

Kansas Maternal & Child Health SFY2017 Funding Request Process

Aid to Local Timeline

Program Guidance/Requirements

Universal Contract

Contract Attachment

Notice of Grant Award

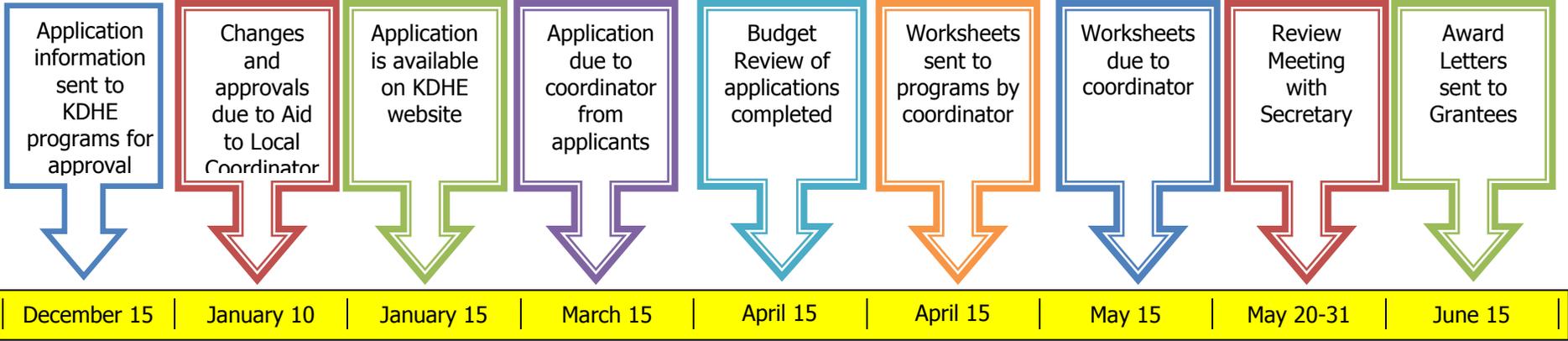
Kansas MCH Service Manual

MCH Application Reviewer Guidance & Rubric

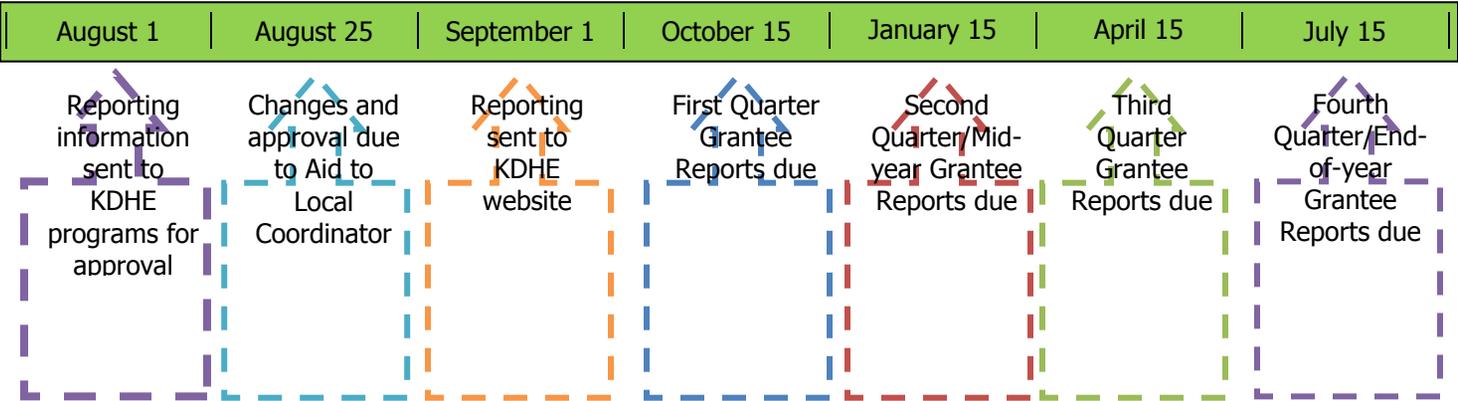
Aid to Local Awards/Grantee List & Map

Aid to Local Timeline

Application



Reporting



KDHE AID TO LOCAL PROGRAM
UNIVERSAL CONTRACT
Effective Date July 1, 2015

1. Parties to Contract
 - 1.1. Kansas Department of Health and Environment [KDHE]
 - 1.2. «AgencyName» [LOCAL AGENCY]

IN CONSIDERATION OF THE PROMISES CONTAINED IN THIS CONTRACT THE PARTIES AGREE AS FOLLOWS:

2. Term of the Contract
 - 2.1. The initial term of this Contract shall be from July 1, 2015, until July 1, 2016.
 - 2.2. The Contract will renew each July 1st for an additional one (1) year period under the terms and conditions in effect at the end of the prior period. Each Party shall notify the other Party in writing no later than July 1st of each year of its desire to renew the contract.
 - 2.3. There may be three (3) annual automatic renewals until July 1, 2019, unless sooner terminated.
 - 2.4. The Contract Attachments shall renew in the same manner except that the amount of money available in each Contract Attachment may vary from year to year. Therefore, the Parties agree that the amount of each grant for each fiscal year shall be determined by the KDHE. The KDHE shall, on or before July 1 of each year, notify the Local Agency of the amount of the grant for each Contract Attachment. The Local Agency may agree to renewal of the Contract Attachment at the funding level proposed by the KDHE by cashing the first warrant of the new grant year.
 - 2.5. The Contract may be sooner terminated by either Party upon providing the other Party with thirty (30) days written notice of termination. KDHE may suspend or terminate the Contract upon immediate notification upon a breach or suspected breach of any provision of the Contract or any attachments thereof.
3. KDHE shall make payments to the Local Agency as specified in the attachment(s), which are made a part of this Contract.
4. Local Agency shall:
 - 4.1. Establish and maintain accounting records that meet the requirements of generally accepted accounting principles.
 - 4.2. Submit to the KDHE the Certified Expenditure Affidavits and Program Progress Reports as outlined in the respective Contract Attachment, and to return to the KDHE within sixty (60) days of the end of the grant period all grant funds remaining unexpended at the end of the grant period. Any revisions to Certified Expenditure Affidavits must be submitted within sixty (60) days of the end of the grant period if any remaining grant funds are to be received. The Local Agency shall keep copies of invoices to support their expenses.
 - 4.3. Maintain time and attendance records that are sufficient to support salary expenditures for individual employees charged to each program. Such records must support salary distributions of employees chargeable to more than one program or cost objective to ensure that no more than 100% of an employee's time is charged to all programs combined.

- 4.4. Obtain an audit in accordance with the Federal Single Audit Act of 1984, as amended, and OMB Uniform Guidance: Cost Principles, Audit, and Administrative Requirements for Federal Awards [2 C.F.R. Part 200], and to submit one complete copy of the single agency audit report to the KDHE within twelve (12) months after the end of the Local Agency's fiscal year.
- 4.5. Afford access, upon written request, to the Secretary of KDHE or Kansas Legislative Post Audit, to any Local Agency documents and other records necessary to certify compliance with KDHE Grant Awards, Kansas Legislative Appropriations, Kansas Statutes, and Federal Grant Acts and Regulations.
- 4.6. Hold as confidential all personal client information obtained or received from recipients of services under this Contract and not to disclose client information except in statistical, summary or other forms that do not identify individual clients, except upon request of the Secretary of KDHE, Kansas Legislative Division of Post Audit, U.S. Secretary of Health and Human Services, Comptroller General or any of their duly authorized representatives, or as otherwise provided by law.
- 4.7. Disclose personal health information (PHI) to the KDHE as requested pursuant to the Health Insurance Portability and Accountability Act (HIPAA) [*See* 45 C.F.R §165.512(b)], or as required by law.
- 4.8. Comply with all relevant federal requirements, including, but not limited to: the Age Discrimination Act of 1975 [42 U.S.C.§6101 *et seq.*], Section 504 of the Rehabilitation Act of 1973 [29 U.S.C. §791 *et seq.*], Title IX of the Education Amendments of 1972 [20 U.S.C. § 1681 *et seq.*], Title VI of the Civil Rights Act of 1964 [42 U.S.C.§ 2000d *et seq.*], The Drug Free Workplace Act of 1988 [41 U.S.C. §701 *et seq.*], The Federal Anti-Lobbying Act of 1990 [31 U.S.C. §1352 *et seq.*], and The Federal Pro-Children Act of 1994 [20 U.S.C. §6081 *et seq.*], which are incorporated by reference into this Contract.
- 4.9. Comply with statutes, rules and regulations pertaining to public health, including, but not exclusively K.S.A. 65-101 *et seq.*
- 4.10. Ensure that grant funds will not be used to supplant other Local Agency funds.
- 4.11. Ensure that any print or on-line publication produced in full or in part by a grant/contract with KDHE shall include an acknowledgement as follows: “Produced through the full or partial support of the Kansas Department of Health and Environment (KDHE). The content of this publication may not necessarily reflect the views of KDHE.” Any conference supported by KDHE in full or in part shall include an acknowledgement: “Support for this conference is provided in full or in part by the Kansas Department of Health and Environment.”
- 4.12. Obtain prior written approval from the KDHE before purchasing any item of equipment from grant funds that costs in excess of \$500.
- 4.13. Participate fully in any required evaluation study and/or on site inspection arranged within normal working hours.
- 4.14. Develop a fee for service system and a schedule of fees for personal health services in accordance with the provisions of K.S.A. 65-220 to 65-225.
- 4.15. Obtain the written approval of the KDHE before entering into any subcontract related to this Contract and/or any of the Contract Attachment(s).

- 4.16. Provide services which have meaningful access to persons with Limited English Proficiency (LEP) pursuant to Title VI of the Civil Rights Act [(42 U.S.C. §2000d *et seq.*) and 45 C.F.R. §80.3(b)]. Meaningful access is to ensure that the Provider, its agents or subcontractors, and LEP person(s) can communicate effectively when services are being provided to LEP persons.
5. The Parties acknowledge and agree that:
 - 5.1. The Provisions found in Contractual Provisions Attachment (Form DA-146a), which is attached hereto, are hereby incorporated in this Contract and made a part thereof.
 - 5.2. Payment(s) may be withheld by the KDHE if any required Program/Fiscal Reports and/or refunds for any previous period have not been received, or if program requirements/objectives are not met as specified in the Contract Attachment(s).
 - 5.3. All revenues received from the delivery of services related to KDHE grant awards shall be identified and reported. Such program income shall be retained by the Local Agency to further the objectives of the grant awards.
 - 5.4. KDHE may cancel this Contract upon thirty (30) days written notice if the Local Agency fails to submit reports as required in this Contract or in the Contract Attachment(s).
 - 5.5. Indirect costs and contributions will be accepted as part of the matching funds after the Local Agency has submitted an annual indirect cost proposal which meets the KDHE requirements.
 - 5.6. This Contract is contingent upon the availability of State or Federal funds. In the event that such funds are exhausted or no longer available, this Contract may be unilaterally terminated without penalty by the KDHE upon thirty (30) days written notice.
 - 5.7. Adjustments in the Contract amount may occur within a grant year as additional funds become available, as funding levels are reduced or in the event that the Local Agency is unable to spend the funds allocated. In such cases the amount of any grant award attachment may be amended as follows:
 - 5.7.1. In the event that additional funds become available, the KDHE shall notify the Local Agency of the availability of additional funds. Acceptance of those funds by the Local Agency shall constitute an agreement to amend the Contract amount, and to expend the funds as specified in the Contract; or
 - 5.7.2. In the event that the Local Agency is unable to expend all of the funds allocated, the Local Agency shall notify the KDHE in writing of the amount of funds to be returned. KDHE may accept this as an amendment of the Contract by returning to the Local Agency a revised List of Grant Awards (LGA). The Local Agency's written notification, together with an amended LGA, shall constitute amendment of the identified Contract Attachment.
 - 5.8. This Contract may be otherwise amended as necessary by a formally executed written amendment agreed to by the Parties.
6. The Local Agency acknowledges and warrants that it is independently familiar with the conditions of participation required of it by the funding source to receive moneys hereunder, and further agrees to be bound by those conditions, and that it is not relying on any representations made about the conditions of participation by KDHE or its employees.

7. Compliance with the PILOT PROGRAM FOR ENHANCEMENT OF CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS.
 - 7.1. Congress has enacted a law, found at 41 U.S.C. 4712, that encourage employees to report fraud, waste, and abuse. This law applies to **all** employees working for contractors, grantees, subcontractors and subgrantees on federal grants and contracts [for the purpose of this document, “Recipient of Funds”]. The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) mandates a pilot program entitled, "PILOT PROGRAM FOR ENHANCEMENT OF CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS", which requires all grantees, their subgrantees and subcontractors to:
 - 7.1.1. Inform their employees working on any Federal award they are subject to the whistleblower rights and remedies of the pilot program;
 - 7.1.2. Inform their employees in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and,
 - 7.1.3. Contractors and grantees will include such requirements in any agreement made with a subcontractor or subgrantee.
 - 7.2. Employees of a contractor, subcontractor, grantee [or subgrantee] may not be discharged, demoted, or otherwise discriminated against as reprisal for "whistleblowing." In addition, whistleblower protections cannot be waived by any agreement, policy, form or condition of employment.
 - 7.3. Whistleblowing is defined as making a disclosure "that the employee reasonably believes is evidence of any of the following:
 - 7.3.1. Gross mismanagement of a federal contract or grant;
 - 7.3.2. A gross waste of federal funds;
 - 7.3.3. An abuse of authority relating to a federal contract or grant;
 - 7.3.4. A substantial and specific danger to public health or safety; or,
 - 7.3.5. A violation of law, rule, or regulation related to a federal contract or grant (including the competition for, or negotiation of, a contract or grant).
 - 7.4. To qualify under the statute, the employee's disclosure must be made to:
 - 7.4.1. A Member of Congress or a representative of a Congressional committee;
 - 7.4.2. An Inspector General;
 - 7.4.3. The Government Accountability Office;
 - 7.4.4. A federal employee responsible for contract or grant oversight or management at the relevant agency;
 - 7.4.5. An official from the Department of Justice, or other law enforcement agency;
 - 7.4.6. A court or grand jury; or,
 - 7.4.7. A management official or other employee of the contractor, subcontractor, grantee, or subgrantee who has the responsibility to investigate, discover, or address misconduct.
 - 7.5. The requirement to comply with, and inform all employees of, the "Pilot Program for Enhancement

of Contractor Employee Whistleblower Protections" is in effect for all grants contracts, subgrants, and subcontracts through January 1, 2017.

7.6. The Local Agency acknowledges that as a condition of receiving funds, it has complied with the terms of the "PILOT PROGRAM FOR ENHANCEMENT OF CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS", and has informed its employees in writing and in the predominant native language of the workforce, that by working on any Federal award, the employees are subject to the whistleblower rights and remedies of the pilot program.

8. Non-Debarment Certification and Warranty.

8.1. The Local Agency acknowledges that KDHE is required to verify that the Recipient of Funds has not been suspended, debarred or otherwise excluded from receiving federal funds. Verification may be accomplished by 1) checking the Excluded Parties List System (EPLS) maintained by the General Services Administration; 2) obtaining a certification from the entity; or 3) by adding a clause or condition to the transaction.

8.2. The Local Agency, as a condition of receiving funds, certifies and warrants that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or by any department or agency of the State of Kansas.

9. This Contract supersedes the prior Universal Contract. The prior Universal Contract is hereby rescinded.

The Parties, through duly authorized representatives, agree to the terms and conditions of this Contract and have executed it as of the date shown below.

Kansas Department of Health and Environment

«AgencyName»

By:

By:

Susan Mosier, MD
Secretary

Signature

Date

Name

Title

Date

CONTRACTUAL PROVISIONS ATTACHMENT

Important: This form contains mandatory contract provisions and must be attached to or incorporated in all copies of any contractual agreement. If it is attached to the vendor/contractor's standard contract form, then that form must be altered to contain the following provision:

"The Provisions found in Contractual Provisions Attachment (Form DA-146a, Rev. 06-12), which is attached hereto, are hereby incorporated in this contract and made a part thereof."

The parties agree that the following provisions are hereby incorporated into the contract to which it is attached and made a part thereof, said contract being the 1st day of July, 2015.

1. **Terms Herein Controlling Provisions:** It is expressly agreed that the terms of each and every provision in this attachment shall prevail and control over the terms of any other conflicting provision in any other document relating to and a part of the contract in which this attachment is incorporated. Any terms that conflict or could be interpreted to conflict with this attachment are nullified.
2. **Kansas Law and Venue:** This contract shall be subject to, governed by, and construed according to the laws of the State of Kansas, and jurisdiction and venue of any suit in connection with this contract shall reside only in courts located in the State of Kansas.
3. **Termination Due To Lack Of Funding Appropriation:** If, in the judgment of the Director of Accounts and Reports, Department of Administration, sufficient funds are not appropriated to continue the function performed in this agreement and for the payment of the charges-hereunder, State may terminate this agreement at the end of its current fiscal year. State agrees to give written notice of termination to contractor at least 30 days prior to the end of its current fiscal year, and shall give such notice for a greater period prior to the end of such fiscal year as may be provided in this contract, except that such notice shall not be required prior to 90 days before the end of such fiscal year. Contractor shall have the right, at the end of such fiscal year, to take possession of any equipment provided State under the contract. State will pay to the contractor all regular contractual payments incurred through the end of such fiscal year, plus contractual charges incidental to the return of any such equipment. Upon termination of the agreement by State, title to any such equipment shall revert to contractor at the end of the State's current fiscal year. The termination of the contract pursuant to this paragraph shall not cause any penalty to be charged to the agency or the contractor.
4. **Disclaimer Of Liability:** No provision of this contract will be given effect that attempts to require the State of Kansas or its agencies to defend, hold harmless, or indemnify any contractor or third party for any acts or omissions. The liability of the State of Kansas is defined under the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.).
5. **Anti-Discrimination Clause:** The contractor agrees: (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq.) and the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111 et seq.) and the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101 et seq.) (ADA) and to not discriminate against any person because of race, religion, color, sex, disability, national origin or ancestry, or age in the admission or access to, or treatment or employment in, its programs or activities; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if the contractor is found guilty of any violation of such acts by the Kansas Human Rights Commission, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration; (f) if it is determined that the contractor has violated applicable provisions of ADA, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration.

Contractor agrees to comply with all applicable state and federal anti-discrimination laws.

The provisions of this paragraph number 5 (with the exception of those provisions relating to the ADA) are not applicable to a contractor who employs fewer than four employees during the term of such contract or whose contracts with the contracting State agency cumulatively total \$5,000 or less during the fiscal year of such agency.

6. **Acceptance Of Contract:** This contract shall not be considered accepted, approved or otherwise effective until the statutorily required approvals and certifications have been given.
7. **Arbitration, Damages, Warranties:** Notwithstanding any language to the contrary, no interpretation of this contract shall find that the State or its agencies have agreed to binding arbitration, or the payment of damages or penalties. Further, the State of Kansas and its agencies do not agree to pay attorney fees, costs, or late payment charges beyond those available under the Kansas Prompt Payment Act (K.S.A. 75-6403), and no provision will be given effect that attempts to exclude, modify, disclaim or otherwise attempt to limit any damages available to the State of Kansas or its agencies at law, including but not limited to the implied warranties of merchantability and fitness for a particular purpose.
8. **Representative's Authority To Contract:** By signing this contract, the representative of the contractor thereby represents that such person is duly authorized by the contractor to execute this contract on behalf of the contractor and that the contractor agrees to be bound by the provisions thereof.
9. **Responsibility For Taxes:** The State of Kansas and its agencies shall not be responsible for, nor indemnify a contractor for, any federal, state or local taxes which may be imposed or levied upon the subject matter of this contract.
10. **Insurance:** The State of Kansas and its agencies shall not be required to purchase any insurance against loss or damage to property or any other subject matter relating to this contract, nor shall this contract require them to establish a "self-insurance" fund to protect against any such loss or damage. Subject to the provisions of the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.), the contractor shall bear the risk of any loss or damage to any property in which the contractor holds title.
11. **Information:** No provision of this contract shall be construed as limiting the Legislative Division of Post Audit from having access to information pursuant to K.S.A. 46-1101 et seq.
12. **The Eleventh Amendment:** "The Eleventh Amendment is an inherent and incumbent protection with the State of Kansas and need not be reserved, but prudence requires the State to reiterate that nothing related to this contract shall be deemed a waiver of the Eleventh Amendment."
13. **Campaign Contributions / Lobbying:** Funds provided through a grant award or contract shall not be given or received in exchange for the making of a campaign contribution. No part of the funds provided through this contract shall be used to influence or attempt to influence an officer or employee of any State of Kansas agency or a member of the Legislature regarding any pending legislation or the awarding, extension, continuation, renewal, amendment or modification of any government contract, grant, loan, or cooperative agreement.

Maternal & Child Health (MCH)

Program Details & Application Guidance

Program Purpose:

The MCH program serves a key role in the provision of maternal and child health services in Kansas and seeks to:

- Improve the health and well-being of the State's mothers, infants, children and youth, including children and youth with special health care needs, and their families.
- Provide and assure mothers and children, in particular those with low income or with limited availability of health services, access to quality MCH services.
- Reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children.
- Reduce the need for inpatient and long term care services.
- Increase the number of children, especially preschool children, appropriately immunized against disease.
- Increase the number of low income children receiving health assessments and follow-up diagnostic and treatment services.
- Promote the health of mothers and infants by providing prenatal, delivery and postpartum care for low income, at-risk pregnant women.
- Promote the health of children by providing preventative and primary care services for low income children.
- Provide and promote family-centered, community-based, coordinated care for women, children and families.

Maternal and Child Health (MCH) programs promote the development of local systems of health care and target six identified population health domains:

1. Women/Maternal health
2. Perinatal/Infant health
3. Child health
4. Adolescent health
5. Children and Youth with Special Health Care Needs (CYSHCN)
6. Crosscutting or Life Course (issues impacting multiple MCH population domains)

State MCH Priorities (2016-2020):

1. Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.
2. Services and supports promote healthy family functioning.
3. Developmentally appropriate care and services are provided across the lifespan.
4. Families are empowered to make educated choices about nutrition and physical activity.
5. Communities and providers support physical, social, and emotional health.
6. Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7. Services are comprehensive and coordinated across systems and providers.
8. Information is available to support informed health decisions and choices.

Specific Program Information (including but not limited to):

- Programs, services, and activities conducted at the local level must be in accordance with the [KDHE MCH Service Manual](#) (revised January 2016), Universal Contract, and Contract Attachment.
- The [MCH Service Manual](#) must be used in the development of the grantee's local policy and procedure manual, including orienting and training staff.
- All MCH program staff and supervisors must complete MCH training via the online [MCH Navigator](#) (<http://mchnavigator.org/trainings/topics.php>). The following two courses are required to be completed within the first three months of grant award or hire, whichever applies. Documentation must be maintained in the personnel file: [MCH 101](#) and [MCH Orientation](#) (complete the module that best fits your role in the agency/program).
- All required client and visit data must be collected and entered into the web-based shared measurement system, [DAISEY](#), by the 10th of each month. Access to necessary equipment and secure internet service is required.

