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Categorical Grant Funds Requirements

These funds support specific or targeted health service needs. Continued funding is not automatic. An annual application for each type of funding must be submitted to KDHE by the deadline.

The applicant must meet local matching requirements for each type of Categorical Grant Funds requested.

Successful administration of grant funds requires that the Local Health Agency:

a. Comply with federal and state policies and regulations.
b. Bill Medicaid or other third party payers for services provided to eligible clients. The project must develop and implement a cost-based sliding fee schedule. Funds generated from client fees or third party reimbursement will be used to support the maintenance of effort and/or expansion of services.
c. Implement an annual staff education plan which identifies education needs of existing staff and plans for upgrading provider skills in identified needs areas; includes a provision for attendance at annual KDHE updates in primary service areas; and, provides for orientation and in-service training of new staff.
d. Provide integrated services, client records and implement multi-program staff meetings.
e. If providing multi-county services, provide each member county with a copy of the Grant Application Guidelines, completed application package, related program contact, Grant Reporting Instructions, and have on file a signed memorandum of agreement with each participating county.
f. Submit documentation of (a) progress in achieving objectives and (b) expenditures (quarterly Certified Affidavit of Expenditures). Documentation is used to understand public health needs and services in the state, and convey information and data to relevant federal and state agencies.
g. Maintain fiscal control and fund accounting procedures to ensure the proper disbursement and the accountability of grant funds. Cost center accounting should be established to document

revenues and expenditures for each type of funding. The accounting system should reflect all receipts, obligations, revenues, and disbursements of grant and local funds.

h. Provide individual employee coverage for Workers Compensation, unemployment insurance, and social security. The agencies are also responsible for income tax deductions, other tax or payroll deductions, and providing any benefits required by law for those employees who are employed on behalf of the grant program.

i. Submit all grant applications at www.Catalystserver.com by March 16, 2015 at 5:00 pm.

Categories

Chronic Disease Risk Reduction

Child Care Licensing Program

Community-Based Primary Care Clinic Grant

Family Planning

Healthy Family Services

HIV Prevention Program - Community

HIV Prevention Program - Opt Out

Immunization Action Plan

Maternal & Child Health

Pregnancy Maintenance Initiative (PMI)

Public Health Emergency Preparedness

Ryan White

State Formula

Teen Pregnancy Targeted Case Management

WIC/ICP Collaborative

State Formula

Program Purpose

State Formula (General Health) Funds are provided by the state legislature to local health departments per Kansas Statute to form the base for public health service support. These funds are intended to help insure that “adequate health services are available to all inhabitants of the State of Kansas.” There are no specific program requirements at this time for this funding however all local health department applicants must complete the “State Formula Required Questions”.

Eligibility

All local health departments may apply to receive State Formula funds.

Program Details

All program details, application requirements and program staff contact information can be found on the attached document State Formula Guidance

Applications are available on January 15, 2015 and are due on March 16, 2015.

Resources:

- Local Maintenance of Effort
- County Population and General Health (State Formula) Award Figures (subject to change)

State Formula Guidance

Program Purpose

State Formula (General Health) Funds are provided to local health departments to form the base for public health service support. These funds are intended to help insure that "adequate health services are available to all inhabitants of the State of Kansas." There are no specific program requirements at this time for this funding however all applicants who are local health departments must complete the "State Formula Program Required Questions" in the Catalyst system. (www.catalystserver.com)

Funding

Funding will be allocated to each local health department based on the formula contained in the Kansas Statutes Annotated (K.S.A. 65-241) applied to funds appropriated for this purpose by the current Legislature. The document, "County Population and General Health Award" lists the amount that will be allocated to each health department based on that projected appropriation level. If the actual appropriation varies from that amount, a new allocation list will be prepared and distributed.

The statute authorizing the State Formula Grant, K.S.A. 65-241 et. seq., requires a "Local Maintenance of Effort".

Local Health Department administrators should communicate with appropriate county officials to ensure that local maintenance of effort amounts are adequately and correctly certified.

Specific Program Information

a. Complete the "State Formula Required Questions" in Catalyst, including submitting the previous year Local Tax Revenue Amount within Administration and Management and uploading a copy of the Health Department budget as an attachment where requested.

Additional Consideration

To be eligible to receive Formula Funding, a health department must:

a. Be a county, city-county, or multi-county department of health.
b. During the current year, receive and expend local tax revenue in accordance with attached KDHE maintenance of effort clarification memorandum.
c. Submit an application requesting funding

Reporting Requirements

a. No narrative report is required.
b. Submit the following information on a quarterly basis: A Certified Affidavit of Expenditures which will require reporting of total local tax and other non-state, non-federal revenue and expenditures.

