006)

Numerator=Total eligibles receiving at least one initial or periodic screen.

Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2005

Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report, report period: 10/1/2004-09/30/2005 (FFY 2005)

Numerator=Total eligibles receiving at least one initial or periodic screen.

Denominator=Total eligibles who should receive at least one initial or periodic screen.

Narrative:

//2009/ In FFY 2006, 88.7% of Medicaid-enrolled infants received at least one initial or periodic screen. This is a slight increase from the previous year (FFY 2005 - 87.6%). But overall, there has been much improvement in getting infants into care.

When evaluating the trend in the last 5 years (from 2002-2006), the increase in the percent of enrollees who received at least one initial or periodic screen is statistically significant. The percent of Medicaid-enrolled infants getting at least one screen increased 9.5%, from 81.0% in 2002 to 88.7% in 2006.

The number of enrolled infants (denominator) continues to increase each year, as does the number actually getting into services (numerator).

Families are linked with medical homes through local MCH agency services such as M&I and Healthy Start. MCH and CSHCN coordinate efforts with both public insurers (Medicaid, HealthWave) and private insurers, and also with private providers (family practitioners, pediatricians). //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 16.2 | 80.1 | 70.3 | 67.4 | 38.3 |
| Numerator | 58 | 313 | 289 | 244 | 158 |
| Denominator | 358 | 391 | 411 | 362 | 412 |
| 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 |

Notes - 2007

Data Source: Kansas medical assistance program reporting system, Well Child for HW21 report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Total eligibles receiving at least one initial or periodic screen.

Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2006

Data Source: Kansas medical assistance program reporting system, Well Child for HW21 report, report period: 10/1/2005-09/30/2006 (FFY 2006)

Numerator=Total eligibles receiving at least one initial or periodic screen.

Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2005

Data Source: Kansas medical assistance program reporting system, Well Child for HW21 report, report period: 10/1/2004-09/30/2005 (FFY 2005)

Numerator=Total eligibles receiving at least one initial or periodic screen.

Denominator=Total eligibles who should receive at least one initial or periodic screen.

Narrative:

/2009/ In FFY 2006, 67.4% of SCHIP-enrolled infants received at least one initial or periodic screen. This is a 4.1% decrease from the previous year (FFY 2005 - 70.3%). After reaching a high of 80% in 2004, there has been a steady decline in the percent of SCHIP infants receiving a screen.

SCHIP staff report that the highly irregular data is due to changes in their automation system, plus a change in SCHIP policy. The policy change removed the mandate that SCHIP infants be current on screens before any other medical services could be provided. Overall, over the past 7 years, it appears that the percent of infants with at least one initial or periodic screening may be just under 40%.

Also, comparing the Medicaid data to the SCHIP data, the SCHIP numbers and ratios are considerably lower. This is because SCHIP infants are only covered for/from their month

of birth in the SCHIP program IF their mothers were enrolled in SCHIP and Kansas has very few teen mothers with incomes that would qualify them for SCHIP (only about 40 - 50 per year). Most of the infants in the program enter after the first few months of life, but before their first birthday. Generally speaking, most medical services and screenings for infants occur at or shortly after birth. So the screenings that would count for this indicator, usually occur prior to enrollment in SCHIP. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 81.2 | 81.4 | 79.2 | 78.5 | 78.5 |
| Numerator | 31475 | 31854 | 28283 | 28831 | 28831 |
| Denominator | 38756 | 39150 | 35724 | 36734 | 36734 |
| 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 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data Source: Center for Health & Environmental Vital Statistics, Kansas Department of Health & Environment.

Numerator: Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Denominator: All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Data reliability is a concern for 2006 due to the high percent of missing data (date of first prenatal visit and date of last menses).

Notes - 2005

Data Source: Center for Health & Environmental Vital Statistics, Kansas Department of Health & Environment.

Numerator: Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Denominator: All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Data reliability is a concern for 2005 due to the high percent of missing data (date of first and last prenatal visit and date of last menses).

Since Kansas started using the revised Birth Certificate in 2005, data from 2005 and after is not comparable to 2004 and before .

Narrative:

/2009/ The percent of Kansas women 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 78.5 percent in 2007. In the previous 5 years (2002-2006), this percent remained essentially the same in the years 2002 through 2004. When comparing 2005 and 2006 Kansas data, there was a slight decrease (0.9%).

According to the National Center for Health Statistics, prenatal care data based on the 2003 revised certificate (starting in 2005 for Kansas) presents a markedly less favorable picture of prenatal care utilization. This is true both in Kansas and nationally among states using the revised birth certificate. Since not all states have implemented the use of the new certificate format, Kansas data may not be comparable to that of other states. In previous years, the mother or prenatal care provider reported the month of pregnancy in which the mother began prenatal care and the number of prenatal care visits. As of 2005, this item was calculated with the exact dates of first and last prenatal visit and the last normal menses date.

In Kansas, the percent of women receiving adequate and adequate plus prenatal care in 2006 than in 2005 for all racial/ethnic groups except for the Asian non-Hispanic women. Analysis of adequate and adequate plus prenatal care separately shows that adequate PNC decreased for women of all races/ethnicities. This decrease was balanced in part by higher adequate plus prenatal care for all groups except black non-Hispanic and Hispanic women. This decrease in adequate and adequate plus prenatal care among different racial/ethnic groups may be partially explained by the Feb 8, 2006 Deficit Reduction Act which included new requirements for citizen documentation when renewing or applying for for Medicaid benefits.

For 2006, Hispanic (28.4%), Other non-Hispanic (23.8%) and Native American Non-Hispanic (23.7%) women were least likely to receive inadequate prenatal care. This data points to racial/ethnic disparities in access to prenatal care possibly due to legal status, cultural barriers, and/or other factors. //2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 96.5 | 94.8 | 75.5 | 95.7 | 95.7 |
| Numerator | 186041 | 254310 | 196212 | 220505 | 220505 |
| Denominator | 192743 | 268158 | 259866 | 230444 | 230444 |
| 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 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report..

CY2007 data will be available after all the claims are paid (should be 98-99% complete by December 31, 2008).

Notes - 2006

Data Source: Medicaid paid claims data file, Kansas Department of Social and Rehabilitation Services (calendar year).

Numerator: # Medicaid enrollees (age1-21) who received a service during the reporting year.

Denominator: # Medicaid enrollees (age1-21) during the reporting year.

Notes - 2005

Data Source: Medicaid paid claims data file, Kansas Department of Social and Rehabilitation Services (calendar year).

Numerator: # Medicaid enrollees (age1-21) who received a service during the reporting year.

Denominator: # Medicaid enrollees (age1-21) during the reporting year.

Narrative:

/2009/ For CY 2006, 220,505 Kansas children and young adults ages 1-21 received at least one service resulting in a Medicaid claim.

The number of Medicaid-enrolled children receiving at least one service increased from 170,513 (94.2%) in 2002 to 220,505 (95.7%) in 2006, a statistically significant increase. The percent receiving at least one service has fluctuated probably due to Medicaid database problems with a low in 2005 of 75.5%.

Even though the percent receiving at least one service shows an increasing trend over the last 5 years, the numbers of participants (denominator) and the numbers age 6-9 receiving dental services (numerator) were lower in 2006 compared to 2004. This is probably due to imposition of checks for residency status in 2006.

The local MCH agencies and school nurses continue to promote a medical home for every child and regular preventive checkups. //2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 39.9 | 47.2 | 50.8 | 53.1 | 55.6 |
| Numerator | 14917 | 18650 | 28237 | 30458 | 31917 |
| Denominator | 37427 | 39480 | 55542 | 57413 | 57439 |
| 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 |

Notes - 2007

Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report and Well Child for HW21 report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Notes - 2006

Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report and Well Child for HW21 report, report period: 10/1/2005-09/30/2006 (FFY 2006)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Notes - 2005

Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report and Well Child for HW21 report, report period: 10/1/2004-09/30/2005 (FFY 2005)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Narrative:

//2009/ The number of children ages 6-9 who are enrolled in Medicaid (eligible for EPSDT services) has increased steadily over the last five years. The percentage of children who access dental services also continues to rise. Whereas only 37.5% received a dental service in 2002, 53% were receiving services in 2006. When evaluating the trend in the last 5 years (from 2002-2006), the increase in the percent of children enrolled who have received any dental services is statistically significant (p-value <.0000).

The MCH program continues to play a key role in establishment of partnerships within and outside the Agency to improve access to dental services for both mothers and children. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 38.9 | 42.5 | 36.2 | 100.0 | 100.0 |
| Numerator | 2229 | 2499 | 2196 | 6790 | 6335 |
| Denominator | 5737 | 5875 | 6072 | 6790 | 6335 |
| 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 |

Notes - 2007

Data Source: Numerator=Social Security Administration, December 2007.
Denominator=Social Security Administration, December 2007.

Notes - 2006

Data Source: Numerator=Social Security Administration, December 2006.
Denominator=Social Security Administration, December 2006.

Reporting mechanism has changed due to the fact that SSA no longer allows monthly printouts and disability determinations be sent to the CSHCN program. All clients receiving SSI are eligible for Medicaid in Kansas and therefore have access to needed rehabilitation services through Medicaid coverage.

Notes - 2005

Data Source: Numerator=Participants in Kansas Title V CSHCN program less than 16 years of age receiving SSI benefits (CSHCN database). State FY 2005=Calendar Year 2005;
Denominator=Social Security Administration, December 2005.

Narrative:

//2009/ The CSHCN program has a good working relationship with the Kansas Department of Social and Rehabilitative Services where the Kansas Disability Determination agency is housed. During the last year due to SSA requirements the CSHCN no longer receives monthly printouts or Disability Determination forms for those clients in Kansas receiving SSI benefits. CSHCN continues to have access to SSA data screens that allow staff to verify current eligibility. The CSHCN program has worked with the Regional SSA office to continue the data screens with modification of data sharing agreements on an annual basis.

The CSHCN program sends application forms to families of children who receive SSI and are not medically eligible for the CSHCN program. No new referrals are formally sent to CSHCN, but negotiations are underway to obtain referrals from the Kansas Disability Determination unit as appropriate.

This year, 100% of State SSI beneficiaries less than 16 years old received rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. This is because all children eligible for SSI are eligible for Medicaid in Kansas and Medicaid provides full coverage of services. //2009//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------------------------|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of low birth weight (< 2,500 grams) | 2006 | payment source from birth certificate | 8.7 | 6.3 | 7 |

Notes - 2009

Live births where the payer source are unknwn or missing are excluded.

Narrative:

/2009/ According to 2006 birth certificate data, Medicaid paid for the delivery of 10,824 (28.0%) Kansas live births. There is some concern 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 95% of live births.

Birth certificate data (2006) indicates 7.0% of Kansas births were low birthweight. For Medicaid births, 8.7% were low birth weight compared to 6.3% for non-Medicaid births.

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 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. //2009//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Infant deaths per 1,000 live births | 2006 | matching data files | 9.1 | 5.8 | 7 |

Notes - 2009

Data source: Kansas Center for Health and Vital Statistics, linked death and birth file, 2006 death cohort.

Narrative:

/2009/ For the time period represented by this data, the infant mortality rate was highest for the Medicaid service population (9.1%) and lowest for the non-Medicaid population (5.8%). The overall infant mortality rate for Kansas was 7.0% where the delivery payer was known.

The MCH program has collaborated with the Kansas City federal Healthy Start Program to conduct Fetal-Infant Mortality Review (FIMR) recommended by the ACOG and the AAP as a best practice strategy in helping communities identify the systems issues that need to be addressed to prevent infant deaths. Also, the Kansas Center for Health and Environmental Statistics and the federal Healthy Start program in Wichita will pilot a Fetal-Infant Mortality Program in the Wichita area to assist the community in addressing this public health concern. //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------------------------|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2006 | payment source from birth certificate | 59.1 | 77.7 | 72.5 |

Notes - 2009

Live births where the dates used to calculate when prenatal care began and payer source are unknown or missing are excluded.

Narrative:

//2009/ In 2006, 72.5% of Kansas infants were born to women receiving prenatal care (PNC) beginning in the first trimester of pregnancy. Only about 60% 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 77.7%.

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.

The 2005 MCH Needs Assessment established access to health care for all women of reproductive age as a priority need for Kansas. This priority includes both access to preconception care and access to prenatal care. See State Performance Measure #1 for Kansas public health initiatives to address this concern. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------------------------|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is | 2006 | payment source from birth certificate | 62.4 | 78.6 | 74.1 |

| | | | | | |
|---|--|--|--|--|--|
| greater than or equal to 80% [Kotelchuck Index] | | | | | |
|---|--|--|--|--|--|

Notes - 2009

Live births where the dates used to calculate when prenatal care began and payer source are unknown or missing are excluded.

Narrative:

/2009/ Kansas' performance on this indicator has declined since the implementation in 2005 of the 2003 revision of the U.S. standard certificates and reports by Kansas Vital Statistics. Regardless of this change, the data continue to show that adequacy of prenatal care is better for non-Medicaid than for Medicaid-enrolled women. In 2006, 74.1% of all livebirths were to women with adequate or adequate plus prenatal care. For Medicaid-enrolled women, 62.4 percent had adequate or adequate plus prenatal care, compared to 78.6% for non-Medicaid livebirths (where delivery payer is 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.

The 2005 MCH Needs Assessment established access to health care for women of reproductive age as a priority need for Kansas. This priority includes access to prenatal care. See State Performance Measure #1 for Kansas public health initiatives to address this need. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|--|-------------|--|
| Infants (0 to 1) | 2007 | 150 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Infants (0 to 1) | 2007 | 200 |

Narrative:

/2009/ Kansas uses the federal minimum eligibility requirements for both Medicaid and SCHIP. Infants are eligible for Medicaid at 150% of the federal poverty level (FPL). Infants are eligible for SCHIP at 200% FPL.

Given the economic downturn for the State, there is declining interest among the legislators in expansion of these programs. This is the case despite health care reform plans and public pressure. Instead, Kansas legislators have supported expansion of charitable and primary care clinics as providers of care to low-income individuals. //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| INDICATOR #06 | YEAR | PERCENT OF |
|----------------------|-------------|-------------------|
|----------------------|-------------|-------------------|

| | | |
|--|-------------|---------------------------------------|
| The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | | POVERTY LEVEL Medicaid |
| Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to) | 2007 | 133 100 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to) | 2007 | 200 200 |

Narrative:

/2009/ Kansas follows the federal minimum eligibility requirements. Children ages 1 through 5 are eligible for Medicaid at 133% FPL and children ages 6 through 18 are eligible at 100% FPL. Children in both age groups are eligible for SCHIP at 200% FPL. //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| | | |
|---|-------------|--|
| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
| Pregnant Women | 2007 | 150 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Pregnant Women | 2007 | 200 |

Narrative:

/2009/ Kansas follows the federal minimum eligibility requirements for both Medicaid and SCHIP. Pregnant women are eligible for Medicaid whose incomes are at or below 150% FPL. At 60 days postpartum eligibility for women drops to less than 35% FPL. Pregnant women are eligible for SCHIP who meet both the age and income eligibility requirements (incomes >200% FPL). //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| | | |
|---|---|---|
| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
| <u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates | 3 | Yes |
| | 3 | Yes |

| | | |
|--|---|-----|
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | | |
| Annual linkage of birth certificates and WIC eligibility files | 3 | No |
| Annual linkage of birth certificates and newborn screening files | 3 | Yes |
| <u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges | 3 | Yes |
| Annual birth defects surveillance system | 2 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 1 | No |

Notes - 2009

Narrative:

/2009/ The MCH program has access to database linkages, registries and surveys as above except for the following: annual linkage of birth certificates and WIC; and Prenatal Risk Assessment Monitoring System (PRAMS). A contract is underway with a vendor to develop a birth defects surveillance module that interfaces with the CSHCN web-based system. This will improve our standing with respect to the CDC standards for birth defects surveillance systems. Hospital discharge survey data are available for at least 90% of in-State discharges.

The MCH program has direct access to data files for: infant birth certificates, infant death certificates, birth defects, hospital discharge data, WIC, and newborn screening files. MCH does not have direct access to data files for Medicaid Eligibility or Paid Claims files.

Linked infant birth and death certificates files: These are available from the Center for Health and Environmental Statistics (CHES). CHES links all deaths to Kansas residents, including infants, to the Kansas live birth certificate. As needed CHES provides a linked birth-death cohort file for special analyses by the SSDI coordinator and MCH epidemiologist. The annual Perinatal Casualty Reports are being rewritten by CHES in order to take into account the changes from the use of the 2003 revision of the birth certificate. These reports will continue to be disaggregated by county and hospital. Individual hospitals receive a copy of the report for their institution's peer review board. The Kansas Perinatal Council (KCP) reviews the data as well. CHES continues to pursue opportunities for producing special analyses of the data.

Birth certificates and Medicaid Eligibility or Paid Claims Files: CHES 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. In 2006, administration of the State's Medicaid program was transferred from Kansas Department of Social and Rehabilitation Services (SRS) to the Kansas Health Policy Authority (KHPA) and CHES

began negotiating with KHPA for Medicaid data. CHES has begun receiving Medicaid claims data. CHES continues to seek out funding opportunities to support program activities to link birth and Medicaid data as well as to perform special analyses of the linked data.

Birth certificates and WIC eligibility files: WIC is coordinating with the Kansas Immunization program and KDHE IT Staff to develop an interface between the Kansas WIC Program system (KWIC) and the Kansas Immunization Registry (KSWebIZ) system. The WIC system data continues to be complete and of acceptable quality and available for evaluation on an ad hoc basis. Additionally, WIC and Immunization staff have held meetings to finalize plans for developing the WIC/Immunization Registry interface to coordinate services and outreach.

Birth certificates and newborn metabolic screening files: KDHE's Information Technology staff (IT) maintains an application to link the Kansas Health and Environmental Laboratories (KHEL) newborn screening files to selected CHES birth record fields. Linking is performed regularly by IT using the algorithm (the linking program) established by IT. However, the linking methodology is weak and misses some records. Due to lack of funding and personnel, KHEL has not been able to continue conducting data quality reviews. MCH is working with IT, CHES and KHEL to identify ways to continue this process and improve quality. Therefore, currently MCH cannot access these files. This linkage is being reevaluated with expansion of the Newborn Screening program.

Hospital discharge data: CHES is continuing to acquire the hospital discharge data from the Kansas Hospital Association (KHA) and is expanding to include specialty hospital inpatient data. About 97 percent of all Kansas community hospitals are members of KHA. KHA will provide these data annually; MCH funds help support this acquisition of data.

BDSS: MCH plans to build a BDSS module onto the CSHCN information system. This would be an enhancement to the existing CSHCN application. SSDI and MCH funds support this process. MCH plans to use the data from the enhanced system to improve access. Families will be notified of the availability of services and supports through CSHCN, early intervention, and other programs.

PRAMS: Kansas submitted an application in response to CDC's PRAMS 2006 Cooperative Agreements, but was not recommended for funding. MCH plans to reapply for the PRAMS grant when it is offered in the future. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|-----------------------------------|---|---|
| Youth Risk Behavior Survey (YRBS) | 3 | Yes |
| Kansas Youth Tobacco Survey | 3 | Yes |

Notes - 2009

Narrative:

/2009/ Youth Risk Behavior Survey:

The YRBS is part of a biennial national effort led by CDC and is conducted by the Kansas State Department of Education (KSDE) and the 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. During the spring of 2005, the KSDE and the KDHE conducted the YRBS in 41 Kansas high schools. For the first time in Kansas YRBS history, weighted data was obtained from 31,862 students in grades 9 through 12. The survey participants included 16,307 males and 15,555 females. In 2007, Kansas again achieved weighted data for the YRBS. The YRBS was completed by 1,733 students 48.5% were female and 51.5% were male. Forty-nine public schools with grades 9-12 participated during the spring of 2007. The survey results provide useful data that can be used to make important inferences about 9th through 12th grade students statewide due to the research based method of random selection used to gather the data. Data from the 2005 and 2007 Kansas YRBS can be found on the Kansas Coordinated School Health Program website at www.kshealthykids.org. The results also were sent to schools and health departments so that data can be used to develop programs to address identified needs.

The Office of Health Promotion (OHP) will conduct the YRBS in the 2008-2009 school year in Kansas high schools and will continue to share the data received with partners across the state. This survey will continue to be administered every other year in the state of Kansas via the Kansas Coordinated School Health Program (KCSH). There are discussions about administering the YRBS at the middle school level, but Kansas would like to obtain trend data at the high school level before adding the middle school survey. Partnerships and collaboration with other State agencies that administer surveys is a goal of KCSH. It is becoming increasingly difficult to administer surveys in schools for a variety of reasons and steps are being taken to increase partnerships at the state level to reduce the burden on schools, while maintaining the integrity of the data.

Previously, the data were not considered representative of the youth population due to non-participation of some school districts. For the last two survey sessions, through the auspices of the KCSH, KSDE and KDHE, Kansas has data representative of the health behaviors of all students in the State. The data are also useful to the Title V program in tracking youth health behaviors. Quality YRBS data are now available due to maximizing participation by local school districts and weighting the data. OHP will continue to work with Kansas Coordinated School Health in partnership with local school districts to maintain this level of participation.

Kansas Youth Tobacco Survey:

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. Survey methodology includes a stratified two-stage cluster sampling design with first stage of random selection of schools in Kansas containing grades 6 to 12 and then second stage of random selection of classes within each school. For statewide weighted estimates, approximately 4,000 students in grades 6 to 12 are surveyed. This sample size is anticipated to increase in future surveillance efforts to provide more detailed information.

These data are important for determining burden of tobacco use, related social factors, perception about tobacco use and initiation susceptibility among youth. Data are also used to determine tobacco control programming and evaluation of program components for their effectiveness in Kansas. The YTS also provide data for nutrition and physical activity components of Health Promotion in Kansas.

The YTS is conducted once every two school years. The YTS was conducted in 2000,

2002, and in 2006. Community specific YTS were conducted in 9 communities in 2000, in 7 communities in 2002, in 4 communities in 2004, and in 17 communities in 2006/2007. We are currently concluding the 2007/2008 YTS. The student survey's are being scanned and we expect the results in summer of 2008. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

//2009/ 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. It 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 and 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 which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside BFH control affecting the outcomes.
//2009//

B. State Priorities

//2009/ The Kansas comprehensive needs assessment, MCH 2010, was completed in 2005. In all, nine priority needs were identified, three for each population group served by the

MCH Services Block Grant. 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. Increase early and comprehensive health care before, during and after pregnancy.

This priority need was selected based on state and regional Perinatal Periods of Risk (PPOR) analysis. As a tool to identify excess mortality and to suggest reasons for excess mortality, PPOR was used to suggest 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 directs resources to address this need at both the state level, and at the community level through grants to local agencies. In addition, through partnerships with stakeholders such as private physicians, March of Dimes, Medicaid, other federal programs, MCH guides policy decision-making and coordinates efforts.

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

2. Reduce premature births and low birthweight.

This priority need was selected based on data showing slight increases for Kansas (see HSA #01A) and the U.S. and data-driven research which points to effective public health interventions. 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.

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

3. Increase 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.

NPM 11 and SPM 3 are the same. Kansas considered revising its priority after the new NPM 11 was released but chose not to do so out of respect for stakeholder input in the 5-year MCH State Needs Assessment process. If anything, the selection of breastfeeding duration as a priority at both the national and state levels validates our process and lends added weight to the priority.

CHILDREN AND ADOLESCENTS

4. Improve behavioral/mental health.

This priority was held over from the last five year needs assessment due to concern that more needs to be done in this area and more can be accomplished through prevention, early identification and intervention in the public health arena. Kansas' capacity is mostly in the areas of early identification and intervention through screening and referrals to treatment. Health promotion and public education to address high risk behaviors of youth

are needed as well as family supports in the community.

NPMs 8, 16, and SPOM 6 relate to this priority.

5. Reduce overweight.

This priority need was selected based on Kansas WIC data showing an increasing trend even among very young Kansans and the strong association between overweight and health status. Most other efforts in Kansas focus on the needs of school-age and adult nutrition and physical activity. The Kansas priority was selected prior to the release of the national priority but it different in one respect, the selection of performance measure. The State performance measure tracks progress in reducing overweight young children (body mass index at or above 95th percentile) whereas the national performance measure is broader and tracks progress in reducing overweight and at risk overweight among children (body mass index at or above 85th percentile). The priority is significant enough that it is useful to track both measures and also to retain the priority as a state priority selected by stakeholders. Kansas capacity to address overweight is enhanced through MCH grants to local communities, school nurses, and also the Governor's Healthy Kansas Initiative. This latter initiative is a replication of the Healthy Arkansas initiative and focuses on lifestyle changes and state/community policy through health education, health promotion, and publications. The effort involves both public and private sectors including the business community and such activities as nutrition education for youth and parents, school health policy, healthy eating options in restaurants, walking trails, and so forth. The Kansas SPM on breastfeeding relates to this objective.

NPM 14 and SPM 5 are related to each other. NPM 11 and SPM 3 relate to this priority.

6. Reduce injuries and deaths.

Nationally and in Kansas, unintentional injury is the leading cause of death for children and adolescents. Kansas is consistently higher than the U.S. in some significant areas (see HIS #3A-3C and #4A-4C). Kansas capacity to address this issue is strengthened through partnerships with the Injury Prevention Program in the Office of Health Promotion, through the statewide SAFE Kids Coalition, and through local MCH agencies and education agencies. The Injury Prevention Program, in particular, utilizes the local school nurse network and the local MCH agency network to address injuries due high risk behaviors of youth, fire/burn injuries (home visitor smoke detector distribution), accidental poisonings (MCH distribution of Poison Control hotline number to parents), and motor vehicle crashes (safety seat installation and checks).

NPM 10, 16, and NOMs 1, 4, and 6 relate to this priority need.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

7. Increase 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.

8. Improve transitional service systems for CSHCN.

Kansas capacity in this area has improved considerably with the realignment of staff duties to include a focus on transitional 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.

9. Decrease financial impact of CSHCN on 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 CSHCN dollars has become more restrictive due to dwindling state and federal dollars and rising costs. Hospitals, labs and private providers continue to work with CSHCN 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. CSHCN continues to engage in policy decisions to ration limited dollars.