- The local grantee must implement or demonstrate efforts toward implementation of evidence-based practices.
- The local grantee must engage in public awareness activities and develop a community referral network for services and supports. A process for follow up must be in place.
- The local grantee must develop a method to receive input on client satisfaction. Input should not be sent to KDHE, rather used internally at the local level to enhance or improve services and inform future activities. Client satisfaction is assessed as part of the monitoring process.
- The local grantee must develop and implement a program evaluation process that utilizes client satisfaction responses and community needs assessment information to assess the program and results in improvements or changes to services based on input.
- Income and family size of all clients must be determined and documented at least annually.
- A sliding fee scale with a minimum of four increments must be established and implemented for all MCH services provided. This program does not require the fee scale to slide to zero.
- At least one person from the grantee MCH program is required to attend technical assistance calls and webinars provided by KDHE.
- Prior approval from KDHE must be obtained to subcontract any required program services.

Eligible Applicants

- Organizations with the capacity to provide quality services to Kansas families and receive reimbursement from third party payers for qualifying services are eligible to apply. Single or multi county/agency applications will be accepted.
- Multi county/agency applicants must designate a lead organization for application. The lead organization will serve as the fiscal agent and grant management entity. Each participating county/agency must provide a letter of commitment that includes agreement with designation of the lead organization.
- Applicants should thoroughly review the [MCH Service Manual](#), consider community and local needs for the legislatively mandated MCH populations, and develop a work plan and budget that aligns with the MCH priorities and measures.
- Priority for services should be given to those with low income or limited availability to health services. MCH services complement KanCare medical assistance programs, and MCH programs serve as a safety-net provider for the MCH population by providing gap-filling health services.
- Preference will be given to high-need areas/communities and applications which indicate a collective impact approach and coordination with other programs, including WIC, early intervention, early childhood/education, developmental/children and family services, family planning, behavioral health, and other health and community service programs.

Funding Information

- Grants will be awarded annually on a competitive basis. Grants are subject to availability of funds. No part of the grant money shall be used for any political purposes. Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment. Payment may be held for failure to meet contract requirements and/or submit timely reports.
 - Base funding awards will be calculated using a formula that includes the population of children 0-22 years and Females 23-44 in the county according to the most current US Census Bureau statistics and number of children under 18 years in poverty according to the most current American Community Survey (ACS).
 - Additional funds will be awarded for applicants providing MCH programming and services in other counties (when not already available or provided).
 - Additional funds will be awarded to applicants demonstrating coordinated efforts, strong community collaboration, and use of evidence-based practices and/or models and interventions.
 - Funds will be used to maintain and improve the MCH programming at the local level. Priority should be given to advancing shared areas of work/issues identified in the community needs assessment and most current MCH state needs assessment and action plan for the following populations: women, pregnant women, infants, children, adolescents, and children and youth with special health care needs.
- Local matching funds must be equal to or greater than 40% of the grant funds requested and awarded. Local program revenues may be utilized to meet the match requirements.

Reporting Requirements:

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

- Financial Status Report (FSR)
- Quarterly Progress Report

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

Request Funds/Apply

To apply for funding, fill out an application in Catalyst (www.catalystserver.com). New applicants can request to be set up in Catalyst and receive a username and password by contacting: support@shpr.org. Applications are available on January 15, 2016, and are due on March 15, 2016.

Before starting your application, please complete the following training courses on Kansas TRAIN (ks.train.org):

- Catalyst Training 1: Catalyst Navigation (Course #1054439)
- Catalyst Training 2: Application Process Overview in Catalyst (Course #1054483)
- Catalyst Training 3: Application Management in Catalyst (Course #1054567)
- Catalyst Training 4: Applying for Funding Announcement(s) in Catalyst (Course #1054672)

Required Application Attachments:

- A.1 - Attach an Agency Organizational Chart
 - Name the attachment [Applicant Agency Name] Agency Organizational Chart
- A.4.2 - Attach a Schedule of Fees/Sliding Fee Scale
 - Name the attachment [Applicant Agency Name] Schedule of Fees/Sliding Fee Scale

Program Details & Guidance

[MCH Service Manual](#)
[MCH Block Grant Website](#)

Program Contacts

Carrie Akin
MCH Administrative Consultant
785-296-1234
cakin@kdheks.gov

Kay White
MCH Administrative Consultant
785-296-1305
kwhite@kdheks.gov

Contract Attachment No. 17

LOCAL AGENCY: «AgencyName»
PROGRAM: Maternal and Child Health
TERM: Until Rescinded
AMOUNT: Per List of Grant Awards

The undersigned parties agree that the following provisions of Contract Attachment No. 17 are hereby incorporated into the KDHE Aid To Local Universal Contract (Universal Contract) and made a part thereof.

STATE AGENCY AGREES TO:

1. Make payments for Maternal and Child Health (MCH) services to the Local Agency as follows:
 - a. Pay 25% of the fiscal year grant amount as first quarter funding on or about July 1, or upon processing of this Contract Attachment if later than July 1 of each year. If the total award amount for the program period is \$2,000 or less, the entire amount will be paid on or about July 1 of each year.
 - b. Pay 12.5% of the fiscal year grant amount on or about October 1 of each year.
 - c. Pay 12.5% of the fiscal year grant amount, less any unexpended grant funds from prior quarters, on or about November 15; February 15; and May 15. Such payments will be made upon receipt and acceptance of quarterly fiscal reports showing expenditures from grant and Local Agency funds and fees for services. Said payments may be increased upon receipt and acceptance of quarterly fiscal reports showing additional approved expenditures from the grant funds. Total payments shall not exceed the contract amount.
 - d. Pay 12.5% of the fiscal year grant amount on or about January 1 and April 1 of each year. Such payments will be made after an evaluation is made to determine if grant funds previously advanced have been expended in accordance with grant objectives.
2. Forward to the Local Agency on or about July 1 of each year a copy of the Notice of Grant Award Amount and Summary of Program Objectives that contains the State Fiscal Year objectives.
3. Provide onsite monitoring and technical assistance visits to the Local Agency. A written response of said visits will be provided to the Local Agency within thirty (30) days.
4. Provide MCH workforce development opportunities for local agency staff through the annual Governor's Public Health Conference held in the spring and other trainings as necessary, including online offerings via KS-TRAIN and the MCH Navigator.
5. Provide regional training for Healthy Start Home Visitors each fiscal year.

6. Review the Kansas Health Services Manual: Maternal and Child Health found at http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf and provide revisions/additions as indicated to reflect program and practice needs.

LOCAL AGENCY AND ITS AGENTS OR SUBCONTRACTORS AGREE TO:

7. Implement a process for determining client satisfaction with services and maintain written documentation of results with subsequent actions. Incorporate client satisfaction information into the process for evaluating program progress and effectiveness.
8. Develop and have on file written local policies and procedures for MCH, based on the program details, funding requirements, and standards/guidelines contained in the Kansas Health Services Manual: Maternal and Child Health. Local policies and procedures are to be reviewed and signed by the physician advisor/consultant on an annual basis.
9. Provide Local Agency matching funds equal to or greater than 40% of grant funds expended per quarter.
10. Submit to the State Agency within sixty (60) days of the receipt of the response to the monitoring and technical assistance visits a corrective action plan for issues identified during the said visit.
11. Submit a budget on or about July 1 outlining projected expenditures for grant funds and Local Agency funds, which is to be approved by appropriate State Agency program staff, and is hereby incorporated in this Contract Attachment and made a part hereof. Failure to submit this budget may result in the withholding of future payments by the State Agency.
12. Establish and implement a sliding fee scale of discounted charges with sufficient proportional increments so that inability to pay is never a barrier to services. The scale must include at least four (4) levels of reduced billing using the Federal Poverty Guidelines.
13. Track real-time client demographics and service/encounter data via an approved web-based electronic data system as required and in accordance with the guidelines provided by the State Agency. This encounter data will be the source for required reports.
14. Participate with other community agencies and organizations in the coordination of essential services for Maternal and Child Health including outreach and referral.
15. For multi-county grants only, provide each subcontractor with a completed MCH grant application, contract and reporting requirements. Have on file a signed Memorandum of Agreement (MOA) with each subcontractor which includes provisions for record keeping, providing matching funds if required and submission of progress to the lead agency. The lead agency will be responsible to compile all subcontractor data and reporting information and incorporate it into comprehensive multi-agency reports to meet identified contract reporting requirements.

IT IS MUTUALLY AGREED THAT:

16. This Contract Attachment No. 17 supersedes any prior Contract Attachment No. 17.
17. Tender and acceptance of the first payment of the fiscal year shall constitute formal acceptance of the terms of the program objectives, which shall be incorporated by reference into the Universal Contract.
18. Failure to comply with this Contract Attachment No. 17 may result in reduction of funds or cancellation of the Contract Attachment No. 17.

Secretary: _____
Susan Mosier, MD, MBA, FACS
Kansas Department of Health & Environment

Date: _____

Authorized Signature: _____
«AgencyName»

Printed Name: _____

Title: _____

Date: _____

**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
NOTICE OF GRANT AWARD AMOUNT & SUMMARY OF PROGRAM OBJECTIVES**

PROGRAM NAME: Maternal & Child Health (#17)

LOCAL AGENCY NAME: «AgencyName»

PROGRAM PERIOD: July 1, 2016 - June 30, 2017

AMOUNT THIS PERIOD: \$ «Amount»

This document is incorporated by reference into Contract Attachment No. 17. Acceptance of the first payment constitutes Local Agency's agreement to the amount of the grant, the program objectives set out below, and the terms of Contract Attachment No. 17. In addition to the general program provisions and objectives set forth in Contract Attachment No. 17, Local Agency agrees to the following Fiscal Year/Local Agency-specific requirements:

1. Target efforts, coordination, and resources as necessary to address the priorities identified in the 5-year statewide needs assessment, *MCH 2020*, as well as community needs.
Provide services within the following domains as indicated in the application for funding:
 - a. Women/Maternal Health
 - b. Perinatal/Infant Health
 - c. Child Health
 - d. Adolescent Health
 - e. Children and Youth with Special Health Care Needs
 - f. Cross-Cutting or Life Course

2. *Estimated service numbers by MCH population health domain:*
 - a. Services will be provided for «Field1» pregnant women.
 - b. Services will be provided for «Field2» post-partum women.
 - c. Services will be provided for «Field3» women.
 - d. Services will be provided for «Field4» infants (birth through 12 months, 0 days).
 - e. Services will be provided for «Field5» children (1 through 11 years).
 - f. Services will be provided for «Field6» adolescents (12 through 22 years).
 - g. Services will be provided for «Field7» children and youth with special health care needs.

3. Submit to the State Agency in Catalyst the reports listed in the KDHE Grant Application Guidance and Grant Reporting Instructions. The State Agency reserves the right to modify in its sole discretion, the reporting requirements during the term of this agreement to meet applicable federal or state reporting requirements.
 - a. Submit the Financial Status Report (FSR) by the 15th of the month following the end of each quarter; October 15 for the 1st quarter, January 15 for the 2nd quarter, April 15 for the 3rd quarter, and July 15 for the 4th quarter. The source and amount of funds received during the reporting period that support activities within the scope of the grantee's approved application/plan shall be identified on the FSR.
 - b. Submit Quarterly Progress Reports by the 15th of the month following the end of each quarter; October 15 for the 1st quarter, January 15 for the 2nd quarter, April 15 for the 3rd quarter, and July 15 for the 4th quarter.

Summary of Program Objectives #17 - Page 2 of 3

- c. A 5% penalty of total grant award amount will be assessed for delinquent year-end (4th quarter) reports beyond August 15th.
4. Track real-time client demographics and service/encounter data as required and in accordance with the guidelines provided by the State Agency.
 - a. Utilize the Data Application and Integration Solutions for the Early Years (DAISEY) system to report client-encounter data. Data must be entered by the 10th of every month for services provided through the end of the preceding month. All encounter data shall be current and available to the State Agency within fifteen (15) days of the end of the calendar year and state fiscal year. This data will be the source for required reports. KDHE must be notified of plans to use an alternative system such as an Electronic Health Record (EHR) to collect client-level data. Entry in DAISEY will still be required. Additional information will be provided as applicable.
 - b. Provide a signed DAISEY Terms of Use Agreement and comply with the terms outlined in the agreement.
5. No more than 25% of the total grant award shall be advanced/made available to the Local Grantee Agency for the period July 1 through September 30. Therefore, any expenses exceeding 25% of the total grant award should not be reported on the 1st quarter affidavit. Additional expenses must be reflected in the Match section.
6. Meet KDHE MCH training requirements for staff as follows:
 - a. At least one member of the local agency professional staff will attend the annual Governor's Public Health Conference or a statewide conference as approved by KDHE MCH staff and provide a summary of key information gained to other grant personnel that did not attend the conference.
 - b. All MCH program staff and supervisors must complete MCH training via the online MCH Navigator (<http://mchnavigator.org/trainings/topics.php>). One of the following two courses is required to be completed within the first three months of grant award or hire, whichever applies. Documentation must be maintained in the personnel file: [MCH101](#) and [MCH Orientation](#) (complete the module that best fits your role in the agency/program).
 - c. At least one staff member of the local agency MCH Program will participate in/attend quarterly technical assistance or training sessions as provided throughout the grant period. Sessions may be via telephone, webinar, or face to face. Additional or more frequent webinars or trainings may be held to address emerging issues and/or provide "just-in-time" training, in which case program staff are encouraged to attend and participate to support successful program implementation.
 - d. All new Healthy Start Home Visitors must complete the Basic Kansas Home Visitation training within six (6) months.
 - e. All Healthy Start Home Visitors must attend the fall regional training provided by KDHE staff and one relevant, statewide conference as approved by KDHE MCH staff.
7. Develop annual staff development plans that identify education needs of staff and plans for providing or obtaining the needed training. An Individual Professional Development Plan or other system of documenting educational updates will be maintained for each staff member.
8. Requirements for Special Health Care Needs (SHCN) Satellite Office grantees only.
 - a. Assist in efforts to expand KS-SHCN community-based services within the assigned region by:
 - i. Providing outreach to community service and medical providers to share information about the KS-SHCN services, eligibility requirements, the Special Bequest Commission, and the Special Health Services Family Advisory Council (SHS-FAC);

Summary of Program Objectives #17 - Page 3 of 3

- ii. Providing recommendations to KS-SHCN of potential service locations for diagnostic evaluations within the assigned region;
 - iii. Providing application materials to recruit new KS-SHCN specialty care providers;
 - iv. Assisting in recruitment of providers of all factions for the Kansas Resource Guide (KRG). Grantee shall attempt to recruit a minimum of ten (10) new medical or community providers per month;
 - v. Assisting families to connect to KS-SHCN Specialty Care Clinics, as appropriate; and
 - vi. Coordinating with KS-SHCN Specialty Care Clinics in their outreach efforts within the assigned region.
 - b. Provide assistance with the application process to families interested in or needing KS-SHCN services by:
 - i. Assisting families in compiling necessary medical and financial information to KS-SHCN and other state and federal financial assistance programs; and
 - ii. Following up with families regarding referrals made to ensure support, collaboration and integrated service delivery across systems.
 - c. Maintain proficiency in using the KS-SHCN web-based client monitoring system to support:
 - i. Entering intakes and applications on clients;
 - ii. Monitoring client status and communicate needs to families, as applicable;
 - iii. Inputting client notes into WebBFH regarding interactions and communications made with KS-SHCN families; and
 - iv. Running update and reminder (i.e. “tickle”) reports on a weekly basis to identify families that need updated applications, information or follow up.
 - d. Host KDHE for two (2) on-site visits during the Contract period, one in the fall and one in the spring.
 - e. Participate in the yearly in-person SHCN Satellite office training day and quarterly conference calls.
 - f. Submit statistical data, narrative, and KRG reports on the required reporting form to KS-SHCN Topeka office.
9. The provisions found in the Health Information Protection Attachment, which is attached hereto, are hereby incorporated in this contract and made a part hereof.

July 14, 2016

HEALTH INFORMATION PROTECTION ATTACHMENT

Specific Program Requirements:

Local Agency agrees to comply with applicable state and federal law regarding the use and dissemination of data, information and records obtained or maintained in the performance of this contract.

Local Agency agrees to use appropriate safety measures, including physical and technical safeguards, and the technology, policy and procedures for its use which reasonably protects the confidentiality, integrity and availability of data, information and records obtained or maintained in the performance of this contract.

Local Agency agrees to prevent the unauthorized access, use, disclosure, modification, destruction, or divulging in any other manner of the data, information and records obtained or maintained in the performance of this contract, including personal client information received from recipients of services under this contract, other than as provided for by this contract or by applicable state and federal law. Local Agency agrees to report to KDHE any attempted or successful unauthorized access, use, disclosure, modification, or destruction, or divulging in any other manner of the data, information and records obtained or maintained in the performance of this contract which it or its officers, employees, agents or subcontractors become aware.

Local Agency agrees to provide a list of the names of all Local Agency employees and agents who are given access to a System on which data, information and records are maintained to KDHE, and shall provide written notification to KDHE whenever any individual is added to or removed from the list. Written notification of the addition or removal of an employee or agent from the list shall be sent to KDHE within 24 hours after an employee is no longer employed by Local Agency, or an individual is no longer acting as an agent of the Local Agency. (Written notification may be provided prior to the time the employee is no longer employed or an individual is acting as an agent for the local agency.) Immediate notice shall be provided to KDHE by phone or email whenever an employee or agent is terminated for cause. The Local Agency shall provide notification required by this provision to the KDHE Contact Person for the System on the KDHE Contact List which will be located at:

http://www.kdheks.gov/doc_lib/index.html

Local Agency agrees to provide appropriate supervision and training to its employees and agents to ensure compliance with access to and confidentiality and use of data, information and records obtained or maintained in the performance of this contract, including but not limited to:

- a) Complying with the confidentiality and access provisions of this contract; and
- b) Protecting confidential data, software and equipment from unauthorized activities, including but not limited to unauthorized access, use, disclosure, modification, or destruction.

Local Agency agrees to report to KDHE any interference with system operations in an information system as soon as practicable, but no longer than 24 hours after the discovery of such disclosure. Notice to KDHE shall consist of notifying the KDHE by phone or email of the occurrence of an unauthorized use, disclosure or security incident, and shall identify such unauthorized use and identify all individuals engaged in such unauthorized use. Notification shall be provided to the KDHE Contact Person for the System on the KDHE Contact List.

Local Agency agrees to mitigate any harmful effect that is known to Local Agency of the use or disclosure of data, information or records obtained or maintained in the performance of this contract in violation of the requirements of this contract, and to communicate in writing such mitigation to KDHE.

Kansas Maternal and Child Health Service Manual



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

Revised January 2016



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

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

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Forward

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

This manual was developed specifically for use by entry level MCH KDHE grantees in the public health workforce.

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

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- 101 - Bureau of Family Health Mission
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101 Bureau of Family Health Mission

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

102 Bureau of Family Health Services Philosophy

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

103 History of MCH in Kansas

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

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

104 MCH Grants

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

- prenatal care services, with a focus on increasing access and utilization of services and first trimester enrollments in prenatal care services;
- comprehensive prenatal and postnatal healthcare;
- follow-up services for the mother and infant up to one year post delivery;
- health, psychosocial and nutrition assessments through a collaborative effort between public health and private medical providers;
- reproductive health services and STD testing and treatment;
- pediatric health services, including well-child visits and immunizations, reduction of unintentional and intentional injuries in children, high-risk infant follow-up, smoking cessation efforts, perinatal mood disorders and identification and referral for substance abuse; and
- Multidisciplinary health professional teams, on site and/or through referral to the appropriate professional(s) within the community or grantee’s service area,

including but not limited to: a physician; registered nurse, including clinicians, practitioners and/or midwives; registered dietitian; and licensed social worker.

All MCH grantees are expected to provide:

- access to multi-lingual translator services;
- culturally-competent services and supports;
- state-wide and community-based referrals for needed specialty care and other services;
- referral for age-appropriate developmental screening; and
- patient- and/or family-centered services, assuring all patients/families are recognized as partners in their health care MCH.

Local MCH grantees must assist clients with accessing health coverage. This includes informing clients of the services available from KanCare (Kansas Medicaid). The local agency staff should assist clients with completing the eligibility application or refer clients to the local contact for this support. It is expected that through these outreach and enrollment efforts, there will be a reduction in the need for primary care services/resources and that these resources will be redirected to other MCH system development and support activities.

105 MCH Services

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

- Reproductive health services
 - Preconception counseling and referral as indicated
 - Linkage to early comprehensive prenatal medical care
 - STD testing and treatment
 - Link to genetic counseling services
 - Pregnancy testing, counseling and referrals as indicated
- Care coordination
 - Reproductive health and reproductive life/family planning services
 - Prenatal care and education
 - Supplemental food and nutrition programs such as Women, Infants and Children (WIC) nutrition program
 - Healthy Start Home Visitor and other community home visiting services
 - High-risk infant case management
 - Early intervention referral and follow-up
 - Care coordination for individuals with special health care needs
 - Direct Assistance Programs for individuals with special health care needs
 - Child health and safety information
 - Community resource linkages
- Risk reduction & counseling

- General health screens/assessments and treatment linkage
- Tobacco/smoking, alcohol and substance use cessation
- Healthy weight counseling
- Domestic violence referral assistance
- Identification of perinatal mood disorders
- Depression screening with mental health service linkage
- Prenatal education classes
- Childbirth education classes
- Parenting education classes
- Family advocacy and leadership classes
- Care coordination training for families of children with special health care needs
- Pediatric (child and adolescent) health services
 - Well-child health assessments
 - Immunizations
 - Child development and mental health screening
 - Reduction of unintentional and intentional injuries
 - Healthy weight guidance
 - Parenting education with anticipatory guidance
 - Mental health screening and referral as indicated

Coordination with Reproductive Health and Family Planning (Title X) Programs/Clinics:

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

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

106 Qualified Workforce

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

Resources

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

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

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

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

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

<http://leadership.mchtraining.net/>

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

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

http://www.phf.org/resourcestools/Pages/Core_Public_Health_Competencies.aspx

107 MCH Goal and Standards

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

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

Standard 1: Community Needs Identification

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

- **Rationale:**

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

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

To learn more about community needs assessments, go to:

- [Center for Disease Control and Prevention Implementing the Community Needs Assessment Process](http://www.cdc.gov/policy/ohsc/chna/index.html)¹
<http://www.cdc.gov/policy/ohsc/chna/index.html>
- Healthy People 2020. “[A Guide to Using Healthy People 2020 in Your Community](http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning).”² <http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning>

- **Local agency grantees:**

¹ CDC Needs Assessment Implementation Process <http://www.cdc.gov/policy/ohsc/chna/index.html>

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

- Identify, define and prioritize specific interventions addressing the specific health care needs of the community.
- Ensure ongoing community involvement in the planning, implementation and evaluation of the program.
- Ensure involvement of representatives of the cultural, racial, ethnic, gender, economic and linguistic diversities within the community.
- Provide educational materials and services in a manner and format that best meets cultural, linguistic, cognitive, literacy and accessibility needs of the community.
- Move toward full compliance with the four mandated [Culturally and Linguistically Appropriate Service standards \(CLAS\)](#).
<http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53> (standards and fact sheet)
- Establish or maintain a committee of community partners/stakeholders, including family representatives, that advises on community MCH health issues. It is desired that at least 25% of committee membership be held by consumers served by local MCH programs.
- Work with other local, state and federal entities in the community to develop a network of complementary services.
- Make every attempt to employ staff that is representative of the population being served.
- Build systems of coordinated health care within your community and/or region.
- Provide Translation/Interpreter services or have bilingual staff available.