Program Contact

Jane Shirley, Director, Local Public Health Program

785-296-1200
jshirley@kdheks.gov
Form: Program Request
County Population and General Health Award

References:

Local Maintenance of Effort
County Population and General Health Award

Curtis State Office Building
1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367

Kansas
Department of Health & Environment

Phone: 785-296-0461
Fax: 785-368-6388
www.kdheks.gov

Robert Moser, MD, Secretary

Sam Brownback, Governor

To: Local Health Departments
From: Bureau of Community Health Systems
Regarding: LOCAL MAINTENANCE OF EFFORT

H.B. 2040, Section 3 (c) as amended by the 2010 Legislature amended K.S.A. 65-242 reads as follows:

"If local tax revenues allotted to a local health department for a fiscal year fall below the level of local tax revenues allotted to the local health department for the preceding fiscal year, the amount of state financial assistance under this act for which such local health department is eligible for the fiscal year shall be reduced a percentage equal to the percentage of reduction in local tax revenue for that fiscal year."

The base period for determining maintenance of effort will be the preceding fiscal year. Calendar years will be used for comparing local contribution levels in relation to General Health grants. Comparison of the new local tax revenues for the present calendar year with the amount of new local tax revenues necessary for the coming calendar year permits county governments to know the minimum new local revenue necessary. If local tax revenues are decreased, the amount of the state grant will be decreased a like amount.

A carryover balance that remains in the health fund cannot be transferred out of the health department's health fund to be used for other than health-related purposes (K.S.A. 79-2934, a part of the municipal budget law). However, transfers to a "health capital outlay" fund would be considered a health-related purpose. Also, a carryover balance that remains in the health fund does not count towards meeting the next year's requirement for availability of new local tax revenues.

In summary:

- To participate in the General Health Grant program to the fullest extent possible (i.e. collect maximum funds possible), the new local tax revenues available for a calendar year must be equal to or greater than local tax revenues available for the previous calendar year. Levels of state fiscal year funding for each participating local health department are determined by formula and are part of the Grant Application Guidelines distributed to local agencies every year.
- Local health-related tax revenues cannot be transferred for other purposes.
- Year end balances in health-related funds cannot be carried forward and counted when determining the amount of NEW local health-related tax revenues available for compliance with K.S.A. 65-242.

COUNTY POPULATION AND GENERAL HEALTH (STATE FORMULA) AWARD FIGURE - SFY 2016

COUNTY	2013 POPULATION	TOTAL ALLOCATION
ALLEN (SEK)**	13,124	$8,977
ANDERSON (SEK)**	7,897	$7,000
ATCHISON (NEK)*	16,749	$11,456
BOURBON (SEK)**	14,852	$10,159
BROWN (NEK)*	9,997	$7,000
JACKSON (NEK)*	13,366	$9,142
WOODSON (SEK)**	3,221	$7,000
BARBER	4,947	$7,000
BARTON	27,509	$18,816
BUTLER	65,803	$45,009
CHASE	2,700	$7,000
CHAUTAUQUA	3,552	$7,000
CHEROKEE	20,978	$14,349
CHEYENNE	2,694	$7,000
CLARK	2,193	$7,000
CLAY	8,406	$7,000
CLOUD	9,292	$7,000
COFFEY	8,412	$7,000
COMANCHE	1,955	$7,000
COWLEY	36,204	$24,763
CRAWFORD	39,278	$26,866
DECATUR	2,930	$7,000
DICKINSON	19,609	$13,412
DONIPHAN	7,851	$7,000
DOUGLAS	114,322	$78,195
EDWARDS	2,945	$7,000
ELK	2,655	$7,000
ELLIS	29,061	$19,877
ELLSWORTH	6,398	$7,000
FINNEY	37,098	$25,375
FORD	34,819	$23,816
FRANKLIN	25,740	$17,606
GEARY	37,384	$25,570
GOVE	2,769	$7,000
GRAHAM	2,593	$7,000
GRANT	7,950	$7,000
GRAY	6,009	$7,000