NPMs 2-6 relate to this State of Kansas priority. //2009//

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 33 | 25 | 52 | 50 | 39 |
| Denominator | 33 | 25 | 52 | 50 | 39 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes - 2007

Data Source: Kansas Newborn Screening program, 2007 .

Notes - 2006

Data Source: Kansas Newborn Screening program, 2006.

Notes - 2005

Data Source: Kansas Newborn Screening program, 2005.

a. Last Year's Accomplishments**Direct Services:**

Medical consultation for children with genetic/metabolic conditions was available statewide through the CSHCN contractual process. CSHCN purchased metabolic formula and food products for individuals with phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD). July of 2006, CSHCN implemented a sliding fee scale for use with families who need metabolic formula. This was based on new legislation passed in the 2006 session. Medications were purchased for children with congenital hypothyroidism.

Enabling Services:

Kansas hospital personnel collected blood spot specimens from day old infants. Specimens were sent by hospital staff to the State public health laboratory for processing. Lab staff notified the newborn screening (NBS) follow-up nurse of abnormal screening results. The NBS nurse notified the primary care physician (PCP) of the screening test results. Also, the PCP was informed of consultation and referrals available through the CSHCN program. Parents were notified of the need for follow-up with the PCP regarding abnormal screening results. The NBS nurse provided case management services to assure that all infants had appropriate testing, diagnosis, referral and treatment services.

In conjunction with the Heartland Genetics Collaborative, an educational DVD was disseminated to each local health department in Kansas for use in educating expectant parents about expanded NBS.

Infrastructure Building Services:

Legislation was passed in the 2007 legislative session mandating expansion of the NBS testing to include the core panel of 29 conditions recommended by the American College of Medical Genetics (ACMG). The law also required the department to convene an Advisory Council to guide the implementation and evaluation process.

In January of 2007, the NBS webpages on the KDHE website were updated.

In April of 2007, the first successful import of Vital Statistics data into the Birth Defects information system was accomplished.

In July of 2007, NBS staff began using the NBS module which is part of the CSHCN data system and is also linked to the Kansas Immunization Registry.

NBS staff continued revising the Newborn Screening Practitioner's Manual utilizing materials from other states.

Staff initiated a comprehensive strategy for reducing the numbers/rates of unsatisfactory specimens from hospitals.

Staff continued follow-up of unsatisfactory newborn screening specimens assuring that babies

return for needed repeat specimens as soon as possible.

NBS staff attended tandem mass spectrometry (MS/MS) training at Duke University.

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 screens. | | X | | |
| 2. Assure that contracts provide statewide coverage for consultations on metabolic conditions. | | | | X |
| 3. Purchase and distribute PKU formula and food products to eligible individuals. | X | | | |
| 4. Arrange transportation, as needed, to 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 MS/MS laboratory and follow-up procedures. | | | | X |
| 7. Notify parents and physicians about abnormal lab results and follow-up recommendations. | | X | | |
| 8. Provide educational materials such as pamphlets, handouts, DVD, and website address to parents and physicians . | | X | | |
| 9. Participate in the newborn screening advisory committee to include QA activities. | | | | X |
| 10. | | | | |

b. Current Activities

Direct Services:

Continue last year's services.

Enabling Services:

Continue last year's services.

Staff will survey local health departments to determine usefulness of the NBS educational DVD for expectant parents that was sent to them last year.

KDHE will send brochures to parents of infants with congenital anomalies, low Apgar scores and low birthweights informing them about services available through KDHE programs including: CSHCN, Part C, Oral Health, WIC and Families Together, and so forth.

Infrastructure Building Services:

Staff from the NBS follow-up program meet approximately 2 times per month with laboratory staff in order to coordinate expansion activities and troubleshoot issues. The State public health laboratory will conclude its pilot testing of conditions detected through tandem mass spectrometry (MS/MS) in order to meet CLIA requirements.

The protocol manual will be completed.

NBS follow-up staff will remain active in the Heartland Genetics and Newborn Screening collaborative by serving as State Genetics Coordinator and advisory board member.

Contracted with DNAXPRT, Inc. to obtain the services of two certified genetics counselors (2 of 4 in the State) to assist with development of provider and patient materials, plus direct patient counseling as necessary.

c. Plan for the Coming Year

Direct Services:

Continue last year's services.

Contracts with certified genetic counselors will be updated to reflect the current status and needs of the NBS program.

Enabling Services:

Continue last year's services.

In coordination with Heartland Genetics and Newborn Screening collaborative, staff will compile results of local health departments about the usefulness of an educational DVD to inform expectant parents about NBS. The survey results will be used to guide future parent education efforts.

Infrastructure Building Services:

NBS follow-up staff will continue every other week coordination meetings with the State public health laboratory staff. Quarterly meetings of the legislatively-mandated, NBS Advisory Council will be used to ensure coordination between the public and private sectors and to evaluate the program.

Staff will post a final version of the NBS Practitioners Manual on the KDHE website.

Through a contract with Envision Technology Partners, Inc , a new birth defects registry will be developed that will interface with the MCH and CSHCN systems and the State Immunization Registry. Information systems will export of birth certificate data into the new Birth Defects Registry. The registry will continue to receive and monitor legislatively-mandated reports submitted by hospitals, birthing centers, and physicians regarding children under age 5 with a primary diagnosis of congenital anomaly or birth defect. MCH epidemiologists will analyze birth defects data.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 60 | 60 | 65 | 65 | 65 |
| Annual Indicator | 59.1 | 59.1 | 65.6 | 65.6 | 65.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 70 | 70 | 75 | 75 | 75 |

Notes - 2007

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, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. The wording of the two questions used to evaluate this outcome did not change; same as 2001. Indicator is comparable across survey years.

Notes - 2006

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, 2005-06

The wording of the two questions used to evaluate this outcome did not change; same as 2001. Indicator is comparable across survey years.

Notes - 2005

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, 2005-06

The wording of the two questions used to evaluate this outcome did not change; same as 2001. Indicator is comparable across survey years.

a. Last Year's Accomplishments

Direct Health Care Services:

CSHCN staff continue to meet with families in the multi-disciplinary clinics to identify needs and workable solutions. Appointments prior to and after the clinic visits are -up labs and other tests.

Enabling Services:

CSHCN staff work with families in the development of the health care plans which are used to outline care coordination. Families help to identify providers used for services. When a provider has not contracted with the CSHCN program, staff work with the provider to become a contracted provider. CSHCN providers may include the following: hospitals, labs, primary care physicians, specialists, pharmacies and interpreters. The MCH toll-free line has a bilingual message for both English- and Spanish-speaking families. Interpreter services are available for non-English speaking families. CSHCN has a bilingual staff person in the Kansas City office.

Population Based Services:

Families in the tiny-K early intervention program (Part C of IDEA) are involved in the development of the Individual Family Service Plan. They also participate in the development of Individual Education Plans for children ages 3-21. When families report difficulties in obtaining services from school districts, families are referred to the Kansas Parent Training and Information Center and Families Together.

Infrastructure Building Services:

Families Together staff continue to sponsor the advisory group for the CSHCN program and they have been active in review of policies for the CSHCN program. One member of the advisory group attended the 2007 AMCHP meeting. CSHCN contracted with Families Together, Inc., the Parent Leadership Network, to strengthen youth/parents as decision makers and leaders. Youth schedules and interest in the topics presented for input were barriers to youth participation. Participants are financially supported to participate in activities that impact policy, programs and services to CYSHCN and their families. Family to family matches is an avenue to network with a veteran family and enhance the capacity of parents.

A transition poster was developed and made available to family/youth leaders as an education tool. The posters were also displayed in the CSHCN-sponsored clinics encouraging families/providers to include transition planning as a component of the visit.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. CSHCN staff meet with families at each multi-disciplinary clinic visit to assess and address family needs. | X | X | X | X |
| 2. Treatment plans are reviewed at each clinic visit with youth and their families to assure understanding and agreement in the plan of care. | X | X | X | X |
| 3. Families help identify service providers of their choice. | | X | X | X |
| 4. The toll-free line has a bilingual message in both English and Spanish to assist families in communicating in their language of preference. | X | X | X | |
| 5. Referrals are made to appropriate community resources to assist families with educational and early intervention issues. | X | X | X | X |
| 6. Families serve on a Parent Advisory Committee to assist the CSHCN program in policy/program development and evaluation. | X | X | X | X |
| 7. Families and youth are financially supported to serve as advisors to CSHCN. | X | X | | |
| 8. Educational materials promoting family/professional partnerships are visibly displayed in the clinics. | X | X | X | X |
| 9. Assure adequacy of bilingual services through hiring of a second staff person in the Kansas City office. | | X | X | |
| 10. Connect families identified through the birth defects information system to needed services. | X | X | X | X |

b. Current Activities

Direct Services:

Continue last year's activities.

Enabling Services:

A second bilingual staff person hired in the Kansas City office continues to expand our efforts to coordinate meaningful services and support family's understanding and compliance with the treatment recommendations.

CSHCN collaborated on the Family to Family grant that was awarded to Families Together, Inc. The four regional offices provide: training to leaders in local communities; dissemination of information through their newsletter and website of interest to CYSHCN families; promotion of parent-parent matches; and marketing of the Family to Family Parent Training opportunities to community sites, such as health departments, clinics and medical societies.

Families Together, Inc. collaborated on the grant application for the Integrated Community Systems (ICS) grant with CSHCN and the University of Kansas Medical Center, Center for Child Health and Development staff.

Population Based Services:

CSHCN solicited advice from the family advisory committee on the Family Satisfaction Survey conducted in 2006.

The ICS grant budgeted funds for tiny K (aka the Part C Infant-Toddler Program) and for the Youth Empowerment Academy to enhance services to families.

c. Plan for the Coming Year

Direct Health Care Services:

The advisory group to the CSHCN program will develop a Charter/By-laws to guide operations and will utilize best practices to better engage families and obtain family input into the program. The advisory group will develop a plan to improve geographic, minority, and youth representation.

Enabling Services:

CSHCN will continue existing services.

In partnership with families, CSHCN will develop a plan for use of technology to improve timely exchange of information that is family centered and family directed.

Population-based Services:

Data from the 2006 Youth Survey of 13-25 year olds will be compared with other State data for the same age group and with data from other States to gain a more comprehensive picture of what families and youth consider important. This information will be utilized for the 2009 MCHB Five Year Needs Assessment and shared with other programs serving the same population.

Monitor the NBS process and implementation including the role of CSHCN in assisting families with diagnosis and treatment.

Review data from the birth defects information system to identify gaps in the current system in identifying families that need help connecting with services and supports.

Infrastructure Building Services:

Collaborate with other programs that have had success and support CYSHCN development in self-directive activities. Evaluate best practices to engage youth as part of the advisory team.

CSHCN will continue to promote attendance at AMCHP of a family member to assure that families are engaged in the CSHCN program at the national level as well as at the State and local levels.

The grant application submitted by CSHCN and the University of Kansas Center for Child Health and Development includes a strong component on youth development supporting self-awareness, self-management of health needs within all aspects of daily living and decision making. Youth and families are engaged as partners.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 60 | 60 | 65 | 60 | 60 |
| Annual Indicator | 58.9 | 58.9 | 55.3 | 55.3 | 55.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 60 | 60 | 60 | 60 | 60 |

Notes - 2007

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, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Substantial additions, wording changes, and skip pattern revisions were made in 2005-06 to the sets of questions used to construct the Care Coordination and Access to Referrals components of the medical home composite measure for this outcome. Indicator is not comparable across survey years.

Notes - 2006

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, 2005-06

Substantial additions, wording changes, and skip pattern revisions were made in 2005-06 to the sets of questions used to construct the Care Coordination and Access to Referrals components of the medical home composite measure for this outcome. Indicator is not comparable across survey years.

Notes - 2005

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, 2005-06

Substantial additions, wording changes, and skip pattern revisions were made in 2005-06 to the sets of questions used to construct the Care Coordination and Access to Referrals components of the medical home composite measure for this outcome. Indicator is not comparable across survey years.

a. Last Year's Accomplishments

Direct Health Care Services:

The CSHCN program authorized care for children eligible for treatment services when the child was seen by the primary care provider related to an eligible condition. A copy of the plan of care was shared with the child's primary care physician (PCP). The CSHCN program continued to

identify and contract with new PCPs to expand medical home options. Champions for Progress funds were used for a pilot demonstration to allow consultations with specialists from the primary care office using telemedicine (Polycam) connections. Primary care practices statewide were identified and four practices planned to adopt telemedicine to extend their practices.

Enabling Services:

The CSHCN program provided assistance with transportation costs if the child lived more than 50 miles from an authorized provider. Program staff worked with the families eligible for Medicaid/SCHIP services to educate them about the process of obtaining transportation reimbursement. The CSHCN program also entered into a formal agreement with an interpretation/translation service in order to help central/field office staff converse with families who do not speak English. Interpretation services were also funded for families when they attended out-patient medical appointments. This service was authorized by care coordination staff. The Farm Worker Migrant Health Program in the State hired Low German-speaking interpreters to assist with this population of Kansans.

CSHCN staff worked with specialty clinics regarding the importance of sharing the clinic reports with the child's PCP when they are seen. For those children who are enrolled in SCHIP or HealthWave XIX, the program changed policy and no longer required a PCP referral when children see a specialist. CSHCN authorized services for those providers who are not in the SCHIP network.

Infrastructure Building Services:

The CSHCN program used providers that are board certified. For local care, the providers held a license with the Kansas Board of Healing Arts. Pediatricians were required to be board-certified in Pediatrics. Staff continued to be involved in the Oral Health Coalition and worked with the coalition on concerns of dental access for all children and those with special health care needs. The rural communities of Kansas had access issues. Many children in the State who are covered by Medicaid/SCHIP have additional access due to lack of providers who accept Medicaid/SCHIP coverage.

CSHCN coordinated activities with the Kansas Child Adolescent Health Council (KCAHC), a physician advisory group to the Bureau of Family Health.

The program provided CSHCN-sponsored specialty clinics with transition posters and take home information supporting transition planning and strengthening partnerships with families and community resources.

The pilot PolyCam initiative, sponsored by CSHCN, provided the foundation for future grant applications that can support continuation of telemedicine. Specialists and Primary Care Physicians (PCP) were identified through the process.

CSHCN supported Leadership Education in Neurodevelopmental and Related Disabilities (LEND) student training on Title V programs.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Reports from the medical specialist are provided to families, the local primary care physician and other providers identified by the family. | X | X | X | X |

| | | | | |
|--|---|---|---|---|
| 2. Contracting PCP can access the state-wide immunization registry and access CSHCN authorization of services and health care plans developed with the family. | | X | X | X |
| 3. All clinics are contracted to help families identify a medical home provider if they do not currently have one. | X | X | X | X |
| 4. CSHCN program provides interpreter services and transportation to assist families who are attending outpatient medical appointments. | X | X | X | |
| 5. CSHCN program shares health care plans with Medicaid/SCHIP managed care. | | X | | X |
| 6. CSHCN program coordinates with the Kansas AAP Child Health Advisory Council educating physicians statewide on topics related to CSHCN. | | X | | X |
| 7. CSHCN tracks medical home status of clients seen in CSHCN-sponsored clinics. | X | X | X | X |
| 8. CSHCN authorizes follow-up services related to the eligible health condition within the medical home. | X | X | X | X |
| 9. Medical providers are board certified and hold a license with the Kansas Board of Healing Arts. | | | | X |
| 10. | | | | |

b. Current Activities

Services provided through the CSHCN program will be continued.

Direct Services:

Families of newborns with low birth weight and low APGAR scores or congenital birth defects, identified via the birth defects registry, are sent a postcard with information about available services. Families requesting additional information about State and local resources are contacted and given the requested information and assistance. Some families continue to choose only the specialty clinic services.

Enabling Services:

Clinic reports are now tracked to assure that the PCP and family receive copies. The goal is for the PCP and the families to receive their copies within two weeks of being seen in all CSHCN-sponsored clinics.

Infrastructure Building Services:

New computer software is connected to the state-wide immunization registry allowing physician access to CSHCN authorization of services and health care plans developed with the family.

In addition to the activities outlined in last year's report, the United Way initiated a 211 resource. Each community has mapped resources and the live responder will be able to assist networking with community supports to enhance the medical home concept of comprehensive, community-based, family centered care.

c. Plan for the Coming Year

Direct Health Care Services:

The CSHCN program will continue all services provided last year.

Enabling Services:

All services will be continued as outlined last year.

Contract language will be changed to support collaboration between PCP and specialty providers.

Information from the new CSHCN data system will be used to identify families with no PCP. Families will receive information about local/regional providers. CSHCN will provide education about the importance of primary and preventive health care and CSHCN follow-up care.

Review with staff the State MCH-Medicaid Coordination: A Review of Title V and Title XIX Interagency Agreements (second edition). Staff knowledgeable about Title V, Title XIX and other funding sources and services will work in the CSHCN-sponsored clinics to provide assistance to medical providers and families. Also they will continue their outreach efforts with families.

Infrastructure Building Services:

The United Way's 211 resource mapping community resources will be continue to assist families networking with community supports to enhance the medical home concept of comprehensive, community-based, family centered care.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 65 | 65 | 70 | 70 | 70 |
| Annual Indicator | 63.9 | 63.9 | 62.9 | 62.9 | 62.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 64 | 64 | 64 | 64 | 64 |

Notes - 2007

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, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Indicator is comparable across survey years (no changes; same as 2001).

Notes - 2006

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, 2005-06

Indicator is comparable across survey years (no changes; same as 2001).

Notes - 2005

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, 2005-06

Indicator is comparable across survey years (no changes; same as 2001).

a. Last Year's Accomplishments

Direct Health Care Services:

During multidisciplinary clinics, insurance coverage (public/private) was assessed. Families that were uninsured and potentially eligible were given information about Medicaid/SCHIP and the CSHCN program. They were encouraged to apply and/or they were assisted with the application process. The CSHCN program continued to be the sole source of coverage for numerous undocumented citizens. The staff continued to use the CSHCN program application to help determine if the applicant is a US citizen and/or here with legal documentation. By adding questions to the CSHCN program application, staff could prescreen for Medicaid eligibility.

Enabling Services:

Families that applied for the CSHCN program were required to apply for the State Medicaid/SCHIP programs, unless they were screened out due to citizenship status on the CSHCN program application. Medicaid/SCHIP applications were sent to each applicant (English or Spanish) depending on the family's language. The Medicaid/SCHIP applications are labeled with the program name and instructions for the Clearinghouse staff to figure a spenddown if the family is not eligible for SCHIP and over Medicaid income guidelines. A staff person has been designated at the Clearinghouse to work with the CSHCN program referrals. CSHCN staff contacted the Clearinghouse to resolve problems when families reported problems. With changes in the phenylketonuria (PKU) metabolic formula coverage, CSHCN staff worked with families to access insurance coverage for the products.

Infrastructure Building Services:

CSHCN staff ensured that billing had been completed with public/private insurance prior to CSHCN payment. CSHCN used contracted providers that took the CSHCN rate of payment as payment in full. In the 2006 legislative session, the newborn metabolic screening and treatment law was amended to require cost sharing with families when providing treatment products for metabolic disorders. CSHCN program staff have implemented a sliding fee schedule.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Families applying for the CSHCN program are required to apply for SCHIP/Medicaid program. | X | X | X | X |
| 2. CSHCN program staff work closely with Clearinghouse staff to assist families in the Medicaid application process. | | X | | X |
| 3. Local resources are identified to assist with medical needs. | X | X | | |
| 4. CSHCN staff assist families to determine if coverage for metabolic formula is a covered benefit. Formula orders are routed through CSHCN for discounted rates for the families. | X | X | | |

| | | | | |
|---|---|---|---|---|
| 5. CSHCN authorizes eligible services with contracted providers that take the CSHNC rate of payment as payment in full. | X | X | X | X |
| 6. Through Title XIX, screening and assessment of social and emotional components fo infant development is now reimbursed. | X | X | X | X |
| 7. CSHCN coordinates with private non-profit organizations to fund medically necessary treatments and equipment not otherwise covered. | X | X | X | X |
| 8. CSHCN reestablished networking and collaborative relationships during the transition on Title XIX/SCHIP program providers. | | X | | X |
| 9. CSHCN tracks the insurance status on all children/youth seen in the CSHCN-sponsored clinics and assists families to apply for eligible programs. | | X | X | X |
| 10. | | | | |

b. Current Activities

Direct Services:

CSHCN continues activities from last year.

Enabling Services:

Screening and assessment of infant social and emotional development is now reimbursed through Title XIX.

CSHCN coordinates with private non-profit organizations to assist families with financing of medically-necessary treatments and equipment not otherwise covered by public or private insurance. Families continue to struggle with insurance denials that are required for eligibility determination for metabolic formula products. CSHCN has established an ordering process so that even insured families who are subject to high deductible and co-insurance payments can receive discounts through the State negotiated discount rate.

Collaboration to seek alternative solutions and creative networking has been an outcome of recent legislation debates over public funding of insurance programs.

Population Based Services:

Kansas was eligible for disaster funding for 69 out of the 105 counties. Through leadership interventions and agency collaborations, access to health care was not disrupted.

Infrastructure Building Services:

CSHCN has been successful in bridging the transition period with two new Title XIX and SCHIP I programs and forging new relationships during this adjustment phase.

c. Plan for the Coming Year

CSHCN continues to support the activities previously described.

Enabling Services:

The enabling services will continue as described in the current year activities.

Infrastructure Building Services:

Kansas will continue to assess legislation, program agendas and efforts to meet the needs of

Kansas families.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 70 | 70 | 75 | 75 | 75 |
| Annual Indicator | 70.9 | 70.9 | 92.5 | 92.5 | 92.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 95 | 95 | 99 | 99 | 99 |

Notes - 2007

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, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Significant revisions were made to the wording, ordering and placement of the question in the 2005-06 survey. Indicator is not comparable across survey years.

Notes - 2006

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, 2005-06

Significant revisions were made to the wording, ordering and placement of the question in the 2005-06 survey. Indicator is not comparable across survey years.

Notes - 2005

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, 2005-06

Significant revisions were made to the wording, ordering and placement of the question in the 2005-06 survey. Indicator is not comparable across survey years.

a. Last Year's Accomplishments

Direct Health Care Services:

The CSHCN program supported services in the local community by encouraging outreach by specialists. Outreach clinics included pediatric cardiology, orthopedic, pediatric rheumatology, otolaryngology, audiology, and developmental pediatrics. An agreement with the Kansas State Department of Education helped to fund Special Child Clinics. The clinics were held throughout

the State, with a multidisciplinary team that is organized based on each community's needs. Special Child Clinics assisted local communities in the diagnosis and treatment of many conditions such as autism. Through Champions for Progress funding, a pilot program was established to provide Polycam systems to primary care physicians that would allow consultation with specialists in their offices. Initial contact was made with primary physicians in the State and sites identified.

Enabling Services:

Interpretation services were provided for families for whom English is a second language. This was authorized by care coordination staff. A bilingual Advanced Registered Nurse Practitioner and receptionist were hired by the contractor to assist with multi-disciplinary clinics in the Kansas City area. They were able to assist with follow-up in the local community as needs were identified in the clinics.

Population-Based Services:

The Kansas early intervention program was a frequent referral source for the CSHCN program. As the program provides services to children in a natural environment (child care center, home etc) the services were easy for the families to use. The CSHCN program also assisted to fund follow-up screening as necessary when identified by the Sound Beginnings (Kansas Newborn Hearing Screening) program. This helped to establish seamless identification and interventions for CSHCN.

Infrastructure Building Services:

A new CSHCN data system was initiated as a module on the Kansas Immunization Registry. Local providers were able to see that clients are involved with the CSHCN program and were able to call for more details.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Outreach clinics are provided by CSHCN contractors. | X | X | X | X |
| 2. CSHCN (ages 0-2) are referred to Part C Early Intervention networks in their communities. | X | X | X | X |
| 3. CSHCN (ages 3-21) are referred to local school districts for Part B services in their communities. | X | X | X | X |
| 4. Special Child Care Clinics are offered in local communities through an interagency agreement with the Kansas Department of Education. | X | X | X | X |
| 5. Interpreter services are covered for visits with local providers as needed. | X | X | X | X |
| 6. CSHCN staff work with local communities to identify needs for specialty outreach, care coordination and agency/program collaboration. | | X | X | X |
| 7. Contracting providers can access the Immunization Registry, CSHCN program authorization for services, and plan of care developed with the family. | | X | X | X |
| 8. CSHCN utilizes the United Way community resource MAPS, to help providers and families obtain needed resources. | X | X | X | X |
| 9. | | | | |

| | | | | |
|-----|--|--|--|--|
| 10. | | | | |
|-----|--|--|--|--|

b. Current Activities

Direct Services:

Continue to support last year's services.

Enabling Services:

The increased utilization of interpretation services is needed. United Way has mapped community resources and is able to assist families with community supports to enhance the medical home concept of comprehensive, community-based, family centered care.

Population Based Services:

Families interviewed for the 2005-2006 national CSHCN survey reported a 92.5 % response to community-based services being organized so they can use them easily. This speaks to the efforts made to map community resources, provide families with local directories and perhaps the strengthening of the medical home teams to meet the family's needs. Ongoing analysis is needed to assure that this data is a valid reflection of the service delivery system.

The Part C Infant-Toddler coordinator hired has experience in developing and implementing infant mental health policies and programs

Infrastructure Building Services:

CSHCN is participating in the Oral Health Advisory meeting, attending Regional Heartland Genetic meetings, and participating in the Working Healthy grant process. CSHCN and Part C staff serve as contributing members on the Early Child Care and Early Education Advisory Committee. Health department directors in underserved areas with large minority populations participate in CSHCN advisory committees.

The new CSHCN data system interfaces with the following: Immunization Registry, MCH, birth defects, and NBS.

c. Plan for the Coming Year

Direct Services:

The CSHCN program will continue to support outreach specialty clinics as described in last year. New contracting health, pharmacy and other ancillary providers will be identified by the CSHCN program. If the family identifies a community provider, an application and information about the CSHCN program will be mailed to the provider.