Standard 2: Infrastructure

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

- **Rationale:**

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

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

Documentation serves as:

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

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

- **Local agency grantees:**
 - Employ adequate staff members to address the identified needs of the population to be served in the community.
 - Establish written fiscal management policies and procedures that include, but are not limited to: payment of debts, payroll, record keeping, auditing and receivables/expenditures.
 - Utilize sound accounting and business practices.
 - Develop and implement the Disaster Response Framework with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing and human services recovery needs of pregnant women, children and adolescents.
 - Establish and implement reporting and billing systems including a sliding fee scale for all clients receiving MCH billable services.
 - Obtain income information from every client, document and updated at least annually. The client's income is used to determine the amount to be charged for services or supplies on a sliding fee schedule of discounts.
 - Establish and implement a sliding fee scale of discounted charges. Scale must include at least four levels of reduced billing using the federal Poverty Guidelines of income and number of people in the family. This scale meets the low income guidelines for those who are eligible for free or reduced charges for billable services. For information on Federal Poverty Guidelines³ go to <http://aspe.hhs.gov/poverty/index.cfm>
 - Establish a written fee collection policy which will be applied consistently for all clients. The policy will include a list of reasonable efforts made to collect outstanding client balances. Under no circumstances shall client confidentiality be jeopardized.
- Utilize electronic data collection of client visits and capture all required data elements via the web-based shared measurement system, DAISEY (Data Application and Integration Solutions for the Early Years). See more under Section 311 (Data Collection).
 - Provide adequate automation of data transmission systems to ensure direct and timely communication to KDHE.

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

- Notify KDHE of any issues, concerns or questions regarding the MCH program.

Standard 3: Outreach

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

- **Rationale:**

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

A priority should be placed on identifying and serving:

- Pregnant adolescents
 - Families exposed to tobacco smoke in the household
 - Families in which substances are used or abused
 - Families exposed to violence and physical abuse
 - Families that have a member with special health care needs
 - Families that have a member with mental health issues
 - Women and children at health, nutritional, or psychosocial risk and/or experiencing barriers to care (e.g. financial, lack of providers)
 - Families with a potential for not entering into and/or complying with health care recommendations
 - Those at risk for poor health outcomes
- **Local agency grantees:**
 - Review the service area data for who is and who is not accessing care; communicate with hospitals, school and local medical providers; establish linkages between the Kansas Department for Children and Families (DCF) and other social, religious and community service agencies; advertise program services; and develop referral systems and strategies to create linkages to needed care.
 - Provide direct outreach and family support from Kansas Healthy Start Home Visitors or community health outreach staff to pregnant women at high risk. Projects must ensure that the pregnant women and mothers with infants have ongoing sources of primary and preventive health care and that their basic needs (housing, psychosocial, nutritional and educational and job skill building) are met.
 - Demonstrate through staff job descriptions the designation of outreach responsibilities to specific staff members.

- Provide home visits and other outreach methodologies in reaching targeted pregnant women and mothers with infants eligible for MCH service provision. See Healthy Start Home Visitor Services, Section 410.
- Utilize the Kansas Resource Guide as a referral tool for families.

Standard 4: Care Coordination

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

- **Rationale:**

Care coordination is defined by the Kansas program as a patient and family-centered approach that utilizes team-based and assessment activities designed to meet the needs of children and youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and financial needs to achieve optimal health.

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

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

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

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

Standard 5: MCH Service Team

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

- **Rationale:**

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

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

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

Standard 6: Family-Centered Care

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

- **Rationale:**

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

The FCP clearly defines the family’s goals, service content, frequency and duration and responsibilities of the MCH team and the family in working toward meeting the goals. The FCP is a working document, produced collaboratively by

program staff and the family members, that contains the agreed upon MCH services. At a minimum the FCP should:

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

Standard 7: Health Risk Assessment and Screening

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

- **Rationale:**

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

The purpose of the Comprehensive Health Risk Assessment is to provide the early identification of health needs and to link families to available community services to

prevent or mitigate poor health and/or developmental outcomes. Population-based education and health promotion activities are instrumental in reducing chronic diseases.

[Bright Futures, 3rd Edition Guidelines](#)⁵, the curriculum incorporates standards of care recommended by AAP, CDC, Medicaid and other government and professional organizations. Bright Futures is a set of principles, strategies and tools that are theory based and systems oriented that can be used to improve the health and well-being of all children through culturally appropriate interventions that address the current and emerging health promotion needs at the family, clinical practice, community, health system and policy levels.

- **Local agency grantees:**
 - Develop an approved screening process for all participants and refer to other programs/funding sources as appropriate.
 - Develop a working relationship with other programs to ease the referral process for clients.
 - Develop a referral system with effective follow-up for all screenings.
 - Screen families for the use of Alcohol, Tobacco and Other Drugs (ATOD) and provided education about the associated risks.
 - Educate families about depression; provide screening and referral to appropriate mental health providers.
 - Educate families about health and safety in the home and community.
 - Educate families about interpersonal violence; provide screening and referral to community support and protective services.
 - Educate parents and assess families for child abuse and neglect and report suspected child abuse and neglect to Department for Children and Families (DCF) appropriately.

Standard 8: Education and Prevention

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

- **Rationale:**

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

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

⁵ http://brightfutures.aap.org/pdfs/bf3%20pocket%20guide_final.pdf

enables a woman to learn the warning signs and symptoms of impending preterm delivery.

Critical strategies to improve the health care provided children and adolescents, including those with special health care needs, are to meet parents' informational needs and elicit their concerns in a systematic, standard way. A primary component of well-child care is Anticipatory Guidance and Parental Education (AGPE). Bright Futures Anticipatory Guidance Cards help "cue" health professionals and families to review key developmental goals for children and adolescents: confidence, success in school, responsibility and independence. Other topics range from safety and healthy eating to fitness and family relationships⁶. The most reliable and valid approach to measure whether parents informational needs are being met is to ask parents directly.

- **Local agency grantees:**

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

Standard 9: Medical Home

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

- **Rationale:**

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 [policy statement](#), the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective care. A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary health care.

⁶ [http://brightfutures.aap.org/3rd Edition Guidelines and Pocket Guide.html](http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html)

In a medical home, a physician or medical provider works in partnership with the family/patient to make sure that all of the medical and non-medical needs of the patient are met. Through this partnership, the doctor can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support and other public and private community services that are important to the overall health of the pregnant woman, child/youth and family. The public health role is to assist individuals and families without identified medical homes. Families will be assisted in selecting a medical home, applying for insurance and securing payer assistance for which they may qualify. Families will be taught to navigate the health care system and partner with physicians and medical providers to assure that all available community resources are known and utilized appropriately.

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

- **Local agency grantees:**
 - Convene a county-based Medical Home Leadership Group of physicians, medical providers and community public and private resource partners.
 - Develop community resource lists and package them in formats appealing to busy medical offices.
 - Work with local community and regional medical providers to accept individuals and families into primary health care services and to serve as their medical home.
 - Assist uninsured individuals and families to complete the Medicaid/KanCare application.
 - Problem-solve situations with families that many doctors' offices do not have the time or knowledge to do.
 - Serve as care coordinator for high risk families.
 - Provide direct medical services only if there are no medical providers in the region.
 - Coach and encourage families to ask questions, document symptoms, voice their needs and priorities, provide feedback and otherwise develop an effective medical home partnership with the primary care provider and other health care providers.
 - Educate families about early intervention and school and community services.
 - Support medical homes by providing or assisting to provide care coordination and family support and education. Public Health staff is often the single best source of up-to-date information about what services are available locally and the exact steps needed to access them.

108 References

American Academy of Pediatrics (AAP) www.aap.org/

American Academy of Family Physicians (AAFP) www.aafp.org/online/en/home.html

American College of Obstetricians and Gynecologists ACOG) www.acog.org/
Association of State and Territorial Health Officials (ASTHO) www.astho.org/
Bright Futures, Georgetown University, promoting and improving the health, education
and well-being of the children and adolescents and their families.

www.brightfutures.org/

Center for Disease Control and Prevention (CDC) www.cdc.gov/

Maternal and Child Health Bureau (MCHB) www.mchb.hrsa.gov/

National Academy for State Health Policy (NASHP) www.nashp.org

National Association of County and City Health Officials (NACCHO)

www.naccho.org/topics/infrastructure/index.cfm

150 - MCH Background

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151 Title V Block Grant to States

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

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

Legislatively-Defined State MCH Population Groups

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

MCH Population Health Domains

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

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

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

Significant Concepts

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

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

The Maternal and Child Health Bureau (MCHB) is the principal focus within Health Resources and Services Administration (HRSA) for all Maternal and Child Health (MCH)

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

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

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

152 Maternal and Child Health⁷

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

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

⁷ Adapted from the Introduction to MCH 101 in-depth module at the HRSA MCH Timeline. www.mchb.hrsa.gov/timeline/.

The MCH program is required by law to serve as a gap-filling provider for families served through the Medicaid program. A partnership exists between the Maternal Child Health Services and Medicaid to serve high risk families. The Maternal and Child Health (MCH) Services Block Grant and Medicaid, authorized by Title V and Title XIX of the Social Security Act (SSA), serve complimentary purposes and goals. Coordination and partnerships between the two programs greatly enhance their respective abilities, increase their effectiveness and guard against duplication of effort. Such coordination is the result of a long series of legislative decisions that mandate the two programs to work together.

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

153 MCH 10 Essential Services

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

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

154 MCH (Title V) Funding

The Maternal and Child Health Bureau (MCHB)⁸ within HRSA administers the Maternal and Child Health Services Block Grant (Title V). Every year Kansas joins other states and territories in submitting an application to the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) for MCH funding.

Applications for funding must include:

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

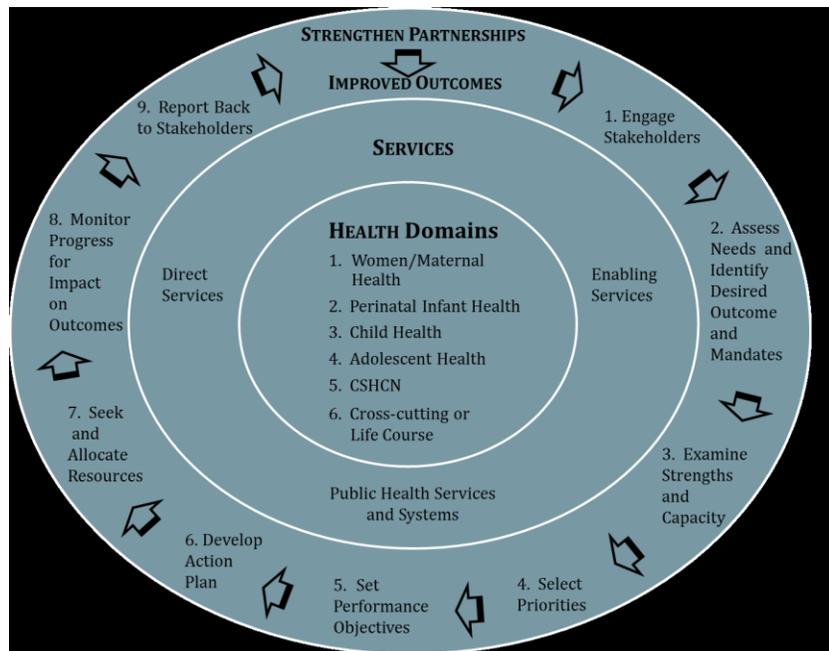
Each state receives an amount based on the proportional number of children in poverty according to the U.S. Census. As poverty levels improve or worsen within states, funding amounts to states fluctuate. States are required to provide a match amount of three dollars for every four dollars in Federal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

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

155 State Comprehensive 5-Year MCH Needs Assessment

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

⁸ Maternal and Child Health Bureau. <http://mchb.hrsa.gov/>



The most current state plan “MCH 2020” includes the following selected state priorities and associated national performance measures and for the five-year period 2016 through 2020.

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

* States select 8 of 15 that address the state priority needs; at least one for each population domain area.

National Performance Measures (NPMs)*	Population Domain
1. Well-woman visit (Percent of women with a past year preventive medical visit)	Women/Maternal Health
2. Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)	Perinatal/Infant Health

3. Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)	Child Health
4. Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)	Child Health
5. Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)	Adolescent Health
6. Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)	Adolescent Health
7. Medical home (Percent of children with and without special health care needs having a medical home)	Children with Special Health Care Needs
8. Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy; B. Percent of children who live in households where someone smokes)	Cross-cutting

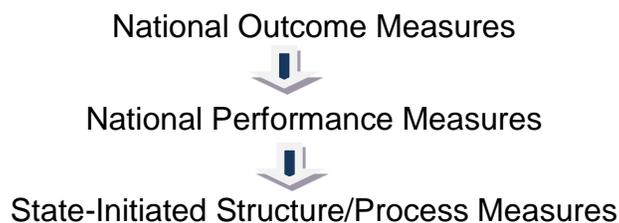
* States select 8 of 15 that address the state priority needs; at least one for each population domain area.

MCH2020 represents a cycle of continuous improvement for maternal and child health programs and services. Between 2016 and 2020, actions and strategies will be implemented, results will be monitored and evaluated and adjustments will be made as necessary to continue to enhance the health of Kansas women, pregnant women, infants, children, and adolescents, including children and youth with special health care needs and their families. The MCH plan will also address cross-cutting priorities.. State priorities and measures are reviewed annually in July and may change based on emerging health needs for the MCH populations.

156 MCH Performance and Accountability

MCH Programs are accountable for continually assessing needs, assuring that services are provided to the MCH population and developing policies consistent with needs. MCH public health professionals are accountable to the public and to policymakers to assure that public dollars are being spent in a way that is aligned with priorities. Some of the factors for which MCH is accountable include: the core public health functions outlined by Centers for Disease Control and Prevention National Public Health Performance Standards Program (NPHPSP)⁹; collecting and analyzing health data; developing comprehensive policies to serve the MCH population; and assuring that services are accessible to all.

National Performance Measure Framework



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

A number of tools and measures have been developed to measure performance and document accountability. The MCHB uses performance measurement and other program evaluation to assess progress in attaining goals, implementing strategies and addressing priorities. Evaluation is critical to MCHB policy and program development, program management and funding. Findings from program evaluations and performance measurement are part of the ongoing needs assessment activities of the Bureau.

157 National Outcome Measures

National Outcome Measures (NOMs)		Population Domain
1.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	Perinatal/Infant Health
2.	Percent of delivery or postpartum hospitalizations with an indication of severe morbidity	Women/Maternal Health
3.	Maternal mortality rate per 1000,000 live births	Women/Maternal Health
4.1	Percent of low birth weight deliveries (<2,500 grams)	Perinatal/Infant Health
4.2	Percent of very low birth weight deliveries (<1,500 grams)	Perinatal/Infant Health
4.3	Percent of moderately low birth weight deliveries (1,500-2,499 grams)	Perinatal/Infant Health
5.1	Percent of preterm birth (<37 weeks)	Perinatal/Infant Health
5.2	Percent of early preterm births (<34 weeks)	Perinatal/Infant Health
5.3	Percent of late preterm births (34-36 weeks)	Perinatal/Infant Health
6.	Percent of early term births (37, 38 weeks)	Perinatal/Infant Health
7.	Percent of non-medically indicated early term deliveries (37, 38 weeks) among singleton term deliveries	Perinatal/Infant Health
8.	Perinatal mortality rate per 1,000 live births plus fetal deaths	Perinatal/Infant Health
9.1	Infant mortality rate per 1,000 live births	Perinatal/Infant Health
9.2	Neonatal mortality rate per 1,000 live births	Perinatal/Infant Health
9.3	Post neonatal mortality rate per 1,000 live births	Perinatal/Infant Health
9.4	Preterm-related mortality rate per 1,000 live births	Perinatal/Infant Health
9.5	Sudden Unexpected Infant Deaths (SUID) mortality rate per 1,000 live births	Perinatal/Infant Health
10.	The rate of infants born with fetal alcohol syndrome per 10,000 delivery hospitalizations	Perinatal/Infant Health
11.	The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations	Perinatal/Infant Health
12.	Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens that are followed up in a timely manner (DEVELOPMENTAL)	Perinatal/Infant Health
13.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	Child Health
14.	Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months	Child Health
15.	Rate of death in children aged 1 through 9 per 100,000	Child Health
16.1	Rate of death in adolescents age 10-19 per 100,000	Adolescent Health
16.2	Rate of deaths to children aged 15-19 years caused by motor vehicle crashes per 100,000	Adolescent Health

16.3	Rate of suicide deaths among youths aged 15 through 19 per 100,000	Adolescent Health
17.1	Percent of children with special health care needs	CSHCN
17.2	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	CSHCN
17.3	Percent of children diagnosed with an autism spectrum disorder	Child Health and/or CSHCN
17.4	Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity disorder (ADD/ADHD)	Child Health and/or CSHCN
18.	Percent of children with a mental/behavioral condition who receive treatment	Child Health and/or Adolescent Health
19.	Percent of children in excellent or very good health	Child Health
20.	Percent of children and adolescents who are overweight or obese (BMI at or above the 85 th percentile)	Child Health and/or Adolescent Health
21.	Percent of children without health insurance	Child Health
22.1	Percent of children ages 19-35 months, with the 4:3:1:3(4):3:1:4 combined series of vaccines	Child Health
22.2	Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza	Child and/or Adolescent Health
22.3	Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine	Adolescent Health
22.4	Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine	Adolescent Health
22.5	Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine	Adolescent Health

158 National Performance Measures

National Performance Measures (NPMs)		Population Domain
1.	Percent of women with a past year preventive medical visit*	Women/Maternal Health
2.	Percent of cesarean deliveries among low-risk first births	Women/Maternal Health
3.	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Perinatal/Infant Health
4.	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months*	Perinatal/Infant Health
5.	Percent of infants placed to sleep on their backs	Perinatal/Infant Health
6.	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool*	Child Health
7.	Rate of hospitalization for non-fatal injury per 100,000 <u>children ages 0 through 9</u> and adolescents ages 10 through 19*	Child Health and/or Adolescent Health
8.	Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day	Child Health and/or Adolescent Health
9.	Percent of adolescents, ages 12 through 17, who are bullied or who bully others*	Adolescent Health
10.	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year*	Adolescent Health

11.	Percent of children with and without special health care needs having a medical home*	Children with Special Health Care Needs
12.	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	Children with Special Health Care Needs
13.	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	Cross-Cutting/Life Course
14.	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes*	Cross-Cutting/Life Course
15.	Percent of children ages 0 through 17 who are adequately insured	Cross-Cutting/Life Course

*Kansas selection

159 State Performance Measures

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

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

Performance measures help to quantify whether:

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

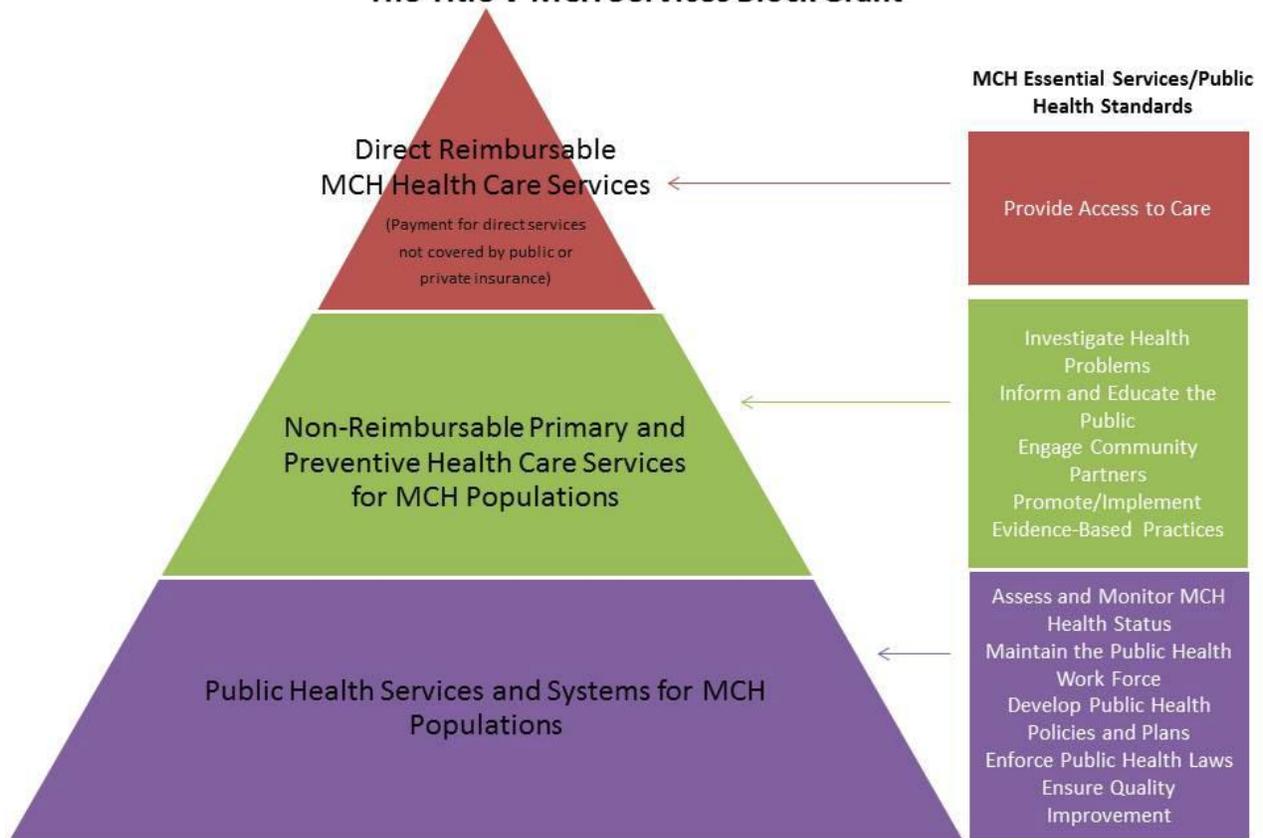
State MCH Performance Measures (SPMs) (as of January 2016; to be finalized by July 2016)

State Performance Measures to assess progress toward priorities for the period 2016-2020 are under development and will be finalized by July 2016.