COUNTY POPULATION AND GENERAL HEALTH (STATE FORMULA) AWARD FIGURE - SFY 2016

COUNTY	2013 POPULATION	TOTAL ALLOCATION
GREELEY	1,290	$7,000
GREENWOOD	6,424	$7,000
HAMILTON	2,609	$7,000
HARPER	5,860	$7,000
HARVEY	34,741	$23,763
HASKELL	4,141	$7,000
HODGEMAN	1,950	$7,000
JEFFERSON	18,813	$12,868
JEWELL	3,046	$7,000
JOHNSON	566,933	$387,776
KEARNY	3,923	$7,000
KINGMAN	7,844	$7,000
KIOWA	2,523	$7,000
LABETTE	20,916	$14,306
LANE	1,720	$7,000
LEAVENWORTH	78,185	$53,478
LINCOLN	3,147	$7,000
LINN	9,516	$7,000
LOGAN	2,798	$7,000
LYON	33,510	$22,921
MARION	12,219	$8,358
MARSHALL	10,002	$7,000
MCPHERSON	29,569	$20,225
MEADE	4,343	$7,000
MIAMI	32,835	$22,459
MITCHELL	6,378	$7,000
MONTGOMERY	34,292	$23,455
MORRIS	5,741	$7,000
MORTON	3,143	$7,000
NEMAHA	10,161	$7,000
NEOSHO	16,430	$11,238
NESS	3,073	$7,000
NORTON	5,622	$7,000
OSAGE	16,142	$11,041
OSBORNE	3,818	$7,000
OTTAWA	6,042	$7,000
PAWNEE	6,971	$7,000

COUNTY POPULATION AND GENERAL HEALTH (STATE FORMULA) AWARD FIGURE - SFY 2016

COUNTY	2013 POPULATION	TOTAL ALLOCATION
PHILLIPS	5,540	$7,000
POTTAWATOMIE	22,691	$15,520
PRATT	9,878	$7,000
RAWLINS	2,589	$7,000
RENO	64,190	$43,905
REPUBLIC	4,820	$7,000
RICE	10,011	$7,000
RILEY	75,394	$51,569
ROOKS	5,190	$7,000
RUSH	3,186	$7,000
RUSSELL	6,933	$7,000
SALINE	55,740	$38,126
SCOTT	5,035	$7,000
SEDGWICK	505,415	$345,699
SEWARD	23,390	$15,999
SHAWNEE	178,831	$122,319
SHERIDAN	2,553	$7,000
SHERMAN	6,115	$7,000
SMITH	3,706	$7,000
STAFFORD	4,359	$7,000
STANTON	2,194	$7,000
STEVENS	5,816	$7,000
SUMNER	23,591	$16,136
THOMAS	7,948	$7,000
TREGO	2,980	$7,000
WABAUNSEE	7,051	$7,000
WALLACE	1,569	$7,000
WASHINGTON	5,629	$7,000
WICHITA	2,192	$7,000
WILSON	9,105	$7,000
WYANDOTTE	160,384	$109,701
	2,893,957	$2,220,250
N.E.K.MULTI-CO.*	40,112	27,598
S.E.K.MULTI-CO.**	39,094	33,136

Chronic Disease Risk Reduction Grant Application

Program Purpose

The purpose of this community grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity, nutrition and chronic disease self-management.

Eligibility

Eligible applicants are local health departments that are expected to serve as the project lead on behalf of the community. A local health department may designate a partner organization to serve as the lead agency. If a partner organization is to serve as the lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant. A consortium of counties may apply together under one application.

Organizations within counties designated as target sites for the "State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke" grant (DP14-1422) are eligible for PAN funding from CDRR. However, applicants must demonstrate how 1422 and CDRR work will be integrated, how duplication will be avoided and how funds will be leveraged if PAN funds are requested.

Funding

Tobacco prevention funding is contingent upon appropriations by the Kansas State legislature. Physical activity nutrition and Chronic Disease Self-Management Education activity funding is contingent upon availability of funds.

Program Details

All program details, application requirements and program staff contact information can be found on the attached document: Chronic Disease Risk Reduction RFP Final Document

Required forms:

CDRR Exec Summary

CDRR Planning Phase Forms

CDRR Coalition Members

CDRR Staffing Plan

CHRONIC DISEASE RISK REDUCTION

Background

Chronic diseases account for roughly 75 percent of health care costs each year.[1] Based on national estimates in 2010, nearly $20 billion was spent in Kansas on chronic disease.[2] As states struggle to meet the staggering costs of health care, the most cost-effective interventions are frequently overlooked. Impressive achievements in population health are possible by reducing the prevalence of risk factors that underlie chronic disease and injury and by helping people actively manage their chronic conditions.