Enabling Services:

The United Way will continue to provide community resource information to assist families to network with community supports.

The CSHCN field office staff will provide families with State and local resources that enhance the medical home team efforts. The Title V toll-free operator will provide information on federal, state and local resources.

Population-based Services:

CSHCN and Families Together, Inc. will continue to support the use of personal health information notebooks and will help families keep them current. This will emphasize community collaboration and will assist in keeping the family center as a key contributing member of the treatment team.

Two newborn screening coordinators will be available to assist in identifying and tracking children. The Kansas NBS program will go from 4 to 29 screened conditions beginning July 1, 2008.

Infrastructure Building Services:

Modifications to the new data system will continue to improve ease of data entry and reporting of program outcomes.

Hospital discharge teams will be contacted about the need of families for copies of medical histories, in-hospital evaluations and treatment plans at time of discharge. This was identified as a priority by the Part C Infant-Toddler early intervention teams. When families have this information earlier, they are better able to share it with their providers. This promotes positive family/professional relationships.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 5 | 5 | 15 | 6.3 | 6.3 |
| Annual Indicator | 5.8 | 5.8 | 50.3 | 50.3 | 50.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 53 | 53 | 55 | 55 | 55 |

Notes - 2007

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, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

Notes - 2006

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, 2005-06

In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

Notes - 2005

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, 2005-06

In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

a. Last Year's Accomplishments

Direct Health Care Services:

CSHCN staff used the timeline that was developed by the Children Have Opportunities in Communities Environments and Schools or Project CHOICES to assist families with early transition issues from toddler age through adolescence. Topics that were discussed at CSHCN specialty clinics include the following: guardianship at age 18 for those unable to make their own decisions; medical care in family practice after the child ages out of pediatric services; SSI/insurance/Medicaid coverage after age 21; independent living options if appropriate; post high-school education; possible referral to Rehabilitation Services (formally Vocational Rehabilitation) if appropriate. The CSHCN program encouraged multi-disciplinary clinics to hold transition clinics for older youth in order to address transition issues. Some of the following clinics held transition clinics for youth with the following special needs: Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord.

Enabling Services:

The Kansas State Board of Education, in coordination with other state programs, conducted an annual transition conference. Families Together, Inc. also provided transition conferences in targeted regions of the State. CSHCN staff participated in these events.

Infrastructure Building Services:

The Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics held transition clinics for the adolescent population.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. CSHCN assures transition clinics Cleft Lip/Palate, Cerebral Palsy, Cystic Fibrosis, and Spinal Cord Injury. | X | X | X | X |
| 2. Families Together, Inc. conducts transition workshops for professionals and families. CSHCN staff provide input and are speakers at these events. | | X | | X |
| 3. CSHCN utilizes technical assistance from the national | | X | | X |

| | | | | |
|---|--|---|---|---|
| Healthy and Ready to Work program. CSHCN utilizes technical assistance from the national Healthy and Ready to Work program to guide Kansas in designing services. | | | | |
| 4. Increase collaboration with the University of Kansas, Center on Disabilities, Department of Commerce, educational system, family and youth organizations continues to build the infrastructure base. | | X | | X |
| 5. CSHCN tracks transition activities in the web-based data system. | | X | X | X |
| 6. CSHCN, in collaboration with the University of Kansas Center for Child Health and Development, submitted a grant application to address transition issues. | | | | X |
| 7. Rehabilitation services referrals are made to support eligible youth to achieve goals. | | X | X | X |
| 8. Education materials and posters are available in CSHCN-sponsored clinics promoting professional/family early transition planning. | | X | X | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Services:

The Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics continue to provide transition clinics.

CSHCN staff consulted with the National Center on Healthy & Ready to Work about transition issues and the development of a transition poster in both English and Spanish.

Enabling Services:

Provided feedback on the 2005-2006 NSCSHCN survey

Population Based Services:

A CSHCN parent advisor was hired as Disability Program Navigator in western Kansas working for the Department of Commerce.

A new school nurse manual for children with chronic health conditions and diseases emphasized health transition planning as a component of the overall transition planning process.

Infrastructure Building Services:

CSHCN is a collaborative partner in the Department of Commerce's "Shared Youth Vision." A pilot project is targeting the Kansas City area. CSHCN participated in the Working Healthy Grant Application.

The University of Kansas Center on Disabilities, in collaboration with CSHCN staff, submitted an application for a Integrated Community System grant with support from KS Chapter of American Academy of Pediatrics, Kansas Family Physicians, Department of Commerce, Kansas Department of Education, Families Together, Inc. Youth Empowerment Academy and Kansas SociRehabilitation Services. National experts were involved in the development of the grant and will continue to support Kansas efforts if Kansas receives an award.

c. Plan for the Coming Year

Direct Health Care Services:

CSHCN will continue to build on the transition data and input from Youth with Special Health Care Needs (YSHCN) and support the objectives of the Integrated Community Systems grant if awarded.

Enabling Services:

CSHCN will continue to collaborate on transition for YSHCN training to professionals and families. The program will provide data to the MCHB Five-Year Needs Assessment team on transition concerns.

Population-based Services:

If awarded, the Integrated Community Systems grant will expand the current efforts to identify, engage and support YSHCN transition to adult providers. The Youth Empowerment Academy which conducts a week long event allowing YSHCN to experience college campus life, will continue to meet with legislative members and develop action plans to meet their individual goals and objectives. This program allows YSHCN to network with other YSHCN and strengthen bonds for future youth involvement in policy and advocacy events.

Infrastructure Building Services:

CSHCN will participate at the State level and pilot project level in the Shared Youth Vision Initiative lead by the Department of Commerce and will continue to identify partners to build the capital and capacity for coordinating services.

CSHCN will continue to support the efforts of the aforementioned programs through active participation and financial support.

CSHCN staff provide information at local, regional and State conferences on services for CSHCN.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 80 | 80 | 82 | 82 | 89 |
| Annual Indicator | 78.1 | 80.6 | 87.5 | 83.6 | 83.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |

| | | | | | |
|------------------------------|----|----|----|----|----|
| Annual Performance Objective | 90 | 90 | 90 | 91 | 91 |
|------------------------------|----|----|----|----|----|

Notes - 2007

Data Source: 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/06/tab03_antigen_state.xls

The 2007 National Immunization Survey estimate is not available. The data reported here is an estimate based on 2006.

National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. For school year 2007-2008, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 3.

Notes - 2006

Data Source: 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/06/tab03_antigen_state.xls

National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. For school year 2006-2007, Hepatitis B and one dose of varicella are required for kindergarten, first and second grade entry.

Notes - 2005

Data Source: 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/05/tab03_antigen_state.xls

National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. Starting school year 2005-2006, Hepatitis B and varicella are required for Kindergarten and first grade entry.

a. Last Year's Accomplishments

In Kansas, the Haemophilus Influenza type B is not required for school entry. For school year 2007-2008, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 3. As these vaccines are only recommended for 19-35 month olds by the Kansas Immunization Program (KIP), only DTP4: Polio3: MMR1 combination is reported. The Immunization Registry (KSWebIZ) reports that the percentage of Kansas's children 19-35 months old has increased from 75-92 percent with 50% of those children having two or more immunizations. There are 154 providers participating in KSWebIZ.

The legislature approved \$200,000 in funding for local health department staffing during WIC clinics -- assessment of immunization status and administration of immunizations. Four clinics were selected: Shawnee, Seward, Cherokee, and Saline counties.

Human Papillomavirus (HPV) vaccine was approved for VFC use. School entry vaccination for kindergarten/first grade included a recommended varicella booster and required Hepatitis B.

KSWebIZ Steering Committee joined KDHE/ Kansas Health Institute (KHI)/Kansas Health Foundation's (KHF) Immunize Kansas Kids (IKK) to study the delivery system/formulate strategies to reach 90% coverage rate. KSWebIZ interfaced with Kansas Medicaid adding children's immunization records beginning May 2007.

The "Immunize and Win A Prize" program continued as a parent incentive to have children using

VFC fully vaccinated by age 2.

Direct Services:

Agreements between Local Health Departments (LHD)/Rural Health Clinics (RHC)/Federally Qualified health Centers (FQHC) allowed vaccination of children with VFC vaccine.

Enabling Services:

School nurses collaborated with LHDs to conduct immunization surveillance/notification of needed vaccines. Healthy Start Home Visitors (HSHV) provided immunization information/referrals to families as outreach/family support services.

Population-Based Services:

Congratulatory birth cards signed by the Governor were sent to all new parents featuring a tear-out immunization schedule and reminder to contact their health providers to protect their new babies.

A new collaborative program for vaccinating underserved girls age 9-26 against HPV was proposed through the Health Care Foundation of Greater Kansas City (HCF), the REACH Foundation, and Kansas Association for the Medically Underserved (KAMU). This program would provide the three series HPV to girls/women not qualifying for VFC vaccine.

Adolescent/adult vaccine information was provided to public health nurses promoting vaccinations to protect infants/young children from exposure to preventable diseases.

Infrastructure Building Services:

KSWebIZ linkages by Kansas WIC (KWIC), Medicaid Management Information System (MMIS), and private provider practice management/billing systems became available in all WIC clinics May 2007 allowing a "read only" immunization record with the recommender reminder for parents.

Health Level 7 (HL7) interfaces with LHD using different data systems was initiated.

The KIP/Kansas Chapter of Academy of Family Physicians (KAFF) /Kansas Chapter of the American Academy of Pediatrics (KAAP) collaboration continued, working to increase VFC providers/ implementation of KSWebIZ.

KIP finalized modules customizing KSWebIZ for school nurses.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Schools / public health agencies / other health professionals will provide printed, verbal and electronic on age-appropriate immunizations to parents points of parent contact using materials provided by the Kansas Immunization Program (KIP). | | X | X | X |
| 2. Four counties will provide immunizations through WIC clinics using registered nurses with all WIC clinics determining immunization status of children at appointments with referral to providers for age-appropriate immunizations. | | | X | X |
| 3. The KIP will provide information, resources and technical | | | | X |

| | | | | |
|--|---|---|---|---|
| assistance to health care providers on vaccines and their use through training, the Kansas Rural Health Information System (KRHIS), and through electronic communication utilizing partners in t | | | | |
| 4. KSWebIZ will continue expansion into health departments, private and public clinics, and schools utilizing interfaces with other data sources, including Medicaid. | | X | X | X |
| 5. The Kansas Chapter of the American Academy of Pediatrics and the KIP will promote and provide training to private physician offices regarding KSWebIZ use to expand providers and more timely immunization of children. | | | | X |
| 6. Healthy Start Home Visitors (HSHV) will provide immunization education and resources, and will refer families to providers to obtain age-appropriate immunizations for their children. | | X | | X |
| 7. Birthing hospitals will provide a birth dose of hepatitis B as VFC provider. | | | X | X |
| 8. Providers will provide education regarding HPV vaccine to all populations and will assist with referrals to VFC providers. | X | | X | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Medicaid vaccination information merged into KSWebIZ. The one-millionth patient was entered into the registry in January. The final IKK report addressing vaccine delivery system in Kansas was released.

Direct Services:

Four WIC clinics were selected for funding to improve immunization rates with the KIP. The project infrastructure/work will continue as funding has been extended.

Enabling Services:

Birth cards/registry reminders are sent to parents regarding immunization. HSHV promote on-time immunizations and school nurses notify parents regarding needed school-age vaccines.

Population-Based Services:

HCF, the REACH Foundation, and KAMU provide HPV vaccine to girls/women age 9-26 at 13 sites in Johnson, Wyandotte, and Allen counties. 40% of the 32 sites in both Missouri/Kansas offering the free vaccine series are in Kansas.

Required school entry vaccines regulations are being revised to reflect current ACIP recommendations.

The 2008 Legislature HB 2097 requires KDHE to increase flu immunization awareness/participation for children age 6 months-5 years in child care facilities, a study for school-based flu vaccination pilot programs, and an immunization education campaign for parents of children grades 6-12.

Beginning the Fall of 2008, there will be 31 school-based KSWebIZ sites.

Infrastructure Building Services:

Sixteen counties are selected for HL7 interface with KSWEBIZ.

Training/implementation of KSWebIZ access by school nurses will begin at the 2008 school nurse conference

c. Plan for the Coming Year

Direct Services:

Hepatitis B (3 doses) and Varicella (1 dose) will be required for all students through grade 5 for the 2008-2009 school year. The requirements are being increased by two grade-levels in an effort to expedite the coverage of the school population for protection against the two diseases.

With the anticipated change in the regulations for required vaccinations for school entry, there will be additional vaccines required: Varicella (2 doses), Hepatitis A, and age appropriate Hib/pneumococcal.

The partnership between KIP and WIC clinics at select sites will be established and ongoing. All WIC clinics will interface with the KIP July 1 providing "read only" access to client immunization records and recommenders.

KSWebIZ will generate reminders to parents regarding due dates for vaccines.

Enabling Services

The Governor's Birth Card Project will continue for all babies born in Kansas, as well as "Immunize and Win A Prize" as a parent incentive for children participating in VFC. An incentive program for parents will be initiated by the WIC program to reward WIC parents who present to WIC clinics with completed age-appropriate immunizations when their child is 2 years of age.

HSHV will continue providing outreach/family support to families with new infants/young children promoting on time immunizations.

School nurses will notify parents regarding vaccines needed by their school-age children.

Population Based Services:

By the 2009 Kansas legislative session, KDHE will report on plans to increase flu immunization awareness / participation for children age 6 months-5 years in child care facilities per HB 2097. This will include a study of the feasibility of a school-based flu vaccination pilot program, as well as an educational campaign for parents of children grades 6-12 regarding immunizations.

Infrastructure Building Services:

Additional counties will be added to KSWebIZ using the HL7 interface with the county data system. It is anticipated that this roll out will be completed in 2 years.

31 pilot school-based KSWebIZ sites will be entering immunization data into the State registry.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
|--|-------------|-------------|-------------|-------------|-------------|

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 20 | 20 | 19 | 19 | 18 |
| Annual Indicator | 20.0 | 20.4 | 19.6 | 19.5 | 19.5 |
| Numerator | 1174 | 1179 | 1135 | 1152 | 1152 |
| Denominator | 58677 | 57850 | 57812 | 59155 | 59155 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 18 | 18 | 17 | 17 | 17 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data Sources: Kansas Vital Statistics, 2006 resident data (numerator) and U.S. Census estimates (Bridged-Race Vintage data set)(denominator).

Notes - 2005

Data Sources: Kansas Vital Statistics, 2005 resident data (numerator) and U.S. Census estimates (Bridged-Race Vintage data set)(denominator).

a. Last Year's Accomplishments

For Kansas, 2006, the teen birth rate (ages 15-17) was 19.5/1,000 females. This was 1.8% lower than 2005. For the years 2002-2006, there is a statistically significant (p=.04) decreasing trend in teen births for this age group. In 2005, the birth rate for Kansas teens (ages 15-17) was 8.3% lower than the national rate. Hispanic teens in Kansas had the highest rate at 56.5/1,000, but this is a 3% decrease from 2005 (58.2/1000). According to The National Campaign to Prevent Teen Pregnancy, among all states, in 2005 Kansas ranked 29th (50=highest) in teen pregnancy.

Direct Services:

Gardasil, a vaccine to prevent some types of human papillomavirus and cervical abnormalities, is now administered through the Vaccines for Children (VFC) program.

Teen Pregnancy Case Management (TPCM) programs provide case management services to Medicaid enrolled women ages 10-21 that are pregnant or parenting one or more children.

Enabling Services:

Seven teen pregnancy prevention projects (school/community education) and six TPCM projects provided sexuality education in Kansas. The director of one Kansas TPCM project was asked by Johnson & Johnson to make a presentation to a group in Washington DC about the Kansas TPCM model. MCH partners with Medicaid to fund the TPCM projects whose primary objectives are as follows: assisting teens with one pregnancy to prevent subsequent pregnancies; keeping their children's immunizations and physicals up-to-date; completing high school/vocational school; and reducing welfare dependency.

KDHE adolescent health staff partnered with Kansas State Department of Education (KSDE) to provide education to Kansas teachers on human sexuality and Kansas laws affecting children

and teens.

Population-Based Services:

School and community based education was provided through the Teen Pregnancy Reduction Projects, Ab Ed Projects, and Peer Education Projects. Educational messages for teens focused on the value of postponing sexual intercourse and pregnancy prevention.

Kansas collaborated with seven states to offer the Region VII 6th Annual HIV/AIDS/STDs & Human Sexuality Education Conference for classroom teachers. The purpose of the conference was to provide data, information and techniques for teaching human sexuality and pregnancy prevention. The conference drew participants from 18 states with about 250 participants.

Infrastructure Building:

Kansas continued the Abstinence Only Education (Ab Only Ed) program under Section 510 of Title V of the Social Security Act. In 2006, Kansas had 9 projects providing education and collecting data. KDHE provided statewide training on "WAIT", "Choosing the Best" and "Quinceanera." Congress reauthorized the Section 510 Title V Abstinence Education funding one quarter at a time this past year. Given the uncertainty of future funding, two agencies did not renew their contracts. This leaves seven community based projects. Kansas has increased the assistance to local education agencies providing Abstinence Education staff training and curriculum using the funding provided for this year.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Require Community-Based Teen Pregnancy Reduction (TPR) programs to educate and encourage Teen Pregnancy Case Management (TPCM) programs to use proven program curricula. | X | X | X | X |
| 2. Collaborate with Kansas State Department of Education (KSDE) to use evidence-based teen pregnancy reduction curriculum in schools. | | X | X | X |
| 3. Serve on the SRS Fatherhood Summit planning committee to increase male role involvement in teen pregnancy prevention and involvement of fathers in the lives of their children. | | X | X | X |
| 4. Educate parents and teens in the prevention of cervical cancer in females with HPV vaccine | X | | X | X |
| 5. Actively explore opportunities to address teen pregnancy disparity issues through educational programs in communities with high disparate populations to promote community involvement in prevention efforts. | | X | X | X |
| 6. Provide information & training to grantees acquired at the AMCHP and CityMatCH roundtable training on TPR. | | X | X | X |
| 7. Plan and participate with KSDE and seven surrounding states to include information on TPR at regional HIV/STD/AIDS prevention conference for professionals health educators. | | X | X | X |
| 8. Serve on an SRS Kansas Child Welfare Quality Improvement Committee to improve the permanency of teens in the foster care | | | | X |

| | | | | |
|--|---|---|---|---|
| system that are pregnant or parenting. | | | | |
| 9. Obtain certification as a Breast Feeding Educator to better support the TPCM grantee staff in the promotion of teen mother breast feeding her child through the first year. | | X | | X |
| 10. Encourage Breast Feeding Educator certification in all grantees of TPCM programs. | X | | X | X |

b. Current Activities

Direct Health Care Services:

The TPCM projects provide case management to Medicaid enrolled teens to assist them in achieving their goals.

Enabling Services:

Abstinence Education, TPCM and Teen Pregnancy Reduction Projects (TPRP) provided training on writing objectives, data use, evaluation criteria, and board development. Wichita State University resources provided board training including selection of members, retention, responsibilities, laws and strategic planning.

Population Based Services:

The TPRP, Peer Education Projects and Disparities Initiative were combined to form the Community-Based Teen Pregnancy Reduction Project (CBTPRP). Seven grants were awarded to communities with high teen pregnancy rates.

KDHE adolescent & school health staff provide information and resources via newsletters, phone e-mails and at the annual school nurse conference on reducing teen pregnancy.

Infrastructure Building Services:

KDHE and KSDE collaborate to offer an STDs and human sexuality education conference to ensure teachers have current medically accurate information and sensitivity for these topics (June 2008).

KDHE partners with Social and Rehabilitative Services to provide a fatherhood conference with emphasis on absent fathers (in the service or jail) and helping families cope.

A Kansas team attended the AMCHP/CityMatCH Teen Pregnancy Prevention Roundtable and Training and received technical assistance on using evidence-based teen pregnancy prevention programs.

c. Plan for the Coming Year

Direct Services:

The TPCM programs will continue to provide culturally-competent, comprehensive services to teens with emphasis on inclusion of both female and male.

Enabling Services:

KDHE staff will continue to provide data, technical support and educational opportunities to grantees, communities and families on their roles in reduction of teen pregnancy.

Population Based Services:

The CBTPRP will continue to use evidence-based programs. Continued funding remains uncertain for the Section 510 Title V Abstinence Only Education program, but the seven grantees will continue as funding allows. Increased Ab Only Ed training and curriculum purchases for interested school districts will continue as funding allows.

Infrastructure Building:

Technical assistance will be provided to the CBTPRP grantees using a logic model for evaluation and planning. All teen pregnancy grantees will work with board members to develop strategic plans that include sustainability provisions given funding uncertainty.

The Kansas AMCHP/CityMatCH Teen Pregnancy Prevention Roundtable and Training team will continue to work together to strengthen delivery of services to Kansas teens and update their strategic plan for the Sedgwick County target area.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 50 | 50 | 36 | 36 | 37 |
| Annual Indicator | 45.1 | 34.2 | 34.2 | 34.2 | 38.2 |
| Numerator | 196208 | 11485 | 11485 | 11485 | 13176 |
| Denominator | 435052 | 33558 | 33558 | 33558 | 34506 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 40 | 40 | 45 | 45 | 45 |

Notes - 2007

Data Source: Smiles Across Kansas: 2007 Update - unpublished weighted data.

Notes - 2006

Data Source: Smiles Across Kansas 2004: The Oral Health of Kansas Children

Notes - 2005

Data Source: Smiles Across Kansas 2004: The Oral Health of Kansas Children

a. Last Year's Accomplishments

Direct Health Care Services:

The state of Kansas is currently not directly involved in placing sealants on children's teeth.

Population-Based Services:

The Office of Oral Health (OOH) collaborated with Oral Health Kansas to design and implement a school screening program for Kansas school children. Kansas law requires all children to have a dental screening every year. Starting in July of 2007, OOH has a two year project to develop an

oral health screening program that will provide schools with uniform screening forms, and a data collection system at the OOH that can be used to track the oral health of Kansas kids.

Enabling Services:

There is one HRSA State Oral Health Collaborative Systems Grant funded school-based dental sealant project was active in a community dental "safety-net" clinic. The project is located in the Flint Hills Community Health Center catchment area and provided sealants for second and sixth graders in school districts in Lyon, Chase, Greenwood and Osage Counties who are dentally underserved.

Kansas safety net clinics have created a model on how to improve access to dental care in underserved areas. The Kansas' State Primary Care Association and the Kansas Association for the Medically Underserved (KAMU) promoted the "Dental Hub" concept for expanding oral health access in rural areas. This concept creates a series of regional "dental hubs" operated by safety-net clinics.

A dental hub is a dental clinic staffed by at least two dentists in a central underserved location, with spokes of care radiating out to satellite sites. The hubs focus on providing preventive, emergency and restorative dental services to the underserved. The spokes of the hub provide preventive services in other areas in the region, for instance, a dental hygienist with portable equipment traveling to a neighboring community, nursing home or school. In 2007 the Kansas Legislature allocated funds to start the implementation of the dental hub concept. The concept was very appealing to legislators as a solution to rural access, and private foundations agreed to match state funds. KAMU has requested more funds in the 2008 session, and private foundations have again agreed to match state funds.

Infrastructure Building Services:

The baseline data was obtained in a 2004 open mouth survey, Smiles Across Kansas. The second survey in 2007 showed no significant changes. The results from the 2007 project indicated that the oral health status of children in Kansas varied substantially based on whether the child's family reports having dental insurance and access to dental care services. When insurance coverage is high, most oral health indicators measured are positive; when insurance coverage is reported to be low or absent, children share a pattern of poor(er) access, worse health, and the absence of some preventive treatments (i.e., dental sealants) that would slow the progression of oral disease. Thirty-six percent of children in the sample had dental sealants. The pattern varied substantially when examined by race (51.8 percent of African American children lacked dental sealants) and ethnicity (76 percent of Hispanic children lacked dental sealants). When more children are connected with dental care providers for routine care, fewer cases of untreated dental decay are expected.

In September Kansas requested a Program Review Visit from other state dental directors to review the State Oral Health Office. An extensive "briefing book" was compiled to educate the team about Kansas prior to their visit. The book included Kansas specific data, policy briefs, legislation, and may be shared with interested stakeholders.

Also in September a meeting was held to address the oral health of children with special health care needs. This meeting was well attended by dental professionals, parents, physicians, safety net clinics and KDHE. In an attempt to reach out and involve dentists in this effort, the OOH contacted and met with dentists who are treating this population.

In November 2007 OOH released Kansas' first comprehensive Oral Health Plan. The plan was developed during a year long collaborative process and included four sections: Dental Workforce, Financing, Public Health and Children's Oral Health. Each section

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. Provide consultation and technical assistance to school-based dental sealant project. | | X | | X |
| 3. Provide leadership to the Oral Health Kansas Coalition. | | | | X |
| 4. Provide leadership to the Kansas Public Health Board and Oral Health Section. | | | | X |
| 5. Continue to provide technical assistance to nurses DIAGNOdent screening project. | | X | | X |
| 6. Encourage concept of “dental home” for children and adults. | | X | | X |
| 7. Support increased public-private partnerships between schools, local public health departments and private practice dentists. | | X | | X |
| 8. Provide targeted education and outreach to families to improve the oral health of children across Kansas. | | X | | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling Services:

Grant funding from United Methodist Health Ministries and REACH Healthcare Foundation provided for three additional part-time staff (Registered Dental Hygienists) who are the State Professional Outreach Coordinators, providing physician's offices training on the application of fluoride varnish at well-baby exams. Kansas has attempted to extend oral health services to underserved populations by utilizing other health care personnel to do oral health education and prevention. The Kansas Medicaid program will reimburse medical providers for fluoride varnish treatments done in their offices up to three times a year.

The purpose of this initiative is: to prevent early childhood caries (ECC) through: (1) targeted early screening, (2) oral health education of caregivers, (3) application of a fluoride varnish to primary teeth (baby) if necessary, and (4) proper referral to a dentist, if appropriate, for care.