160 MCH Pyramid

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

Public Health Services for MCH Populations: The Title V MCH Services Block Grant



Direct Services

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

Direct services include, but are not limited to:

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

Enabling Services

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

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

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

Public Health Services and Systems

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

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

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

161 Essential Public Health Services to Promote Maternal and Child Health

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

- Mobilize partners, including families, at the federal, state and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services and developing supportive policies;
- Integrate systems of public health, health care and related community services to ensure access and coordination to assure maximum impact;
- Conduct ongoing assessment of the changing health needs of the MCH population (as impacted by cultural, linguistic, demographic characteristics) to drive priorities for achieving equity in access and positive health outcomes;
- Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and efficient use of resources;
- Inform and educate the public and families about the unique needs of the MCH population;
- Promote applied research resulting in evidence-based policies and programs;
- Promote rapid innovation and dissemination of effective practices through quality improvement and other emerging methods; and
- Provide services to address unmet needs in healthcare and public health systems for the MCH population (i.e. gap-filling services for individuals.)

162 Local Core MCH Public Health Services for Women’s and Maternal Health

- **Direct Services**
 - Well Women Care for Uninsured Women (gap filling)
 - Comprehensive prenatal care (gap filling)
 - Health screening and exams not provided through other programs (gap filling)
 - Genetic Screening, counseling and diagnosis (gap filling)
- **Enabling Services**
 - Medicaid/KanCare information and outreach
 - Health Literacy and eligibility assistance
 - Translation/transportation services
 - Resources, referrals and/or care coordination
 - Health education regarding healthy lifestyles: physical activity and nutrition; smoking cessation; substance abuse; breastfeeding; immunizations; injury prevention
- **Public Health Services and Systems**
 - Public education and social marketing campaigns related to healthy lifestyles
 - Countywide public health projects and outreach
 - Coalition leadership and collaboration
 - Community needs assessment, program planning and evaluation

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

- **Direct Services**
 - Provision of perinatal and postnatal care services (gap filling)
 - Provision of infant care services (gap filling)
 - Immunizations
 - Genetic Screening, counseling and diagnosis (gap filling)
- **Enabling Services**
 - Medicaid/KanCare information and outreach
 - Health Literacy and eligibility assistance
 - Translation/transportation services
 - Resources, referrals and/or care coordination
 - Childbirth and parenting classes
 - Newborn metabolic screening follow-up
 - Newborn hearing screening follow-up
 - Health education regarding healthy lifestyles: safe sleep; breastfeeding; newborn care; infant growth and development; immunizations; physical activity and nutrition; injury prevention; parent-infant bonding.
- **Public Health Services and Systems**
 - Public education and social marketing campaigns related to healthy lifestyles
 - Safe Haven
 - text4baby
 - Countywide public health projects and outreach
 - Coalition leadership and collaboration
 - Community needs assessment, program planning and evaluation

164 Local Core MCH Public Health Services for Child Health

- **Direct Services**
 - Well child care for uninsured children (gap filling)
 - Immunization (gap filling)
 - Developmental screenings (including social/emotional)
 - Vision and hearing screenings
- **Enabling Services**
 - Health education regarding fitness, nutrition, motor vehicle safety, emergency preparedness, immunization, pregnancy prevention, substance abuse
 - Providing Medicaid/KanCare information and eligibility requirements to families with young children
 - Resources, referrals and/or care coordination
 - School readiness activities
 - Providing information regarding quality childcare and after school activities
- **Public Health Services and Systems**
 - Public education and outreach related to:

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

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

- **Direct Services**
 - Well child care for uninsured children (gap filling)
 - Immunization (gap filling)
 - Developmental screenings (including social/emotional)
 - Vision and hearing screenings
 - Provision of Specialty Care in Specialty Clinics (gap filling)
 - Diagnostic Services in Diagnostic and Evaluation (D&E) Clinics (gap filling)
- **Enabling Services**
 - Health Consultation for Medical Home, Specialty Care, Transition to Adult Health Care, Early Intervention and School Services.
 - Individual and Family Care Coordination Services Health Care Resources, Referrals and Care Coordination for CYSHCN, Families and Providers
 - Health education regarding fitness, nutrition, motor vehicle safety, emergency preparedness, immunization, pregnancy prevention, and substance abuse
 - Providing Medicaid/KanCare information and eligibility requirements to families with young children
 - Resources, referrals and/or care coordination
 - Family Advocacy and Support
 - Newborn metabolic screening follow-up
 - Newborn hearing screening follow-up
 - School readiness activities
 - Providing information regarding quality childcare and after school activities
- **Public Health Services and Systems**
 - Public education and outreach related to:
 - Child Abuse Prevention
 - Injury Prevention
 - Importance of immunizations
 - Collaboration and coordination with early intervention and public schools special education, social services and family support services
 - Early childhood and school based collaborations and coalitions
 - Administration of medication
 - School screening and entry examinations
 - Providing health related assistance to school nurses

- To ensure adequate health services for children with special health care needs by partnering and collaborating with:
 - Primary care,
 - Habilitative and rehabilitative services,
 - Other specialty medical treatment services,
 - Mental health services and
 - Home health care

166 Local Core MCH Public Health Services for Adolescent Health

- **Direct Services**
 - Adolescent well visit for uninsured children (gap filling)
 - Immunization (gap filling)
 - HPV (male and female)
 - Flu shot
 - Vision and hearing screenings
 - Sexual and reproductive health (gap filling)
- **Enabling Services**
 - Health education regarding fitness, nutrition, motor vehicle safety, pregnancy prevention, substance abuse, sexual and relationship behaviors, unintentional and intentional injuries
 - Providing Medicaid/KanCare information and eligibility requirements
 - Resources, referrals and/or care coordination
 - Suicide prevention hotline
 - Abstinence education
 - Counseling services
- **Public Health Services and Systems**
 - Public education and outreach related to:
 - Injury Prevention and risky behaviors
 - Teen pregnancy prevention
 - Collaborating with schools to improve health, nutrition and fitness to include:
 - Administration of medication
 - School screening and entry examinations
 - Providing health related assistance to school nurses

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

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

- Access to health care – Medical Home
- Adequate insurance coverage
- Behavioral health/mental health
- Cultural competence
- Emergency planning
- Injury
- Intimate partner violence
- Nutrition

- Oral health
- Physical activity
- Sexually Transmitted Infections (STI)
- Smoking and Substance Abuse

200 - Social Determinants of Health & Disparities

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201 - Description of Social Determinants and Health Disparities

202 - Health Disparities Defined

203 - Public Health and Disparities

201 Description of Social Determinants and Health Disparities

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

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

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

202 Health Disparities Defined

There are many definitions of health disparities.

" . . . Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." ~ National Institutes of Health (NIH) *Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities* (October 6, 2000) [NIH Strategic Plan](#)

Translation: differences in getting diseases among certain population groups, how long you live with them, deaths that result, and additional problems and health conditions that may exist.

". . . Differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation."

United States Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health* (November 2000) [HP2010 Improving Health](#)

" . . .Inequalities in the distribution of valued goals (e.g., health) and access to resources for achieving those goals (e.g., use of health care or preventive services) University of Kansas (KU) Workgroup on Health Promotion. "*Promoting Health for all: An Action Planning Guide for Improving and Eliminating Health Disparities in Community Health*"

With the launch of Healthy People 2010 in January 2000, the Department of Health and Human Services provided the United States with standards for improving the public health system at the local, state, and national levels based on two overarching goals:

1. Increase quality and years of healthy life among all ages of people living in the United States.
2. Eliminate health disparities among different segments of the population by specifically targeting the segments that need to improve the most.

These goals are maintained by Healthy People 2020.

203 Public Health and Disparities

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

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

According to Healthy Kansans 2010 (set of recommendations to improve the health of all Kansans that is aligned with Healthy People 2010), lower socioeconomic and education levels, inadequate and unsafe housing, lack of access to care, quality of care, and living in close proximity to environmental hazards disproportionately affect racial, ethnic, and underserved populations and contribute to poorer health outcomes.

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

300 - MCH Administrative Manual

Fiscal/Grant Management

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301 Grant Applications

The Maternal and Child Health (MCH) program grant application is part of the Aid-To-Local (ATL) process within the Kansas Department of Health and Environment. In January of each year, the Grant Application Guidelines and Grant Reporting are available on the [KDHE ATL website. www.kdheks.gov/doc_lib/index.html](http://www.kdheks.gov/doc_lib/index.html)

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

To apply for funding, fill out an application in [Catalyst. www.catalystserver.com](http://www.catalystserver.com)

Note: Existing/previous grantees will receive a Catalyst user name and password in advance. New applicants should contact the Catalyst Operations Support Team at support@shpr.org.

Before starting the application, complete the following training courses on [Kansas TRAIN: https://ks.train.org/DesktopShell.aspx](http://ks.train.org/DesktopShell.aspx)

- Catalyst Training 1: Catalyst Navigation (Course #1054439)
- Catalyst Training 2: Application Process Overview in Catalyst (Course #1054483)
- Catalyst Training 3: Application Management in Catalyst (Course #1054567)
- Catalyst Training 4: Applying for Funding Announcement(s) in Catalyst (Course #1054672)

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

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

302 Contracts and Subcontracts

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

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

- Contracts are issued for one-year periods based on review of the application, contract agency performance and compliance with both general and special conditions of the contract.
- The MCH grantee shall notify KDHE in writing within ten (10) working days of any change of key personnel.
- KDHE shall be notified of any change in office or service location from that shown in the contract at least ten (10) working days prior to such change.
- Changes in the services to be provided by the MCH grantee as outlined in the contract require prior written approval by KDHE. Discontinuation of any service may result in a decrease in the contract amount or termination of the contract.
- A request for approval of program adjustments must be submitted in writing to the Bureau of Family Health, Children & Families section if there is a ten (10) percent or more variance in the line item of the current budget. Approval must be granted before changes are implemented. The request should indicate what portion of the narrative or budget will be changed along with justification.
 - Adjustments less than ten (10) percent of a line item may be made within the budget without prior approval. This includes moving less than 10 percent of the total budget amount for a program within the budget, revisions to the “other funds” categories and changes in a single category of personnel of less than .20 FTE. Examples include replacing one full-time nurse with two part-time nurses.
- Amendments - A contract amendment is in order when an actual increase or decrease to the grant award amount is made. These are typically initiated by KDHE. KDHE and local agencies monitor expenditures to assure budget allocations are adhering to contract agreements.
- **Universal Contract**
KDHE Aid-To-Local Program
 1. Disclose personal health information (PHI) to the State Agency as requested or as required by law [45 C.F.R. 165.512(b)] unless disclosure is prohibited by the Health Insurance Portability and Accountability Act (HIPAA).
 2. Comply with all relevant federal requirements.
 3. Comply with statutes, rules and regulations pertaining to public health, including but not exclusively K.S.A. 65-101 et seq.
 4. The Local Agency, its agents or subcontractors, shall provide services which have meaningful access to persons with Limited English Proficiency (LEP) pursuant to Title VI of the Civil Rights Act [(42.U.S.C. 2000d et seq.) and 45 C.F.R. 80.3(b)].
- **Notice of Grant Award Amount and Summary of Program Objectives.**
Grantee will be asked to submit a revised final budget for the amount awarded.

Awarding Funds

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

failure to meet contract requirements and/or submit timely reports.

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

Subcontracts

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

303 Contract Revisions

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

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

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

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

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

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

Process

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

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

304 Budgets

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

305 Documentation of Local Match

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

- Federal funds, with two exceptions, are not allowable as match. Exceptions:
 - Medicaid dollars received for services provided
 - Native American Tribes eligible under P.L. 93-638 may use those federal funds for match.

306 Financial Accountability

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

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

Fringe Benefits

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

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

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

Financial Status Report (FSR) / Affidavit of Expenditures

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

1. The State Fiscal Year begins on July 1 each year.
2. 25 percent of the total grant amount shall be available to the local agency for the period July 1 through September 30.
3. Agency must spend the grant money and 40 percent match dollars by the end of the fiscal year, June 30.
4. All salary amounts charged must be supported in your agency accounting records and by the individual employee time sheets.

5. Fringe benefits may only be requested on that portion of the employee’s salary supported by the MCH contract and must be based on the salary rate specified in the MCH application.
6. The “TRAINING” category on the FSR should include expenses related to fees, accommodations, mileage, etc. Travel costs directly tied to training should go in this category instead of “TRAVEL”.
7. The “OTHER” category on the FSR must be itemized. “MISC” or “OTHER” responses will not be accepted. This category could include phones, internet charges, etc.
8. At least half (50 percent) of your grant award should be spent and reported by December 31. At least half (50 percent) of the required match amount should be spent and reported by December 31.

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

307 Reporting Schedule

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

- Financial Status Report (FSR)
- Quarterly Progress Report

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

308 Fiscal Record Retention

State/KDHE

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

Local

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

309 Inventory or Capital Equipment

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

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

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

Equipment

1. Equipment is defined as any item having a useful life of one year or more and a unit acquisition cost of \$2,000 or more.
2. Items such as office supplies, medical supplies and data system supplies are excluded from the definition of equipment and thus considered supplies.
3. If any agency desires to purchase equipment that was not approved as part of the current application budget line item, prior approval is required.
4. MCH funds may not be used to purchase motor vehicles.
5. Contract agencies may request in writing to delete equipment from their inventories if the equipment has been lost, stolen, broken, is obsolete, or no longer meets the definition of equipment as defined in this policy. The Bureau of Family Health will return a written approval letter or authorized E-mail.

310 Income

Program Income

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

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

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

Cash Donations

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

Other Sources of Funding

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

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

Determining Income

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

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

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

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

Income shall be calculated using the following definitions:

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

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

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

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

Sliding Fee Scale

A Sliding Fee Scale is required with a minimum of four increments and implemented for all MCH services provided. <http://aspe.hhs.gov/poverty/>

Income and Discount Eligibility Guidelines

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

311 Data Collection

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

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

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

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

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

Learn more about the DAISEY team and DAISEY software.

<http://daiseysolution.com/wp-content/uploads/2014/03/about-daisey.pdf>

Getting Started with DAISEY:

The DAISEY for KDHE website (<http://daiseysolution.com/kdhe/>) provides all of information you need to get started.

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

312 Monitoring

Site visits are conducted to evaluate the performance of local agencies. Site visits are also a mechanism for State staff to receive feedback from local agency staff as well as to provide technical assistance and training. Unless otherwise notified, all aspects

(clinical, community outreach and information, fiscal and administrative) of the MCH program will be reviewed.

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

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

Audit or Examination of Records

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

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

Grant Compliance

At any time your agency is not in compliance with the grant requirements, then your agency may be placed on provisional status and monies will be held until requirements

are met. Reasons to withhold payments or monies include, but are not limited to the following:

- Financial Status Report (FSR) is not received.
- Quarterly Progress Report is not received.
- Data is not current or imported in DAISEY by the 10th of each month.
- A response to a monitoring (site) visit is past due.
- Home Visitor did not attend a required Statewide Conference.
- Home Visitor did not attend the required Fall Regional training.
- Any other requested information to determine compliance with contract requirements is not received.

Withholding of Support

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

Suspension

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

Contract Termination

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

Changes of Key Personnel

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

Changes in Location

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

Changes in Service

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

313 Client Satisfaction/MCH Survey Cards

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

350 - Guidelines for Records Management

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351 - Scope of Records Management

352 - Statutes and Laws for Records Management

353 - Resources

351 Scope of Records Management

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

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

352 Statutes and Laws for Records Management

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

353 Resources

Confidentiality and Protection of Health Information

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

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

Information on the HIPAA Privacy Rule is available at:

www.hhs.gov/ocr/hipaa/.

Information on the other HIPAA Administrative Simplification Rules is available at www.cms.hhs.gov/HIPAAGenInfo/.

Family Education Rights and Privacy Act (FERPA)

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

www.ed.gov/policy/gen/guid/fpco/index.html.

Kansas Public Health Statutes and Regulations

Kansas Public Health Statutes and Regulations Book

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

Medical Records Management for Public Health

Public Health Resource Manual

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

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

Records Retention

Records Retention in Government

Locate policies, programs and information for records retention and historic preservation at the Kansas Historical Society. Records management for State, local and municipal government agencies can be found at

www.kshs.org/government/index.htm.

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

400 - Maternal and Infant Health

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401 Program Description

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

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

402 Program Purpose

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

403 Multidisciplinary Health Professional Team

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

Interventions should emphasize risk reduction associated with poor pregnancy outcomes as well as quality of life for mothers, infants and families. Services should include, but not be limited to: outreach to identify high-risk pregnant women; pregnancy testing and case management for pregnant clients. Further, follow-up for the mother, infant and family that is based on identified risks should be available for one year postpartum. The overarching goal of the MCH Program's women and infant services

can be summed up as: healthy mothers giving birth to healthy infants. This goal is accomplished by promoting public/private partnerships to facilitate ready access to affordable and risk appropriate care leading to a reduction in the negative consequences associated with preterm birth, low birth weight and infant mortality.

410 - Guidelines for Outreach and Family Support: Home Visiting and the Kansas Healthy Start Home Visitor (HSHV) Services

411 Description of Services

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

A HSHV works in tandem with, and is supervised by, professional nursing and/or social work staff as part of the constellation of maternal and child health promotion and prevention services to improve birth outcomes and healthy infant development.

Through home visits and other contacts, the HSHV provides outreach, support, and referrals to other community services to pregnant women and families with infants up to one year postpartum. The HSHV services are not independent of other MCH services, but are to complement and assist with MCH services to pregnant women and families with infants. The program is universal in approach, available to all without additional eligibility limitations. HSHV services are short-term, providing just one to a few visits, and are distinct from other longer-term, intensive home visiting programs.

The HSHV services are intended to increase knowledge, change beliefs and alter behaviors by increasing the number of women accessing early and comprehensive health care before, during and after pregnancy. A HSHV provides education on health and safety promotion, parenting, and preventive programs relevant to the prenatal and postnatal periods and infant development. They provide assistance to families in linking them to resources and in navigating access to systems of care. An important role of the HSHV is to have a broad knowledge of available community resources.

Under public health nurse supervision, visitors provide in-home interventions such as education and support. In addition, home visitors have the potential to:

1. Increase the use of cost-effective preventive health care services such as prenatal care, family planning, immunizations, nutrition and well childcare.
2. Promote early entry into and compliance with prenatal care.
3. Discourage unhealthy maternal behaviors such as alcohol and tobacco use.
4. Identify families at risk and link them with services and supports.
5. Improve and enhance parenting and problem solving skills.
6. Reduce costs through use of paraprofessional visitors under nursing supervision.

412 Eligibility for Services

There is no eligibility requirement. Services are available to ALL pregnant women and families with newborns and infants up to one year postpartum, including those with adoptive and foster children.

413 Program Philosophy, Goals and Objectives

Support and education for pregnant women and families with newborns can increase the use of preventive health services and reduce the incidence of poor outcomes for

infants and their families. Basic assumptions underlying family-centered home visiting efforts include the following:

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

Outcome objectives to be met by grantee agencies providing HSHV services include short-term and intermediate outcomes including:

- **Short-term Outcomes**

- Families identify and use community resources
- Pregnant women demonstrate improved health behaviors such as decreasing substance abuse (e.g. cigarette smoking and alcohol use)
- Pregnant women access early prenatal care to reduce the incidence of premature and low birth weight babies
- Parents demonstrate nurturing parenting skills

- **Intermediate Outcomes**

- Mothers and their families utilize cost-effective preventive health care services such as prenatal care, family planning, immunizations, nutrition and well child services
- Mothers and their families demonstrate enhanced parenting and problem solving skills

414 Qualifications of Supervisors

The HSHV is supervised by professional staff that includes registered nurses or other professional staff, such as a social worker. The nurse or social work supervisor will be responsible for recruitment, screening, interviewing, selection, orientation and supervision of the home visitor(s). The supervisor will:

1. Be a graduate of an approved school of professional nursing or social work
2. Be licensed as a registered nurse or social worker in Kansas
3. Ideally, supervisors should have a minimum of one (1) year of experience as a public health professional and providing services to the target population

415 Responsibilities of Supervisors

1. Supervise the activities of the HSHV
2. Include home visitors in appropriate agency staff meetings
3. Consult with the home visitor on a regular and as needed basis, specifically to review client records and to discuss services needed for the family
4. Determine which families require a nurse visit after consultation with the home visitor
5. Have a thorough understanding of the role of the HSHV and the requirements to be met for the MCH grant
6. Assist the HSHV in identifying learning needs
7. Complete an annual written personnel evaluation
8. Periodically accompany home visitors on home visits to evaluate content of visits and effectiveness of the home visitor

9. Ensure that the registered nurse/social worker will make follow-up visits to families when the home visitor observes current or potential problems
10. Ensure that the home visitor has appropriate supervisor access and support in the event of client crises or emergencies
11. Promote effective interagency cooperation with community resources/programs
12. Consult with other professionals who have provided referrals to HSHV services
13. Promote outreach activities in the local community to promote HSHV services
14. Ensure that all reports are completed and forwarded timely and accurately
15. Review/sign documentation of the home visitor

416 Qualifications of Home Visitors

1. Minimum of a high school diploma or GED
2. Ability to differentiate between home visitor and nursing responsibilities
3. Demonstrate the ability to respect the confidentiality of a client relationship
4. Demonstrate effective communication skills
5. Present a warm, concerned attitude toward families
6. Be knowledgeable of available community resources and how to utilize them
7. Take direction and carry out decisions made by supervisor
8. Complete reports in a timely and accurate manner
9. Work independently in a dependable manner
10. Be free from all communicable diseases
11. Model a healthy lifestyle while interacting with clients
12. Meet additional requirements of agency
13. Preferably have successful delivering support and education services

417 Responsibilities of Home Visitors

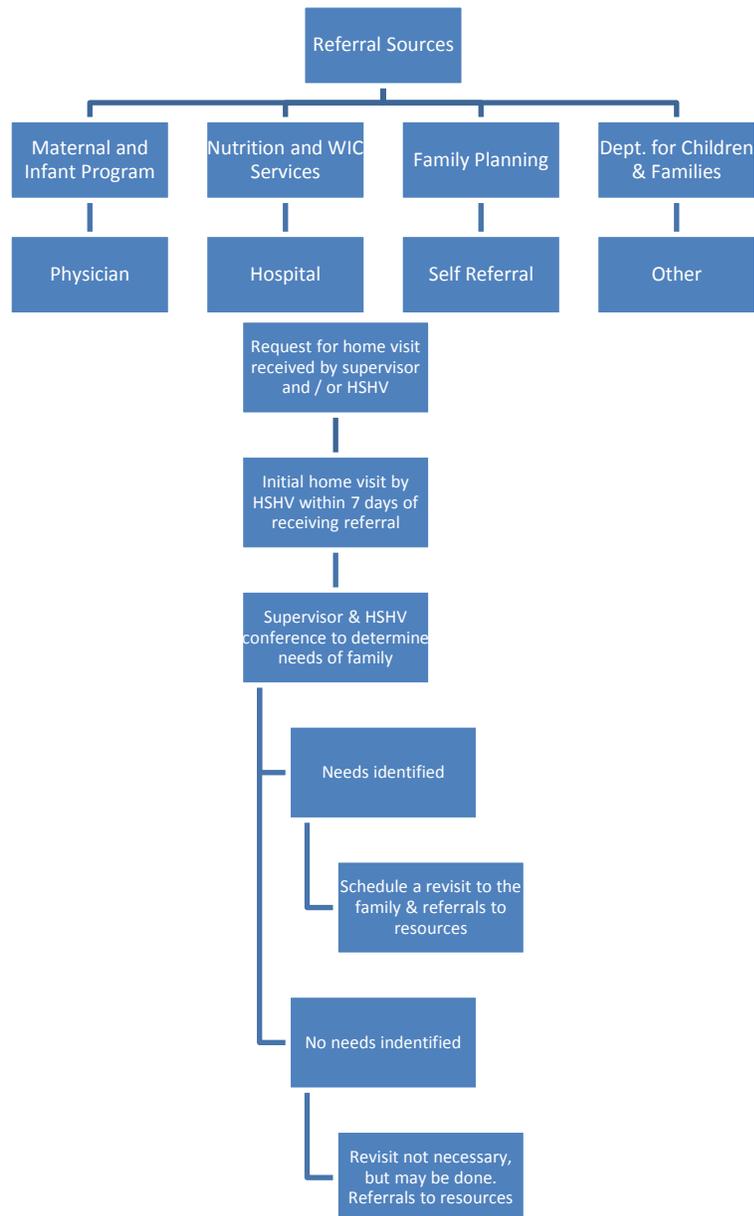
The role of the HSHV is to provide support and information to each mother/family visited, serving as a screener in identifying potential problems to be referred to the professional supervisor. Services are ideally provided in the client's home; however, services can be provided in a variety of settings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

1. Visit families to provide nonthreatening, friendly support
2. Visit each mother/family currently expecting a baby or with an infant < 12 months of age within seven (7) days of referral
3. Provide a resource list to families for local service options such as transportation, child care, DCF, health and medical services, social services including other longer-term home visiting programs, etc.
4. Refer to local resources as indicated, facilitate successful linkages, and follow up
5. Follow-up with needed and appropriate educational information
6. Observe families for any current or potential problems
7. Alert supervisors of existing or potential problems
8. Conduct return visits for ongoing as necessary and determined with supervisor
9. Seek client referrals from local health department programs, hospitals, physicians, DCF and all available local resources to initiate visits to a client prior to and during the hospitalization period
10. Participate in outreach activities in the local community to promote HSHV
11. Complete reports in a correct and timely manner

12. Participate in required training provided by KDHE

418 Provision of HSHV Services

Most agencies provide family support services to pregnant women including 1-4 visits prenatally and postnatally. Generally 1-2 visits are done with the mother; however the number of visits to be made is a decision of the supervising professional staff and the home visitor based on needs identified in the family.