TOBACCO USE - Tobacco use is the leading cause of preventable death and disease in Kansas. Annually, cigarette use alone causes approximately 3,800 deaths in Kansas, costing more than $927 million in medical expenditures and $863 million in lost productivity from an experienced workforce that dies prematurely.[3] Additionally, youth continue to use tobacco at an alarming rate. Data from the 2011/2012 Kansas Youth Tobacco Survey (KYTS) reveal that 13.0 percent of high school students reported using cigarettes. The KYTS also indicates that 11.1 percent of high school male students in Kansas currently use smokeless tobacco. Data compiled by the Centers for Disease Control and Prevention (CDC) show that smoking prevalence among youth and adults declines faster as spending for tobacco control programs is increased. The risks of tobacco use extend beyond actual users. Secondhand smoke exposure increases the risk for lung cancer and heart disease.[4]

OBESITY- Obesity, defined as a body mass index $\geq$ 30 kg/m2, increases the risk for several chronic diseases including coronary heart disease, type 2 diabetes, certain cancers, stroke and osteoarthritis.[5] These conditions have their own promising practices to combat obesity, such as chronic disease self-management programs. In 2012, 29.8 percent of Kansas adults 18 years and older were obese.[6] The percentage of Kansas adults who were obese in 2012 was significantly higher among Kansans 25 years and older, persons with less than college education, those whose annual household income was less than $35,000 and those living with a disability. In addition, obesity is highly prevalent among Kansas adults with chronic health conditions.[6] For example 56.4 percent of Kansans with diabetes and 39.9 percent of Kansans with arthritis are obese.[6] In 2013, 28.9 percent of Kansas high school students in grades 9-12 were overweight or obese (16.3% overweight, 12.6% obese.)[7]

PHYSICAL ACTIVITY - Regular physical activity is associated with reduced risk of several chronic health conditions including coronary heart disease, stroke, type 2 diabetes and certain cancers.[8] Participating in physical activity also delays the onset of functional limitations,[9] prevents obesity[5] and is essential for normal joint health.[10] The U.S. Department of Health and Human Services' *2008 Physical Activity Guidelines for Americans* recommend that adults participate in at least 150 minutes a week of moderate-intensity aerobic activity, or 75 minutes a week of vigorous-intensity aerobic activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. The *Guidelines* also recommend that children and adolescents participate in at least 60 minutes of physical activity per day.

In 2011, 16.5 percent of Kansas adults 18 years and older met these physical activity guidelines.[11] The percentage of Kansas adults meeting current physical activity guidelines was significantly lower among females, Kansans 25 years and older compared to those aged 18 to 24 years, those with less than college education, those whose annual household income was less than $50,000, residents of less population-dense counties, those living with a disability and those with arthritis. In 2013, 71.7 percent of Kansas high school students in grades 9-12 did not engage in recommended levels of physical activity (i.e. at least 60 minutes per day).[12]

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[1] The Power to Prevent, Call to Control: At A Glance 2009. Centers for Disease Control and Prevention website. 2009. Available at: www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm. Accessed December 14, 2012.

[2] U.S. Health Care Costs. Kaiser Family Foundation, Kaiser EDU website. 2012. Available at http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#footnote/. Accessed December 17, 2012.

[3] Smoking Attributable Morbidity, Mortality and Economic Cost. Centers for Disease Control and Prevention.

[4] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[5] U.S. Department of Health and Human Services. Public Health Service; National Institutes of Health; National Heart, Lung and Blood Institute. Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. NIH Publication No. 98-4083; 1998.

[6] 2012 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

[7] 2013 Kansas Youth Risk Behavior Survey. Kansas State Department of Education.

[8] U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans.*

[9] Huang Y, Macera CA, Blair SN, Brill PA, Kohl HW, Kronfeld JJ. Physical fitness, physical activity, and functional limitations in adults 40 and older. *Medicine Science in Sports and Exercise.* 1998;30:1430-1435.

[10] Minor MA. Exercise in the treatment of osteoarthritis. *Rheum Dis Clin North Am.* 1999;25:397-415.

[11] 2011 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

[12] 2013 Kansas Youth Risk Behavior Survey, Kansas State Department of Education.

NUTRITION - Research shows that eating at least two and a half cups of fruits and vegetables per day is associated with a reduced risk of many chronic diseases, including cardiovascular disease and certain types of cancer. A diet rich in fruits and vegetables can also help adults and children achieve and maintain a healthy weight.[13] In 2011, 41.4 percent of Kansas adults 18 years and older consumed fruit less than 1 time per day and 22.3 percent consumed vegetables less than 1 time per day.[11] The percentage of Kansas adults who consumed fruits or vegetables less than 1 time per day was significantly higher among males, adults 18-34 years old and those with less than a college level education.[11] In 2013, only 16.4 percent of Kansas high school students in grades 9-12 ate fruits and vegetables five or more times per day.[12]

CHRONIC DISEASE SELF-MANAGEMENT EDUCATION: Chronic Disease Self-Management Education (CDSME) programs are evidence-based classes with curriculum developed by Stanford University to improve the quality of life of those living with chronic disease.[14] The program specifically addresses arthritis, diabetes and lung and heart disease, but teaches skills useful for managing a variety of chronic diseases. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshop participation is recommended for anyone living with one or more chronic conditions, family and friends of those living with a chronic condition and caregivers. These interactive workshops provide participants with techniques to deal with problems associated with chronic disease, nutrition, appropriate exercise, appropriate use of medications, communicating effectively with family, friends and health professionals and how to evaluate new treatments. Participants also learn and practice problem-solving and action planning.