Infrastructure Building:

Hygienists that hold an extended care permit (ECP) can provide hygiene services without general or direct supervision by a dentist in certain types of community settings. ECP hygienists must meet minimum practice hour requirements and have a Kansas-licensed sponsoring dentist who reviews their treatment records and findings. As of April 2007 fifty Kansas dental hygienists held an extended care permit, but the state does not collect information on where they are working or if they are using their ECP to provide independent services.

c. Plan for the Coming Year

In 2008, the Kansas Department of Health and Environment Office of Oral Health collaborated on a survey that was sent to all licensed dental hygienists to research the practice patterns by Kansas hygienists, with the intention of projecting workforce needs for the future. The oral health access problem is multi-factorial. Workforce programming must be based on not only the size of the current and future oral health workforce, but also reference the geographic location of

professional shortage areas, provisions of the Kansas Dental Practice Act, and the availability of dental/dental hygiene educational programs.

Kansas recently added a dental benefit for adults on the frail elderly waiver. The OOH will continue to provide technical assistance to the Department of Aging regarding this benefit.

Kansas is fortunate to have many effective oral health advocates and interested policy makers. The state oral health coalition, Oral Health Kansas and the OOH will continue to effectively define the oral health access problem for community partners, state legislators and private foundation funders.

The OOH will continue to collaborate with Oral Health Kansas to implement a school screening program for Kansas school children. Kansas law requires all children to have a dental screening every year. Although some communities voluntarily comply with this statute, there is no uniform screening device or data collection system. OOH will continue the two year project to develop an oral health screening program that will provide schools with uniform screening forms, and a data collection system at the OOH that can be used to track the oral health of Kansas kids.

In collaboration with Oral Health America, OOH has compiled data for a 2008 Kansas report card. The final report's targeted release date is the Oral Health Kansas fifth anniversary in September. The oral health website will continue to be updated to keep stakeholders informed of the ongoing activities and progress toward goals. The OOH continues to provide oral health training, technical consultation, and educational materials.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 5 | 5 | 5 | 4 | 5.5 |
| Annual Indicator | 5.4 | 5.1 | 5.9 | 4.0 | 4.0 |
| Numerator | 31 | 29 | 33 | 23 | 23 |
| Denominator | 574120 | 564421 | 555339 | 574097 | 574097 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 3.8 | 3.8 | 3.7 | 3.7 | 3.6 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data Sources: Kansas Vital Statistics, 2006 resident unintentional injury data (numerator); U.S. Census estimates, Bridged-Race Vintage data set (denominator).

Notes - 2005

Data Sources: Kansas Vital Statistics, 2005 resident unintentional injury data (numerator); U.S. Census estimates, Bridged-Race Vintage data set (denominator).

a. Last Year's Accomplishments

According to the 2007 Annual Report (2005 Data) of the Kansas State Child Death Review Board (SCDRB), 2005 trends are consistent to the previous year data, particularly in relation to the Unintentional Injury-Motor Vehicle Crash category. As in every year since the inception of the SCDRB, the majority of children dying in MVC were not properly restrained or using appropriate safety restraints.

In 2005, there were 106 child pedestrians 1-14 years involved in accidents with 2 deaths, 107 pedal cyclists age 1-14 years involved in accidents with 2 deaths, and 35 children killed in MVC.

According to the Kansas Information for Communities 2006 Data, the mortality rate for children ages >14 as a result of unintentional injury--motor vehicle crash was 4.0/100,000 children, 32.6% lower than in 2005.

Direct Services:

Special funding was received to purchase/distribute 600 booster seats at 14 locations in the state. An additional 1,420 boosters were purchased for distribution in a 10 county area of Northeast Kansas.

Kansas SAFE KIDS coordinated with the Kansas Traffic Safety Resource Office (KTSRO)/local communities for CPS training/inspection/ provision of car seats providing education/resources.

Enabling Services:

Healthy Start Home Visitors (HSHV) continued outreach and family support to provide injury prevention information / education, including current laws, correct use/installation of car seats, booster seats and seat belts. Of the 99 Child Passenger Safety (CPS) stations in Kansas, 29 local health departments (LHD) had CPS inspectors that included HSHV.

There are 44 sites whose safety technicians have received training on transporting children with special health care needs (CSHCN). 3 of those sites are located in LHD.

Population-Based Services:

A northwest LHD specifically targeted children ages 0-21 and their parents for health education regarding the use of bicycle helmets, seat belts, and child/infant car seats. Classes were held two evenings a month for this population, as well as providing bicycle helmets, and car seats to low-income families. This project was collaborative partnership between the health department and the school nurse.

HSHV continued to inform families with new babies of the Child Passenger Safety Seat Act, KSA 8-1344 and collaborated with community SAFE KIDS coalitions and the Kansas Safety Belt Education Office (KSBEEO) to provide resources for CPS seats/seat belt use, and injury prevention education.

On August 10, 2007 Safe Kids Worldwide, the parent organization to SAFE KIDS Kansas, announced an association with Boys & Girls Clubs of America (BGCA) to provide child safety education to a broader group of youth who are at high risk of being injured in and around an automobile. In Kansas, this will allow for additional families and children to be reached who may not seek out services.

Infrastructure Building Services:

A Primary Seat Belt Law, SB 8, was passed and signed by the governor requiring each occupant of a passenger car who is at least 14 years of age but less than 18 years of age, to have a safety belt properly fastened about such person's body at all times when the vehicle is in motion. The Primary Seat Belt Law took effect July 1, 2007. Between July 1-December 31, 2007, drivers and passengers in cars ages 14-17 who weren't wearing seat belts could be given a warning ticket. Beginning January 1, 2008 there will be a \$60 fine assessed per violation.

MCH staff collaborated with the KDHE Office of Health Promotion (OHP) SAFE KIDS and Emergency Medical Services for Children (EMS-C) coalitions coordinating pediatric injury treatment/prevention educational programs across the state targeting community level child health providers, school nurses and providing resources/information through the monthly ZIPS newsletter.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Promote participation in the Kansas SAFE Kids Coalitions utilizing educational resources provided by SAFE Kids Kansas. | | | X | X |
| 2. Direct providers to resources that will assist in analyzing Kansas Department of Transportation injury data to target prevention efforts specific to their community. | | | X | X |
| 3. Participate on the Emergency Medical Services for Children Coalition to assist in identifying pediatric injury factors and develop skill building for assessing / triage of severely injured children in the school setting. | | | X | X |
| 4. Provide technical assistance to review data provided by the Kansas Child Death Review Board of deaths of children ages that are involved in pedestrian and motor vehicle crashes and communicate factors contributing to deaths to promote discussion and | | | X | X |
| 5. Inform providers of proposed and passed legislation that to reduce deaths of children ages involved in pedestrian and motor vehicle crashes. | | | X | X |
| 6. Inform HSHVs of training opportunities for child passenger seat technician certification. | X | | X | X |
| 7. HSHV will provide education, instruction, and referral to resources to families with infants, young children, and adolescents on proper child passenger safety, pedestrian safety, and safe practices while using wheeled equipment, such as bicycles, ska | X | X | X | |
| 8. Identify injury prevention, safety and physical activity programs (Cycle Smart, Walk This Way, Safe Routes to School) and provide information / resources in the ZIPS newsletter, MCH conference, Healthy Start Home Visitor (HSHV) regional training and | | X | X | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Services:

KTSRO/local communities for CPS training/inspection/ provision of car seats providing

education/resources. Of 98 CPS sites, 30 LHD are child safety seat inspection stations with 3 trained for CSHCN.

The Safe Routes to School program continues.

Enabling Services:

KDOT, SAFE KIDS/EMS-C coalitions to provide information regarding CPS training opportunities for staff in local MCH programs.

Population-Based Services:

LHD and school nurses provide injury prevention education about booster seats, seat belt usage, and pertinent laws to parents of children birth through adolescence, including passenger restraint education/surveillance of the school-aged population while riding in private vehicles.

SB 294 bill was introduced in the 2008 Legislature for a Graduated Drivers License System for teen drivers, but did not pass.

Infrastructure Building Services:

Beginning January 1 the Primary Seat Belt Law is enforced with a ticket/\$60 fine for drivers/passengers in cars ages 14-17 not wearing seat belts.

SAFE KIDS/EMS-C coalitions provides information/education to school /public health nurses/community level child health providers to improve the emergency care system for children. EMS-C is sponsoring training for school nurses on School Nurse Emergency Services for Children.

The ZIPS newsletter continues to be the vehicle for information/resources regarding prevention of unintentional injuries, including motor vehicle related injury / death.

c. Plan for the Coming Year

The Kansas 2010 MCH 5-Year Needs Assessment identified injury reduction as one of three priorities to be addressed for the Child and Adolescent populations for the following five years. The focus of this priority is preventable injuries, both intentional and unintentional injuries. Local MCH agencies will continue to be provided with information/resources for injury prevention programs within their agencies. CPS and seat belt usage will continue to be primary activities for local agencies.

Direct Services:

SAFE KIDS will continue to work with community groups to distribute child safety seats and booster seats to low-income families, including CSHCN.

Enabling Services:

HSHV and other MCH staff will continue to inform, educate, and link families to resources for motor vehicle safety.

Population-Based Services:

SAFE KIDS policy platform will actively support change regarding motor vehicle policy issues that include: strengthening the safety belt law and enforcement of and compliance with existing law, education of the public regarding the use of belt positioning boosters and increase the availability

of boosters for children weighing between 40-80 pounds in vehicles equipped with lap/shoulder belts.

Infrastructure Building Services:

LHD will target specific populations within their communities based on community needs assessments/concerns identified by the community to address unintentional injury/death involving MVC.

Information about the results of the 2007 Kansas High School Survey / Youth Risk Behavior Survey Results will be distributed to MCH staff and school nurses, as well as programs and resources available through the OHP, through the ZIPS newsletter.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 25 | 23 |
| Annual Indicator | | | 22.5 | 22.2 | 22.2 |
| Numerator | | | 2883 | 1267 | 1267 |
| Denominator | | | 12813 | 5708 | 5708 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 24 | 25 | 26 | 27 | 27 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

The numbers presented for 2006 do not represent all the WIC participants due to a new data base roll-out.

Notes - 2005

2004 Data Source: Kansas WIC data, CDC's Pediatric Nutrition Surveillance System (PedNESS). Year 2005 is populated with 2004 data since 2005 data is not available at the time of reporting.

a. Last Year's Accomplishments

In Kansas, 2006, 22.2% of WIC infants were breastfed at least 6 months, 1.3 % lower than in 2005. Since 2000-2006, the percent of mothers who breastfeed their infants at 6 months of age has fluctuated with no apparent trend. In 2006, the percent of Kansas mothers breastfeeding at 6 months was 11.9% lower than the percent for U.S. mothers (25.2%).

Enabling Services:

Kansas law allows a mother to breastfeed in any place she has a right to be and to postpone jury duty until such time as the mother is no longer breastfeeding her child. Continued to distribute "breastfeeding licenses" that include information on the law to local health departments and home visitors. The cards ask the reader to report good and bad breastfeeding experiences in businesses. The requests have lessened but "Thank You" letters and "Informational" letters continue to be sent.

Three breastfeeding support billboards are displayed in prominent locations along the Kansas Turnpike.

Breastfeeding resources, based on the recommendations of the Breastfeeding Taskforce, were distributed to LHDs.

Worked with LHDs to strengthen five existing local breastfeeding coalitions and to foster the establishment of one new local breastfeeding coalition.

Population-Based Services:

Coordinated World Breastfeeding Week (WBW) in August of 2007 by providing all local agencies with a packet of ideas to help with the promotion of WBW. Five agencies were awarded \$200 worth of breastfeeding education and/or resource materials for outstanding promotion efforts.

Infrastructure Building Services:

Supported a speaker for the biennial La Leche League Professional Meeting. In attendance were 220 Kansas health professionals representing the state and local health departments including WIC RD's, RN's, and Breastfeeding Peer Counselors, and home visitors and hospital staff.

Supported Breastfeeding Peer Counselor Programs in 18 Kansas counties. Peer counseling is a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Worked with LHDs to develop action plans to improve the clinic atmosphere to support breastfeeding dyads.

Distributed the local breastfeeding resource directory to LHDs.

Presented information on the benefits of breastfeeding workplace support to the Governor's Child Health Advisory Board. At the request of this advisory board, a model workplace support policy and business support materials were developed. The board recommended that the policy be implemented in all State of Kansas agencies.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Support community breastfeeding coalitions by encouraging LHDs to play an active role. | | X | | |
| 2. Communicate breastfeeding information to a variety of state and community agencies. | | | | X |
| 3. Disseminate breastfeeding newsletter for LHDs to send to community contacts. | | | X | |
| 4. Support LHDs through WIC and MCH to continue and implement breastfeeding-friendly policies. | | | | X |
| 5. Support LHDs through WIC and MCH to continue and | | | | X |

| | | | | |
|--|--|--|--|--|
| implement breastfeeding-friendly policies. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling Services

Continue the Breastfeeding Support Billboard campaign with new billboards on the Kansas Turnpike and one moved to another busy Kansas highway.

Developed and distributed with the assistance of the Breastfeeding Taskforce a series of "Breastfeeding Reminder Post Cards" and a Crib Card.

Work with Medela to provide "Breast Pump 101" seminar to three locations in Kansas for LHD WIC staff and MCH staff.

Work with LHDs to foster the establishment of one new local breastfeeding coalition and the strengthening of five existing breastfeeding coalitions.

Population-Based Services

Coordinate World Breastfeeding Week (WBW) in August of 2008 by providing all local agencies with a suggestions and resources for promotion of WBW. Provide the two agencies with the most successful community partnership promotion with up to \$200 worth of breastfeeding education and/or resource materials.

Infrastructure Building

All WIC staff including breastfeeding peer counselors attended training on communication and critical thinking to enhance breastfeeding promotion and support skills.

Establish a Kansas Breastfeeding Coalition expanding the Breastfeeding Taskforce.

Supported Certified Breastfeeding Educator Training in April of 2008.

State and local staff attended the USBC biennial conference in January of 2008.

Updated "Breastfeeding Promotional and Support" and "Breastfeeding Management" training modules.

c. Plan for the Coming Year

Establish a Breastfeeding Resource Room for the Bureau of Family Health.

Continue breastfeeding support billboards.

Support existing Breastfeeding Peer Counselor Program.

Support development of a State breastfeeding coalition and new local breastfeeding coalitions.

Population-Based Services:

Coordinate World Breastfeeding Week (WBW) in August of 2009 by providing all local agencies with a packet of ideas to help with the promotion of WBW and provide the two agencies with the most outstanding promotions with up to \$200 worth of breastfeeding education and/or resource materials.

Infrastructure Building:

Underwrite speaker for Biennial La Leche League Professional Meeting. Encourage WIC staff involved in the promotion and support of breastfeeding including peer counselors to attend.

Work with LHDs to improve staff competencies related to breastfeeding, including helping to sponsor Certified Breastfeeding Educator Training in at least one location.

Update existing training modules for "Breastfeeding Promotion and Support" and "Breastfeeding Management" and disseminate using the Kansas TRAIN resource.

Continue to work with the Governor's Child Health Advisory Board on breastfeeding workplace support.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 98 | 98 | 98 | 98 | 98 |
| Annual Indicator | 95.3 | 96.2 | 87.9 | 95.3 | 96.4 |
| Numerator | 38434 | 38925 | 35825 | 39951 | 41388 |
| Denominator | 40326 | 40449 | 40734 | 41910 | 42947 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 98 | 98 | 98 | 98 | 98 |

Notes - 2007

Data Sources: Newborn Hearing Screening program 2007 (numerator); Vital Statistics occurrent births for 2007 (denominator).

Notes - 2006

Data Sources: Newborn Hearing Screening program 2006 (numerator); Vital Statistics occurrent births for 2006 (denominator).

Notes - 2005

The 2005 data is low because of the poor follow-up during the 15 month period beginning January 2005 when the Sound Beginnings extracts were not available to our program.

Data Sources: Newborn Hearing Screening program 2005 (numerator); Vital Statistics occurrent births for 2005 (denominator).

a. Last Year's Accomplishments

Kansas has continued to screen at 95% or better since 2003. The percent of newborns screened before hospital discharge was 96.4 in 2007 an increase of 1.1% since 2006. Percentages for 2005 are reduced due to the implementation of a new web-based birth certificate system through the Office of Vital Statistics did not allow for records from birth to be extracted for 15 months, March 2006, significantly impacting the program's ability to track infants needing additional testing in that first month of life. The program has been able to reestablish the 96% screening rate seen in 2004 this past year.

Population Based Services:

The screening is implemented at the local level by hospitals, birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings 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. Audiology/EHDI Coordinator and Advisory member 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.

Infrastructure Building:

The Sound Beginnings Advisory Committee continued to meet quarterly and establish goals for each year to support the program and stakeholders.

English and Spanish newborn hearing screening informational brochures were provided to families at the hospital. Audiologists and Early Childhood Special Educators provided resource guides to families of infants and toddlers who have been identified with hearing loss.

Training for EHDI stakeholders was provided by Genevieve DelRosario at the annual EHDI Conference with a focus on pediatric vestibular evaluation. Otoacoustic Emission (OAE) training for Baldwin, Leavenworth and Blue Valley Parents as Teachers and to Infant Toddler Programs serving Riley and Southwest Counties of Kansas was provided by Sound Beginnings staff.

A Team for Kansas completed work with the National Initiative for Children's Health Care Quality (NICHQ) Newborn Hearing Screening Learning Collaborative to improve follow-up working through the medical home. Improvements continued to be modeled to decrease loss to follow-up in Kansas by working with physician's offices after a failed screen stressing the importance of this being a developmental emergency with action to be taken to help the family.

Funding in the amount of \$50,000 was approved from State general funds to implement a hearing aid loan bank.

Participated in Deaf Day at the Capital, State meetings working with stakeholders, Early Childhood Hearing Outreach State Team meeting, Kansas Commission for the Deaf and Hard of Hearing Board Meetings and activities, Sound START Committee meetings, Deaf Blind Consortium meetings.

Audiology EHDI Coordinator provided hearing screens at state agency Health Fairs to educate

consumers on screening equipment used with newborns.

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 Sound Beginnings 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. Sound Beginnings 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:

Sound Beginnings will continue with Advisory Committee meetings and dissemination of brochures.

Continued submission of screening and diagnostic evaluation results through 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 upon request, due to limited staff of the program. 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 on the NICHQ Learning Collaborative is ongoing for reduced loss to follow-up.

c. Plan for the Coming Year

Population Based Services:

The screening is implemented at the local level by birthing facilities including hospitals, birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administers the statewide system for Early Hearing Detection and Intervention including a 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.

Infrastructure Building:

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

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.

Sound Beginnings 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.

Continued work on the NICHQ Newborn Hearing Screening Learning Collaborative model to implement successful tests of change for reduced loss to follow-up in the state.

Support through mini grants 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 Part C Coordinator continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education including the National EHDI conference.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 5.5 | 5 | 5 | 6 | 6.5 |
| Annual Indicator | 6.4 | 6.4 | 6.3 | 6.2 | 7.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 7 | 6.9 | 6.8 | 6.7 | 6.6 |

Notes - 2007

The 2007 estimate is not available. The data reported here is an estimate based on 2006.

Data Source: Table HIA-5. Health insurance coverage status and type of coverage by state -- children under 18: 1999 to 2006.

<http://www.census.gov/hhes/www/hlthins/historic/hihist5.html>

Notes - 2006

Data Source: Table HIA-5. Health insurance coverage status and type of coverage by state -- children under 18: 1999 to 2006.

<http://www.census.gov/hhes/www/hlthins/historic/hihist5.html>

Notes - 2005

Data Source: Table HIA-5. Health insurance coverage status and type of coverage by state -- children under 18: 1999 to 2006.

<http://www.census.gov/hhes/www/hlthins/historic/hihist5.html>

a. Last Year's Accomplishments

The current economy has created challenges in insuring children and families. A 2008 report from the Kansas Health Institute (KHI) updating the March 2007 Current Population Survey, shows that the percentage of children covered through a parent/guardians employment-based insurance appears to have declined from 66.6 percent in 2004-2005 to 63 percent in 2005-2006.

The KHI report finds that almost half (47 percent) of the uninsured in Kansas are young adults age 19-34, a vulnerable population of childbearing age. In addition, although most uninsured Kansans are non-Hispanic whites (70 percent), 18 percent of those uninsured Kansans are Hispanic, representing just 7 percent of all Kansans. Sixteen percent of Black, non-Hispanic Kansans are uninsured.

HealthWave, the State Children's Health Insurance Program (SCHIP) that includes Medicaid, transitioned from the State Social Rehabilitation Services (SRS) office to the Kansas Health Policy Authority (KHPA) in July 2007. Two managed care groups are responsible for administering Medicaid/HealthWave: Children's Mercy Family Partners and Unicare. According to SRS, as of July 2006, there are 37,505 Kansas children enrolled in HealthWave 19 (Medicaid) or HealthWave 21 (SCHIP).

In January 2008, KHPA reported that there are 122,674 members in the HealthWave XIX

program (Medicaid) and 38,241 members in HealthWave XXI (SCHIP). However, according to the 2008 KIDS COUNT DATABOOK, there are still 51,000 children or 7% of Kansas's children under age 19 who remain uninsured. Kansas Action for Children (KAC) reports that the fastest growing group of uninsured children is those children whose parents earn between 200% and 250% of poverty. Health insurance coverage is a critical component for children in accessing a medical home and services.

Barriers to enrolling children in public insurance include: Medicaid/HealthWave requires parents to re-enroll their children on an annual basis, there continues to be undocumented children that are ineligible for Medicaid/HealthWave coverage, and finally, the identification requirements through the federal Deficit Reduction Act of 2005 for applications created a backlog of 14,000 Medicaid/SCHIP applications with approximately 18,000-20,000 beneficiaries losing coverage between 2006-2008.

Enabling Services:

HSHV/MCH assisted families to enroll in Medicaid/HealthWave programs. Local health department (LHD) staff continued assisting families with enrolling their children in Medicaid/HealthWave and in understanding their coverage plan.

Population-Based Services:

Schools continued enrolling eligible women and children who qualify for free/reduced school lunches in Medicaid/HealthWave.

Infrastructure Building Services:

A proposed 2007 legislative initiative to provide health insurance to all children ages 5 and under called Healthy Kansas First Five Program was not funded. However, the KHPA received an additional \$81,105 SGF for FY2007 and \$623,731 from SGF for FY2008 to fund positions to reduce the SCHIP application backlog with the goal to eliminate the backlog by January 2008. KHPA reported that the backlog of Medicaid/HealthWave applications created by the 2005 identification requirements had been alleviated with an original backlog of 6,500 applications in October 2007 to less than 4,500 in January 2008. KHPA reports the goal for Medicaid/HealthWave application processing is 25 days.

The Kansas Child Adolescent Health Council (KCAHC), comprised of physicians from the Kansas Chapter of the American Academy of Pediatrics (KAAP) and MCH staff, gathered information pertaining to the rate of uninsured children in Kansas providing guidance/ resources to assist in determining barriers to insuring children for medical/dental care.

The Kansas Early Childhood Comprehensive Systems (KECCS) comprised of state-level partners, stakeholders, and others interested in early childhood, began implementing strategies identified in the KECCS plan to assist with insurance coverage, access to care/services, and early childhood development/education.

KDHE Office of Oral Health advocated for dental providers to assist families with HealthWave enrollment, as well as providing care.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Assist families with obtaining and completion of the Medicaid/HealthWave application and the establishment of a medical and dental home. | | X | | X |
| 2. Local health departments develop outcome-based plans to | | | | X |

| | | | | |
|---|--|---|---|---|
| decrease the percent of children without health insurance in their regions and access to a regular source of health and dental care. | | | | |
| 3. Schools will provide all families with information for free/reduced school lunch program and the Medicaid/HealthWave Programs for school-aged children | | X | X | X |
| 4. Promote outreach activities in local education agencies by school nurses, school social workers, and school psychologists to enroll Medicaid eligible women and children. | | X | | |
| 5. Healthy Start Home Visitors (HSHV) will provide information, applications, and will assist families to enroll in Medicaid/HealthWave programs during home visits | | | X | X |
| 6. Assist local health agencies to create a community plan for identifying source of care for those uninsured children who remain ineligible for Medicaid/HealthWave Programs. | | X | X | |
| 7. Promote local coordination and collaboration between agencies to identify and enroll families in disparate populations who qualify for Medicaid/HealthWave Programs and to refer families not qualifying for Medicaid/HealthWave to safety net clinics. | | X | X | |
| 8. Childcare professionals will provide information for Medicaid/Healthwave and will encourage families to establish a medical and dental home, linking children who do not qualify for Medicaid/Healthwave to local health departments or safety net clinics | | | X | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling Services:

In May the Legislature approved an expansion for health care services for pregnant women and children in May. The Health Care Package extends HealthWave eligibility limits from 200 to 250 percent of poverty. No funding was allocated for the expansion.

Population-Based Services:

HSHV provide HealthWave outreach to families in several settings, including childcare.

MCH educates families of children who receive either free or reduced school lunches of their eligibility for Medicaid/HealthWave.

Infrastructure Building Services:

KHPA proposed 21 Health Reforms to transform the healthcare system/insurance in Kansas. The expanded Health Care Package for pregnant women/children was a component. Funding of the proposed reforms was not agreed upon, but the 21 recommended reforms supported philosophically.

KAAP/KHPA are working together to improve capacity/standards for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) to increase provider participation. KHPA is providing regional provider training for the Kansas Medical Assistance Program (KMAP).

The State MCH program is developing training for Child Care Health Consultants (CCHC) for LHD nurses targeting children/families in childcare for health/safety, including linking to insurance/medical homes.

The KECCS grant has been extended until August 2009. KECCS, stakeholders and the State MCH program are implementing strategies to attain outcome objectives identified for early childhood populations.

c. Plan for the Coming Year

Enabling Services:

It is anticipated that the proposed Health Care Reform package will be reintroduced with continued discussion on funding of the program. Additionally, funding for the Health Care Expansion Package for pregnant women/children will need to be addressed.