419 Making a Home Visit

An important aspect of promoting the health of population has been the tradition of providing services to individual families in their homes. Home visits give a more

accurate assessment of the family structure and behavior in the natural environment. These visits provide opportunities to observe the home environment and to identify barriers and supports for reaching family health promotion goals. Meeting the family on its home ground also may contribute to the family's sense of control and active participation meeting its health needs.

Every grantee agency providing HSHV services should have a well understood and practiced safety policy. Additionally, if the visit is to be valuable and effective, careful and systematic planning must occur.

Phases and Activities of a Home Visit

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

420 Community Collaboration and Local Coordination

Every community has different kinds of organizations and services. In every locality opportunity exists for building cooperative relationships that will benefit families served. The agencies and organizations listed below have an interest or a mandate in helping families. Contacting one or more organizations can help HSHVs to locate resources and information to assist families. These may be partners in local projects or initiatives to address health and safety needs of families. The list is not comprehensive and may not fully apply to each locality; however these organizations are included to provide a starting point in which to explore community and regional resources.

Local referral sources include:

- Local health department and public health services
 - Maternal and Infant Health services
 - Women, Infants and Children (WIC) Nutrition Services
 - Reproductive Health/Family Planning

- Immunizations
- Developmental screening
- Well child screening and health assessment
- Department for Children and Families (DCF)
- Hospital(s) that serve the community and/or county
- Physicians that serve pregnant women and infants
- Regional medical and dental safety net clinics
- Mental health services
- School nurses and administrators
- Licensed and registered child care facilities
- Information and referral services
- Ministerial alliances
- Early childhood educators
- Early childhood, business, and health coalitions
- County extension offices
- Other home visiting programs

421 Healthy Start Home Visitor Services Pamphlets

In addition to locating resources, it is imperative that the HSHV provide education and outreach to other organizations to strengthen their understanding of the role of the HSHV in addressing the health and safety of the mother both prenatally and after delivery. English and Spanish pamphlets titled, “Healthy Start Home Visitor Services” are found at www.kdheks.gov/c-f/healthy.html. These pamphlets have space on the back of the pamphlet to insert local agency information and can be used in outreach efforts.

422 Orientation and Training Standards

Orientation of new home visitors consists of six components:

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

423 Initial Training for Healthy Start Home Visitors

Newly hired HSHVs will attend the Kansas Basic Home Visitation Training within the first six months of employment, pending availability of training. For information about the Kansas Basic Home Visitation Training, go to <http://www.kdheks.gov/c-f/healthy.html>.

The training is provided by the Kansas Head Start Association and includes both online and in-person components.

424 Continuing Education

As a requirement of the state's MCH Grant, all HSHVs will attend the fall regional HSHV training and one relevant, quality statewide conference per MCH Aid-to-Local Grant Guidelines or KDHE approval. HSHV and other MCH staff will be directed to KS-TRAIN as continuing education is made available. All staff should register on KS-TRAIN <http://ks.train.org> to receive notification of courses.

Another source for training is the [MCH Navigator](http://www.mchnavigator.org/), an online learning portal for MCH professionals funded by the Federal Maternal and Child Health Bureau, provides foundational and essential knowledge for those working to improve the health of women, infants, and families. <http://www.mchnavigator.org/>

Training records are maintained through KS-TRAIN, when possible. An Individual Professional Development Plan or other system of documenting educational training on all MCH personnel must be maintained and available for review. The plan should be updated annually. The plan is a valuable record that documents and demonstrates educational objectives met by staff and can assist in determining other learning needs of staff.

425 Confidentiality

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

Basic guidelines for maintaining confidentiality:

- Do not leave confidential records out in the open.
- Write only what is necessary, be objective and factual.
- Subjective information, assumptions and opinions should not be included in documentation. Consult with the supervisor for documentation standards.
- Parents have the right to read any and all portions of their files so be thoughtful about what you write.

426 Administrative Information and Documenting Services

It is essential that services being provided to families are documented by the HSHV. This documentation is part of the permanent client medical record. Documentation is to be done in a timely, objective and accurate manner. Each agency should have policies and procedures in writing that address documentation and maintenance of the client

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

427 Documentation of Visits for the Client's Permanent Health Record

HSHV services are reported as services provided by a trained home visitor under the supervision of a professional registered nurse or other professional staff member (e.g., Social Worker). Outreach services by registered nurses are reported as visits under Maternal and Infant or Child Health. HSHVs assist professional nursing staff in providing outreach and family support to pregnant women and mothers with newborns by assisting in health and safety promotion and preventive programs, as well as referring to resources (e.g., medical home, dental home, social/emotional services). The most essential role of the HSHV is to assist the family in identifying needs and providing families with resources and linkages to services.

Each agency is to have policies and procedures for documentation of services to clients including home visitation services. The documentation forms: Prenatal Visit Report and Postnatal Visit Report can be used by the HSHV and supervisor for documenting prenatal and postnatal services.

428 Client Visit/Encounter Data

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

Grantees must capture all required data elements via the web-based shared measurement system, DAISEY (Data Application and Integration Solutions for the Early Years). See more under Section 311 (Data Collection).

429 Evaluating Outreach and Family Support Services

Data obtained from home visitors assists MCH grantees in demonstrating progress being made toward meeting the National Performance Measures (NPM) and State Performance Measures (SPM) for the Title V MCH program.

Timely and accurate documentation of services in the client's permanent health record at the agency, as well as completion of required reports for the agency/state database, assure continuity in services through record keeping/follow-up. The data collected for the HSHV outreach and family support services to the mother provides the following:

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

- Number of visits made overall

430 Do's and Don'ts of Successful Home Visitation

The following will assist home visitors in providing a valuable service to the families served:

Some “do's” to consider:

- Be culturally sensitive, respecting cultural and ethnic values
- Be a good listener
- Plan and identify specific goals or objectives for each visit
- Be flexible
- Arrive promptly to your home visits
- Realize the limitations of your role
- Enable parents to become more independent
- Communicate appropriately
- Dress appropriately and comfortably
- Be confident
- Remember that small successes lead to big successes
- Be yourself
- Monitor your own behavior - you represent your agency and serve as a role model for the parent who is watching you
- Remember at all times to respect the confidentiality of the families
- Remember that each family is trying to do their best with the resources available

Some “don'ts” to avoid:

- Don't impose values
- Don't bring other visitors without the parent's permission
- Don't socialize excessively during the visit
- Don't exclude other members of the family from the visit
- Don't talk about families in public
- Don't be the center of attention
- Don't expect perfection from the parent

431 Federal Healthy Start Programs Serving Kansas

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

450 – Special Health Care Needs Regional Office Guidance

Table of Contents

451 – Description of Services

452 – Eligibility for Services

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454 – Local Agency Grantee Responsibilities

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451 Description of Services

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

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

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

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

452 Eligibility for Services

All participants must meet the following eligibility criteria:

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

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

453 Program Philosophy and Priorities

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

Cross-System Care Coordination: “Patient and family-centered approach that utilizes team-based and assessment activities designed to meet the needs of children and

youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and functional needs to achieve optimal health.”

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

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

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

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

454 Local Agency Grantee Responsibilities:

Assist in efforts to expand SHCN community-based services by:

- Providing outreach to community services and medical providers in the assigned region to share information about the SHCN program, eligibility requirements, the Special Bequest Commission, and the Special Health Services Family Advisory Council (SHS-FAC);
- Providing recommendations to SHCN of potential service locations for diagnostic evaluations within the assigned region;
- Providing application materials to recruit new SHCN specialty care providers;
- Assisting in recruitment of providers of all factions for the Kansas Resource Guide (KRG). Grantee shall attempt to recruit a minimum of ten (10) new medical or community providers per month;
- Assisting families to connect to SHCN Specialty Care Clinics, as appropriate;
- Coordinating with SHCN Specialty Care Clinics in their outreach efforts within the assigned region;
- Provide assistance with the application process to families interested in or needing SHCN services;
- Assist families in compiling necessary medical and financial information to SHCN and other state and federal financial assistance programs; and

- Follow up with families regarding referrals made to ensure support, collaboration and integrated service delivery across systems.

Develop proficiency in using the SHCN web-based client monitoring system to:

- Enter intakes and applications on clients;
- Monitor client status and communicate needs to families, as applicable;
- Input client notes into SHCN data system regarding interactions and communications made with SHCN families;
- Run update and reminder reports on a weekly basis to identify families that need updated applications, information or follow up;
- Host KDHE to two (2) on-site visits during the Contract period, one in the fall and one in the spring; and
- Establish and maintain accounting records that meet the requirements of generally accepted accounting principles. Program costs shall be identifiable grantee records, and supported by time and attendance or equivalent records for individual employees.

455 Data Reporting

Statistical data and Kansas Resource Guide reports will be submitted quarterly on the required reporting form to the Special Health Care Needs Program. The narrative report will be submitted semi-annually on the required reporting form to the Special Health Care Needs Program.

456 Confidentiality

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

Kansas Maternal & Child Health Application Reviewer Manual



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



KANSAS
MATERNAL &
CHILD HEALTH



Department of Health
and Environment

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

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

MCH GRANT APPLICATION REVIEWER MANUAL/GUIDANCE
State Fiscal Year (SFY) 2017

TIMELINE

March 15, 2016: *Electronic applications must be submitted to KDHE.*

March 30, 2016: *MCH staff conduct procedural review of applications to confirm compliance with application requirements. Any application received by grant reviewers complies with: eligibility criteria and required documentation.*

April 6, 2016: *Grant applications are electronically distributed to reviewers.*

April 25, 2016 by 5 p.m.: *Deadline for grant reviewers to return scored applications to program **by email**.*

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WHAT is the Maternal and Health (MCH) Grant?

Through a competitive application process, the KDHE Bureau of Family Health awards MCH funding to local programs providing services to women, pregnant women, infants, children, adolescents, and families, including children and youth with special health care needs. Special emphasis should be placed on serving at-risk individuals, assuring services, in order to meet specific MCH outcomes. In addition, local agencies increase access and participation in prenatal care services, increase first trimester enrollments in prenatal care services and facilitate access to comprehensive prenatal and postnatal healthcare and follow-up services for the mother and infant up to one year post delivery. Health, psychosocial and nutrition assessments are provided through a collaborative effort between public health and private medical providers.

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

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

BACKGROUND: TITLE V & KEY COMPONENTS

The following information is provided to assist the reviewer with reading and scoring MCH grant applications. Some of the terms provide definitions for key components of the application. Some of the terms are required elements of successful grant applications.

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

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

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

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

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

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

Role of Title V MCH Services Block Grant

Title V legislation and the MCH Program enable states to:

- a) provide and assure mothers and children access to quality MCH services;
- b) reduce infant mortality and the incidence of preventable diseases;
- c) provide rehabilitation services for blind and disabled individuals; and
- d) provide and promote family-centered, community-based, coordinated care, and facilitate the development of community-based systems of services.

Significant Concepts:

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

MCH Population Health Domains

1. Women's/Maternal Health
2. Perinatal/Infant Health
3. Child Health
4. Children and Youth with Special Health Care Needs
5. Adolescent Health

6. Cross-Cutting or Life Course

Definitions

Legislatively-defined State MCH Population Groups:

- (a) pregnant women, mothers, and infants up to age 1;
- (b) children; and
- (c) children with special health care needs.

Children and Youth with Special Health Care Needs (FEDERAL): “Children and youth with special health care needs (CYSHCN) are those who have, or are at risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”

Children and Youth with Special Health Care Needs (STATE): “A child with special health care needs” means a person under 21 years of age who has an organic disease, defect or condition which may hinder the achievement of normal physical growth and development.”

Priority Populations: Priority should be placed on identifying and serving:

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

At-Risk: Targeting services to at-risk children and families served should be considered when awarding points. Applications that target services to at-risk population(s) and families should be viewed more favorably. At-risk means:

- Income would qualify them for participation in the federal free or reduced lunch program
- Primary language is not English
- Lack access to a consistent source of health care
- Residing in communities/neighborhoods with limited resources such as quality child care, health facilities, parks, and playgrounds
- Infants/children at risk for developmental delay
- Families who have a child with a developmental delay
- Individuals/families who have less than a high school education
- Military families
- Teen parents

Public-Private Partnerships/Collective Impact: Applicants that ground their applications in a public-private partnership framework should be scored more favorably. This may include businesses, civic and community leaders, community organizations, Unified School Districts (USD), parents, and local government representatives. Preference will be given to applications which indicate a collective impact approach and coordination with other programs, including food and nutrition, education, developmental/ children and family services, family planning and other health and community service programs

Priority Needs: Title V legislation directs states to conduct a state-wide MCH Needs Assessment every 5 years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and CSHCN. From this assessment, states select seven to ten priorities for focused programmatic efforts over the five-year reporting cycle. The most current state plan “MCH 2020” includes the following priority needs for the five-year period 2016 through 2020.

1. Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.
2. Services and supports promote healthy family functioning.

3. Developmentally appropriate care and services are provided across the lifespan.
4. Families are empowered to make educated choices about nutrition and physical activity.
5. Communities and providers support physical, social, and emotional health.
6. Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7. Services are comprehensive and coordinated across systems and providers.
8. Information is available to support informed health decisions and choices.

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

National Outcome Measures (FFY2017)

National Outcome Measures (NOMs)		Population Health Domain
1.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	Perinatal/Infant Health
2.	Percent of delivery or postpartum hospitalizations with an indication of severe morbidity	Women/Maternal Health
3.	Maternal mortality rate per 1000,000 live births	Women/Maternal Health
4.1	Percent of low birth weight deliveries (<2,500 grams)	Perinatal/Infant Health
4.2	Percent of very low birth weight deliveries (<1,500 grams)	Perinatal/Infant Health
4.3	Percent of moderately low birth weight deliveries (1,500-2,499 grams)	Perinatal/Infant Health
5.1	Percent of preterm birth (<37 weeks)	Perinatal/Infant Health
5.2	Percent of early preterm births (<34 weeks)	Perinatal/Infant Health
5.3	Percent of late preterm births (34-36 weeks)	Perinatal/Infant Health
6.	Percent of early term births (37, 38 weeks)	Perinatal/Infant Health
7.	Percent of non-medically indicated early term deliveries (37, 38 weeks) among singleton term deliveries	Perinatal/Infant Health
8.	Perinatal mortality rate per 1,000 live births plus fetal deaths	Perinatal/Infant Health
9.1	Infant mortality rate per 1,000 live births	Perinatal/Infant Health
9.2	Neonatal mortality rate per 1,000 live births	Perinatal/Infant Health
9.3	Post neonatal mortality rate per 1,000 live births	Perinatal/Infant Health
9.4	Preterm-related mortality rate per 1,000 live births	Perinatal/Infant Health
9.5	Sudden Unexpected Infant Deaths (SUID) mortality rate per 1,000 live births	Perinatal/Infant Health
10.	The rate of infants born with fetal alcohol syndrome per 10,000 delivery hospitalizations	Perinatal/Infant Health
11.	The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations	Perinatal/Infant Health
12.	Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens that are followed up in a timely manner (DEVELOPMENTAL)	Perinatal/Infant Health
13.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	Child Health
14.	Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months	Child Health
15.	Rate of death in children aged 1 through 9 per 100,000	Child Health
16.1	Rate of death in adolescents age 10-19 per 100,000	Adolescent Health
16.2	Rate of deaths to children aged 15-19 years caused by motor vehicle crashes per 100,000	Adolescent Health
16.3	Rate of suicide deaths among youths aged 15 through 19 per 100,000	Adolescent Health
17.1	Percent of children with special health care needs	CYSHCN
17.2	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	CYSHCN

17.3	Percent of children diagnosed with an autism spectrum disorder	Child Health and/or CYSHCN
17.4	Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity disorder (ADD/ADHD)	Child Health and/or CYSHCN
18.	Percent of children with a mental/behavioral condition who receive treatment	Child Health and/or Adolescent Health
19.	Percent of children in excellent or very good health	Child Health
20.	Percent of children and adolescents who are overweight or obese (BMI at or above the 85 th percentile)	Child Health and/or Adolescent Health
21.	Percent of children without health insurance	Child Health
22.1	Percent of children ages 19-35 months, with the 4:3:1:3(4):3:1:4 combined series of vaccines	Child Health
22.2	Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza	Child and/or Adolescent Health
22.3	Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine	Adolescent Health
22.4	Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine	Adolescent Health
22.5	Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine	Adolescent Health

National Performance Measures (FFY2017)

	National Performance Measures (NPMs) <i>(Kansas selections (8 of 15) are in bold)</i>	Population Health Domain
1.	Well Woman Care (Percent of women with a past year preventive visit)	Women/Maternal Health
2.	Low risk cesarean deliveries (Percent of cesarean deliveries among low-risk first births)	Women/Maternal Health
3.	Perinatal regionalization (Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU))	Perinatal/Infant Health
4.	Breastfeeding [(A) Percent of infants who are ever breastfed (B) Percent of infants breastfed exclusively through 6 months]	Perinatal/Infant Health
5.	Safe Sleep (Percent of infants placed to sleep on their backs)	Perinatal/Infant Health
6.	Developmental screening (Percent of children, 9 through 71 months, receiving a developmental screening using a parent-completed screening tool)	Child Health
7.	Child Injury (Rate of injury-related hospital admissions per population aged 0 through 19 years)	Child Health and/or Adolescent Health
8.	Physical activity (Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day)	Child Health and/or Adolescent Health
9.	Bullying (Percent of adolescents, 12 through 17, who are bullied)	Adolescent Health
10.	Adolescent well visit (Percent of adolescents with a preventive services visit in the last year)	Adolescent Health
11.	Medical home (Percent of children with and without special health care needs having a medical home)	Children with Special Health Care Needs
12.	Transition (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care)	Children with Special Health Care Needs
13.	Oral Health [(A) Percent of women who had a dental visit during pregnancy (B) Percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year]	Cross-Cutting/Life Course
14.	Smoking during Pregnancy and Household Smoking [(A) Percent of women who smoke during pregnancy (B) Percent of children who live in households where someone smokes]	Cross-Cutting/Life Course

15.	Adequate insurance coverage (Percent of children 0 through 17 who are adequately insured)	Cross-Cutting/Life Course
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State Performance Measures

At the state level, the MCHB performance and accountability cycle begins with a needs assessment that includes reporting on health status indicators. Analysis of these data and other information leads to the identification of priority needs. MCH performance and outcome measures are developed to address those needs and resources are allocated. Program implementation, ongoing monitoring and evaluation follow.

State MCH Performance measures must be relevant to major MCHB priorities, activities, programs and dollars. The measures should be prevention focused, important and understandable to MCH partners, policymakers and the public with logical linkage from the measure to the desired outcome. Kansas-specific measures reflect local concerns that arise from a state needs assessment, required and completed every five years.

Performance measures help to quantify whether:

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

State MCH Performance Measures (SPMs) <i>(as of April 2016; to be updated annually)</i>	Population Health Domain
1. Percent of preterm births (<37 weeks gestation)	Women/Maternal Health
2. Percent of children living with parents who have emotional help with parenthood	Cross-cutting
3. Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes/day	Child Health
4. Number of Safe Sleep (SIDS/SUID) trainings provided to professionals	Cross-cutting
5. Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them	Cross-cutting

LOCAL MATCH

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

HOME VISITING: KANSAS HEALTHY START HOME VISITOR (HSHV) SERVICES

The Kansas Title V MCH program is an integrated delivery of services to the MCH population, providing services to families and children in a variety of settings including the home setting. In order to provide

outreach and family support services, MCH grantees may opt to implement Healthy Start Home Visitor (HSHV) services.

Most agencies provide family support services to pregnant women including 1-4 visits prenatally and postnatally. Generally 1-2 visits are done with the mother; however the number of visits to be made is a decision of the supervising professional staff and the home visitor based on needs identified in the family.

The HSHV services are intended to increase knowledge, change beliefs and alter behaviors by increasing the number of women accessing early and comprehensive health care before, during and after pregnancy. A HSHV provides education on health and safety promotion, parenting, and preventive programs relevant to the prenatal and postnatal periods and infant development. They provide assistance to families in linking them to resources and in navigating access to systems of care. An important role of the HSHV is to have a broad knowledge of available community resources.

Under public health nurse supervision, visitors provide in-home interventions such as education and support. In addition, home visitors have the potential to:

1. Increase the use of cost-effective preventive health care services such as prenatal care, family planning, immunizations, nutrition and well childcare.
2. Promote early entry into and compliance with prenatal care.
3. Discourage unhealthy maternal behaviors such as alcohol and tobacco use.
4. Identify families at risk and link them with services and supports.
5. Improve and enhance parenting and problem solving skills.
6. Reduce costs through use of paraprofessional visitors under nursing supervision.