REQUEST FOR PROPOSAL - This document is a request for proposals for local healthy community programs that include tobacco use prevention and control and may include community physical activity, nutrition and obesity prevention activities. This funding solicits program grant applications from communities to establish or continue tobacco control programs at the local level that are sustainable, accountable and eventually comprehensive as recommended by CDC's Best Practices for Comprehensive Tobacco Control Programs 2014. All applications must address tobacco, while work in physical activity, nutrition and CDSME is optional. This document provides background and guidelines for developing a full proposal and submission instructions. This is a competitive grant process, meaning that grants will be awarded based upon the quality and clarity of the proposed activities and achievability of proposed outcomes. Please follow the directions carefully. Applications will be scored based on adherence to guidelines.

Chronic Disease Risk Reduction (CDRR) Grant Overview

The purpose of this community grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity, nutrition and chronic disease self-management. Examples of these strategies can be found in the American Journal of Preventive Medicine's *The Guide to Community Preventive Services: Tobacco, Obesity, Physical Activity, Nutrition* (www.thecommunityguide.org), the National Association of County and City Health Officials' *Recommendations for Comprehensive Tobacco Use Prevention Programs* (http://www.naccho.org/topics/HPDP/tobacco/upload/Tobacco-Prevention-Learners-Guide.pdf) and *The Community Health Promotion Handbook: Action Guides to Improve Community Health* (http://www.cdc.gov/steps/actionguides). The grant program is structured to promote community program progress in two distinct phases:

1. ***Planning and Capacity (1 year maximum):*** appropriate for applicants who lack a functioning chronic disease control coalition and/or lack a recent community assessment upon which they can plan and justify CDRR activities. Grant funds support completion of an approved community-wide and/or targeted assessment tool, establishment of a functional chronic disease prevention coalition including at a minimum a tobacco committee or sub-committee focused on tobacco, preparation for future participation in the Youth Tobacco Survey (YTS) and attendance at three state trainings. At least 0.25 full-time equivalent (FTE) (a minimum of 10 hours per week) must be dedicated to grant implementation. Planning applicants may propose community interventions in their application.

   Planning and Capacity Phase Deliverables:

   - Community chronic disease prevention plan based on or guided by community and/or targeted assessment results (e.g., CHANGE Tool Community Action Plan, tobacco retail assessments, Microscale Audit of Pedestrian Streetscapes, etc.)

[13] U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, Washington, DC: U.S. Government Printing Office;2010.
[14] http://patienteducation.stanford.edu/programs/cdsmp.html

- Functional chronic disease prevention coalition. All CDRR grantees are required to have a community coalition or a subcommittee of a larger community health coalition that focuses on tobacco strategies outlined in workplan.
- Attend the Annual CDRR Summit (counts as one of three required trainings) and 3 quarterly meetings held in state regions.

Timeline and Staffing:

- Maximum of one year
- 0.25 FTE minimum
- 25 percent local match

2. ***Implementation:*** applicants with a functioning coalition and a community-wide or targeted assessments completed within the past five years should apply at the implementation level. Grant funds support local tobacco control, physical activity, nutrition and chronic disease self-management programming, participation in the county and state level YTS as requested, and attendance at three state trainings and 3 regional meetings. Implementation applicants must include tobacco programming to be eligible for physical activity, nutrition and CDSME programming funding. Tobacco prevention funding is contingent upon appropriations by the Kansas State legislature. Physical activity, nutrition and CDSME activity funding is contingent upon availability of funds. At least 0.5 FTE (a minimum of 20 hours per week) must be dedicated to grant implementation.

   Implementation Phase Deliverables:

   - Tobacco control activities
   - Functional chronic disease prevention coalition that meets at least quarterly. All CDRR grantees are required to have a community coalition or a subcommittee of a larger community health coalition that focuses on tobacco strategies outlined in workplan.