The MCH program will continue to work with the KDHE Center for Health Disparities, the Office of Local and Rural Health's Refugee and Farmworker Health programs, to assist MCH staff in communities in locating resources to assist these populations with insurance coverage and access to care.

Population Based Services:

There will be an expansion of early childhood services in Kansas supported by the Governor and the Legislature. All ECH programs are being proposed to be under one governing agency. The current proposal for ECH services includes prenatal populations and children up to school age. The decision regarding which agency will be responsible for this new state-level cabinet or department will be announced by the Legislature in January 2009. Components of the KECCS plan that impacts this population includes insurance coverage for pregnant women and children.

Infrastructure Building Services:

The MCH Program will assist KHPA to enroll all eligible children in child health insurance programs, monitor progress in enrollment and to determine strategies to be incorporated into the education of providers enrolling families in public insurance programs.

KHPA is planning on providing EPSDT training for additional LHD nurses in September.

MCH staff will continue to support and promote outreach activities in local health and education agencies to enroll Medicaid eligible women and children and to encourage their use of health services available to them.

The MCH child consultant will train nurses in LHD as Child Care Health Consultants using the National Training Institute (NTI) at Chapel Hill's model. This project targets providers/families of out children under the age of 8 years whose children are in childcare. The nine-month training will provide nurses the resources/skills to serve as a CCHC within their community/region.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 30 | 30 |
| Annual Indicator | | | 30.3 | 30.8 | 30.8 |
| Numerator | | | 10114 | 6900 | 6900 |

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| Denominator | | | 33378 | 22404 | 22404 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 29 | 29 | 28 | 28 | 28 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

The numbers presented for 2006 do not represent all the WIC participants due to a new data base roll-out.

Notes - 2005

Year 2005 is populated with 2004 data since 2005 data is not currently available.

a. Last Year's Accomplishments

Among Kansas WIC participants (children ages 24 - 59 months), 30.8% were at risk of overweight or overweight. This percent is not significantly different from the percent nationally (31.2%). The percentage of WIC participants at risk of overweight or overweight (2006) increased 1.6% from 2005. However, the change did not reach significance. In the last 5 years with available data (2002-2006), there is a statistically significant increasing trend in the percent of WIC participants at risk of overweight or overweight

a. Last Year's Accomplishments

Worked with the Bureau of Health Promotion in promoting the Kansas Kids Fitness Day. Kansas Kids Fitness Day is a statewide event focused on increasing physical activity among 3rd grade students in Kansas. The event was held May 5th, 2007 with approximately 17,500 participants at 39 sites located throughout the state.

As a part of the action plan developed by the Kansas USDA nutrition programs, three communities held community wide events to increase healthy eating behaviors including increased consumption of fruits and vegetables and increased physical activity. Incentives to increase physical activity and encourage healthy eating behaviors were provided to event participants.

Participated in developing legislative initiatives for the Governor's Taskforce on obesity.

Partnered with the Kansas Dietetics Association Foundation, the Kansas Head Start Association and the Kansas Nutrition Network to publicize the Ellyn Satter Institute workshop, "Children, The Feeding Relationship and Weight".

School nurses were surveyed to assess if school aged children were being weighed, measured and referred, as appropriate. Of the 45,802 health screenings reported, BMIs were assessed on only 9%.

The Coordinated School Health program continues to provide grants for schools to form School Councils and complete the School Health Index. These grants can be used to address obesity and physical activity.

Supported and participated in the Cornerstones of a Healthy Lifestyle Blueprint for Nutrition & Physical Activity (blueprint) training. The training outlined practical, consumer-focused, state and local strategies for improving eating and physical activity and provided communities, consumers, organizations, agencies, and programs with strategies and potential actions to address priority nutrition and physical activity issues in the context of their own community resources and needs. Key strategies recommended under this blueprint were the promotion of Fruits & Veggies-More Matters, a Healthy Kansas Community Assessment Tool to assess the built environment, Walk Kansas promotion, and the Dine Out Kansas Healthy Restaurant awards. Thirty local health departments participated in this training. In addition, these same communities were encouraged to attend a Built Environment summit in 2007.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Support the nutrition education and/or nutrition assistance programs of the Kansas Nutrition Network and the Early Childhood Action Team. | | X | X | X |
| 2. Support the Kansas Council on Physical Fitness annual Kansas Kids Fitness Day. | | X | X | |
| 3. Support the Early Childhood Action Team's goals to stress the interrelatedness of physical activity and nutrition. | | | X | X |
| 4. Support local health departments plans for decreasing childhood obesity and increasing physical activity through the WIC and MCH Programs. | | | | X |
| 5. Provide consultation for the Kansas Child Health Assessment and Monitoring Project. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling Services:

Worked with the Office of Health Promotion to promote a statewide event focused on increasing physical activity among 3rd grade students. The event was held May 2nd with approximately 17,600 participants at 40 sites located throughout the state.

Partnered with various organizations to coordinate efforts to reduce childhood obesity by increasing physical activity and improving nutrition.

Infrastructure Building:

As a part of the action plan developed by the Kansas USDA nutrition programs, three communities held community wide events to increase healthy eating behaviors. Incentives to increase physical activity and encourage healthy eating behaviors were provided to event participants.

Continue purchasing the "Help me be Healthy" series of educational pamphlets for use in all Kansas WIC clinics.

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

The Coordinated School Health program continues provides grants for schools to form School Councils and complete the School Health Index. These grants can be used to address obesity and physical activity.

The 30 LHDs across the state that attended the 2007 Cornerstones of a Healthy Lifestyle Blueprint for Nutrition & Physical Activity training were encouraged to attend a Built Environment summit.

All WIC local agencies expanded on existing Nutrition Education Action Plans that focused on increasing fruit and vegetable consumption.

c. Plan for the Coming Year

Continue working with the Office of Health Promotion to promote the Kansas Kids Fitness Day. Kansas Kids Fitness Day is 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.

Infrastructure Building:

The action plan developed by the Kansas USDA nutrition programs will continue to include additional communities that will implement community wide events to increase healthy eating behaviors including increased consumption of fruits and vegetables and increased physical activity.

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

Funding for the Cornerstones of a Healthy Lifestyle Blueprint for Nutrition & Physical Activity will be expanded to cover 33 communities to continue and expand priority activities.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 12.3 | 13.5 |
| Annual Indicator | | | 14.0 | 14.2 | 14.2 |
| Numerator | | | 5577 | 5814 | 5814 |
| Denominator | | | 39701 | 40896 | 40896 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 13.5 | 13 | 13 | 12.5 | 12.5 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

2005 data is not comparable to data from previous years since it is collected from the revised birth certificate.

Notes - 2005

Year 2005 is populated with 2004 data representing live births where the mother reported tobacco use on the birth certificate (1989 revision). It is estimated that 2005 Kansas birth certificate data (revised 11/2003) will be available October, 2006.

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 birthweight (<2,500 grams) is a key predictor for infant mortality. In 2005, the percentage of pregnant women reporting smoking during pregnancy was 16.2%. In 2006, 14.2% of women reported smoking during the last three months of pregnancy. It is not clear from this data whether this is due to an actual reduction in smoking or just a decrease in the reporting of this behavior.

Direct Health Care Services:

Tobacco cessation assistance was provided to pregnant women referred to the Kansas Tobacco Quitline and to local tobacco cessation clinical provider services.

Enabling Services:

Maternal & Infant (M&I) program prenatal care coordinators throughout the state provided screening, counseling and referral to tobacco cessation services.

Infrastructure Building Services:

The Kansas Tobacco Use Prevention Program (TUPP) provided a five-hour train-the-trainer course for individuals in the use of person-to-person and small group contact to educate healthcare professionals in techniques for counseling pregnant women regarding tobacco cessation. Participants received a toolbox of materials specific to supporting their presentations and discussions along with a variety of promotional materials. Also, prenatal healthcare providers were encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Encourage MCH and WIC staff in local agencies to attend tobacco cessation training. | | | X | X |

| | | | | |
|--|---|---|---|---|
| 2. Provide TA to LHD staff and perinatal healthcare providers on the use of 5A's Tobacco Cessation training and Kansas Tobacco Quitline information to assist pregnant women that smoke tobacco to quit. | X | | X | X |
| 3. Inform all perinatal healthcare providers that Medicaid covers the patch, Zyban, individual counseling, and group counseling services to assist pregnant women in Kansas quit tobacco use and provide billing codes. | X | | X | X |
| 4. Support KS Tobacco Use Prevention Program (TUPP) in efforts to create smoke-free communities and homes in Kansas. | | X | | X |
| 5. Link LHD staff and perinatal healthcare providers to the National Partnership To Help Pregnant Smokers Quit telephone conference for updates in practice methodologies | | X | | X |
| 6. Provide LHD staff and local perinatal healthcare staff with relevant tobacco cessation resources via the Web, professional conferences, newsletter articles and other routine communications. | | X | | X |
| 7. Require grantees and encourage all perinatal healthcare providers to assess every pregnant woman for smoking behaviors and tobacco use, educate them on the risks associated with continued smoking, and locate local smoking cessation services. | | X | X | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Health Care Services:

Pregnant women are being provided tobacco cessation assistance by referrals to the Kansas Tobacco Quitline and local tobacco cessation clinical provider services.

Enabling Services:

Local health care providers and MCH grantee agencies are given relevant tobacco cessation information/resources through ZIPS newsletter articles and routine communications. Kansas home visitation staff provides outreach and support to pregnant women and family members. Providing these families with available community resources for smoking cessation helps address this issue.

Local agency staff are encouraged to assess all pregnant women for smoking behaviors and tobacco use and provide education on the risks associated with continued smoking and either provide services or refer to services to aid in smoking cessation within their community.

Infrastructure Building Services:

The Kansas TUPP encourages local agencies that affect approximately 70% of the total state population to use the Quitline and other materials that aid people to quit smoking. In addition, the Kansas TUPP encourages local programs (44) to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

The Kansas TUPP disseminates an annual report to interested stakeholders via the Web and print materials. This report evaluates the efforts of participating organizations implementing the 5 A's approach.

c. Plan for the Coming Year

Direct Health Care Services:

Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A's tobacco use prevention method through local tobacco cessation clinical provider services with additional support from the Kansas Tobacco Quitline.

Enabling Services:

Local healthcare providers and MCH grantee agencies will continue to receive relevant tobacco cessation information/resources through newsletter articles and in routine communications. Kansas home visitation staff will continue outreach to pregnant women and family members providing smoking cessation resources and referrals. MCH program staff will further develop relationships with partnering organizations, programs and agencies to maintain and develop tobacco cessation resources for pregnant and preconceptional women.

Population-Based Services:

MCH program staff will encourage grantees and partners to pursue available tobacco cessation training, provide smoking cessation opportunities to pregnant women and refer them to the Kansas Tobacco Quitline and other local resources for follow-up support services.

Infrastructure Building Services:

Some capacity is in place to provide smoking cessation counseling and referral by prenatal service providers in the state. Training opportunities are in the planning stages to enhance the smoking cessation skills of providers and local agencies with available resources. MCH Program staff will provide technical assistance to local grantee agencies regarding billing for tobacco cessation counseling in an effort to support sustainability. The Kansas TUPP encourages local programs to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates as well.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 6.5 | 6.5 | 6.3 | 8 | 7.5 |
| Annual Indicator | 9.7 | 8.3 | 7.9 | 9.5 | 9.5 |
| Numerator | 60 | 51 | 48 | 58 | 58 |
| Denominator | 619453 | 614974 | 610153 | 607746 | 607746 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 9.4 | 9.3 | 9.2 | 9.1 | 9 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

(2006 data=2004-2006).

Reporting years were combined to calculate 3 year rolling averages due to small sample size.

ICD-10 coding: X60-X84, Y870.

Data Source: Kansas Vital Statistics (numerator); U.S. Census estimates, Bridged-Race Vintage data set (denominator).

Notes - 2005

(2005 data=2003-2005).

Reporting years were combined to calculate 3 year rolling averages due to small sample size.

ICD-10 coding: X60-X84, Y870.

Data Source: Kansas Vital Statistics (numerator); U.S. Census estimates, Bridged-Race Vintage data set (denominator).

The annual performance objective of 6.3 in 2005 triggered a data alert that the KS objective differed from performance by more than 10%. Therefore for future years, the objectives have been increased to fall within the 10% value validation range.

a. Last Year's Accomplishments

In 2006, the suicide rate among Kansas youth ages 15-19 was 11.9/100,000. For 2003-2005, the suicide rate for Kansas youth was 1.7% higher than the U.S. rate. For the period 1997-2006, using rolling 3 year averages, there is a statistically significant decreasing trend in completed suicides by Kansas youth (15-19). However, the 2004-2006 rolling average was 21.3% higher than that for 2003-2005. Completed suicides in 2006 were in geographically diverse areas of the State.

Youth suicide is the second cause of death in Kansas 15-24 year olds. For the U.S. is the third cause of death for this age group. According to the 2005 Kansas Youth Risk Behavior Survey (YRBS), thirteen percent of Kansas' high school students had seriously considered attempting suicide during the past 12 months. This has risen to 14% in 2007, about 1 out of every 8 students.

The percentage of students who made a plan about how they would attempt suicide during the past 12 months was 9.6% in 2005 and again in 2007 (1 of 10). Of students surveyed in 2005 and again in 2007, 6.5% and 6.7% respectively of the students who were surveyed actually attempted suicide one or more times during the past 12 months. The percent of students that attempted suicide and had to be treated by a doctor or nurse during the past 12 months was 1.6% in 2005 and 2.1% in 2007. Often the youth who attempt suicide have associated mental health or other behavioral concerns such as depression, substance abuse, and a sense of hopelessness, increased stress and a lack of family support.

Direct Services:

The schools and school counselors provided family therapy counseling through facilitation with the local mental health consortiums and the use of telemedicine technology.

Enabling Services:

The mental health consortiums provided education and conferences for training in best practices.

Population-Based Services:

Social and Rehabilitative Services (SRS) and the National Alliance on Mental Illness (NAMI) offered a conference. Consumers, family members and providers received support and training in best practices.

School nurses attended training on establishing a Yellow Ribbon suicide prevention program in their schools. The school nurse survey indicates, of the nurses reporting, 15 of them now have a Yellow Ribbon program in their schools.

Infrastructure Building Services:

The Governor's Mental Health Services Planning Council divided into subcommittees to look at housing, vocational rehabilitation, forensics, service delivery, family health, aging and solicit consumer input. They had several recommendations to the Governor and Social and Rehabilitative Services (SRS): create a suicide prevention website and resource center, support an anti-stigma campaign, implement "The Corridor" model to decrease attitudinal barriers to seeking help, and education the public that suicide is preventable.

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 Suicide Prevention Subcommittee to develop a state-wide suicide prevention strategic plan that includes strategies addressing teens. | | X | | X |
| 2. Provide suicide prevention education and assessment tools to Kansas school nurses and counselors at professional conferences and through individual TA. | X | X | X | X |
| 3. Provide mental health information and resources to the school personnel, MCH, Community and consortiums. | | X | X | X |
| 4. Promote suicide prevention awareness with publicity of the Governor's proclamation signing of Suicide Prevention Week in Kansas. | | | X | X |
| 5. Assist in connecting school nurses and counselors to Kansas University telemedicine program linkages so they can obtain mental health counseling via telemedicine for students in underserved communities. | X | X | | X |
| 6. Survey school nurses regarding current implementation of suicide prevention efforts in the schools they serve to measure increase in suicide prevention efforts over last five years. | | | X | X |
| 7. Work with the Office of Health Promotion, Emergency Medical Services-Children (EMS-C) in providing a program for school nurses on trauma and mental health emergencies to promote avoidance of suicide attempts. | | X | | X |
| 8. Work with the Office of Health Promotion, Emergency Medical Services-Children (EMS-C) and the Office of Local and Rural Health, Trauma Registry in improving data collection regarding teen suicide attempts. | | | X | X |
| 9. Assist the Office of Health Promotion and stakeholders in Southeast Kansas in developing a broad-based suicide prevention plan for their primary schools and extending into college | | X | X | X |
| 10. | | | | |

b. Current Activities

Direct Health Care Services:

Kansas schools continue to connect to the Telemedicine network through their local mental health centers, and the University of Kansas to access mental health services.

Trego County obtained KDHE grant funding to enable them to do extensive Yellow Ribbon prevention training in their county and surrounding counties. It appears after the training, the suicide epidemic ceased.

Enabling Services:

The suicide committee applied for SAMHSA for Garrett Lee Smith funding for suicide prevention for 15-24 year olds. At this writing, awards have not been announced.

Suicide prevention hot lines are available in Kansas: The National Hopeline Network, 1800-SUICIDE, the National Suicide Prevention Lifeline 1800-273-TALK, and in Sedgwick County, the Suicide prevention line 316-660-7500.

Population-Based Services:

Access to mental health services continues to expand through the University of Kansas (KU) Telemedicine program. This program works with KU School of Medicine, area mental health agencies and links them with schools and physician offices for mental health services.

The Governor did a proclamation for Suicide Prevention Week to increase awareness of suicide as a significant public health problem in Kansas.

Infrastructure Building Services:

KDHE adolescent health staff participates on the Suicide Prevention Steering sub-committee for the Governor's Mental Health Planning Council. The council submitted a state-wide suicide prevention plan and is awaiting approval.

c. Plan for the Coming Year

Direct Health Care Services:

Kansas schools will continue to connect to the telemedicine network through their local mental health centers, and the University of Kansas to access mental health services.

Enabling Services:

Adolescent health staff will explore ways to integrate mental health, substance use prevention, bullying prevention into MCH programs, school health programs and the community.

Population-Based Services:

Technical assistance will be available to Kansas school nurses and health department nurses to develop a Yellow Ribbon Suicide Prevention Program in their schools and communities. School nurses will be encouraged to initiate a Yellow Ribbon Suicide Prevention Program in their schools. Work will begin on using Gatekeeper as another suicide prevention program in the communities.

KDHE will support efforts through consortiums to reduce access to lethal means and methods of

self harm.

Infrastructure Building Services:

After the statewide suicide prevention plan is approved, the Governor's Mental Health Planning Council will promote the goals and strategies of the plan.

KDHE staff will continue to urge participation in training programs offered in our state and on-line to increase the number of mental health professionals well trained in reducing suicide risk in Kansas.

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

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 85 | 86 | 84 | 84 | 85 |
| Annual Indicator | 78.5 | 80.4 | 83.1 | 79.5 | 79.5 |
| Numerator | 321 | 385 | 402 | 380 | 380 |
| Denominator | 409 | 479 | 484 | 478 | 478 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 85 | 86 | 86 | 87 | 87 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data Source: Kansas Vital Statistics, 2006 resident data with instate births.

Kansas's level III hospitals are HCA Wesley Medical Center (Wichita), Via Christi-St. Joseph, (Wichita), Stormont-Vail Regional Medical Center (Topeka), HCA Overland Park Medical Center (Overland Park), Shawnee Mission Medical Center (Merrian) and Kansas Bell Memorial Hospital (Kansas City).

Notes - 2005

Data Source: Kansas Vital Statistics, 2005 resident data with instate births.

Kansas's level III hospitals are Columbia Wesley Medical Center (Wichita), Via Christi-St. Joseph, (Wichita), Stormont-Vail Regional Medical Center (Topeka), Columbia Overland Park Medical Center (Overland Park), and Kansas Bell Memorial Hospital (Kansas City).

a. Last Year's Accomplishments

In 2006, the percent of very low birthweight infants delivered in subspecialty perinatal care facilities was 79.5%. No statistically significant trend exists in the five-year period 2002-2006.

Direct Health Care 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:

Local agency Maternal and Child Health (MCH) staff provided pregnant women with the warning signs of premature labor along with instructions of what to do if they experience any of the signs of early labor.

Infrastructure Building Services:

Due to modifications in the Kansas vital statistics data system, the Perinatal Casualty Report (a set of perinatal outcome data), prepared by KDHE was not available for distribution. However, MCH staff conducted a survey of all inpatient obstetrical facilities about their use of the report in evaluating appropriate management and referral of high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers. Also, MCH program staff monitored residence and occurrence data relating to delivery site for very low birth weight infants.

Kansas maintained a provider-driven perinatal referral system that facilitates access to inter-city/county/region consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system included five hospitals across the state that are self-designated subspecialty perinatal care centers providing out-patient and in-patient high risk obstetrical/fetal and neonatal services: Wesley Medical Center, Via Christi-St. Joseph, and St. Francis Hospitals in Wichita; Stormont-Vail Health Care Center in Topeka; Overland Park Regional Medical Center in Overland Park; and the University of Kansas Medical Center in Kansas City. Three of the subspecialty perinatal centers continued to provide formalized perinatal transport systems to maximize the potential for the delivery of referred high-risk obstetrical cases from outlying communities.

The KPC received technical assistance by a MCH Bureau consultant to help focus their work and provide them a means to track progress. The KPC chose to work on obtaining a Family Planning Waiver for Kansas, develop a substance abuse protocol for pregnant women and to partner with the State WIC Program to educate hospitals and businesses on breastfeeding.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Disseminate information on educational opportunities regarding the identification, management and treatment of high-risk pregnancies through partnering Web sites, e-mail list serves and newsletter articles to LHD staff and local perinatal | | X | | X |

| | | | | |
|--|---|---|---|---|
| healthcare | | | | |
| 2. Analyze the perinatal casualty study data to guide policy discussion aimed at the reduction of infant mortality and morbidities. | | | | X |
| 3. Develop for dissemination state-wide protocols for obstetrical care coordination/case management of at-risk maternal transfer prior to delivery. | | X | X | X |
| 4. Develop online searchable database of obstetrical delivery facilities including the self-designated level of NICU perinatal health care services provided. | | | | X |
| 5. Broaden representation of Kansas Perinatal Council (KPC) by seeking members representative of actively practicing OBGYN's and the Kansas Hospital Association. | | | | X |
| 6. KPC will provide education and consultation to obstetrical delivery facilities and advocate for the delivery of very low birthweight infants in subspecialty perinatal care facilities. | | | X | X |
| 7. Distribute/analyze survey regarding reports to perinatal care providers for evaluation of high-risk obstetrical case management. | X | | | |
| 8. Develop map of Kansas perinatal care system in relation to subspecialty perinatal care facilities catchment area. | | | | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Health Care Services:

Services are provided in subspecialty perinatal care facilities in metropolitan Wichita, Topeka and Kansas City.

Enabling Services:

Local obstetrical care providers utilize a variety of methods to identify women at high risk for preterm delivery or who present with complications that will potentially lead to the delivery of very low birth weight infants.

Infrastructure Building Services:

Through its partnership with the Kansas Perinatal Council (KPC), Perinatal Association Kansas (PAK) and the March of Dimes, MCH provides a forum for dialogue about state perinatal issues and provides educational opportunities to MCH grantees, private providers and hospitals on current best practice in perinatal health. MCH disseminates educational opportunities via partner websites, list serves and newsletters.

The KPC continues to pursue the objective of obtaining a Family Planning Waiver for Kansas through the Kansas Health Policy Authority (KHPA) and KDHE. Also, KPC is working toward developing a substance abuse protocol for pregnant women and working in tandem with the newly formed Kansas Breastfeeding Coalition to increase breastfeeding initiation and duration rates.

The KPC invited a member of the Kansas Hospital Association (KHA) to become part of KPC without success.

c. Plan for the Coming Year

Direct Health Care Services:

Services will continue to be provided in subspecialty perinatal care facilities in metropolitan Wichita, Topeka and Kansas City.

Enabling Services:

MCH program staff will continue all of the items listed in Current Activities section.

Population-Based Services:

MCH plans to develop website resources and disseminate educational materials to providers of care to pregnant women information to recognize the signs of preterm labor and other high-risk obstetrical conditions with instructions to seek immediate obstetrical care.

MCH will encourage PAK and KPC to make a concerted effort to provide professional education and consultation to obstetrical delivery facilities and advocate for delivery of these infants in subspecialty perinatal care facilities.

Infrastructure Building Services:

MCH program staff plans to continue all of the items listed in the Current Activities section.

MCH will continue to pursue membership representation from the KHA to become part of the KPC in an effort to enhance its standing and partnership with hospitals statewide.

MCH will pursue the development of an online searchable database of obstetrical delivery facilities including the self-designated level of perinatal care services each facility offers. MCH plans to further analyze the statistics related to VLBW infants in terms of delivering hospital, maternal and infant transport, the effects of race and ethnicity, access to healthcare and infant outcomes to help guide policy development in this arena.

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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 87 | 88 | 88 | 89 | 78 |
| Annual Indicator | 87.2 | 85.9 | 76.0 | 75.0 | 75.0 |
| Numerator | 34298 | 33967 | 27687 | 28286 | 28286 |
| Denominator | 39353 | 39553 | 36430 | 37733 | 37733 |
| 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 |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 78 | 79 | 79 | 80 | 80 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report. Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2006

Data Source: Vital Statistics, 2003 Birth Certificate Revision. Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2005

Data Source: Vital Statistics, 2003 Birth Certificate Revision.
2005 data is not comparable to previous years. The denominator is the number of live births where the dates necessary to calculate this variable were reported on the birth certificate.

a. Last Year's Accomplishments

In 2006, 75% of infants were born to pregnant women receiving prenatal care in the first trimester. This data is not comparable to Kansas data prior to 2005 due to the revision of the Kansas Birth Certificate. Also, U.S. data for 2005 on this performance measure was 70.2%. Kansas exceeded the U.S. on this measure by 5.8% percent in 2005.

Direct Services:

In 2006, MCH grants supported all health departments and served 11,893 mothers and infants who received prenatal care/care coordination, postpartum and infant health services. Eight agencies continued to provide medical prenatal care due to lack of available providers in their community.

Enabling Services:

Healthy Start Home Visitors (HSHV) provided education, support and referrals to community services for 10,783 women during outreach visits. Educational materials (SIDS resource kits for African Americans) and home safety equipment were distributed. The HSHV encouraged use of the toll-free, Make a Difference Network (MADIN) number that provides pregnant women information about community resources.