MCH GRANT APPLICATION SCORE SHEET
State Fiscal Year (SFY) 2017

REVIEWER: _____

DATE: _____

Applicant/Organization: _____

Total MCH Amount Requested \$ _____

SHCN Regional Office Request

HSHV Request

Total Score	/133 Points
Basis/Rationale for Decision:	

RECOMMENDATION:

- Approve for funding (*no conditions*)
- Approve for funding *with clarification or modification of:*
 - Proposed Detailed Budget
 - Service Numbers
 - Goals/Objectives/Measures
 - MCH Domains/Priorities/Issues
 - SHCN Regional Office Plan (optional)
 - HSHV Plan (optional)
- Not recommended for funding

INTERNAL USE ONLY

Existing Grantee [SFY 2016] Award: \$ _____

New Applicant

SFY2017 Recommendation/Award

- Recommended for Funding Yes No
- Award Amount \$ _____ Increase Decrease Level

Applicant/Organization:

Instructions: For each of the scoring criteria, assign a point value using a whole number. Reviewers should score each criteria on a continuum from the minimum to maximum point value according to the answer/response provided (clear, concise, addresses requirement/question, and aligns with the vision/mission/services for Title V and Maternal and Child Health). For example, a scoring criteria with a point value of 3 may be awarded a 0, 1, 2 or 3. If an attachment is not included, score would be 0.

GROUPING A: ADMINISTRATION AND MANAGEMENT

Goal A.1 Applicant Structure and Overview	Staff Names, Positions, and Email Addresses	/3 points (<i>1 point each</i>)
	Hours of Operation	/1 point
	Org. Chart <u>Attached</u> (clearly shows MCH program)	/1 point
Comments/Questions:		
		Points Awarded /5
Goal A.2 Capacity Building and Accountability	Verification of Staff Licensure	/1 point
	Documentation of Mandated Training	/1 point
	Performance Appraisal Process	/3 points
	Professional Development Plan	/3 points
A.2.1.2 Provide Orientation and Training of New Staff	Orientation of New Staff	/3 points
Comments/Questions:		
		Points Awarded /11
Goal A.4 Reimbursement for Services		
A.4.1 Insurance & Third Party Billing	List contracts with Insurance & Third Party Billing	/2 points (Private and Public)
A.4.2 Sliding Fee Scale	Attached Sliding Fee Scale/Schedule of Fees	/1 point
A.4.3 Insurance & Medicaid	Enrollment of Clients into insurance and Medicaid	/2 points
Comments/Questions:		
		Points Awarded /5
SUBTOTAL GROUPING A		/21 POINTS

GROUPING B: DATA AND INFORMATION

Goal B.2 Data Collection Method		
B.2.1 Collect Minimum Data Requirements	Plan for Collecting and Entering Client Data in DAISEY	/5 points
	Who will collect the information	/1 point
	If alternate/importing	System:
B.2.2 Track Participant Information by Identified Categories	Capacity to Analyze/Report Data	/5 points
Comments/Questions:		
		Points Awarded /11
SUBTOTAL GROUPING B		/11 POINTS

GROUPING C: EVALUATION

Goal C.1 Measure Program Effectiveness		
C.1.1 Develop Goals, Objectives, and Outcome Measures	Describe Program Goals, Objectives & Outcome Measures	/9 points
C.1.2 Monitor Progress	Plan to Monitor Progress Toward Meeting Goals, Objectives & Outcome Measures	/3 points
C.1.3 Measure Client Satisfaction	Measure Client Satisfaction	/3 points
Comments/Questions:		
		Points Awarded /15
SUBTOTAL GROUPING C		/ 15 POINTS

GROUPING D: INTERVENTIONS TO IMPROVE PUBLIC HEALTH

Goal D.1 Population Served	Estimated Number to be Served		/1 point
	Prenatal/Pregnant Woman	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
	Post-Partum Woman	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
	Woman	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
	Infant	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
	Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
	Adolescent	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
	CSHCN	<input type="checkbox"/> Yes <input type="checkbox"/> No	#
D.1.2 Service Area	Counties to be Served		/1 point
D.1.3 Services Undocumented/ Uninsured	Services to Undocumented/Uninsured Population		/3 points

Comments/Questions:		
		Points Awarded /5
Goal D.2 Provide Services Based on Community Need		
D.2.1 Community Demographics	Role in CNA	/3 points
D.2.3 Community Needs Assessment	How is Community Needs Assessment being used to inform decisions on services provided and How the services are delivered?	/3 points
Comments/Questions:		
		Points Awarded /6
Goal D.4 Population Domains and Related Issues	Population Domains Selected	/1 point Select Domains Addressed: <input type="checkbox"/> Women's/Maternal Health <input type="checkbox"/> Perinatal/Infant Health <input type="checkbox"/> Child Health <input type="checkbox"/> Adolescent Health <input type="checkbox"/> CSHCN <input type="checkbox"/> Cross-Cutting/Life Course
	Described services provided	/15 points
	Strategies and Curriculums	/10 points
	Does the application specify Becoming a Mom? Evidence-based?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Detail related to the State Priority & Measure	/15 points
	If not providing direct services - Described how needs are met in the community	/1 point
Comments/Questions:		
		Points Awarded /42
Goal D.6 Education	Education is Provided	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>No Point Value (If yes, review all questions below)</i>
	How Education is Provided	/1 point
	Who Provides Education	/1 point
	Source/Curriculum	/1 point
Comments/Questions:		
		Points Awarded /3
Goal D.8 MCH Referrals	Agencies to Refer are Identified	/1 point
	Initial Referral Process	/1 point
	Follow-up Process	/3 points
	Tracking Plan/Process	/1 point

Comments/Questions:		
		Points Awarded /6
Goal D.9 Challenges and Barriers	Identified Challenges and Barriers	/1 point
	Identified Plan to Address	/2 point
Comments/Questions:		
		Points Awarded /3
SUBTOTAL GROUPING D		/65 POINTS

GROUPING E: COMMUNICATIONS AND PROMOTION

Goal E.1 Increase Public Awareness of Services and Generate Buy-in	Plan to Promote Services	/2 points
	Outreach Activities	/2 points
	Targeting and Recruiting Clients	/2 points
Comments/Questions:		
		Points Awarded /6
SUBTOTAL GROUPING E		/6 POINTS

GROUPING F: PARTNERSHIPS

Goal F.1 Develop Key Collaborative Partnerships	Key MCH Partners	/3 points
	Collaboration with Partner(s)	/3 points
Comments/Questions:		
		Points Awarded /6
Goal F.2 Engage Schools and Boards of Education in Service Provision	How the School/Board of Education will be engaged	/1 point
	Role of the School/Board of Education	/2 points
Comments/Questions:		
		Points Awarded /3
Goal F.3 Develop Referral Sources for Related Services	Future Partnerships to Address Gaps and Needs	/2 points
Comments/Questions:		
		Points Awarded /2
SUBTOTAL GROUPING F		/11 POINTS
Budget	Local Match at least 40% <input type="checkbox"/> Yes <input type="checkbox"/> No	/1 point
	Budgeted items are detailed and acceptable	/3 points
Comments/Questions:		
		Points Awarded /4

SUBTOTAL BUDGET	/4 POINTS
TOTAL SCORE	/133 Points

OPTIONAL PROGRAMMING: D.5 (SHCN) & D.7 (Home Visiting)

Goal D.5 Special Health Care Needs		<i>No Point Value</i>
D.5.1 Expand SHCN Community	Provide outreach to community service & medical providers regarding KS-SHCN program	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Types of Specialty Care Providers in the Area	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Work with Specialty Care Providers	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Support to Outreach Clinics	<input type="checkbox"/> Yes <input type="checkbox"/> No
D.5.2 Expand Kansas Resource Guide	Kansas Resource Guide (KRG)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Utilized/Referred to KRG	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Recruit Providers	<input type="checkbox"/> Yes <input type="checkbox"/> No
D.5.3 SHCN Regional Office	Interest in serving as a Regional Office	<input type="checkbox"/> Yes, Region <input type="checkbox"/> Yes, More info. <input type="checkbox"/> Yes, County <input type="checkbox"/> No
Comments/Questions:		

Goal D.7 Home Visiting Services	Home Visiting Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>No Point Value (If yes, review all questions below)</i>
	Estimated number to be served		
	When		/2 points
	Where		/2 points
	Who Providing		/1 point
	Frequency		/1 point
	Duration of Visits		/1 point
	Topics to be Addressed		/3 points
Comments/Questions:			
Points Awarded			/10

Aid To Local FY17 Grant Worksheet

Entity: Maternal & Child Health

Grant: Maternal & Child Health July 1, 2016 - June 30, 2017

External Grantee	Awarded
Barton County Health Department	\$ 56,650.00
Butler County Health Department	\$ 65,546.00
Chautauqua County Health Department	\$ 8,358.00
Cherokee County Health Department	\$ 30,905.00
City-Cowley County Health Department	\$ 47,625.00
Clay County Community Health Services	\$ 36,401.00
Cloud County Health Department	\$ 9,024.00
Coffey County Health Department	\$ 9,963.00
Coffeyville Regional Medical Center	\$ 34,431.00
Community Health Center of Southeast KS	\$ 57,000.00
Crawford County Health Department	\$ 66,468.00
Dickinson County Health Department	\$ 36,241.00
Doniphan County Health Department	\$ 10,232.00
Ellsworth County Health Department	\$ 3,271.00
Finney County Health Department	\$ 95,264.00
Flint Hills Community Health Center Inc.	\$ 70,204.00
Ford County	\$ 69,000.00
Franklin County Health Department	\$ 21,788.00
Geary County Health Department	\$ 66,955.00
Grant County Health Department	\$ 13,087.00
Gray County Health Department	\$ 7,688.00
Greeley County Health Department	\$ 5,730.00
Greenwood County Health Department	\$ 10,328.00
Hamilton County Health Department	\$ 6,724.00
Harvey County Health Department	\$ 55,764.00
Haskell County Health Department	\$ 7,483.00
Hays Area Children's Center Inc	\$ 37,348.00
Hodgeman County Health Department	\$ 3,445.00
Jefferson County Health Department	\$ 18,037.00
Johnson County Department of Health and Environment	\$ 234,385.00
Lawrence-Douglas County Health Department	\$ 115,599.00
Leavenworth County Health Department	\$ 74,540.00
Lincoln County Health Department	\$ 4,510.00
Linn County Health Department	\$ 11,988.00
Marshall County Health Department	\$ 13,041.00
Meade County Health Department	\$ 4,672.00
Mercy Hospital Fort Scott	\$ 28,782.00
Miami County Health Department	\$ 22,897.00
Mitchell County Health Department	\$ 12,466.00
Montgomery County Health Department	\$ 47,433.00
Morris County Health Department	\$ 7,724.00
Morton County Health Department	\$ 3,677.00
Nemaha County Community Health Services Inc.	\$ 15,116.00

Aid To Local FY17 Grant Worksheet

Entity: Maternal & Child Health

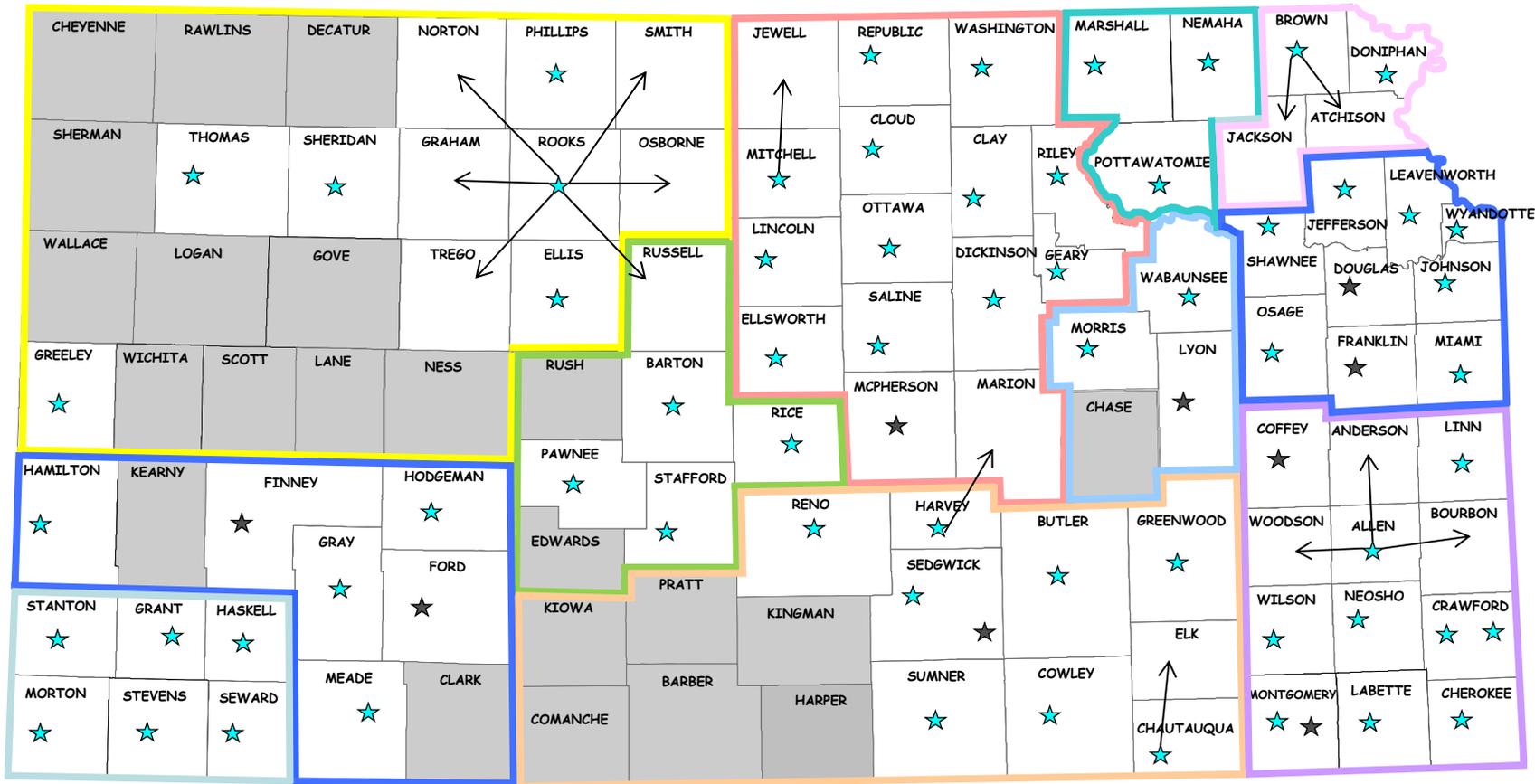
Grant: Maternal & Child Health July 1, 2016 - June 30, 2017

External Grantee	Awarded
Neosho County Health Department	\$ 26,442.00
Northeast Kansas Multi-County Health Department	\$ 81,712.00
Osage County Health Department	\$ 12,709.00
Ottawa County Health Department	\$ 9,090.00
Pawnee County Health Department	\$ 10,279.00
Phillips County Health Department	\$ 9,213.00
Pottawatomie County Health Department	\$ 33,170.00
Public Health of Labette County Kansas	\$ 29,425.00
Reno County Health Department	\$ 117,368.00
Republic County Health Department	\$ 6,927.00
Rice County Health Department	\$ 11,952.00
Riley County Health Department	\$ 105,246.00
Rooks County Health Department	\$ 46,187.00
Saline County Health Department	\$ 110,450.00
Sedgwick County Health Department	\$ 563,086.00
SEK Multi-County Health Department	\$ 61,155.00
Seward County Health Department	\$ 68,168.00
Shawnee County Health Agency	\$ 396,100.00
Sheridan County Health Department	\$ 4,653.00
Stafford County Health Department	\$ 7,231.00
Stanton County Health Department	\$ 3,997.00
Stevens County Health Department	\$ 14,797.00
Sumner County Health Department	\$ 30,895.00
Thomas County Health Department	\$ 14,791.00
Unified Government of Wyandotte County	\$ 684,104.00
University of Kansas Medical Center Research Institute - SOM Wichita	\$ 359,746.00
Wabaunsee County Health Department	\$ 7,109.00
Washington County Health Department	\$ 9,233.00
Wilson County Health Department	\$ 11,167.00
TOTALS	\$4,404,192.00

**Base Funding: Formula/Guide - American Community Survey 2009-2013 AVG # of Children
under 18 in Poverty (75%); 2013 Census Children 0-11 and Females 23-44 (25%)**

MCH Unit

Local Program Grantees – SFY 2017



SPECIAL HEALTH CARE NEEDS SATELLITE OFFICES			
1	Stevens County HD	7	Nemaha County HD
2	Topeka Administrative Office (Temporary)	8	Northeast KS Multi-County HD
3	Hays Area Children's Center	9	Morris County HD
4	Barton County HD	10	Topeka Administrative Office (Temporary)
5	University of Kansas School of Medicine, Department of Pediatrics	11	Crawford County HD
6	Saline County HD		

★	Maternal Child Health (MCH) with HSHV
★	Maternal Child Health (MCH) without HSHV
↗	Indicates other counties that are funding partners
■	No Maternal Child Health (MCH) grantee program

Kansas Special Health Care Needs (KS-SHCN)

SFY2017 Funding Request Process

Funding Request Application

Funding Request Guidance

Accepted Proposals

Special Health Care Needs (SHCN) SFY17 Application

Period: 07/01/2016 - 06/30/2017

This document outlines each section with related application question associated with the SHCN SFY17 Application. This document is intended to be used as a guide and it is encouraged that applicants utilize as such. The application is available online at http://www.kdheks.gov/doc_lib/index.html.

Each section of the application has a section for “Attachments.” Applicants should only include attachments as necessary to supplement or provide supporting documentation to their application responses. The attachment option should **not** be used as a replacement for entering a response in any section. If adding an attachment, please make note of that in the response section whenever possible.

Applicants should also refer to the SFY2017 Aid to Local Guidance for additional information. Questions should be directed to the program contacts as follows:

Heather Smith
Special Health Services (SHS) Director
785-296-4747 / hsmith@kdheks.gov

Kayzy Bigler
KS-SHCN Program Manager
785-296-1316 / kbigler@kdheks.gov

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Priority: D.1 – All children and youth with special health care needs (CYSHCN) receive family-centered, coordinated care.....	6
Objective: D.1.1 - Assist, empower and equip individuals and families to navigate systems for optimal health outcomes throughout the life course.	6
Objective: D.1.2 - Improve communication and outreach among service providers, individuals, and families to help with coordination of care.....	6

Objective: D.1.3 - Increase collaboration between the KS-SHCN and other systems of care to support change.	7
Priority: D.2 – Support optimal health and well-being for family caregivers of CYSHCN.	7
Objective: D.2.1 - Support activities and initiatives to educate family caregivers on the importance of taking care of their own health needs and the impact of their health on those they care for.	7
Objective: D.2.2 - Engage and support collaboration among systems for the provision of respite services for SHCN family caregivers in order to proactively address their health care needs, including physical, emotional, and dental health.	7
Objective: D.2.3 - Provide training and education opportunities to support informed, engaged, empowered and equipped family caregivers and providers.	8
Priority: D.3 – Behavioral health needs and supports will be integrated into the Kansas Special Health Care Needs system of care.	8
Objective: D.3.1 - Collaborate with other agencies serving individuals with behavioral health needs to support an integrated continuum of care.	8
Objective: D.3.2 - Educate families about behavioral health issues and provide referrals and resources of available services and peer supports.	8
Objective: D.3.3 - All KS-SHCN families will have a behavioral health assessment and be supported in obtaining necessary services.	9
Priority: D.4 – Support a society that is culturally sensitive, well-informed, and respectful of all people with disabilities through training and education.	9
Objective: D.4.1 - Equip and empower children, youth, and families to advocate for needed services, supports, and family/professional partnerships.	9
Objective: D.4.2 - Provide training and education for providers to promote diversity, inclusion, and integrated supports in the provision of services for the SHCN population.	9
Priority: D.5 – Provide gap-filling health services for CYSHCN and their families through partnerships, collaboration, and direct care supports.	10
Objective: D.5.1 - Collaborate with agencies and providers in the oral health system to support increased access to, and payment of, oral health services for CYSHCN.	10
Objective: D.5.2 - Partner with public and private insurance companies to enhance coverage of services for individuals with special health care needs for primary and specialty care.	10
Objective: D.5.3 - Increase support for outreach clinics & utilization of telehealth for the CYSHCN population.	10
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Grouping A - Administration and Management

Overview A.1 – Project Details

Attachments:

- Name/title of Project(s):
- Request Type: Is this a new pilot project (in development or first year of implementation) or an established project in which you are requesting new or continued funding for?:
 - Pilot Project (Development Phase)
 - Pilot Project (Year 1 Implementation)
 - Established Project (New Funding Request)
 - Established Project (Continuation Funding Request)
- Does the project include research involving human subjects?:
 - Yes, I have already obtained IRB approval.
 - Yes, I have not obtained IRB approval at this time, but will prior to the project start date.
 - No, my project does not require IRB approval.
 - Unknown, I would like assistance from KDHE in determining this.

Requirement A.1.1 – Scope of Work

Attachments:

- Type of Service: Please select the types of services to be provided under this project proposal. Refer to the guidance for official definitions or more information around these services:
 - Direct Services: clinical, direct interaction with client/patient, billable to insurance.
 - Enabling Services: non-clinical, enable families or individuals to access services, improves health outcomes.
 - Public Health Services and Systems: infrastructure supports, indirect benefits to individuals or families, community-focused to improve health and well-being.
- Priority Alignment: Please select the relevant priorities associated with the services to be provided under this project proposal. Refer to the guidance for official definitions or more information around these services:
 - Cross-System Care Coordination: patient/family-centered, team-oriented, multi-system approach
 - Behavioral Health Integration: collaborative services, focus of prevention and/or treatment, home- or community-based approach, community education
 - Family Caregiver Health: activities or resources to supports the health and well-being of family caregivers
 - Training and Education: family advocacy and leadership, system navigation supports, medical and community provider resources, youth leadership

- Direct Health Services and Supports: 1-on-1 care services, access to services, telehealth implementation supports
- Please provide a brief summary of the work to be provided within the request. Demonstrate how this will impact overall health outcomes of children and youth with special health care needs. (350 words or less):
- Describe how the proposed activities fit within your organizations mission, vision, or core values:

Requirement A.1.2 – Sustainability

Attachments:

- Outline the anticipated timeframe that SHCN funding will be utilized for the proposed activities:
 - 1 Year
 - 2 – 3 Years
 - 4 – 5 Years
 - 5+ years
- Describe the plan for integration within your current organizational structure:
- Describe the long-term sustainability plan for cost-sharing with other funding sources:
- Explain how activities will be sustained if this funding were no longer available:

Overview A.2 – Project Contacts

- Primary Contact (First/Last Name, Title, Phone, Email):
- Fiscal/Financial Contact (First/Last Name, Title, Phone, Email):
- Administrative Contact (First/Last Name, Title, Phone, Email):
- Please list all individuals who must be included as a signatory on the final contract, including name, credentials and official organizational title:
- Please list all individuals who should be included as a reviewer on the final contract, including name, credentials, and official organization title:

Grouping B – Data and Information

Strategy: B.1 – Target Population

Attachments:

- Select the target age groups of the CYSHCN population to be served throughout this project:
 - Infants < 1 year
 - Early Childhood 1-5 years
 - Childhood 6 – 12 years
 - Adolescence 13 – 17 years
 - Young Adult 18 – 26 years
 - I do not plan to target CYSHCN throughout this project
- What percentage of your target population are estimated to have Medicaid/KanCare?:
- What percentage of your target population are estimated to be uninsured?:
- What percentage of your target population are estimated to have private insurance?:

- What percentage of your target population are estimated to be served through a home and community based services (HCBS) waiver?:
- What percentage of your target population are estimated to live in an urban area?:
- What percentage of your target population are estimated to live in a rural area?:
- What percentage of your target population are estimated to live in a frontier area?:
- Identify the regions of the state you will provide services to through this proposal:
 - Northeast
 - Northwest
 - Southeast
 - Southwest
 - North Central
 - South Central
- Will your project target a specific racial or ethnic population? Please specify.
 - Yes, please specify in text box
 - No

Requirements B.2.1 through B.2.4

The following requirements must be considered when applying for funding, however there is not a written application component or specific item to respond to. This will be integrated into the final contract if funding is awarded.