   Optional: Physical activity, nutrition and chronic disease self-management activities.
   Timeline and Staffing:

   - 0.5 FTE minimum
   - 25 percent local match

Required of All Grantees:

Activities

1. Support state surveillance if requested.
2. Promote the "Brief Tobacco Intervention" web-based training to local providers.
3. Attend three approved trainings.
4. Host two Community Health Specialist site visits during first and third quarters of grant year.
5. Engage in public relations efforts geared toward decision-makers such as speaking engagement, fact sheets, meetings, and informational letters to local and state officials. Have staff or a coalition member attend chronic disease health promotion technical assistance opportunities.
6. Complete a community assessment if the most recent community assessment is five years old or older.
7. Complete CDRR Coalition Assessment as recommended by Community Health Specialist. See coalition assessment appendix.
8. Submit regular earned media reporting via online survey (http://www.surveymonkey.com/s/CDRREarnedMedia).
9. Complete mid and final year reports.

   Complete one success story per approved program area per year: one for tobacco, one for PAN and one for CDSME, if applicable. Use the Success Story form.

Communication with Chronic Disease Risk Reduction

1. Inform Community Health Specialist of ongoing grant activities including but not limited to media campaigns, youth events, coalition meetings, etc.
2. Submit all communications items (including legislative letters and other media) to KDHE Communications Coordinator for review at least two weeks prior to date needed.
3. Provide agenda and minutes to Community Health Specialist after coalition meetings.

4. Submit surveys to BHP epidemiologist for review in advance of survey administration.

Eligibility

Eligible applicants are local health departments, which are expected to serve as the project lead on behalf of the community. A local health department may designate a partner organization to serve as the lead agency. If a partner organization is to serve as the lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant. A consortium of counties may apply together under one application.

Organizations within counties designated as target sites for the "State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke" grant (DP14-1422) are eligible for PAN funding from CDRR. However, applicants must demonstrate how 1422 and CDRR work will be integrated, how duplication will be avoided and how funds will be leveraged if PAN funds are requested.

Match

All applicants must provide a minimum of 25 percent match for every dollar awarded. The 25 percent match may be in cash, in-kind or a combination of both from county and/or public and private sources. Sources of in-kind match may include: school programs, Safe and Drug Free Schools funds, Kansas Healthy Schools, Safe Routes to School, Kansas Health Foundation and Sunflower Foundation Trails grant, Kansas Department of Transportation Enhancement grant and others as determined by the program director. Local funds that support existing evidence-based cessation program services and local funds provided for enforcement activities may also serve as local match. Please consult the regional Community Health Specialist for assistance in determining the amount of cash match required for a specific program. The applicant must document all costs used to satisfy the matching requirements. Program resources may be used for consultants, staff, survey design and implementation, data analysis, or other expenses associated with surveillance and evaluation efforts to fulfill the match requirement.

Grant Timeline

March	April	May	June	July	August
March 16, CDRR Grant application due		Award notices sent		July 1, Grant year begins, 25% of award funds distributed	
September	**October**	**November**	**December**	**January**	**February**
September 1, revisions due Site Visit #1	October 1, 25% of award funds distributed			January 1, 12.5% of award funds distributed January 15, mid-year report and affidavit of expenditures due	February 15, 12.5% of award funds distributed
March	**April**	**May**	**June**	**July**	
	April 1, final 25% of award funds distributed Site Visit #2		June 30, Grant year ends	July 15, end of year report and final affidavit of expenditures due	

KDHE's Responsibility to Grant Recipient

1. Attend and present at coalition meetings and other events as requested.
2. Provide technical assistance for evaluation, media, programming, integration of activities, coalition building, etc.
3. Schedule first and third quarter site visits to check progress with grant activities.
4. Provide guidance through processes that require state agency oversight (Internal Review Board (IRB), media approval, etc.).
5. Send relevant information on resources, funding opportunities, trainings, professional development, etc.

Application

Incomplete applications will not be considered.
Please direct any questions to your regional Community Health Specialist.

To apply, applicants must procure an account with Catalyst (http://www.catalystserver.com; info@catalystserver.com). Login to http://www.CatalystServer.com, apply for CDRR funding, remove and/or add optional workplan items, fill in requested information and attach the below completed supplemental forms to the CDRR budget in Catalyst.

Supplemental Application Forms

1. **Executive Summary:** The Executive Summary requires the applicant to describe the community to be served and summarize how their proposal will meet identified needs. This description should include population demographic information, identified disparate population(s) and poignant results of the most recent community assessment. Applicants with a community assessment plan that is over five years old or missing should describe plans for implementing a community assessment.
2. **Coalition Membership Form:** A functional coalition is a requisite for successful community-based chronic disease prevention. Please have each participant sign to indicate their support for the grant application. Sectors of community support are provided as a guideline for composition of an optimal community coalition for chronic disease risk reduction. Applicants are encouraged, but are not required to have an organization represented in every sector. Applicants should include all sectors with direct relevance to selected goals and outcomes. Each sector may have multiple participants. A minimum of five active sectors are required for the coalition to be considered functional.
3. **Planning Phase Forms:** For planning phase applicants only (Connection Map, Identifying Linkages Between Community Priorities and Tobacco Control, Types and Levels of Partnerships).
4. **Staffing Plan Form:**
    a. List the Position Name for each proposed staff member, the staff member's name and credentials, and provide a brief explanation of the scope of duties for this position related to the program. The staffing plan should reflect the organizational capacity to complete the program activities and evaluation through an appropriate amount of FTE. Minimum FTE requirements as specified for each phase must be dedicated to the program.
    b. Grant funds for staffing are to be used for grant coordination and activity implementation through local health educators/outreach workers.
    c. No more than 10 percent of administrators' salaries may be funded by CDRR.