The Kansas Medicaid program provided high-risk communities additional funding for "Healthy Babies Initiatives" that provide extra case management and care coordination for pregnant women receiving Medicaid. MCH program staff continued collaboration with the Farm Worker Health Program to help assure outreach and access to prenatal care services for a mostly Hispanic migrant population, many whose primary language is Low German or Spanish.

Population-Based Services:

Efforts continued to identify women at risk for late entry and/or noncompliance with prenatal care in coordination with the Supplemental Nutrition Program for Women Infants & Children (WIC), Maternal & Infant (M&I), Kansas HSHV and Family Planning service programs. MCH program staff continued an educational partnership with the March of Dimes (MOD) in disseminating information on perinatal healthcare topics with a focus on the importance of early prenatal care and prevention of premature delivery.

Infrastructure Building Services:

MCH program staff was unable to provide statistical perinatal outcome reports and related Kansas and U.S. perinatal statistics to local community perinatal healthcare providers to use in service planning due to modifications in the Kansas Department of Health and Environment's data system. However, a survey of delivering facilities was conducted to gain their perspective regarding the set of perinatal reports historically sent them.

MCH staff provided technical assistance to local agency M&I clinics in the development and continuation of translation services and print materials primarily in Spanish to meet the needs of the increasing Hispanic population in Kansas to encourage them to seek early prenatal care. MCH program staff continued collaboration with the MOD, the Juvenile Justice Authority, Pregnancy Maintenance Initiative projects and Comprehensive School Health Centers to encourage early and regular prenatal care for all pregnant women. Workforce development and training were provided during the second annual Governor's Conference on Public Health with concentration on preconception care. In addition, transition to a case management model of prenatal care from a direct medical prenatal care model by one local agency resulted in a strengthened community collaboration.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Design system of comprehensive care coordination/case management services to address risk factors for all prenatal women. | X | X | X | X |
| 2. Target local resources to engage populations within communities that are at risk for late entry into or are noncompliant with regular prenatal care services, ie. Teens, low income, and immigrant populations. | | X | X | |
| 3. Provide outreach and education regarding benefits of early prenatal care via churches and hair care specialists. | | X | X | X |
| 4. Develop online prenatal, delivery and postnatal provider databases as support resources for LHD's and local perinatal healthcare providers. | | | | X |
| 5. Provide MCH home visitors with the Pregnant Medicaid List containing contact information of pregnant clients to whom they must contact to provide education and support. | | X | | X |
| 6. Use available data to enhance understanding of LHD staff to assess local community understanding of benefit to early prenatal care (e.g., KIC, Vital stats, Peristats, etc.) | | | | X |
| 7. Educate benefits of early and comprehensive prenatal health care for all pregnant women to Juvenile Justice Authority, Pregnancy Maintenance Initiative projects and Kansas Coordinated School Health . | | X | X | X |
| 8. Utilize and publicize the toll-free Make a Difference Information Number (MADIN) as a resource for women to link to early prenatal services in Kansas. | | X | X | X |
| 9. Provide gap coverage of medical prenatal services in eight underserved communities. | X | | | |
| 10. Promote optimal health during the interconception period. | | | X | X |

b. Current Activities

A care coordination/case management model is used locally to provide prenatal services supported by MCH grants. The number of clinics providing this service delivery model of care remained stable over the past year.

Enabling Services:

MCH program staff supports local education and outreach strategies by identifying resources to help assure access for pregnant women into comprehensive prenatal care services.

Population-Based Services:

Early prenatal care outreach is provided through coordination with Family Planning, WIC and HSHV programs. These programs offer assistance in navigating the healthcare system. Some programs offer assistance in filling out associated paperwork for Medicaid and HealthWave (SCHIP) assistance as well.

Infrastructure Building Services:

MCH program staff collaborates with a variety of partners including the Perinatal Association of Kansas, their subcommittee, the Kansas Perinatal Council and the MOD in identifying/promoting best practice strategies to address perinatal health issues. MCH program staff provides technical assistance/training to local communities in the use of available data in determining community needs for prenatal care. MCH program staff completed development of a database consisting of various perinatal healthcare providers. As an adjunct to the database of perinatal healthcare providers, MCH program staff has developed a searchable database of breastfeeding resources for local providers use.

c. Plan for the Coming Year

Direct Services:

Care coordination will continue through MCH grants to local agencies from KDHE. The provision of medical prenatal health care services will continue in some communities to fill in provider gaps.

Enabling Services:

MCH will continue to provide local agencies technical assistance in service provision and assist in finding resources for access to prenatal care for pregnant women. MCH program staff will continue to foster relationships among perinatal healthcare providers, State agencies, businesses, the health insurance industry and other interested partners in an effort to support the concepts of increased access to prenatal care for pregnant women and healthier birth outcomes.

Population-Based Services:

Early prenatal care outreach will continue through coordination with Family Planning and WIC service providers and Kansas HSHV programs. Local MCH grantees will continue education and outreach strategies with guidance and support from MCH program staff.

Infrastructure Building Services:

MCH will continue to build on collaborations with current partners and the entire array of local obstetrical and perinatal health care providers in order to maximize resources. Support will be provided to programs designed to promote and assure access to early and comprehensive prenatal care and to promote optimal health in the interconception period. MCH staff will continue workforce development efforts and training through the annual Governor's Conference on Public Health and HSHV training events. MCH program staff will disseminate best practice information through perinatal healthcare provider database and encourage use of the breastfeeding resources database as well.

MCH program staff will provide linkages to best practices in the area of promoting healthier birth outcomes among disparate populations and give technical assistance to local agencies in their implementation.

D. State Performance Measures

State Performance Measure 1: *The percent of women in their reproductive years with public or private health insurance coverage*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 90 | 90 |
| Annual Indicator | 82.0 | 83.1 | 81.8 | 80.3 | 80.3 |
| Numerator | 417929 | 424383 | 416378 | 401212 | 401212 |
| Denominator | 509670 | 510690 | 509019 | 499641 | 499641 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

a. Last Year's Accomplishments

Elimination of health risks and comprehensive management of disease prior to pregnancy increases the likelihood of a pregnant woman delivering a healthy infant. Access to health services including preventive, primary care and tertiary care often depends on whether a person has health insurance. In Kansas, from 2002 to 2006, there is a statistically significant decreasing trend in the number of women ages 18-44 who reported having health insurance. In 2006, the percent of Kansas women ages 18-44 that reported they have health insurance is 0.8% higher than for U.S. women, that is, 80.3% for Kansas women versus 79.7% for U.S. women.

Direct Health Care Services:

Women were assisted in completing application documents for Medicaid and HealthWave (SCHIP) programs by health department staff, Supplemental Nutrition Program for Women, Infants and Children (WIC) staff, school nurses, and home visitation staff.

Enabling Services:

The Statewide Farmworker Health Program (SFHP) provided outreach and assisted with access to health care for the predominately Hispanic and Low German speaking farm worker population with no insurance. However, only 48% of Hispanic women in all race categories reported having health insurance in 2006.

Healthy Start Home Visitors (HSHV's) supported families by providing information on local resources and assistance in filling out forms for medical services and public assistance.

Population-Based Services:

Unicare and Family Health Partners together provided the managed care programs consisting of Medicaid managed care blended with HealthWave (Kansas SCHIP). Unicare offered a free service, Maternicall, nursing case management services by phone.

Infrastructure Building Services:

The MCH program with its network of statewide partners continued to work toward the priority of

comprehensive health care for pregnant women before, during and after birth that was identified in the MCH 2010 Statewide Needs Assessment.

March of Dimes continues to be a major partner in supporting MCH priorities as identified above through programs, outreach and advocacy efforts on the part of pregnant women and infants.

Research studies of Kansans' health insurance status (e.g., those completed by the Kansas Health Institute) often do not include breakdowns by gender. MCH staff advocate for studies to include gender breakdowns to identify financial barriers to preconceptional and prenatal care.

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 preconceptional women | | X | X | X |
| 3. Increase efforts to assist uninsured women to enroll in Medicaid/HealthWave. | X | X | X | X |
| 4. Teach adolescents the importance of reducing risk behaviors of smoking, drinking and other physically harmful lifestyles prior to pregnancy. | | | X | X |
| 5. Provide outreach and education to hard to reach populations and disparate populations | | | X | X |
| 6. Promote health insurance coverage availability for all women of childbearing age in the State. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Services:

Women are assisted in completing application documents for Medicaid/HealthWave programs by health department staff, WIC staff, family planning staff, school nurses, and HSHV's.

Enabling Services:

The SFHP provides outreach and finds access to health care for the mainly Hispanic and Low German speaking uninsured farm workers.

HSHV's link families to local services and assist them in navigating the health care system.

Population-Based Services:

The Unicare Maternicall program provides prenatal care information to pregnant women in the Medicaid managed care system.

Infrastructure Building Services:

In the ZIPS newsletter (Zero to 21: Information Promoting Success) to statewide partners, MCH disseminates information on public health issues including access to prenatal care, preconception

health, and interconceptional birth spacing.

MCH monitors access to early and comprehensive health care services for women using information from health insurance coverage report data within the Behavior Risk Factor Surveillance System (BRFSS).

Using various means, MCH links grantees to resources on best practices and improving health care access for culturally diverse populations.

The Kansas Legislature passed portions of the Health Reform Act of 2008 that includes dental coverage for pregnant Medicaid beneficiaries and expansion of Medicaid eligibility for pregnant women. All this however is subject to availability of appropriations.

c. Plan for the Coming Year

Direct Services:

Medical prenatal services will be provided in communities with limited access to services for the uninsured.

Enabling Services:

The MCH program will continue to collaborate with the Farmworker Health program primarily in services for the Hispanic and Low German speaking population and uninsured.

MCH program staff will provide linkages for partners to providers whose purpose is to serve medically underserved populations.

HSHV's will provide community resource information to women with new infants. This includes information about public health insurance coverage and assistance with enrollment. Also, HSHV's will offer information on how to access family planning services.

Population-Based Services:

MCH program staff will promote and support Unicare's Maternal system in which nurses provide phone follow-up of pregnant Medicaid enrollees.

Infrastructure Building Services:

The ZIPS newsletter produced by MCH program staff will continue to serve as a means of providing best practice and current program information to its grantees and partners.

MCH program staff will disseminate to its grantees and partners information on how women can achieve healthier birth and infant outcomes including preconception health strategies and adequate interconceptional birth spacing (promotion of national Web casts, recommendations on preconception health from the CDC/ATSDR Preconception Work Group and the Select Panel on Preconception Care and linkages to best practice on partnering Web sites).

MCH program staff will continue to monitor BRFSS data on health insurance coverage for women 18-44 and advocate for expanded Medicaid coverage. Further, KDHE will use the State health insurance database to assess prenatal care access especially as it relates to disparate populations.

MCH program staff will encourage grantees and partners to participate in cultural diversity trainings as they become available and monitor for implementation into the practice setting.

MCH program staff will promote community collaborations that seek to improve access to prenatal care for all of their residents.

It is anticipated that the Health Reform Act of 2008 will be prominent again in the 2009 legislative session including the need for appropriations for the expansion of dental services to pregnant women and expansion of Medicaid eligibility for pregnant women.

State Performance Measure 2: *The percent of women who report cigarette smoking during pregnancy*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 11 | 16 |
| Annual Indicator | 12.1 | 12.4 | 16.3 | 16.5 | 16.5 |
| Numerator | 4750 | 4906 | 6475 | 6729 | 6729 |
| Denominator | 39353 | 39553 | 39701 | 40896 | 40896 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 16 | 15.8 | 15.5 | 15.3 | 15.3 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report. Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2006

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2005

Year 2005 data is not comparable to previous years since 2005 data was collected with the 2003 revised birth certificate.

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 birthweight (<2,500 grams) is a key predictor for infant mortality. In 2005, the percent of pregnant women reporting smoking during pregnancy was 16.2%. In 2006, 16.5% of women reported smoking during the last three months of pregnancy. Due to changes in the Kansas birth certificate in 2005, no comparisons may be made with data prior to calendar year 2005, however, a 2% increase is noted between 2005 and 2006.

Direct Services:

Tobacco cessation assistance was provided to pregnant women referred to the Kansas Tobacco Quitline and through local tobacco cessation clinical provider services.

Enabling Services:

Maternal and Infant (M&I) prenatal care coordinators were encouraged to assess all pregnant women for smoking behaviors and tobacco use and provide education on the risks associated with continued smoking and either provide services or refer to services to aid them in smoking cessation.

Population-Based Services:

MCH program staff encouraged grantees and partners to pursue available tobacco cessation training, provide smoking cessation opportunities to pregnant women, and refer them to the Kansas Tobacco Quitline for follow-up support services.

Infrastructure Building Services:

The Kansas Tobacco Use Prevention Program (TUPP) provided a five-hour train-the-trainer course for individuals in the use of person-to-person and small group contact to educate healthcare professionals in techniques for counseling pregnant women regarding tobacco cessation. Participants received a toolbox of materials specific to supporting their presentations and discussions along with a variety of promotional materials. Also, prenatal healthcare providers were encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Encourage tobacco cessation training by all prenatal service providers. | | X | X | X |
| 2. Provide relevant tobacco cessation materials and resources to local agencies. | | X | X | X |
| 3. Educate and encourage all pregnant women who smoke to discontinue smoking during pregnancy. | X | | X | X |
| 4. Prevent smoking behavior in preconceptional women and adolescents. | X | X | | X |
| 5. Use 5A Smoking Cessation program with added support from KS Quitline as standard protocol for all MCH grantee providers of prenatal service to women who smoke. | | | X | X |
| 6. Collect and analyze smoking data from all MCH grantees. | | | X | X |
| 7. Provide technical assistance on billing for smoking cessation interventions to develop program sustainability. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Services:

Tobacco cessation assistance is provided to pregnant women referred to Kansas Tobacco Quitline and through local tobacco cessation clinical provider services.

Enabling Services:

Local health care providers and MCH grantee agencies are given relevant tobacco cessation information and resources through ZIPS newsletter articles and in routine communications.

Outreach staff provides information on available community resources for smoking cessation to pregnant women and members of their households.

Population-Based Services:

M&I prenatal care coordinators provide screening, counseling and referral to Quitline or local tobacco cessation services for pregnant women.

Infrastructure Building Services:

The Kansas TUPP encourages local agencies that affect approximately 70% of the total state population to use the Quitline and other materials that aid people to quit smoking. In addition, the Kansas TUPP encourages the local programs (44) to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

The Kansas TUPP disseminates an annual report to interested stakeholders via the Web and print materials. This report evaluates the efforts of participating organizations implementing the 5 A's approach. Also, prenatal care providers are encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

c. Plan for the Coming Year

Direct Services:

Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A Tobacco Use Prevention Method through local tobacco cessation clinical provider services and via referral to the Kansas Tobacco Quitline.

Enabling Services:

Local prenatal care providers and M&I programs will continue to receive relevant tobacco cessation information/resources via newsletter articles and routine communications. Also, they will continue to be encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

Outreach staff will continue to provide information about available community smoking cessation resources to pregnant women and members of their households.

Population-Based Services:

M&I programs will be further encouraged to implement systematic changes in their clinics with a focus on tobacco cessation and provide data on their progress.

Infrastructure Building Services:

Some capacity is in place to provide smoking cessation counseling and referral by prenatal service providers in the state. Training opportunities are in the planning stages to enhance the smoking cessation skills of providers and local agencies with available resources.

MCH staff will monitor data related to smoking behaviors and tobacco use.

MCH staff will provide technical assistance to local grantee agencies regarding billing for tobacco cessation counseling in an effort to support sustainability.

KDHE will continue to work with local, regional and state-level organizations to implement prenatal smoking cessation activities.

State Performance Measure 3: *The percent of mothers who breastfeed their infants at least 6 months*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 25 | 26 |
| Annual Indicator | 19.6 | 24.4 | 22.5 | 22.2 | 22.2 |
| Numerator | 1653 | 2872 | 2883 | 1267 | 1267 |
| Denominator | 8435 | 11771 | 12813 | 5708 | 5708 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 27 | 28 | 29 | 29 | 29 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

The numbers presented for 2006 do not represent all the WIC participants due to a new data base roll-out.

Notes - 2005

a. Last Year's Accomplishments

In Kansas, 2000-2006, the percent of mothers who breastfeed their infants at 6 months of age has shown no apparent trend. However, in 2006 the percent (22.2%) was 11.9% less than that for the U.S. (25.2%).

Enabling Services:

The Kansas law allows a mother to breastfeed in any place she has a right to be and to postpone jury duty until such time that the mother is no longer breastfeeding her child. Continued to distribute "breastfeeding licenses" that include information on the law, to LHD and home visitors. The cards ask the reader to report good and bad breastfeeding experiences in businesses. The requests have lessened but "Thank You" letters and "Informational" letters continue to be sent.

Three breastfeeding support billboards continued in prominent locations along the Kansas Turnpike.

Breastfeeding resources, based on the recommendations of the Breastfeeding Taskforce, were distributed to LHD.

Worked with LHD to strengthen five existing local breastfeeding coalitions and to foster the establishment of one new local breastfeeding coalition.

Population-Based Services:

Coordinated World Breastfeeding Week (WBW) in August 2007 by providing all local agencies with a packet of ideas to help with the promotion of WBW. Five agencies were awarded \$200 worth of breastfeeding education and/or resource materials for outstanding promotion efforts.

Infrastructure Building Services:

Supported speaker for biennial La Leche League Professional Meeting. 220 Kansas health

professionals representing the state and local health departments including WIC RD's, RN's, and Breastfeeding Peer Counselors, and home visitors and hospital staff attended.

Supported Breastfeeding Peer Counselor Programs in 18 Kansas counties. Peer counseling is a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Worked with LHD to develop action plans to improve the clinic atmosphere to support breastfeeding dyads.

Distributed the local breastfeeding resource directory to LHD

Presented information on the benefits of breastfeeding workplace support to the Governor's Child Health Advisory Board. At the request of this advisory board, a model workplace support policy and business support materials were developed. The board recommended that the policy be implemented in all Kansas state offices.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Support community breastfeeding coalitions by encouraging LHDs to play an active role. | | X | | |
| 2. Communicate breastfeeding information to a variety of state and community agencies. | | | | X |
| 3. Disseminate breastfeeding newsletter for LHDs to send to community contacts. | | | X | |
| 4. Support LHDs through WIC and MCH to continue and implement breastfeeding friendly policies. | | | | X |
| 5. Increase breastfeeding knowledge of LHD staff for both MCH and WIC programs. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling Services:

Continue the Breastfeeding Support Billboard campaign with new billboards on the Kansas Turnpike and one moved to another busy Kansas highway.

Developed and distributed with the assistance of the Breastfeeding Taskforce a series of "Breastfeeding Reminder Post Cards" and a Crib Card.

Work with Medela to provide "Breast Pump 101" seminar to three locations in Kansas for LHD WIC staff and MCH staff.

Work with LHD to foster the establishment of one new local breastfeeding coalition and the strengthening of five existing breastfeeding coalitions.

Population-Based Services:

Coordinate World Breastfeeding Week (WBW) in August 2008 by providing all local agencies with a suggestions and resources for promotion of WBW. Provide the two agencies with the most successful community partnership promotion with up to \$200 worth of breastfeeding education and/or resource materials.

Infrastructure Building:

All WIC staff including breastfeeding peer counselors attended training on communication and critical thinking to enhance breastfeeding promotion and support skills.

Establish a Kansas Breastfeeding Coalition expanding the Breastfeeding Taskforce.

Supported Certified Breastfeeding Educator Training in April 2008.

State and local staff attended the USBC biennial conference in January 2008.

Updated "Breastfeeding Promotional and Support" and "Breastfeeding Management" training modules.

c. Plan for the Coming Year

Enabling Services:

Establish a Breastfeeding Resource Room for the Bureau of Family Health.

Continue breastfeeding support billboards.

Support existing Breastfeeding Peer Counselor Program.

Support development of a state breastfeeding coalition and new local breastfeeding coalitions.

Population-Based Services:

Coordinate World Breastfeeding Week (WBW) in August 2009 by providing all local agencies with a packet of ideas to help with the promotion of WBW and provide the two agencies with the most outstanding promotions with up to \$200 worth of breastfeeding education and/or resource materials.

Infrastructure Building:

Underwrite speaker for Biennial La Leche League Professional Meeting. Encourage WIC staff involved in the promotion and support of breastfeeding including peer counselors to attend.

Work with LHD to improve staff competencies related to breastfeeding, including helping to sponsor Certified Breastfeeding Educator Training in at least one location.

Update existing training modules for "Breastfeeding Promotion and Support" and "Breastfeeding Management" and disseminate using the Kansas TRAIN resource.

Continue to work with the Governor's Child Health Advisory Board on breastfeeding workplace support.

State Performance Measure 4: *The percent of children and adolescents that receive behavioral/mental health services*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 6 | 7 |
| Annual Indicator | | 4.9 | 5.0 | 5.4 | 5.4 |
| Numerator | | 41411 | 41701 | 46970 | 46970 |
| Denominator | | 852755 | 842406 | 862298 | 862298 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 7 | 8 | 8 | 8 | 8 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data Source: Kansas Community Health Centers

Notes - 2005

Data Source: Kansas Community Health Centers.

a. Last Year's Accomplishments

The Healthy People 2010 objectives relevant to this SPM are found in Focus Area 18 Mental Health and Mental Disorders. The goal of this focus area is to improve mental health by improving access to behavioral and mental health services for children and adolescents. Two of the HP2010 objectives on mental health which Kansas will address with MCH grant funds are: Objective 18-6: Increase the number of persons seen in primary health care who receive mental health screening and assessment and Objective 18-7: Increase the proportion of children with mental health problems who receive treatment (Developmental).

The 1999 Surgeon General's Report on mental health indicates that about 20 percent of children have mental disorders with at least a functional impairment. Additionally, about 11% of these children are diagnosed, but not treated. Kansas MCH improves screening of children and youth in school and public health settings by providing training and support to professionals.

Kansas now has trend data from the Youth Risk Behavior Survey (YRBS). School failure, substance abuse, violence, and suicide are potential outcomes of mental and behavioral disorders and serious emotional disturbances (SEDs). Kansas YRBS data identified 21.0% in 2005 compared to 20.6% in 2007 students smoked cigarettes during the past 30 days; 43.9% drank alcohol during the past 30 days in 2005 compared to 42.4% in 2007.

Direct Services

Kansas continues to use Telemedicine network from Kansas University Medical Center (KUMC), connecting students to mental health counseling with age appropriate psychiatrist.

Enabling Services:

The MCH programs that chose an objective related to healthy parenting to prevent mental health/behavioral health problems, made home visits and did teaching on ongoing health/parenting education to mother's of children at high risk for child abuse and neglect.

The MCH child health staff in local health departments (LHD) were encouraged to implement of

Bright Futures Guidelines for Mental Health.

KDHE partnered with SRS to sponsor the Annual Statewide Fatherhood Summit. The summit addressed incarcerated parents and families and how this affects the entire family unit, as well as friends and neighbors. The conference provided skill building tips on helping siblings/children cope with the stigma and stress associated with incarcerated relatives.

Population-Based Services:

At the annual Kansas school nurse conference, presentations were provided on identifying risk factors contributing to mental health concerns: bullying, cyber-bullying, gangs and identify signs of mental illness and know referral sources.

Infrastructure Building Services:

The Governor established a Governor's Mental Health Services Planning Council (GMHSPC) after the 2006 National Association of Mental Illness (NAMI) issued a report titled, Grading the States: A Report on America's Health Care System for Serious Mental Illness. Kansas received an overall grade of "F". The task of the Council was to review the report and to identify opportunities to improve the Kansas mental health system.

The American Academy of Pediatrics (AAP) issued a new policy statement in 2006 calling for better developmental surveillance/ screening within medical homes. The National Academy for State Health Policy selected Kansas to be a participant in the Assuring Better Child Health and Development (ABCD) Screening Academy. A team comprised of MCH staff, Kansas Academy of Pediatric (KAAP) staff, and members of the Kansas Health Policy Authority (KHPA), received training and technical assistance with this project. The recommendations include screening for development and social-emotional development.

The new AAP policy statement recommendations were incorporated into the Kan Be Healthy (Medicaid / SCHIP) recommendations for screenings. In addition to recommendations and technical support for screening for developmental delay and autism, there will be recommendations for screening for mental health of older children and for postpartum depression in mothers.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Screen all children for behavioral/mental health issues at Kan-Be-Healthy visits that are done in MCH clinics. | X | X | X | X |
| 2. Provide workforce development opportunities on mental health screening and early detection to local MCH grantees, School Nurses, Parent groups, and other KDHE programs at professional conferences. | | X | X | X |
| 3. Create awareness of usable tools for screening and guidance available in Bright Futures Mental Health for providers in Kansas. | | X | X | X |
| 4. Identify and publicize in the Children & Family newsletter the health needs in the schools that would benefit from utilizing telemedicine for the school age population. | | | | X |
| 5. Participate in the Governor's Mental Health Services Planning Committee and assist in critiquing a plan for Kansas. | | X | X | X |

| | | | | |
|---|--|---|---|---|
| 6. Determine how to improve collaboration and communication between KDHE, SRS and GMHSPC. | | | | X |
| 7. Provide education for school nurses and MCH grantees on how to be affective when identifying and referring depression. | | | X | X |
| 8. Prepare information for distribution on training school/community members on how to establish Students Against Destructive Decisions (SADD) organizations in their | | X | X | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Services:

LHD/school-based clinics provide individual/family therapy counseling through the regional mental health centers and telemedicine.

Enabling Services:

The GMHSPC provide recommendations for timely/appropriate treatment for mental illness using evidence-based practice, inclusion of consumers/family in major public policy decisions and regular/frequent monitoring of the help line performance. of the help lines.

Population-Based Services:

At the Kansas school nurse conference, presentations on chronic health conditions, including various medications used to treat mental illness, is covered.

Students Against Destructive Decisions (SADD) Kansas Chapter had a convention and gave SADD organizations awards/offered training on starting SADD community organizations.

Infrastructure Building Services:

KDHE/KAAP Kansas Child and Adolescent Health Council works on updating policies/utilizing best practices. The Kan-Be-Healthy (Medicaid periodic screening exam) was updated to incorporate the recommended developmental screening tools.