- B.1.1 – Track data on insurance status for persons served through this proposal
- B.1.2 - Track data on the utilization of HCBS waivers for persons served through this proposal.
- B.1.3 - Track data on the type of community in which person served through this proposal live.
- B.1.4 - Track data on the race and/or ethnicity for person served through this proposal, if applicable.

Strategy: B.2 – Data Collection and Reporting

Attachments:

Requirement B.2.1 – Data Collection Methodology

Attachments:

- Describe your capacity to collect and analyze data around the population demographic information outlined in Strategy B.1. of this application:
- Describe your capacity to collect data on the Title V National Performance Measures:
- Describe your capacity to collect data on the Title V National Outcome Measures:

Grouping C – Evaluation

Method: C.1 – Measure Program Effectiveness

Strategy: C.1.1 - Develop goals, objectives, and outcome measures

Attachments:

- Describe your outcome measures for the proposed project:

- Describe what data you will collect to show progress on your proposed outcome measures:

Strategy: C.1.2 - Monitor progress on meeting community needs

Attachments:

- How will you monitor progress towards meeting your community needs?

Requirements C.1.2.1 through C.1.2.2

The following requirements must be considered when applying for funding, however there is not a written application component or specific item to respond to. This will be integrated into the final contract if funding is awarded.

- Requirement C.1.2.1 - Identify baseline data for each outcome measure. (NOTE: Must be submitted within 30 days of contract start date.)
- Requirement C.1.2.2 - Identify the level of change you expect from this project for each outcome measure. (NOTE: Must be submitted within 30 days of contract start date AND show improvement from baseline data submitted.)

Strategy: C.1.3 - Measure consumer satisfaction

Attachments:

- How will you measure consumer satisfaction with the proposed project activities?
- Describe how you will utilize consumer satisfaction data to support your proposed project.

Grouping D – Interventions to Improve Public Health

Priority: D.1 – All children and youth with special health care needs (CYSHCN) receive family-centered, coordinated care.

Objective: D.1.1 - Assist, empower and equip individuals and families to navigate systems for optimal health outcomes throughout the life course.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.1.2 - Improve communication and outreach among service providers, individuals, and families to help with coordination of care.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.

- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.1.3 - Increase collaboration between the KS-SHCN and other systems of care to support change.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Priority: D.2 – Support optimal health and well-being for family caregivers of CYSHCN.

Objective: D.2.1 - Support activities and initiatives to educate family caregivers on the importance of taking care of their own health needs and the impact of their health on those they care for.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.2.2 - Engage and support collaboration among systems for the provision of respite services for SHCN family caregivers in order to proactively address their health care needs, including physical, emotional, and dental health.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.

- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.2.3 - Provide training and education opportunities to support informed, engaged, empowered and equipped family caregivers and providers.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Priority: D.3 – Behavioral health needs and supports will be integrated into the Kansas Special Health Care Needs system of care.

Objective: D.3.1 - Collaborate with other agencies serving individuals with behavioral health needs to support an integrated continuum of care.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.3.2 - Educate families about behavioral health issues and provide referrals and resources of available services and peer supports.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.3.3 - All KS-SHCN families will have a behavioral health assessment and be supported in obtaining necessary services.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Priority: D.4 – Support a society that is culturally sensitive, well-informed, and respectful of all people with disabilities through training and education.

Objective: D.4.1 - Equip and empower children, youth, and families to advocate for needed services, supports, and family/professional partnerships.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.4.2 - Provide training and education for providers to promote diversity, inclusion, and integrated supports in the provision of services for the SHCN population.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Priority: D.5 – Provide gap-filling health services for CYSHCN and their families through partnerships, collaboration, and direct care supports.

Objective: D.5.1 - Collaborate with agencies and providers in the oral health system to support increased access to, and payment of, oral health services for CYSHCN.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.5.2 - Partner with public and private insurance companies to enhance coverage of services for individuals with special health care needs for primary and specialty care.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Objective: D.5.3 - Increase support for outreach clinics & utilization of telehealth for the CYSHCN population.

Attachments:

- Describe how your project will address a specific need or problem, as related to this objective.
- Describe the strategies or activities you intend to implement throughout the project year. Include the specific outcome measure associated with the project.
- Describe any current initiatives that align with or impact the proposed strategies under this objective.
- Outline any new partnerships you feel need to be engaged to make the proposed strategies under this objective successful.

Grouping E – Communications and Promotions

Strategy: E.1 – Increase awareness of the SHCN Program among community partners.

Attachments:

- Describe your plans for promoting services and supports included in this application in the community:
 - Outline your target outreach population:
-

Strategy: E.2 - Increase awareness of the SHCN Program among potentially eligible clients.

- Describe your plans for identifying clients eligible for the SHCN program. (NOTE: Use criteria in guidance as a reference).
 - Describe your capacity to track and monitor referrals made to the SHCN program.
-

Strategy: E.3 – Promote the Kansas Resource Guide

- Describe how you will integrate the Kansas Resource Guide within proposed activities.
- What resources would be most beneficial to add to the Kansas Resource Guide to support proposed activities?
- Upon review of the Kansas Resource Guide, outline the key community providers not present in the Kansas Resource Guide directory. Describe your influence on identified providers to assist in recruiting them as a directory provider.
- Upon review of the Kansas Resource Guide, outline key resources or information that you believe would be most beneficial to include on the website. (NOTE: This should not be community providers for inclusion in the directory, rather information for the general public intended to provide knowledge, support, or opportunity for consumers.)

**KANSAS SPECIAL HEALTH CARE NEEDS (KS-SHCN)
SFY 2017 AID TO LOCAL (ATL) GUIDANCE**

http://www.kdheks.gov/doc_lib/index.html

INTRODUCTION

The Kansas Department of Health & Environment is responsible for administering the Title V Maternal and Child Health (MCH) Services Block Grant for the State of Kansas [funded through the U.S. Department of Health & Human Services (HHS), Human Resources & Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)]. The MCH Block Grant and affiliated programs are organized within the Division of Public Health, Bureau of Family Health.

The Title V MCH Block Grant plays a key role in the provision of maternal and child health services in Kansas, including the Kansas Special Health Care Needs (KS-SHCN) program. Service or programs funded with Title V funding through the KS-SHCN program must support program priorities, outcomes, and measures while furthering identified mutual objectives and supporting respective responsibilities.

The KS-SHCN program promotes the functional skills of persons, who have or are at-risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction. SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions. Additionally, the program provides services to persons of all ages with metabolic or genetic conditions screened through the Newborn Screening.

LEGISLATION AND SCOPE

Enacted in 1935 as a part of the Social Security Act, the Title V MCH Program is the Nation's oldest Federal-State partnership. Specifically, the Title V program seeks to:

1. Assure access to quality care, especially for those with low-incomes or limited availability of care;
2. Reduce infant mortality;
3. Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women);
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
5. Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children;
6. Implement family-centered, community-based systems of coordinated care for children with special health care needs (CYSHCN); and
7. Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

The 2016 Title V MCH Block Grant Application Guidance outlines the constructs of a service system for children and youth with special health care needs (CYSHCN). These include state program collaboration with other state agencies and private organizations, state support for communities, coordination of health components of community-based systems, and coordination of health services with other services at the community level. Additional information regarding these constructs may be found in **Appendix A: Kansas Block Grant Basics**.

Kansas statutes, K.S.A. 65-5a01 through K.S.A. 65-5a16 and K.S.A. 65-180, and regulations, K.A.R. 28-4-401 through 28-4-413 and 28-4-510 through 28-4-514, provide guidance to the program and services provided by the KS-SHCN program. Additionally, services provided through funding from the KS-SHCN program must align with state and federal program objectives and measures to be eligible for funding.

As a recipient of Title V Funding, the KS-SHCN program must adhere and comply with all requirements outlined in *Appendix A: Kansas Block Grant Basics*. The requirements for this funding opportunity are aligned with federal expectations and requirements and outlined throughout this document.

TARGET POPULATION FOR SERVICES

Activities must address needs of the children and youth with special health care needs (CYSHCN) population and is defined as children and youth, age birth through 21 years, “who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.” It is not expected to limited services or supports under this grant proposal to those actively receiving services through the KS-SHCN program.

Services may be extended to adults over age 21 with genetic conditions screened for and diagnosed through the Kansas Newborn Screening program. A complete list of these conditions can be found on the KS Newborn Screening website at www.kdheks.gov/newborn_screening/index.html.

KS-SHCN ATL REQUIREMENTS

Higher standards of accountability prevail for the MCH Block Grant due to scarcity of resources from State, Federal and other funding sources. Funding sources require regular, in-depth review of performance and outcome measures, as well as evidence of progress (through use of data) toward outcomes for MCH and SHCN populations. A shift from direct services to community-based, population-based, and infrastructure building services has been identified at the state and federal level.

Applications for funding must clearly outline the type of service to be addressed by the activities within the proposal. Definitions can be found in *Appendix B: Title V 2016-2020 MCH Services Pyramid*.

Funding requests are reviewed through a healthy equity lens for alignment with the Title V/Bureau of Family Health and the Division of Public Health’s core values of: health equity, social and environmental determinants of health, life course approach, and systems integration. There is great interest in funding activities that will be implemented as part of a comprehensive approach with potential for improved population health.

The request for funds must clearly describe the activities and/or services to be provided and alignment with one or more of the outlined priorities, performance measures, populations, and types of service.

KS-SHCN began an extensive strategic planning process in July 2013 consisting of stakeholder meetings and engagement of families, medical providers, community partners, and program staff. The strategic planning process focused around four key principles: 1) increasing the value of the program for those served; 2) evaluating relevancy of program services offered for families; 3) evaluating cost effectiveness of direct and clinical services; and 4) identifying opportunities for improvement by utilizing quality improvement methodology. Through this process, five new priorities emerged: Cross-System Care Coordination, Addressing Family Caregiver Health Needs, Behavioral Health Integration, Training and Education, and Direct Health Care Services.

Projects submitted shall directly tie to one or more of the KS-SHCN priorities. Projects not aligned with the priorities will not be considered. These definitions have been developed to support applicants understanding of the KS-SHCN priorities.

Cross-System Care Coordination

Projects addressing this priority must show evidence of existing partnerships or the capacity and plan to build new partnerships, in support of cross-system communication, collaboration, planning and information sharing, referrals, and patient navigation.

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

Family Caregiver Health

Projects addressing this priority must show evidence of capacity to address needs or provide support to family caregivers. Services must support the physical, emotional, social, or financial well-being of families.

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

Behavioral Health Integration

Projects addressing this priority must show evidence of collaborative services for the prevention and treatment of emotional disorders. Services must support the functioning of children, youth, or families.

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

Direct Health Services and Supports

Projects addressing this priority must include services delivered one-on-one between a health professional and patient. This may include primary, specialty, or ancillary health services. This could also include the utilization of telehealth services. Only services that are not billable and/or reimbursable by private or public insurance are eligible for funding under this request. Sufficient evidence must be presented within the proposal that outlines the need for services, inability to bill/obtain reimbursement for services, and fill a specific gap in services for the KS-SHCN population.

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

Training and Education

Projects addressing this priority must clearly outline a specific training need among one or more of the following: families, community members, medical and community providers, local and state service programs, or legislators. Training and education projects must support diversity in the provision of services for the KS-SHCN population, and include a written plan for the provision and evaluation of training/education activities.

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

The objective of the KS-SHCN program is to support a comprehensive, quality system of care for children and youth with special health care needs (CYSHCN). As such, Title V desires collaborative relationships with partners, such as private insurers, state Medicaid and CHIP agencies, pediatricians and family physicians, community providers and service organizations, and families.

Preference will be given to applications who show desire and capacity to coordinate with public/private insurers, medical and community providers, developmental/children and family services, education, and other programs providing services and supports to the CYSHCN population or their families.

In March 2014, The Lucille Packard Foundation for Children’s Health and the Association of Maternal and Child Health Programs (AMCHP) released the “Standards for Systems of Care for Children and Youth with Special Health Care Needs,” a core set of structure and process standards for system of care for CYSHCN. This report can be found online at <http://www.amchp.org/programsandtopics/CYSHCN/Documents/Standards%20Charts%20FINAL.pdf>. Highlights of this publication can be found in **Appendix C: Highlights of the Standards for Systems of Care for CYSHCN.**

Preference will be given to applications who show ability to address one or more of the system standards to meet the needs of CYSHCN and their families through community and population based services.

The applicants’ capacity must show ability to support a strong system of care, build infrastructure, and increase probability for long-term sustainability of improved services for CYSHCN, as related to the system standards.

FUNDING EXPECTATIONS AND LIMITATIONS

The following are allowable under this funding proposal:

- Any planning, implementation, and evaluation activities associated with the proposed project. Sub-grantees are allowed with prior approval and must be identified in the grant application and submitted budget.
- Administration and grant oversight, limited to no more than 10 percent of funds utilized for this purpose.
- Personnel/staff time for activities provided, with appropriate time and effort reporting.
- Clinical services are allowable only if provided by licensed professionals and are not eligible to bill insurance and/or Medicaid.
 - Clinical service providers are expected and required to bill insurance and/or Medicaid for services, pursuant to K.A.R 28-4-405.
 - In the event the clinical provider is not eligible to bill insurance and/or Medicaid, sufficient evidence outlining an exception to this requirement may be presented for consideration.
 - Provider honorariums are not allowable if the provider is eligible to bill for services and are subject to KS-SHCN review and approval.

Local Match Requirement

A minimum of 25% is required for non-clinical activities under the grant application. Special consideration will be provided to those with a match greater than 25%.

Sources that may be used for matching funds are: reimbursement for service from third parties such as insurance and Title XIX; client fees; local funds from non-federal sources; or in-kind contributions. In-kind contributions must be documented in accordance with generally accepted accounting principles. Records for tracking match must be made available for review, upon request.

Non-cash contributions or in-kind donations may be used to meet the required match. In-kind or non-cash support may include:

- Personnel/staff time, space, commodities, or services
- Contributions at a fair market value and documented in the organization accounting records

IMPORTANT: Non-allowable match funds include those associated with inpatient care or other funds used to match other federal, state, or foundation grants.

Review and Award Timeline

All required information must be provided in order for the request to be reviewed, by March 15, 2016 and submitted online, accessible through Catalyst (www.catalystserver.com).

- For grantees receiving funding in SFY16, your administrative and program contacts will receive a Catalyst user name and password in advance. If a username and password has not yet been received, contact the Catalyst Operations Support Team (support@shpr.com).
- New applicants can request a username and password by contacting: support@shpr.org
- Before starting your application, please complete the following training courses on Kansas TRAIN (ks.train.org):
 1. Catalyst Training 1: Catalyst Navigation (Course #1054439)
 2. Catalyst Training 2: Application Process Overview in Catalyst (Course #1054483)
 3. Catalyst Training 3: Application Management in Catalyst (Course #1054567)
 4. Catalyst Training 4: Applying for Funding Announcement(s) in Catalyst (Course #1054672)

Applications are available on January 15 and are due on March 15.

If further information or additional discussion is necessary to assure the needs and desired outcomes for both the requestor and KS-SHCN are addressed, you will be notified by email and provided with a timeline for response. If a response is not received, the application will not be considered.

Applicants will be notified, in writing, of approval or denial by May 15, 2016. Upon agreement of terms, a fully executed contract or agreement will be developed and submitted for approval and signature.

Grant activities are expected to follow the State Fiscal Year timeline and begin on or after July 1, 2016 and end on or before June 30, 2017. Multi-year projects are allowable and will be granted under certain circumstances. Requests for multi-year projects can be made by entering the start and end dates under A.1.2. "Outline the anticipated timeframe that SHCN funding will be utilized for the proposed activities." Attach a written request, dated and signed on organization letterhead, under A.1.2.

REPORTING REQUIREMENTS

Reports of activities and invoices of services that address MCH/KS-SHCN priorities, measures, outcomes, and indicators shall be submitted regularly throughout the grant period. Specific reporting requirements will be determined based upon the funding request submitted and the KS-SHCN program needs. These details will be included in the contractual agreement. Reports and invoices shall be provided on the form(s) provided by the KS-SHCN program.

Generally, the following requirements will be expected of all accepted grantees. Specific details of reporting needs will be outlined in the contract, based upon information provided in the application.

Documentation or Reporting Requirements	Due Date
Revised Budget, if requested	Within 15 days of accepted grant application
Baseline Data Measures	Within 30 days of contract start date
Preferred Site Visit Dates	Within 30 days of contract start date
Affidavit of Revenues and Expenditures	Quarterly*
Individuals Served Data	Quarterly*
Narrative Progress Report	November 15 and May 15
Annual Report	Within 45 days of contract end date

**Items due quarterly will be due 30 days following the end of the quarter (July through September, October through December, January through March, April through June). These dates are applicable, regardless of contract start date.*

PROGRAM CONTACTS

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Kansas Title V MCH Block Grant Basics

The Kansas Department of Health & Environment is responsible for administering the Title V Maternal and Child Health (MCH) Services Block Grant for the State of Kansas. The MCH Block Grant and affiliated programs are located within the Division of Public Health, Bureau of Family Health.

The Title V MCH Block Grant plays a key role in the provision of maternal and child health services in Kansas. Funds from this grant are distributed among a number of programs which target the improvement of the health of all women, infants, children and adolescents, including children and youth with special health care needs (CYSHCN), and families.

As part of Kansas' Block Grant requirements, the Kansas Department of Health:

- 1) Submits an Application/Annual Report for Federal funds to the Federal Maternal and Child Health Bureau each year in July;
- 2) Adheres to the strict requirements concerning how Title V funds are spent:
 - a) At least thirty percent (30%) for preventive and primary care services for children.
 - b) At least thirty percent (30%) for services for CYSHCN. Funds are to be spent on:
 - i) services described as "family-centered, community-based, coordinated care (including care coordination services); and
 - ii) the development of community-based systems of services for CYSHCN and their families.
 - c) Not more than ten percent (10%) for administering the funds.
 - d) Funding is also to be spent on preventive and primary care services for pregnant women, mothers, and infants up to age one. However, there are no requirements regarding percentage to be spent.
 - e) The State must match federal funds at \$0.75 for every \$1 of federal funding.
- 3) Conducts a statewide needs assessment every five years. The needs assessment identifies state maternal and child health priorities, goals, and performance measures that assess state progress and accountability for a five-year period. The 2016-2020 Needs Assessment is currently in progress and will be completed by June 2015.

As a recipient of Title V Funding, the KS-SHCN program must adhere and comply with all requirements listed above. The requirements for this funding opportunity are outlined throughout this document and may vary slightly from the above guidelines.

Maternal and Child Health Block Grant Transformation

The Federal Maternal and Child Health Bureau (MCHB) began a process to transform the Title V MCH Block Grant to reduce burden, maintain flexibility and improve accountability. By working in partnership with State Title V leaders, families and other stakeholders, they expect the transformation of the block grant to help achieve their mission to improve the health and well-being of all of America's mothers, infants, children, and youth – including children and

Appendix A: Kansas Title V MCH Block Grant Basics

youth with special health care needs (CYSHCN) and their families. The improvements will be phased in, beginning with the 2015 MCH Block Grant application.

Reduce Burden: Streamline the Annual Report and Application

- Require only a needs assessment summary and integrate into the application
- Pre-populate State data
- Eliminate Health Systems Capacity Indicator
- Reduce the number of forms from 21 to 11
- Simplify, clarify and reduce redundancies

Maintain Flexibility: Apply a Logic Model

- Continuously analyze performance and reassess performance measures and strategies
- Implement 3-tiered performance measurement with national outcome measures, national performance measures and structural-process measures
- Include measures for six domains: maternal and women's health, perinatal and infant health, child health, adolescent health, life course, and children with special healthcare needs

Improve Accountability: New Accountability Framework

- Develop a one-stop maternal and child health data center
- Support States in developing evidence-based and -informed structural process measures
- Realign Special Projects of Regional and National Significance (SPRANS) and other HRSA programs to "move the needle" on maternal and child health

Additionally, MCHB has amended the MCH Services Pyramid (Figure 1, next page). Previously, this pyramid included four types of services. This pyramid has been modified to include the following three services: (1) Direct Services; (2) Enabling Services; and (3) Public Health Services and Systems and are defined as outlined below:

1. *Direct Services* are directly provided to individuals, by state or local agency staff or by grantees or contractors. Title V programs commonly support prenatal care, well-child and school-based health services, and specialty services for children and youth with special health care needs.
2. *Enabling Services* are non-clinical services that enable individuals and families to access health services and improve health outcomes. These services are usually targeted to families that have special needs or face specific barriers.
3. *Public Health Services and Systems* include activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development and the 10 essential public health services. These generally encompass the functions that indirectly benefit families by laying the foundations for the policies and programs that can improve the health and well-being of the individuals and families.