Budget

The budget should be entered into Catalyst with detailed budget item descriptions. The CDRR budget form "Staffing Plan" should be completed and attached to your CDRR Catalyst budget. The "Staffing Plan" form is available for download at http://www.kdheks.gov/doc_lib/index.html.

Funds may be used for reasonable costs associated with the program's activities including:

- salary
- travel
- registration fees
- supplies
- advertising (requires prior approval from the Communication Coordinator to ensure statewide coordination)
- consultation
- facility rental
- equipment rental
- speakers/presenters
- educational materials

Grant Funds may **NOT** be used to:

- provide meals or snacks
- provide direct services, individual or group cessation services
- provide direct patient care or rehabilitation
- provide personal health services medications (NRT therapy)
- supplant existing funding from Federal, State, or private sources
- directly enforce policies
- pay for an internship
- provide incentives and promotional items
- provide staff time for direct classroom instruction of students of any age

- lobby government entities, or defray other costs associated with the treatment of diseases
- purchase capital equipment

Communities are encouraged to get partner contributions for food, which may be used as matching funds. The Kansas Department of Health and Environment funds cannot be used to supplant existing funding from Federal, State or private sources.

Review Procedures

Applications will initially be reviewed for completeness and responsiveness. Incomplete applications and applications that do not meet the eligibility criteria will not advance for further review. Applicants will be notified if their applications did not meet eligibility or published submission requirements.

Information about the application will be provided at the Chronic Disease Risk Reduction Summit January 22-23, 2015 and a FAQ document will be made available online. Submit questions regarding the Chronic Disease Risk Reduction Grant application via email, with the subject "CDRR Questions," to TUPP@kdheks.gov. Questions and responses will be listed on a Frequently Asked Question (FAQ) document on the KDHE Bureau of Health Promotion webpage http://www.kdheks.gov/bhp/index.html in the links section on the right side of the page.

Community Health Promotion staff may respond to questions regarding application processes however, to provide an equitable and fair process to all applicants, staff will not respond to questions regarding application content. Community Health Promotion staff will not read the application prior to submission. Grant applications will be reviewed by a team of external reviewers. If requested by an external reviewer, and available, the applicant organization's performance and compliance as a CDRR grantee during the past two fiscal years will be considered and discussed when scoring and ranking grant applications. Planning Grants will be scored separately to eliminate competition barriers for new applicants.

Although not an exhaustive list, reviewers look for the following qualities:

- Does the application demonstrate the chronic disease-related strengths, weaknesses and barriers faced by the community?
- Does the applicant demonstrate they have a functioning, diverse community coalition or the capacity to develop a strong coalition capable of carrying out chronic disease risk reduction interventions?
- Are the proposed activities aligned with evidenced-based strategies as described in the RFP?
- Do the proposed activities effectively integrate any paid or earned media into policy, systems and environmental activities?
- Are the proposed activities logically organized and likely to result in a positive impact on demonstrated community needs?
- Are the objectives and indicators proposed by the grantee feasible, measurable and demonstrative of activity progress and success?
- Are the staffing and budget sections sensible and justified by the proposed activities?
- Is the application complete, of high overall quality and clearly and persuasively written?

Award Administration Information - Successful applicants will receive a Letter of Award and Grant Contract from the Kansas Department of Health and Environment. The first disbursement of grant funds may be expected on or before July 31, 2015. Any requested revisions to program activities, evaluation and/or budgets must be completed before the second disbursement of grant funds. Grant activities will be expected to start on July 1, 2015, and continue through June 30, 2016.

Unsuccessful applicants will receive notification of the result of the application review by mail.

Reporting

All awardees must complete mid-year and final reports by providing budget and workplan progress updates in Catalyst and responding to requests for supplemental information from KDHE. The Mid-year report and Affidavit of Expenditures for the period of July 1 through December 31, 2015, will be due no later than January 15, 2016. The Final Report and Affidavit of Expenditure for the period of July 1, 2015 – June 30, 2016 will be due no later than July 15, 2016.