KAAP is training physicians on the new developmental screening recommendations. Dr. Pamela Shaw, an ABCD Team Member, presented developmental screening guidelines at the Public Health Conference attended by MCH programs.

KDHE adolescent staff presently sits on the Governor's Mental Health Services Planning Council subcommitt

c. Plan for the Coming Year

Direct Services:

All children, birth to 21 years of age will be screened for behavioral mental health at each KBH assessment.

Enabling Services:

The KDHE child health staff will provide training on implementation of Bright Futures, Mental Health guidance.

Continued support of the GMHSPC with emphasis on early identification and treatment of mental

health issues in the school age population and utilizing the telemedicine network.

Population-Based Services:

Provide school nurses with information at the annual Kansas school nurse conference on identification of risk factors, symptoms and referral sources for mental health concerns. Encourage the use of Bright Futures Guidelines for Mental Health.

Information and resources on mental health issues will be given in a monthly newsletter, ZIPS, that is circulated to MCH providers, school nurses, grantees and anyone requesting the newsletter.

Infrastructure Building Services:

MCH staff will be working with the KCAHC to provide guidance on issues of best practice and to provide a strong leadership voice for children and adolescent mental health across Kansas.

The KAAP, in partnership with the MCH program and KHPA, will continue to train providers on the ABCD recommendations for models of service delivery and financing. Education in the use of recommended screening tools for development and social-emotional development, will be provided to nurses, as well as physicians. Training will be supported/provided for other stakeholders interested in mental health in infants, children, adolescents, and their families.

State Performance Measure 5: *The percent of children who are overweight*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 6 | 6 | 12 | 12 | 11.5 |
| Annual Indicator | 12.6 | 13.6 | 12.9 | 13.8 | 13.8 |
| Numerator | 3412 | 4020 | 4306 | 3092 | 3092 |
| Denominator | 27076 | 29559 | 33378 | 22404 | 22404 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 11.5 | 11 | 11 | 10.5 | 10.5 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Kansas WIC data of children, ages 2-<5, used as a proxy measure. The numbers presented for 2006 do not represent all the WIC participants due to a new data base roll-out.

Notes - 2005

Kansas WIC data of children, ages 2-<5, used as a proxy measure. The 2005 objective was updated to a more realistic level.

a. Last Year's Accomplishments

Among Kansas WIC participants, 2006, (children ages 24-59 months) 13.8% were overweight, 6.8% lower than WIC participants nationally (14.8%). The percent of WIC participants that are overweight (2006) increased 7.0% from the percent in 2005. There is a statistically significant increasing trend in the percent of WIC participants who are overweight in the last 5 years with available data.

a. Last Year's Accomplishments

Enabling Services:

As a part of the action plan developed by the Kansas USDA nutrition programs, three communities held community wide events to increase healthy eating behaviors including increased consumption of fruits and vegetables and increased physical activity. Incentives to increase physical activity and encourage healthy eating behaviors were provided to event participants.

Partnered with the Kansas Dietetics Association Foundation, the Kansas Head Start Association and the Kansas Nutrition Network to publicize the Elyn Satter Institute workshop, "Children, The Feeding Relationship and Weight".

Population-Based Services:

Worked with the Office of Health Promotion in promoting the Kansas Kids Fitness Day. Kansas Kids Fitness Day is a statewide event focused on increasing physical activity among 3rd grade students in Kansas. The event was held May 5th, 2007 with approximately 17,500 participants at 39 sites located throughout the state.

School nurses were surveyed to assess if school aged children were being weighed, measured and referred, as appropriate. Of the 45,802 health screenings reported, BMIs were assessed on only 9%.

The Coordinated School Health program continues to provide grants for schools to form School Councils and complete the School Health Index. These grants can be used to address obesity and physical activity.

Infrastructure Building:

Participated in developing legislative initiatives for the Governor's Taskforce on obesity.

Supported and participated in the Cornerstones of a Healthy Lifestyle Blueprint for Nutrition & Physical Activity (blueprint) training. The training outlined practical, consumer-focused, state and local strategies for improving eating and physical activity and provided communities, consumers, organizations, agencies, and programs with strategies and potential actions to address priority nutrition and physical activity issues in the context of their own community resources and needs. Key strategies recommended under this blueprint were the promotion of Fruits & Veggies-More Matters, a Healthy Kansas Community Assessment Tool to assess the built environment, Walk Kansas promotion, and the Dine Out Kansas Healthy Restaurant awards. Thirty local health departments participated in this training. In addition, these same communities were encouraged to attend a Built Environment summit in 2007.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Support the nutrition education and/or nutrition assistance programs of the KNN and the Early Childhood Action Team. | | X | X | X |
| 2. Support the Kansas Council on Physical Fitness annual Kansas Kids Fitness Day. | | X | X | |
| 3. Support the Early Childhood Action Team's goals to stress the interrelatedness of physical activity and nutrition. | | | X | X |

| | | | | |
|---|--|--|--|---|
| 4. Support LHDs plans for decreasing childhood obesity and increasing physical activity through the WIC and MCH Programs. | | | | X |
| 5. Provide consultation for the Kansas Child Health Assessment and Monitoring Project. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling Services:

Worked with the Office of Health Promotion to promote a statewide event focused on increasing physical activity among 3rd grade students. The event was held May 2nd with approximately 17,600 participants at 40 sites located throughout the state.

Partnered with various organizations to coordinate efforts to reduce childhood obesity by increasing physical activity and improving nutrition.

The Coordinated School Health program continues provides grants for schools to form School Councils and complete the School Health Index. These grants can be used to address obesity and physical activity.

Population-Based Services:

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

Infrastructure Building:

As a part of the action plan developed by the Kansas USDA nutrition programs, three communities held community wide events to increase healthy eating behaviors. Incentives to increase physical activity and encourage healthy eating behaviors were provided to event participants.

Continue purchasing the "Help me be Healthy" series of educational pamphlets for use in all Kansas WIC clinics.

The 30 LHDs across the state that attended the 2007 Cornerstones of a Healthy Lifestyle Blueprint for Nutrition & Physical Activity training were encouraged to attend a Built Environment summit.

All WIC local agencies expanded on existing Nutrition Education Action Plans that focused on increasing fruit and vegetable consumption

c. Plan for the Coming Year

Enabling Services:

Continue working with the Office of Health Promotion to promote the Kansas Kids Fitness Day. Kansas Kids Fitness Day is 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.

Population-Based Services:

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

Infrastructure Building:

The action plan developed by the Kansas USDA nutrition programs will continue to include additional communities that will implement community wide events to increase healthy eating behaviors including increased consumption of fruits and vegetables and increased physical activity.

Funding for the Cornerstones of a Healthy Lifestyle Blueprint for Nutrition & Physical Activity will be expanded to cover 33 communities to continue and expand priority activities.

State Performance Measure 6: *The rate of adolescent deaths due to motor vehicle crashes when using no seat belt*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 20 | 13 |
| Annual Indicator | 26.4 | 17.2 | 13.4 | 14.3 | 14.3 |
| Numerator | 54 | 35 | 27 | 29 | 29 |
| Denominator | 204865 | 203322 | 201966 | 202458 | 202458 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 12.5 | 12 | 11.5 | 11 | 11 |

Notes - 2007

The 2007 column is populated with 2006 data since 2007 data is not available at the time of this report.

Notes - 2006

Data Source: Fatal Accident Reporting System (FARS), U.S. Department of Transportation Data (numerator); U.S. Census estimates, Bridged-Race Vintage data set (denominator).

Notes - 2005

Data Source: Fatal Accident Reporting System (FARS), U.S. Department of Transportation Data (numerator); U.S. Census estimates, Bridged-Race Vintage data set (denominator).

a. Last Year's Accomplishments

Unintentional injury is the leading cause of death for Kansas' adolescents ages 15 to 19 in 2006 with motor vehicle crashes (MVC) causing the majority of deaths. According to Kansas FARS data, from 2002-2006, there is a decreasing trend in deaths due to motor vehicle crashes where the occupant was not wearing a seat belt. The adolescent death rate due to a motor vehicle accidents without using a seatbelt is 22.2% higher for Kansas than for the U.S. In Kansas between 2005 and 2006, there was a 7.1% increase in motor vehicle crash deaths where the youth was not wearing a seat belt.

Kansas' 2005 YRBS data showed that 15% of high school students never or rarely wore a seatbelt. This remained unchanged in 2007. Kansas Trauma Registry data for 2006 showed that 73% of teen (ages 15-19) that died as a result of a motor vehicle crash were not using seat belts.

Suggested reasons for Kansas' higher MVC rate include teen drivers don't believe they will be involved in a MVC thus do not buckle up. In the more remote rural areas in Kansas, there is a higher fatality rate (Kansas Department of Transportation [KDOT] data) than for urban areas possibly because the MVC is not immediately discovered and the emergency response teams may be several minutes away. The driver's use of alcohol is another factor in motor vehicle related deaths. KDOT data shows that among 108 alcohol-related deaths in 2006, 15 of the deaths occurred with drivers under age 21. The Youth Risk Behavior Survey (2007) indicates that 31% of Kansas students (grades 9-12) reported within the previous 30 days they rode with a driver who had been drinking alcohol and 15% reported they drank alcohol and drove within the previous 30 days.

Enabling Services:

Information was provided to school nurses across Kansas at the Annual Kansas School Nurse conference on establishing a chapter for Students Against Destructive Decisions (SADD) that emphasizes keeping children alcohol free.

Population-Based Services:

Mothers Against Drunk Drivers (MADD), SADD, Kansas Family Partners (KFP), Kansas Department of Transportation (KDOT), Kansas Highway Patrol (KHP), Leadership to Keep Children Alcohol Free and Kansas Safe Kids, and the Bureau of Family Health (BFH) collaborated to teach adolescents and providers across Kansas about the importance of wearing seat belts and not drinking and driving.

Infrastructure Building Services:

The MCH program collaborated with the aforementioned coalitions to support the passage of stricter seat belt laws. Kansas passed laws that require everyone in the vehicle under the age of 18 to have a safety belt properly fastened at all times when the passenger car is in motion and requires anyone in the front seat to wear a seat belt. Fines are imposed for non-compliance. A law strengthening the underage drinking law now holds property owners accountable for any child age 20 or younger that consumes alcohol on their property.

The Kansas Trauma Program with KDHE is developing a state wide trauma plan. This plan includes: data collection used to improve, response time, patient care, injury prevention and rehabilitation; regulations designating level of trauma care a hospital provides; and providing training for prehospital and hospital rural trauma teams.

The MCH program continues to have a strong partnership with Kansas Family Partnership, Inc (KFP), Kansas Department of Transportation (KDOT) to recognize Students Against Destructive Decisions (SADD) chapters for outstanding prevention work at their State Leadership Conference. Several chapters were recognized for their efforts to keep peers from drinking and driving and encouragement of seat belt use.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Promote seat belt usage by adolescents through support of legislation and local efforts to increase seat belt usage. | X | X | X | X |
| 2. Formulate work plans with State SADD leadership to increase | | X | X | X |

| | | | | |
|--|--|---|---|---|
| incentives for SADD chapters to promote seat belt use in schools. | | | | |
| 3. Provide training and resources to assist public health staff and school nurses to determine adolescent seat belt usage rates for the population they serve. | | X | X | X |
| 4. Discuss seat belt usage as anticipatory guidance with all adolescents receiving a Kan-Be-Healthy service in MCH clinics. | | X | | X |
| 5. Propose a Graduated Driver's License system to give teens more experience under safer conditions. | | X | X | X |
| 6. Make available technical assistance to school nurses how they can decrease MVCs in their communities by using resources available with the KS Dept. of Transportation and SADD. | | | X | X |
| 7. Participate on the advisory board for Leadership to Keep Children Alcohol Free, and examine the effectiveness of initiatives used across KS to decrease drinking and driving. | | | X | X |
| 8. Search for and inform local communities of available funding sources to promote healthy choices for teens. | | X | X | X |
| 9. Publish articles for the KDHE and Children & Family Section ZIPS newsletter informing readers of the benefits and asking them to help remind teens to use seat belts. | | X | X | X |
| 10. | | | | |

b. Current Activities

Enabling Services:

Through the Governor's Discretionary Portion of the Federal Safe and Drug-Free Schools and Communities Act Grant Program, 16 schools and community projects received funds to support programs aimed at preventing violence in and around schools; preventing illegal use of alcohol, tobacco and drugs; and involving parents and communities in their efforts. This grant is administered by the Kansas Department of Education.

Population-Based Services:

MCH supports the Coordinated School Health Initiatives to include proper passenger restraint education and surveillance of the school-aged population of daily restraint usage while riding in private vehicles.

MCH supports and promotes KDOT prevention programs that provides schools and community groups with the DARE program, drug dog demonstrations, roll over demonstration, and mock traffic accident enactments.

Infrastructure Building Services:

The MCH adolescent health consultant works with coalitions in an effort to encourage adolescent positive decision-making skills.

The Kansas Trauma Program continues to provide training to the six regions in Kansas offering Rural Trauma Team Development Course, Trauma Nursing Core Course, Prehospital Trauma Life Support, Advanced Trauma Life Support, and Pediatric Education for Prehospital Providers, and Pediatric Advanced Life Support.

Kansas was unsuccessful in passing a Graduated Driver's License law to give teens more driving experience under safer conditions.

c. Plan for the Coming Year

Enabling Services:

The Bureau of Health Promotion and the Emergency Medical Systems program will provide Emergency Medical Training for School Nurses course at the Annual Kansas School Nurse Conference.

MCH will continue to support the SADD and Safe and Drug Free Schools efforts to create and sustain safe and drug-free learning environments that support student academic achievement.

Population-Based Services:

MCH will continue efforts to educate the public and private sector on teen behaviors and preventative measures which will include messages of encouragement for the development of positive decision-making skills through hands on trainings and publications.

Infrastructure Building Services:

Kansas will continue to support efforts to continue Youth Risk Behavior Surveillance data collection. The MCH programs will continue to develop objectives to decrease the incidence of accidental morbidity and mortality.

The Kansas Trauma Program will continue to build a comprehensive trauma system in Kansas to decrease morbidity and mortality. This will include training of emergency responders in the care of pediatric populations.

Kansas will again attempt to pass a Graduated Driver's License law to give teens more driving experience under safer conditions.

State Performance Measure 7: *The percent of infants with special health care needs who receive care within a medical home*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 65 | 65 |
| Annual Indicator | | 58.9 | 58.9 | 58.9 | 82.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 85 | 87 | 89 | 91 | 92 |

Notes - 2007

Data Source: Survey from families with high risk infants using the vital export file, October 2007 - July 2008. Data prior to 2007 are not comparable due to differences in data source

Notes - 2006

The 2006 data are not available - plan to survey families with high risk infants using the vital export file.

The estimate (58.9%) is based on the 2001 national CSHCN survey: CSHCN (age 0-17) received coordinated ongoing comprehensive care within a medical home.

Notes - 2005

The 2005 data are not available - unable to collect until the vital export file is available to survey families with high risk infants.

The estimate (58.9%) is based on the 2001 national CSHCN survey: CSHCN (age 0-17) received coordinated ongoing comprehensive care within a medical home.

a. Last Year's Accomplishments

CSHCN obtains data for this performance measure from the Vital Statistics birth defects export file. The first download of the export file from the new Vital Statistics data system (initiated 1-1-2005) was obtained in the Spring of 2007. However verification of birth defects reporting is still in process. The export ifile contains infants with congenital anomalies, low birthweight, and low Apgar scores.

Population-Based Services:

Staff developed a letter to be mailed to families of infants identified as high risk or having a birth defect. The letter contained information on resources available for the family if concerns or needs are identified. Information was included about the CSHCN program, Early Intervention services, WIC and oral health.

Infrastructure Building Services:

Staff collaborated with Vital Statistics on data elements needed for the new birth defects system. MCH epidemiologists provided a list of data elements needed for federal reporting and for mailings to families per State statute. CSHCN, WIC and Part C developed materials to mail to families with information about services.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Data is being collected to establish a base line to determine if this priority is being addressed through other established program agendas. | | X | X | X |
| 2. Follow up phone calls are made to families requesting more information to connect them with a medical home, state and locally based programs. | X | X | X | X |
| 3. Program development continues to promote information sharing in a timely and HIPAA approved manner between agencies serving the same population. | | X | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Population-Based Services:

Using the Vital Statistic's birth defects export file, survey cards are mailed to families/infants with congenital anomalies, low birthweight, and low Apgar scores. The data review is in process.

c. Plan for the Coming Year

Direct Services:

Follow-up phone calls will be made to families that return the survey cards. Assistance will be provided to connect families with appropriate State and local services.

Population-Based Services:

Staff concurred that mailings to families need to continue for another 6 month evaluation period, or one year.

Infrastructure Building Services:

Data will be compared to other data sets to determine if there exists an alternative data source profiling this information. This information will benefit multiple programs in the design of future surveys and data collection.

Knowledge about the scope of high risk or at-risk children will provide for proactive rather than reactive intervention planning.

This State priority will be reviewed at the 2009 MCHB Five-Year Needs Assessment meetings that will be scheduled. Analysis of the data, along with stakeholder input, will determine if this priority has been addressed using other data sets. This will assure families are being identified and receiving eligible services.

State Performance Measure 8: *The percent of youths with special health care needs who receive transition services to adult medical care*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 60 | 60 |
| Annual Indicator | | 46.6 | 47.1 | 47.1 | 47.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 60 | 60 | 65 | 65 | 65 |

Notes - 2007

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, 2005-06; Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

Notes - 2006

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, 2005-06; Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

Notes - 2005

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, 2005-06; Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

a. Last Year's Accomplishments**Direct Services:**

CSHCN staff have used the timeline that was developed by the Children Have Opportunities in Inclusive Communities Environments and Schools (CHOICES). The CHOICES Project assisted families with early transition issues from toddler age through adolescence. Some topics discussed at CSHCN specialty clinics included: guardianship at age 18 for those unable to make their own decisions; medical care in family practice after the child ages out of pediatric services; SSI/insurance/Medicaid coverage after age 21; independent living options if appropriate; post high-school education; possible referral to Rehabilitation Services (formally Vocational Rehabilitation) if appropriate. The CSHCN program has encouraged multi-disciplinary clinics to hold transition clinics for older youth in order to address transition issues. Some of the following clinics held transition clinics for youth with special healthcare needs (YSHCN) with: Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord.

Enabling Services:

The Kansas State Department of Education (KSDE) , in coordination with other state programs, conducts an annual transition conference. Families Together, Inc. also provides transition conferences in targeted regions of the state. CSHCN staff participate in these events.

The CSHCN program collaborated with the Kansas Chapter of the American Academy of Pediatrics (KAAP) on issues related to medical home and transition services.

Infrastructure Building Services:

CSHCN staff were members of the planning committee for an annual transition conference. Presentations have been done in the past related to "Transition in the Lifespan". In the 2006-07 school year, the Kans Trans Conference continued to build on youth transition issues. The focus this year was on youth involvement. An outstanding breakout session was presented by a youth with mental health issues and the stigma associated with his disability. National speakers provided the attendees with the tools to address the new IDEA indicators that require school districts to report on transition outcomes. CSHCN also presented a breakout session entitled

What Does Health Have to Do with Transition? Technical assistance was provided by the National Center Healthy and Ready to Work.

CSHCN staff collaborated with youth in the development of a new transition poster. Youth are part of a list serve of local stakeholders which receives information on issues such as new funding opportunities. CSHCN staff have participated in the development of a comprehensive employment grant for Kansas. This has allowed for strengthening our involvement with the disability community and representing the health related needs of comprehensive employment.

The Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics have transition clinics in place for the adolescent population.

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 | X | X | X |
| 2. Education and Families Together, Inc. conduct transition workshops for professionals and families. CSHCN staff provide input and are speakers at these events | | X | X | X |
| 3. CSHCN staff participate in local, regional, state and national workshops, to promote inclusion and increase awareness of the needs of this population. | | | | X |
| 4. The Kansas Council on Disability Concerns is inviting speakers to present their program mission and transition focused activities at the monthly meetings. | | X | | X |
| 5. Transition information, notebooks and internet links are shared with youth, families and professional providers to support transition planning. | X | X | X | X |
| 6. Kansas has utilized TA and handouts from the National Healthy and Ready to Work Center. | | X | | X |
| 7. Practice models from other programs and states are being reviewed for recommendation to the stakeholders at the Five Year Needs Assessment | | X | X | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct Services:

Continue services as outlined for last year.
 The Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics now provide transition clinics.
 Consulted with National Center on Healthy and Ready to Work on transition issues.

Enabling Services:

Continue services as outlined for last year.
 Provided feedback CHAMI team on the 2005-2006 NSCSHCN survey

Population-Based Services:

A CSHCN parent advisor was hired as Disability Program Navigator in western Kansas working for the Department of Commerce.

A new school nurse manual assisting the care of children with chronic health conditions/diseases was written/posted on-line. The manual emphasizes health transition planning as a component of the overall transition planning process.

Infrastructure Building Services:

CSHCN is a collaborative partner in the Department of Commerce's "Shared Youth Vision". A pilot initiative is targeting the Kansas City area.

The University of Kansas Center on Disabilities, in collaboration with CSHCN, submitted an Integrated Community System for CSHCN Grant with support KAAP, Kansas Family Physicians, Department of Commerce, KSDE, Families Together, Inc. Youth Empowerment Academy and Kansas Rehabilitation Services. Consultations with national experts in the field of promoting and implementing transition to adult programs were involved in the development of the grant and will continue to support Kansas efforts if the grant is awarded

c. Plan for the Coming Year

Direct Services:

Continue with current year's activities.

Build on the transition data and input from YSHCN and support the objectives of the Integrated Community Systems grant if awarded.

Enabling Services:

Continue to collaborate on Transition for YSHCN trainings to professionals and families. Provide data to the MCHB Five Year Needs Assessment team on transition concerns.

Population-Based Services:

If awarded, the Integrated Community Systems grant will expand the current efforts to identify, engage and support YSHCN transition to adult providers. The Youth Empowerment Academy conducts a week long event allowing YSHCN to experience college campus life, meet with legislative members and develop action plans to meet their individual goals and objectives. This program allows YSHCN to network with other YSHCN and strengthen bonds for future youth involvement in policy and advocacy events.

Infrastructure Building Services:

CSHCN participates at the state level and pilot project level in the Shared Youth Vision Initiative lead by the Department of Commerce. Continue to identify partners to build the capital and capacity for coordinate services.

CSHCN supports the efforts of the above mentioned programs through active participation and financial support.

This state priority will be reviewed at the 2009 MCHB Title V Needs Assessment meeting. It is anticipated with the initial efforts made over the past 5 years, expanded date and implementation practices from other states, and the collaborative partnerships forged in writing the Integrated Community System grant, this state priority will continue to be supported.

State Performance Measure 9: *The percent of 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 | 2003 | 2004 | 2005 | 2006 | 2007 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | 20 | 20 |
| Annual Indicator | | 24.4 | 21.4 | 21.4 | 21.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Annual Performance Objective | 20 | 20 | 20 | 20 | 20 |

Notes - 2007

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, 2005-06; Percentage of CSHCN whose conditions cause financial problems for the family.

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measures. Indicator is comparable across survey years.

Notes - 2006

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, 2005-06; Percentage of CSHCN whose conditions cause financial problems for the family.

Indicator is comparable across survey years.

Notes - 2005

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, 2005-06; Percentage of CSHCN whose conditions cause financial problems for the family.

Indicator is comparable across survey years.

a. Last Year's Accomplishments

Direct Services:

With reductions in funding, the CSHCN program has had to decrease services offered to clients over the last few years. Staff worked with hospitals and other vendors to continue to take our rate of payment in full for patient services, however some families may have had increased cost for services.

During multidisciplinary clinics, insurance coverage (public/private) is assessed. Families that are uninsured and were potentially eligible, were given information about Medicaid/SCHIP and the CSHCN program. They were encouraged to apply and/or they were assisted with the application process. T

he CSHCN program continued to be the sole source of coverage for numerous undocumented citizens. State CSHCN staff continued to use the CSHCN program application to help determine if the applicant is a US citizen and/or here with legal documentation. Many families were filling out

the Medicaid application but were not able to complete the application due to lack of documentation of citizenship. By adding questions to the CSHCN program application we could prescreen families for Medicaid eligibility.

Enabling Services:

Families that applied for the CSHCN program were required to apply for the State Medicaid/SCHIP programs, unless they were screened out due to citizenship status on the CSHCN program application. Medicaid/SCHIP applications were sent to each applicant (English or Spanish) depending on the families' languages. The Medicaid/SCHIP applications were labeled with the state program name and instructions for the Clearinghouse staff to figure a spend-down if the family was not eligible for SCHIP and were over Medicaid income guidelines. A staff person had been designated at the Clearinghouse to work with the CSHCN program referrals. CSHCN staff contacted the Clearinghouse to resolve problems when families reported problems.

Infrastructure Building Services:

CSHCN staff ensured that billing had been completed with public/private insurance prior to CSHCN payment. CSHCN used contracted providers that would take the CSHCN rate of payment as payment in full.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Current legislative action has increase the newborn screening from 4 to 29 tests. CSHCN is monitoring how these changes will impact families. | | X | X | X |
| 2. CSHNC is developing new guidelines to address implementation of the expanded newborn screening agenda. | X | X | X | X |
| 3. Families applying for CSHCN are required to apply for SCHIP/Medicad programs. | X | X | | |
| 4. Families are reminded to keep the EPSDT current for added program benefits and support. | X | X | X | X |
| 5. CSHCN program collaborates with private organizations to fund eligible medically necessary treatment and equipment not otherwise covered. | X | X | | X |
| 6. Families are encouraged to recycle no longer needed medical equipment to the Kansas Equipment Exchange program to be refurbished and recycled. | | X | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

CSHCN continues last years activities.

Infrastructure Building Services:

New CSHCN providers (specialists, primary care providers, pharmancies, therapist and clinics serving the underserved population) continue to be added expanding the CSHCN contracted provider options.