Public Health Services for MCH Populations: The Title V MCH Services Block Grant

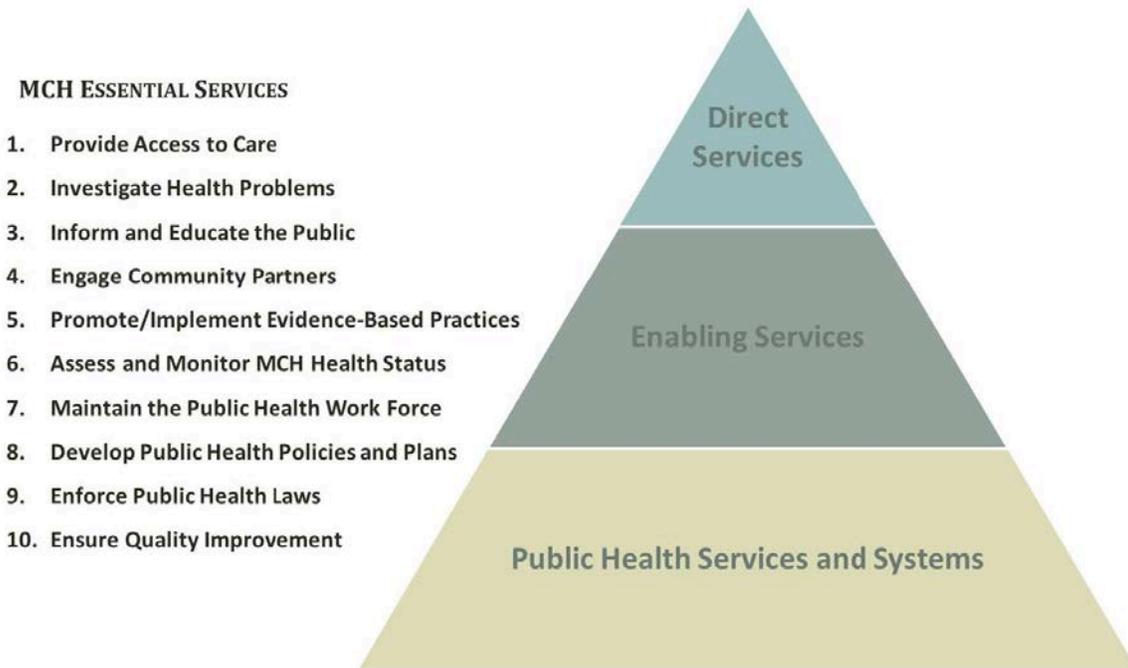


Figure 1: MCH Pyramid

Performance Measurement Process and Reporting Expectations

As indicated, MCHB has implemented a 3-tiered performance measurement process, including national outcome measures, national performance measure, and state-identified evidence-based or –informed strategy measures. In addition, States are expected to develop state performance measures to address the priorities identified through the five-year needs assessment. As part of the 2016-2020 Kansas Title V Needs Assessment, new state priorities will be selected and will inform the work related to this performance measurement process.

- The national outcome measures (NOMs) are the ultimate focus and desired results of any set of public health program activities and interventions. These are usually longer term and tied to the ultimate program goal. NOMs are provided by MCHB.
- The national performance measures (NPMs) are narrative statements that describe a specific population need that, when successfully addressed, will lead to a specific health outcome within a community or population. These generally have a specified time frame and include specific objectives. MCHB proposed 15 NPMs, allowing states to choose 8 NPMs based on their identified state priorities.
- The state-identified evidence-based or –informed strategy measures (ESMs) assess the impact of State Title V strategies and activities and directly measure the State’s impact

Appendix A: Kansas Title V MCH Block Grant Basics

on the selected national performance measures. States will develop ESMs based upon the selected NPMs.

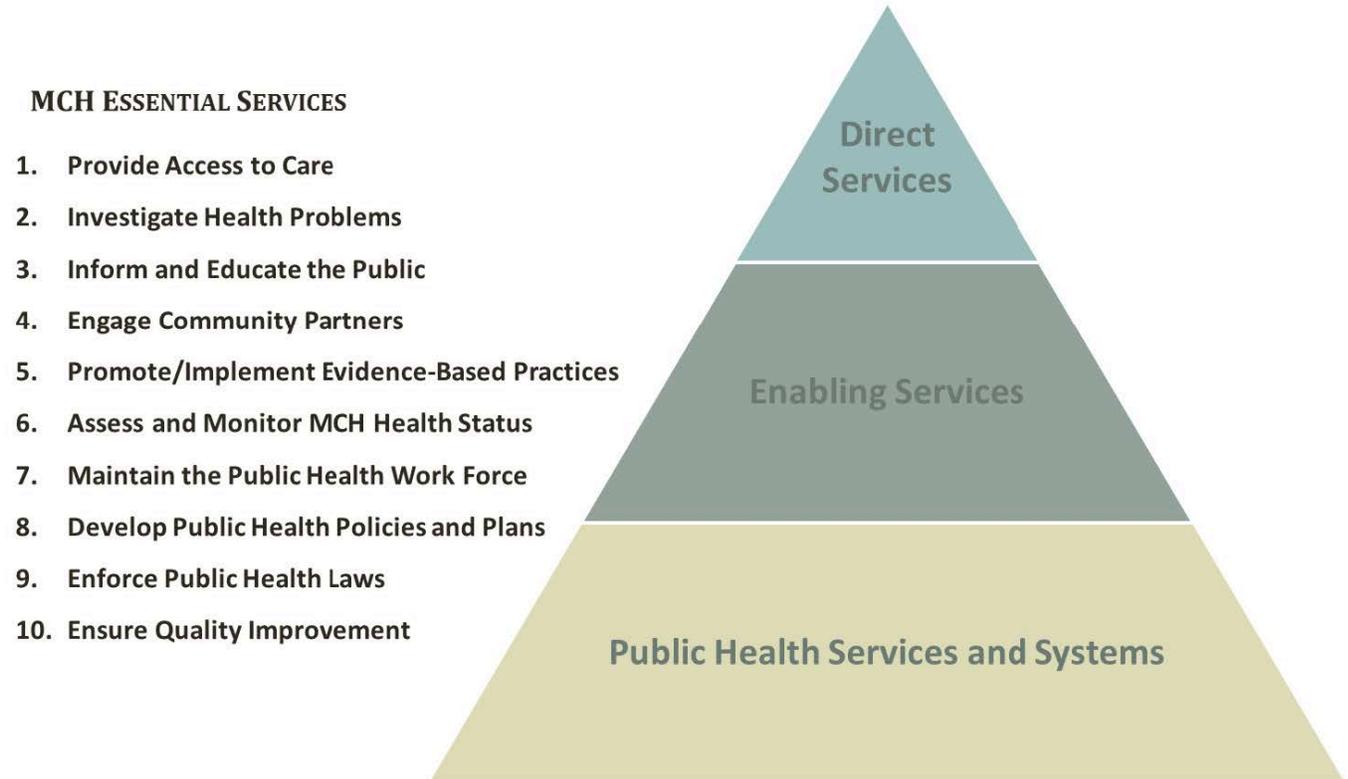
- The state performance measures (SPMs) are used to address priorities identified through the five-year needs assessment. State will develop these based on state priorities not fully addressed through the selected NPMs and developed ESMs.

As you may conclude, the State is expected to assure compliance with a fairly complicated performance measurement system, as well as hold partners in which funding is provided to accountable for these measurements as well. All work approved through this funding process must assist the state in moving towards identified objectives through this performance measurement system.

For information on Title V, the Bureau of Family Health, and the KS-SHCN program:

- KDHE Bureau of Family Health/MCH: www.kdheks.gov/bfh
- KDHE Kansas Special Health Care Needs Program: www.kdheks.gov/shcn
- KDHE Title V Block Grant Information and Resources: <http://www.kdheks.gov/c-f/mch.htm>
- Federal Maternal & Child Health Bureau: <http://mchb.hrsa.gov/>
- MCH 3.0 Block Grant Transformation: <http://mchb.hrsa.gov/blockgrant/index.html>

Public Health Services for MCH Populations: The Title V MCH Services Block Grant



Direct Services are directly provided to individuals, by state or local agency staff or by grantees or contractors. Title V programs commonly support prenatal care, well-child and school-based health services, and specialty services for children and youth with special health care needs.

Enabling Services are non-clinical services that enable individuals and families to access health services and improve health outcomes. These services are usually targeted to families that have special needs or face specific barriers.

Public Health Services and Systems include activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development and the 10 essential public health services. These generally encompass the functions that indirectly benefit families by laying the foundations for the policies and programs that can improve the health and well-being of the individuals and families.

Utilization of the Standards for Systems of Care for CYSHCN

The Title V Program strives to support a comprehensive, quality system of care for the children and youth with special health care needs (CYSHCN) population. In Kansas, this is the responsibility of the Kansas Special Health Care Needs program (KS-SHCN).

Historically, KS-SHCN has provided a variety of services under the Title V MCH Block Grant, as well as with the support of the State through State General Funds. While the vision and mission of the program has not changed, the national and state health care systems have evolved dramatically over the last two decades. Therefore, KS-SHCN has undergone an extensive strategic planning effort to assure program activities and initiatives are aligned with the needs of families in our State. Additionally, changes in the Title V MCH Block Grant are supporting the shift from direct health services to enabling and public health services and systems.

KS-SHCN is dedicated to meeting the needs of families, as defined in section 501(a)(1) of the Title V legislation, to enable each state:

- To provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services;
- To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;
- To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and
- To provide and promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)*) for children with special health care needs (CSHCN) and to facilitate the development of community-based systems of services for such children and their families.

**The term "care coordination services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. ~ Section 501(b)(3) of Title V Legislation*

As part of the extensive strategic planning process, KS-SHCN has committed to utilizing the "Standards for Systems of Care for CYSHCN," published in March 2014 by the Lucille Packard Foundation and the Association of Maternal and Child Health Programs. This was a product of the National Consensus Framework for Systems of Care for CYSHCN Project. For many years,

Appendix C: Highlights of the Standards for Systems of Care for CYSHCN

the MCH field has called for structure and process standards for systems of care for CYSHCN, to support their work. These standards are intended to be used by a range of national, state and local stakeholder groups including state Title V CYSHCN programs, health plans, state Medicaid and CHIP agencies, pediatric provider organizations, children's hospitals, insurers, health services researchers, families/consumers, and others. The KS-SHCN program, as the Kansas Title V CYSHCN Program, is dedicated to working with partners to support stronger systems of care and acknowledge that these standards are in no way intended to be addressed independently or in a silo.

Overall System Outcomes for CYSHCN

The standards are grounded in the six core outcomes for systems of care for CYSHCN, developed by the federal Maternal and Child Health Bureau (MCHB), and an added outcome based on the collaborative work of stakeholders during development of the standards. These seven overall system outcomes for the CYSHCN population include:

- 1. Family Professional Partnerships:** Families of CYSHCN will partner in decision making at all levels and will be satisfied with the services they receive.
- 2. Medical Home:** CYSHCN will receive family-centered, coordinated, ongoing comprehensive care within a medical home.
- 3. Insurance and Financing:** Families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need.
- 4. Early and Continuous Screening and Referral:** Children are screened early and continuously for special health care needs.
- 5. Easy to Use Services and Supports:** Services for CYSHCN and their families will be organized in ways that families can use them easily and include access to patient and family-centered care coordination.
- 6. Transition to Adulthood:** Youth with special health care needs receive the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence.
- 7. Cultural Competence:** All CYSHCN and their families will receive care that is culturally and linguistically appropriate (attends to racial, ethnic, religious and language domains).

Core Domains for System Standards

In addition to the guiding principles outlined above with the system outcomes, the standards are broken down into 10 core domains. Throughout the publication, the system standards (structure and process) are outlined based on these core domains. Additionally, the existing national principles and frameworks, federal requirements of relevant federal laws, and the overall availability of relevant quality measures are cross-referenced for each core domain. A list of the core domains and overall system outcomes can be found on the next page.

Appendix C: Highlights of the Standards for Systems of Care for CYSHCN

Overall System Outcomes for CYSHCN:^{3,4}

1. **Family Professional Partnerships:** Families of CYSHCN will partner in decision making at all levels and will be satisfied with the services they receive
2. **Medical Home:** CYSHCN will receive family-centered, coordinated, ongoing comprehensive care within a medical home
3. **Insurance and Financing:** Families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need
4. **Early and Continuous Screening and Referral:** Children are screened early and continuously for special health care needs
5. **Easy to Use Services and Supports:** Services for CYSHCN and their families will be organized in ways that families can use them easily and include access to patient and family-centered care coordination
6. **Transition to Adulthood:** Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence
7. **Cultural Competence:** All CYSHCN and their families will receive care that is culturally and linguistically appropriate (attends to racial, ethnic, religious, and language domains)

Core Domains for System Standards

1. Screening, Assessment and Referral
2. Eligibility and Enrollment
3. Access to Care
4. Medical Home, including:
 - Pediatric Preventive and Primary Care
 - Care Coordination
 - Pediatric Specialty Care
5. Community-based Services and Supports, including:
 - Respite Care
 - Palliative and Hospice Care
 - Home-based Services
6. Family Professional Partnerships
7. Transition to Adulthood
8. Health Information Technology
9. Quality Assurance and Improvement
10. Insurance and Financing

~Table pulled from 2015 AMCHP Conference Presentation, "Translating the National Standards for CYSHCN – Application and Implementation at the State Level" by Treeby Brown, Meredith Pyle, and Karen VanLandeghem

Overview of Standards by Core Domain

This section will outline some general examples of standards

Screening, Assessment and Referral	<ul style="list-style-type: none"> - Early identification, including newborn screening - Needs identified by insurance plans - EPSDT (Early Periodic Screening, Diagnosis, and Treatment) and Bright Futures - Documented, transportable plans of care
Eligibility and Enrollment	<ul style="list-style-type: none"> - Outreach and coordination with community organizations - Policies for transition between plans and for gaps in coverage - Comprehensive member services with specialty staff
Access to Care	<ul style="list-style-type: none"> - Statewide access - Physical, mental health, dental, and specialty care – with provider choice - Transportation and interpreter supports
Medical Home <i>(including pediatric preventive and primary care, care coordination, and pediatric specialty care)</i>	<ul style="list-style-type: none"> - Medical team; care coordination - 24-7 access; additional time for visits - Prevention and Treatment - Routine, emergent and urgent needs are met

Appendix C: Highlights of the Standards for Systems of Care for CYSHCN

Community-Based Services and Supports	<ul style="list-style-type: none"> - Patient and family centered - Respite services; home-based services - Palliative and hospice care - Transportation and interpreter supports
Family Professional Partnerships	<ul style="list-style-type: none"> - Families are active members of the team - Connection with family organizations, peer support - Strength-based; Informed - Culturally and linguistically appropriate
Transition to Adulthood	<ul style="list-style-type: none"> - Youth engagement - Transition and transfer of care policies and processes - Transition assessment and plan in place and current - Coordination between pediatric and adult providers
Health Information Technology (HIT)	<ul style="list-style-type: none"> - Use of electronic health record systems; meaningful use - Families are partners in electronic health information (EHI) - HIT incorporates Medicaid health policy priorities - EHI is accessible and shared across care settings
Quality Assurance and Improvement	<ul style="list-style-type: none"> - Quality assurance and improvement processes for CYSHCN - Child medical record reviews include sample of CYSHCN - Utilization review/appeals for CYSHCN include integrated care team
Insurance and Financing	<ul style="list-style-type: none"> - Plans are affordable and no risk for loss of benefits - Coverage/payment facilitates access to needed providers - Comprehensive habilitative services coverage - Promote care coordination and medical homes

Other existing national principles and/or frameworks were identified for each of the ten domains. These other frameworks include:

- Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents
- Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP
- Joint Principles of the Patient Centered Medical Home
- National Quality Forum Framework for Care Coordination
- Key Elements of High-Performing Pediatric Care Coordination Framework
- The Functions of Care Coordination
- The Ten Steps for Plan of Care Development
- Ease of Use Framework
- National Respite Guidelines: Guiding Principles for Respite Models and Services
- Principles of Quality Respite Care
- NHPCO Guiding Principles for Pediatric Palliative Care and Hospice
- Six Core Elements of Health Care Transition
- National Association of Insurance Commissioners



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TITLE V MATERNAL & CHILD HEALTH (MCH) SERVICES BLOCK GRANT PROGRAM
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State Priorities

States conduct a 5-year needs assessment to identify 7-10 state MCH priorities.

1. Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.
2. Services and supports promote healthy family functioning.
3. Developmentally appropriate care and services are provided across the lifespan.
4. Families are empowered to make educated choices about nutrition and physical activity.
5. Communities and providers support physical, social, and emotional health.
6. Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7. Services are comprehensive and coordinated across systems and providers.
8. Information is available to support informed health decisions and choices.

National Performance Measures (NPMs)

States select 8 of 15 that address the state priority needs; at least one from each population domain area.*

- NPM1: Well-woman visit (Percent of women with a past year preventive medical visit)
- NPM4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)
- NPM6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- NPM7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)
- NPM9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)
- NPM10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)
- NPM11: Medical home (Percent of children with and without special health care needs having a medical home)
- NPM14: Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy; B. Percent of children who live in households where someone smokes)

Evidence-Based or -Informed Strategy Measures (ESMs): To be developed by May 2016.

States create ESMs designed to impact the NPMs. These measures would assess the impact of State Title V strategies and activities contained in the State Action Plan.

State Performance Measures (SPMs): To be developed by May 2016.

States select 3-5 measures to address state priorities not addressed by the National Performance Measures.

***MCH Population Domains**

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

Background: The Title V Maternal and Child Health (MCH) Block Grant is the linchpin for MCH services in the United States. Administered by the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB), the block grant operates through a Federal/State partnership in all 50 States, the District of Columbia and 9 jurisdictions. Title V was authorized in 1935 as part of the Social Security Act to stem the declining health of mothers and children in the midst of the Great Depression. Title V became a block grant program as part of the Omnibus Budget Reconciliation Act (OBRA) of 1981.

Many of these projects are pilot programs, either under development or in the first year of implementation. The intent of the pilot projects is to provide the most financial support during the initial development and first year of implementation, with a gradual reduction in funding until the initiative is self-sustaining or other funding has been secured. Evaluation and sustainability plans are required to support effective data collection and long-term sustainability of the initiative. Pilot projects are denoted with an *.

Service Type	Project	Description	Funding
Specialty and Outreach Clinical Services	Specialty Care Clinics	<p><i>Provide direct services and non-clinical support through a multi-disciplinary approach. Assure coverage from board certified, licensed, or registered providers. Conduct patient/family satisfaction surveys. Address the needs of patients served, through assessment, monitoring, and education to promote optimal health outcomes. Assure appropriate referrals are made based upon assessment results.</i></p> <ul style="list-style-type: none"> - University of Kansas Medical Center, Center for Child Health and Development - PKU (established patients only), Cystic Fibrosis, Cleft Lip/Cleft Palate (\$61,847) - KU School of Medicine, Department of Pediatrics - Genetics, Cleft Lip/Cleft Palate, Cystic Fibrosis, Specialty Team (\$53,644) - Cerebral Palsy Research Foundation - Wheelchair Posture and Seating (\$153,837) 	\$269,328
	Developmental Evaluation Clinics	<p>University of Kansas Medical Center, Center for Child Health and Development</p> <p><i>Provide outreach clinics designed to improve health outcomes and support referral to services for those with developmental delay, through a multi-disciplinary team, consisting of a developmental pediatrician and/or psychologist, a licenses speech or occupational therapist, a licensed social worker, and a registered dietitian.</i></p>	\$43,603
	Outreach Specialty Clinics	<p><i>Provide Kansas children access to family-centered, community-based, coordinated care in their local communities to support improved school attendance, reduced time away from work for parents/caregivers, and increased compliance with clinical recommendations.</i></p> <ul style="list-style-type: none"> - University of Kansas Medical Center, Department of Pediatrics - Salina, Hays, Manhattan, Garden City, Hutchinson, Topeka, and Pittsburg - Rheumatology, Cardiology (\$18,669) - Cerebral Palsy Research Foundation - Dodge City, Garden City, Hays, and Liberal - Wheelchair Evaluations (\$14,174) 	\$32,843
	Dental Hygienist Services	<p>Oral Health Kansas</p> <p><i>Provide support for a dental hygienist as part of the multi-disciplinary team in select clinics, providing oral health education, oral screenings, and fluoride varnishes to patients seen in clinic.</i></p>	\$3,859
Care Coordination Activities	Hospital to Home Transition Program*	<p>Craig Home Care</p> <p><i>A community-based transition to home program, following a hospitalization for medically fragile patients. Includes the provision of increased education and coordination (both initially and ongoing) to caregivers and families, increased surveillance and support in the home following discharge, and increased coordination and partnership with the discharging institution and insurers.</i></p>	\$90,780
	Patient Navigation & Supports*	<p><i>Assist patients and families with identifying and overcome medical, behavioral, educational, social, developmental, and financial barriers through care coordination. Assist patients with developing the skills needed to successfully transition to adult medical care through age- and developmentally-appropriate transition planning. Provide current information on health related topics through patient and family education.</i></p> <ul style="list-style-type: none"> - Cerebral Palsy Research Foundation (\$10,259) - KU School of Medicine (\$108,230) 	\$118,489
	Caring for Children, Focusing on Family*	<p>Barton County Health Department</p> <p><i>Provide families support through case management and assistance with navigating services. Will also develop a mechanism for families to communicate with one another for peer supports, including parent/caregiver education. Will research and assess capacity of the system for respite care services.</i></p>	\$25,000

	Connecting the Docs*	Community Health Center of Southeast Kansas <i>Support for a full-time Care Coordinator in the FQHC in Southeast Kansas to provide services to low-income special needs children. Ultimately, this will lead to the development of a replicable model to implement Phase 3 of the KS-SHCN Care Coordination program.</i>	\$49,590
Community Services	Satellite Offices	Region 1: Stevens County Health Department (\$4,500) Region 2: TBD: Southwest Region (Temporary coverage from Topeka Administrative Office) (\$7,000) Region 3: Hays Area Children's Center (\$8,000) Region 4: Barton County Health Department (\$4,000) Region 5: KU School of Medicine, Department of Pediatrics (\$29,500) Region 6: Saline County Health Department (\$16,500) Region 7: Nemaha County Health Department (\$2,500) Region 8: Northeast Kansas Multi-County Health Department (\$2,500) Region 9: Morris County Health Department (\$2,500) Region 10: TBD: Northeast Region (Temporary coverage from Topeka Administrative Office) (\$34,000) Region 11: Crawford County Health Department (\$10,000)	\$121,000
	Health in the Classroom*	Northeast Kansas Multi-County Health Department <i>Working alongside special education co-Ops, teachers and parents to promote coordinated care, nurses will make monthly visits to local area schools with special education cooperatives to go into the classroom setting and provide health, nutrition and wellness education to students with special healthcare needs.</i>	\$25,976
	Telehealth*	Saline County Health Department <i>Utilizing telehealth to improve patient appointment services and partnering with other providers in the community to offer telehealth as a way to reach those in rural areas.</i>	\$5,750
	Native American Needs Assessment*	University of Kansas Medical Center, Department of Pediatrics <i>A survey will be developed and an analysis conducted to identify gaps and barriers to meeting the health care needs of the Native American children.</i>	\$13,482
	Behavioral Health Integration*	University of Kansas Medical Center, Center for Child Health and Development <i>A behavioral health assessment will be developed and shared with those who attend clinics in Kansas City. Referrals, resources and services will be provided to those identified with a need.</i>	\$32,590
Youth Leadership Development	FACES of Change*	Kansas Youth Empowerment Academy <i>A seven-month leadership program for youth with disabilities that will foster attitudes of civic engagement and services through the development of leadership skills. Implementation began in April of 2016 and will conclude the first session series in November 2016. The second series will begin in 2017.</i>	\$63,000
Parent Training and Support	Project to Educate and Empower Parents of CYSHCN	Family to Family Health Information Center <i>Support for a Parent Health Information Specialist (PHIS) to consult directly with parents of children or youth with special health care needs to provide support to address social, behavioral and community needs. This also includes training for parents and providers.</i>	\$33,125