CSHCN continues to work with providers and families to utilize alternative funding sources within local communities and disease specific foundations.

c. Plan for the Coming Year

This state performance measure will be reviewed at the 2009 State Five Year Needs Assessment meeting.

With the current economic downturn, there is an over-utilization of alternative funding resources which are depleting capacity. This will most certainly be a topic to consider as a top priority for the state. Early intervention, prevention of secondary disabilities, intentional and unintentional injuries need to be more strongly implemented to reduce the demand and burden on families to care for children who could remain healthy and disability free.

E. Health Status Indicators

/2009/ 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.

Health Status Indicator #01A

The percent of live births weighing less than 2,500 grams

Low birthweight (LBW) is a Kansas MCH priority in the MCH 2010, the 5-Year State MCH Needs Assessment. In Kansas, 2006, 7.2 % or 2,942 live births were LBW, an increasing trend (p-value <.01) in the last decade. The number of LBW live births has increased 3.9% from 1997. In Kansas, low birth weight is an important issue since 60.5% of all infant deaths occurred among the 7.2% of infants born at LBW.

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 2006, 55.9% of all plural births in Kansas were LBW.

The risk of LBW was greater for smokers than for nonsmokers (11.2% versus 6.4%), creating an excess LBW risk of 4.8% 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.

For 2005, the most recent year national data (final) is available, the percent of Kansas births with low birth weight is 12.4% lower than for the U.S.

Health Status Indicator #01B

The percent of live singleton births weighing less than 2,500 grams.

This health indicator removes the impact of multiple births on the low birth weight rate. Since 1997, there is no significant trend. In Kansas for 2006, the percent of singleton LBW births decreased 1.2% from 2005. The decrease is not statistically significant. For 2005, the most recent year national birth data (final) is available, the percent of Kansas singleton births with LBW is 14.0% lower than for the U.S.

Health Status Indicator # 02 A

The percent of very low birth weight (VLBW) live births.

Kansas' VLBW rate was 1.3% in 2006. This is, a 3.8% decrease from 2005. In the last decade (1997 -- 2006) there has been little change in trend. In 2005, 79.5% of VLBW infants were born at facilities for high-risk deliveries and neonates a 4.3% decrease from 2005. For 2005, the most recent year U.S. birth data (final) is available; the percent of Kansas live births with VLBW is 14.1% lower than the U.S. percent.

Health Status Indicator # 02B

The percent of VLBW live singleton births.

This health indicator removes the impact of multiple births on the VLBW percent. In Kansas for 2006, 1.0% of live singleton births were VLBW, essentially the same as 2005. In the last decade (1997-2006) this rate has shown no significant change in trend. For 2005, the most recent year U.S. birth data (final) is available, the percent of Kansas singleton live births with VLBW is 14.1% lower than for the U.S.

Health Status Indicator # 03A

The death rate due to unintentional injuries per 100,000 children aged 14 years or younger.

In 2006, the death rate for children due to unintentional injuries was 10.6 per 100,000 (n = 61). In the last five years (2002-2006), the trend has been level except in 2005 when it went down to 10.3%. Over this same time period, Kansas unintentional injury death rates (ages 0-14) have been consistently higher than for the U.S. (20.8% in 2005, the most recent year with final U. S. death data).

To prevent mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry is creating a system which will identify risk factors and suggest interventions to be implemented at the community level.

Health Status Indicator # 03B

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes (MVCs) among children age 14 or younger.

In 2006, the death rate for children due to motor vehicle crashes was 4.0 per 100,000 (n = 23) down 32.6% from 5.9/100,000 in 2005. Over the last five years (2002-2006), this rate has fluctuated in Kansas with no significant trend. For the same time period, Kansas' MVC death rates (ages 0-14) have been consistently higher than for the U.S.

MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry is creating a system that will identify risk factors and suggest interventions to be implemented at the community level.

Health Status Indicator # 03C

The death rate per 100,000 from unintentional injuries due to MVCs among youth ages 15-24.

In 2006, the death rate for youth in this age group due to MVCs was 29.0/100,000 (n = 120) down 7.3% from 2005. In the last five years (2001-2005), this rate has fluctuated with a significant decreasing trend. For this time period, Kansas' MVC death rates (ages 15-24) have been consistently higher than for the U.S. (20.6% higher in 2005).

These data led to adoption of SPM 6 and collaborative efforts with SAFE Kids and other groups to address the issue. New legislation in the 2008 session imposes driving restrictions on teens and this will need to be tracked over time.

Health Status Indicator # 04A

The rate per 100,000 of all nonfatal injuries among children ages 14 and younger.

The non-fatal unintentional injury rate has fluctuated in the past five years (2002-2006) with a high of 284.0/100,000 in 2004 and a low of 248.7/100,000 in 2002. In 2006, there was a significant decrease (5.1%) from 2005.

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 is creating a system that will identify risk factors and suggest interventions that can be implemented at the community level.

Health Status Indicator # 04B

The rate per 100,000 of nonfatal injuries due to MVCs among children ages 14 and younger.

In 2006, injuries from MVCs were the third leading cause of unintentional injury hospitalization for this age group. In the last five years (2002-2006), the rate has fluctuated with a high in 2003 of 45.3. Since 2003, the rate has declined with a 6.7% decrease from 2005 to 2006.

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.

Health Status Indicator # 04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes to youth ages 15-24.

Injuries from MVCs are the leading cause of injury hospitalization among youth in this age group with the highest rate in the 15-19 year old age group. During the last five years (2002-2006), the rate has fluctuated from a high in 2003 of 194.1. Since 2003, the rate has declined, with a 10.9% decrease from 2005 to 2006.

This decrease in hospitalizations caused by MVCs 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 (see SPM #6) 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.

Health Status Indicator # 05A

The rate per 1,000 women ages 15-19 with a reported case of chlamydia.

Chlamydia continues to be the most commonly reported STD in Kansas - 96 of 105 counties reported at least one case in 2006. For the year, 2,663 cases (27.2 per 1,000) of chlamydia were reported in this age group, representing a 7.9% (198 cases) increase from the previous year.

Health Status Indicator # 05B

The rate per 1,000 women ages 20-44 with a reported case of chlamydia.

Chlamydia continues to be the most commonly reported STD in Kansas. Ninety-six of 105 counties reported at least one case in 2006. For that year, 5,029 cases (10.7 per 1,000) of chlamydia were reported for this age group, representing a 4.9% (229 cases) increase from the previous year.

Health Status Indicator #06A-06B
Demographic Data - Infants and Children (ages 0-21)

The racial distribution for Kansas children in Kansas is about 88% white, 8.4% black or African-American, 1.3% American Indian or Native Alaskan, 2.3% Asian, and Others - negligible number. From Table HSI #06B the ethnicity for all Kansas children 0 through 24 is 11.9% Hispanic or Latino. This rises to 15.5% for the younger age groups (infant and 1-4).

Health Status Indicator #07A-07B
Demographic Data - Live births to women

Live birth data by maternal age and race is readily available through Kansa's Vital Statistics. Kansas started using the revised birth certificate in 2005 which allowed for expanded race categories including native Hawaiian or other Pacific Islander and multi race.

For 2006 data, 98.5% of births were to women who only selected one race, while 1.5% selected two or more races. White race alone was selected for 81.8% of live births, black race was 7.0% of live births, Asian 2.8% of live births, Native American 0.8% of live births, native Hawaiian or other Pacific Islander 0.2%, and race was unknown 0.2% of live births.

In 2006, women of Hispanic ethnicity accounted for 16.1% (n=6,568) of live births. With the revised birth certificate, race data was collected in a different manner for Hispanic mothers. Before 2005, mothers of Hispanic origin were assigned white race unless they indicated another race. In the years 2002-2004 almost 1% (0.9%) Hispanic mothers selected "other" race. In 2006, about 1 out of 3 (33.4%) selected "other race" as their race. Thus, the counts for white births through 2004 are not compatible with births by race from 2005 forward. With less Hispanics included in the white race data, certain percents or rates among white females may be affected such as teen pregnancy rates and smoking during pregnancy.

Health Status Indicator #08A-08B
Demographic Data - Deaths of infants and children (ages 0-24)

The death certificate data for children by age group by race (HSI #08A) is readily available from Vital Statistics as is death certificate data for children by age group by ethnicity (HSI #08B). These tables are useful as a tool in public health planning and implementation efforts, as for instance when estimating the school age population for a particular intervention or when there is a need to pull together data quickly for a meeting. In 2006, there were 721 deaths to children ages 0-24 with 293 of deaths to 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 8% of the States' children but 15% of the deaths to children. Black infants comprise 9% of the States' infants but 17% of the deaths to infants. This is not the case for Hispanics. Hispanic children comprise 13% of the States' children but 15% of the deaths to children. Hispanic infants comprise 16% of the States' infants and 16% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age.

Health Status Indicator #09A-09B

Demographic Data - Miscellaneous situations or for enrollment in programs (children ages 0-19)

While the number of children ages 0-19 is declining, the number enrolled in Medicaid, SCHIP, WIC and the Food Stamp program continues to increase. There has been a significant increase in the number of children living in foster care. The percent of high school dropouts (grades 9-12) appears to be on the rise.

Health Status Indicator #10

Demographics - Geographic Living Area for Children (ages 0-19)

From table HSI #10, about 60% of Kansas children live in metro areas. Breakdowns of geographic residency are: 71% urban, 26% rural, and 3% frontier to total 100%. The tables for

For the overall Kansas population, 6.4% have incomes >50% of the federal poverty level (FPL), 12.8% have incomes below 100% FPL, and 29.2% >200% FPL.

Health Status Indicators #11

Demographics - Poverty Level Information for Kansas

Data show that children are more likely to live in poverty in Kansas with 8.9 % of children 0-19 in households with incomes >50% FPL compared to 6.4% for all Kansans; 17.8% of children 0-19 live below 100% FPL compared to 12.5% of all Kansans. For those living below 200% FPL, over one third (38.6%) of Kansas children ages 0-19 live below 200% FPL compared to 29.4% of all Kansans. //2009//

F. Other Program Activities

KWIC, the new web-based WIC data system, is fully implemented throughout the state. The data system ensures more timely access to participation and budget information, risk data for evaluation purposes, and annual unduplicated counts. The system serves as a model in the country and the Kansas program is providing consultation to other states that are considering adapting the Kansas system.

/2007/ Envision, the vendor that developed the KS Immunization Registry (KIR) has been awarded contracts to build new CSHCN and MCH data modules onto the KIR system. The MCH & CSHCN systems were outdated and lacked certain administrative, fiscal and programmatic tracking and reporting capabilities. //2007//

The Kansas Information for Communities (KIC) system on the KDHE website allows data users to prepare their own queries for vital event data such as births and pregnancies <http://kic.kdhe.state.ks.us/kic/>. The system is updated each year. MCH staff train local staff in use of the system for community needs assessment in selecting local MCH priorities. KIC started as an MCH SPRANS Project.

Kansas Infant-Toddler Services at KDHE purchased three PhotoScreeners and conducted a pilot project to determine the effectiveness of the new technology in detecting vision problems not detected using traditional tools and methods outlined in the Kansas Vision Screening Guidelines. This research project was expanded to additional sites with funding from the Kansas Lions Club.

The Sunflower Foundation provided funding for a WIC project to address nutrition and physical

activity in young children. The project evaluated four different strategies for delivering physical activity and healthy eating behavior messages to young children participating in WIC programs.

BCYF staff were participants in the internal review process for the revision of Vital Statistics Certificates (Birth, Death, Marriage and Divorce). In the spring of 2003 MCH participated in meetings regarding suggested changes and merging of current certificates with the US Standard Certificates. The new system was implemented in January of 2005 although various components of the new system are still undergoing development such as the export files to congenital anomalies and newborn hearing screening.

The focus of the Kansas Robert Wood Johnson Turning Point project is development of capacity to address racial/ethnic disparities in health status. A key element in that effort is better understanding of health data related to minority health status and partnering with minority communities to improve the documentation of health and disease in those communities. One of the products of the project is the document, Racial and Ethnic Minority Health Disparities in Kansas. This was released at Spring 2005 Minority Health Conference in Lawrence, Kansas.

Kansas MCH participated in the Rhode Island Kids Count School Readiness Initiative. MCH participated on the five member state team. This group has evolved into the Early Learning Coordinating Council with oversight of the State Early Childhood Comprehensive Systems Plan. The composition of the group has evolved as well, with foundation and business support for early childhood efforts. BCYF staff participate in a number of early childhood/school readiness work groups.

CSHCN contracted with Envisage consulting to evaluate their current data system. The current system is inadequate given the needs of the program. Envisage provided the program with recommendations for a new data system which will be considered as part of the CSHCN strategic plan. Kansas is a recipient of the Champions for Progress Incentive Award. The award was used to convene a statewide stakeholder's meeting that focuses on CSHCN and their families. Regional meetings are planned for this summer.

KDHE staff is involved in discussions with SRS to ensure referral for evaluation to Part C Infant-Toddler Services of all children birth to three years of age who have been victims of a substantiated case of abuse or neglect. KDHE plans to work with SRS and Part C providers across the state to assure appropriate evaluation and intervention for children identified with social/emotional/mental health needs through this process. Five percent of all children enrolled in KDHE, Part C Infant-Toddler Services are in foster care.

KDHE participates with the Kansas Department of Social and Rehabilitation Services in planning an annual Kansas Fatherhood Summit to promote healthy father/male involvement in the lives of children through collaborative efforts. We also serve with Kansas Citizens United for Rehabilitation of Errants (KS CURE) in planning mentoring programs for children of prison inmates to help maintain the family structure in this difficult circumstance.

The American Lung Association of Kansas continues to provide leadership through the Kansas Asthma Coalition (KAC) with focus on evidence-based diagnosis and treatment through provider and consumer education efforts. MCH staff continues to provide asthma education to school and public health department nurses and serve on the KAC providing training on "Indoor Air Quality Issues." This resulted in an American Lung Association "Lung Champion" award for efforts in providing indoor air quality and asthma management education.

MCH child and adolescent health staff hosted an Adolescent Vaccine Update Teleconference for Kansas School and Public Health Nurses. This teleconference was a collaborative effort by BCYF and the Kansas Immunization Program, and was funded by Aventis Pasteur Pharmaceuticals. BCYF staff received a National Customer Service Award in October, from Aventis Pasteur recognizing their efforts in protecting human life through immunization.

Kansas Home Visitation Training Task Force was formed in 2002 to address the need for consistent training for home visitation staff across multiple programs, including Head Start, Parents as Teachers, Healthy Start Home Visitors, Part C Infant Toddler Programs and others. The Nebraska Early Childhood Training Center curriculum was selected by the Task Force as the standardized curriculum for Kansas home visitors. Funding for this project was obtained from the Region VII ACF office and from the Kansas Head Start Collaboration Office.

/2007/Kansas continues to invest in the development of staff core competency and leadership skills. Three MCH staff have completed the Kansas Public Health Certification (CPH) course and three will complete the program this year. //2007//

G. Technical Assistance

FFY 05, Steps in Establishing a Birth Defects Information System

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 are maintained within the BCYF.

Technical assistance was obtained from Judith Gallagher from Health Systems Research to develop a strategic plan in collaboration with members of the newly formed Child and Adolescent Health Council. The members adopted a plan for the coming year: review of screening statutes in the state and other screening issues such as tools in use by practitioners.

FFY 06, Review of Current Kansas Newborn Screening System and Recommendations for Expanded Newborn Screening.

The MCH/CSHCN staff developed and submitted a request for a team review, headed by Brad Therrell of the National Newborn Screening and Genetics Resource Center in Austin, Texas. This request is pending at the time of the application submission although an August, 2005 has been suggested. Members of the KPC, Child and Adolescent Health Council, and the Kansas Heartland Genetics Consortium will be invited to participate in this process as stakeholders.

/2007/ The NNSGRC technical assistance in August of 2005 brought a team of experts to Kansas: Brad Therrell, Director, NNSGRC; Frank Desposito, MD, Chair of the N.J. NBS Advisory Panel; Harry Hanon, NBS Quality Assurance Chief; Gary Hoffman, Director of the Wisconsin NBS Screening Laboratory; Julie Miller, Program Manager, Nebraska NBS Program; and Marie Mann, Project Officer for NBS at the MCHB. The team evaluated the current NBS system, explained the steps necessary to expand newborn screening to the ACMG recommendations. A comprehensive report was provided to the State in March of 2006. An advisory panel will develop a report and make recommendations to the 2007 Legislature. For FFY 07, NBS expansion continues to be our primary technical assistance need. Kansas will request additional consultation in developing a legislatively mandated report to the 2007 legislature with recommendations on XNBS. //2007//

/2009/ In the coming year, BFH will request technical assistance to address one of the following key priorities: 1) core data for periodic review by perinatal council members - what data should be reviewed at regular intervals? 2) basic intro training for BFH staff in Public Health Accreditation/Standards; 3) facilitation of joint Medicaid/MCH meeting to redo the Title V/Title XIX Interagency Agreement. Each of these is needed. TA will be based on quality and availability of trainer/facilitator. //2009//

V. Budget Narrative

A. Expenditures

/2009/ Expenditures Narrative FFY 07

Form 3 - FFY 07 Block Grant partnership expenditures were as follows: \$4,772,923 federal; \$4,377,812 state; and \$5,007,212 local. In comparison, for FFY 06, Block Grant partnership expenditures were: \$4,714,706 federal; \$3,873,142 state; and \$4,413,563 local match. Comparing FFY 06 and FFY 07 there were increases in all expenditures categories.

In FFY 07, MCH spent federal dollars within the amount available and also compatible with the priority needs identified in the State Needs Assessment.

In FFY 07, the following KDHE programs expended federal MCH funding to support initiatives relating to maternal and child health: Office of Health Assessment \$26,158; Director of Health \$1,768; Office of Oral Health \$69,418; Office of Local and Rural Health \$43,578; and Child Care Licensing and Registration \$142,024. Within the Bureau of Family Health (the MCH unit within KDHE) \$355,274 in federal MCH funds was spent for staff and operating costs working in programs for Pregnant Women & Infants, and for Children & Adolescents. Staff and operating costs for the CSHCN program were \$415,510. Nutrition consultation through the WIC program was \$2,948.

Aid to Local agencies and contracts with providers for MCH services totalled \$2,204,292 and CSHCN contracts and supplies totalled \$941,538. Newborn screening follow-up expenditures (2 salaries) were \$86,708, one epidemiologist salary and operating was \$60,000. Expenditures for administration (2 salaries) \$84,919, and indirect costs totalled \$338,788.

Fiscal controls have been imposed to assure that expenditures of MCH dollars are in line with reductions. In actual dollars, Kansas has lost over \$300,000 in federal dollars since FFY 94 so that the amount of the federal grant today is \$4.7 million. In inflationary terms, the Kansas federal MCH grant has lost over 35% of its spending value. What cost \$5 million (the FFY 93 funding level) would cost \$7.3 million today when considering inflation. MCH dollars have been directed towards priority work with accountability for work performed. Dollars that would be better spent elsewhere are shifted when possible.

For FY 07, the PMI funding of \$400,000 accounts, in large part, for the increase in State expenditures from FFY 06 to FFY 07.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements of 40%, however, most provide a 100% plus match. 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 populations. When considering all Block Grant partnership expenditures, the Children and Adolescent (C&A) services funding is significantly greater than funding for CSHCN, less so for Pregnant Women & Infants (P&I). The reason for this twofold. First, CSHCN contracts require no local matching dollars. Secondly, MCH grants to local communities do not require services to CSHCN. Various solutions to address this have been proposed such as requiring CSHCN 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 overallocation of resources to the C&A population group.

Form 5 - Direct health care expenditures are approximately 36% of the total MCH budget. Enabling services are 51% of the overall budget with population-based and core public health at 6% each.

With State expenditures of \$4,377,812 in FFY 07, 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 and local funds (91%). When considering both State and local matching funds, Kansas provides a 196% match.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet. //2009//

An attachment is included in this section.

B. Budget

//2009// Budget Narrative FFY 09

Form 2 - For FFY 08, the Block Grant partnership budget was: \$4,772,234 federal; \$4,023,212 state; and \$4,624,845 local match.

For FFY 09, the Block Grant partnership budget is: \$4,700,774 federal; \$4,659,442 state; and \$4,261,972 local match. In very rough terms, overall Kansas Maternal and Child Health Services' funding is one-third federal, one-third, State, and one-third local funding. Another way of stating this is to say that the State provides nearly a 100% match for the federal dollars and so do the local agencies.

Comparing the two budgets, there is a decrease in federal dollars corresponding to the decrease in the amount of the federal award. The increase in State dollars is due to new newborn screening funds for follow-up and treatment and to underbudgeting for CSHCN in FFY 08. A decrease in local agency matching funds is projected based on SFY 08 trends. Detailed information about the FFY 09 budget is provided in the attached Excel spreadsheet. The spreadsheet shows how Kansas plans to meet its 30-30 requirement with \$1,524,389 (32%) of the federal grant allocated to children and adolescents and \$1,495,435 (31%) allocated to children with special health care needs.

Form 3 - Kansas' budget for FFY 09 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 \$4,659,442 (99%). Kansas also anticipates receiving \$4,261,972 in local match.

Form 4 - Of its overall MCH budget (fed, state/local match), Kansas allocates about \$2.5 million to services for pregnant women and \$2.5 for infants. Another \$5.4 million is

allocated to children and adolescents and \$2.5 million for CSHCN.

Form 5 - Again, considering the overall MCH budget, about \$5.2 million is allocated to direct services, \$5.9 million to enabling services such as case management and transportation. Slightly less than \$1 million each to population-based services and to core public health infrastructure services.

As of July 1, 2007, the indirect cost rate for the Kansas MCH program went 14.4% to 20.1%. It is projected to go up another percentage point as of July 1, 2008. Costs for administration of the program (for Kansas MCH this is defined as MCH administration and indirect costs) are within the 10% limit set in federal Title V law. At this time, Kansas is in compliance with all requirements of the law.

The full amount of the anticipated federal Title V award, \$4,700,774 is budgeted for FFY 09.

The MCH/CSHCN 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 with Special Health Care Needs Section administers grant funding for medical specialty clinics and a statewide system of services for children and their families.

Contracts for this section include:

Advanced Orthopedics - \$10,800

Cerebral Palsy Research - \$156,400

Center for Child Health & Development at KU - \$169,340

Center for Child Health and Development, KU, Kansas City Office - \$145,068

Department of Pediatrics at KU Medical Center - \$163,759

Families Together, Inc. - \$45,000

Wichita Medical Practice - \$95,000

Via Christie Medical Center in Wichita - \$18,000

Wesley Clinics, Wichita - \$48,450

UKSM, Wichita Office \$261,012

SIDS Network of Kansas - \$75,000

In addition, Wichita Medical Research and Educational Foundation is reimbursed \$14 per sickle cell lab test. The Kansas State Department of Education and the Kansas Department of Social and Rehabilitation Services provide federal funding of \$34,730 total to support the toll-free number -- Make a Difference Information Network. The State Department of Education provides \$7,000 for Special Child Clinics (rural outreach clinics (e.g., Oakley). In SFY 08, CSHCN received \$208,000 new funds from Tobacco Settlement funds to help offset costs related to PKU formula. In SFY 09, CSHCN is receiving an additional \$200,000 in Tobacco Settlement funds to help with diagnostic and treatment costs associated with expansion of newborn screening. So the total funding for CSHCN from Tobacco Settlement funds (called Children's Initiative Funds in Kansas) is now at \$408,000.

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-- 84 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 58 contracts with local health departments and 3 other local agencies for coverage of all counties. It is projected that there will be nine contracts for the Section 510 Abstinence Education program. Seven teen pregnancy prevention projects and six teen pregnancy case management projects are funded. There are 14 contracts for school nurse/public health nurse collaborative practice.

For more detail about the breakdown of the Federal State Title V Block Grant partnership, please see the attachment to this section.

Following is the list of MCH contracts with local agencies for SFY 09 -- totalling \$4,085,776

*Barber Co Health Dept \$4,413
Barton Co Health Dept (multi county) \$61,248
Butler Co Health Dept \$51,244
Chase Co Health Dept \$2,798
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 B \$9,989
Douglas Co Health Dept \$70,409
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 \$2,910
Grant Co Health Dept \$8,606
Gray Co Health Dept \$5,016
Greeley Co Health Dept - \$5,595
Greenwood Co Health Dept \$7,473
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 \$17,213
Johnson Co Health Dept \$215,615
Kearny Co Health Dept \$5,268
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 B \$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 \$4,699
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 \$5,904
Phillips Co Health Dept \$9,341
Pottawatomie Co Health Dept \$29,906
Pratt Co Health Dept \$8,407
Rawlins Co Health Dept \$2,165
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 B \$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 \$5,875
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 \$6,539
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 Prevention Contracts for SFY 09 -- totalling \$356,694

Crawford Co Health Dept \$47,111
Flint Hills Community Health Center \$18,845
Ford Co Kids Count \$55,431
Labette Co Health Dept \$39,000
Wichita Family Services Institute \$89,173
YWCA of Topeka \$65,679
Finney Co Health Dept \$41,455

Teen Pregnancy Case Management Contracts for SFY 09 -- \$460,670

Four Co Mental Health Center \$76,274
Hunter Health Clinic \$73,034
Geary Co Health Dept \$81,567
Douglas Co Health Dept \$77,557
Wichita Family Services Institute \$54,204

School-Public Health Nurse Collaboratives for SFY 09 -- \$54,934

annual competitive process -- LHDs in Barber, Franklin, Greeley, Harvey, Haskell,
Jefferson, Lane, Lincoln, Mitchell, Ottawa, Phillips, Rawlins, Sheridan, Thomas, Trego
Counties

Pregnancy Maintenance Initiative contracts for SFY 09 -- \$400,000

Bethlehem House of El Dorado, Catholic Charities, Family Life Services, Gerard House

SIDS Network of Kansas contract for SFY 09 -- \$75,000

Women's Right to Know budget for SFY 09 -- \$36,000

Detailed information about the Title V budget for FFY 09 is provided in the attached Excel spreadsheet.

//2009//

An attachment is included in this section.

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.