Appendix

CDRR Coalition Self-Assessment Instructions and Tool

CDRR Coalition Self-Assessment Instructions

CDRR programming relies on engaged, highly functional coalitions to implement chronic disease risk reduction interventions. Coalitions can leverage local resources and capitalize on local partners and relationships to achieve goals that would be near-impossible for one or two individuals working alone. Coalitions, however, require work to create and maintain. To facilitate the health of coalitions associated with the CDRR program, the CDRR grant requires completion of the CDRR Coalition Self-Assessment every other year.

The CDRR Coalition Self Assessment is designed to improve coalition organization and functionality. It does this by identifying coalition strengths and weaknesses, which are used by CDRR Community Health Specialist Staff to facilitate discussions about coalition improvements. The assessment provides a general picture of a coalition's stage of development and may point out areas in which technical assistance, training or other support is needed.

This assessment is not a test. There are no right or wrong answers and there is no personally identifying information requested on the questionnaire. To get the most out of the assessment, it is important that each question be answered honestly and by as many coalition members as possible. A coalition assessment can only “fail” if it does not result in coalition improvement.

When your coalition is ready to conduct a coalition assessment, contact your Community Health Specialist to schedule an assessment date. It is recommended that you schedule an assessment in the first half of the grant year to give your Community Health Specialist sufficient time to analyze results and report back to the coalition.

The Coalition Self-Assessment Process:

1) Discuss the assessment with your coalition and pick a couple possible dates to have the assessment.
2) Contact your Community Health Specialist and decide on a date to have the assessment.
3) Your Community Health Specialist will attend the designated coalition meeting and administer the assessment.
4) Your Community Health Specialist collects, aggregates and analyzes the results of your assessment.
5) At another meeting later in the grant year, your Community Health Specialist will present the results of the coalition assessment and facilitate a discussion about the results and how the information can be used.

SFY2016 Chronic Disease Risk Reduction Program
Application Outline

A. Administration and Management

Category A.1 Capacity Building and Management

Strategy A.1.1 Build Internal Capacity

Describe plan for meeting all of the requirements listed under this strategy.

- Attend three approved trainings
- Have staff or a coalition member attend CDRR technical assistance opportunities
- Apply for external grants that augment community-based primary prevention work
- Serve as a mentor for another CDRR grantee as requested

Strategy A.1.2 Meet Reporting Requirements

Describe plan for meeting requirements listed under this strategy.

- Host two site visits during the first and third quarters of the grant year
- Submit regular earned media and speaking engagement reporting via online survey (http://www.surveymonkey.com/s/CDRREarnedMedia)
- Complete mid and year-end reports

Strategy A.1.3 Communicate and coordinate local work with state staff

Describe plan for meeting requirements listed under this strategy.

- Inform Community Health Specialists of ongoing grant activities including but not limited to media campaigns, youth events, coalition meetings, etc.
- Submit all communications items (including legislative letters and other media) to KDHE Communications Coordinator for review at least two weeks prior to date needed.
- Provide agenda and meeting minutes to Community Health Specialists after each coalition meeting.
- Submit surveys to TUPP epidemiologist for review in advance of survey administration.

B. Data and Information

Submit surveys to TUPP epidemiologist for review in advance of survey administration.

Category B.1 Assessments and State Surveillance Support

Strategy B.1.1 Describe plan to gather and use data to plan and evaluate interventions

Describe plan for meeting requirements listed under this strategy.

- Complete a community assessment (e.g., CHANGE Tool) if most recent community assessment is five or more years old. Consult with regional Community Health Specialist to identify an appropriate assessment tool and community partners.

Strategy B.1.2 Supporting state surveillance when requested.

Describe plan for meeting requirements of supporting state surveillance when requested.

- Recruit schools and administer the Youth Tobacco Survey as requested
- Collect and submit local policies to the state as requested

D. Interventions to Improve Public Health

Please reference the Chronic Disease Risk Reduction Guidance Document for more details regarding strategies. For work plans selected, it is necessary to describe the SMART objective, annual milestone, target population, target organization, activity narrative, action steps, performance measures, and data sources for selected performance measures.

Goal Area 1- Prevent initiation of tobacco use among young people

- **Strategy- Increased Restriction of Tobacco Use and Enforcement of Anti-Tobacco Policies and Programs in Schools and on College/University Campuses**
    - Increase the number of schools or school districts implementing 100% tobacco-free policies.
    - Increase the number of colleges/universities implementing 100% tobacco free policies
- **Strategy- Increased Knowledge of the Dangers of Tobacco Use, Attitudes Against Tobacco Use, and Support for Policies to Reduce Tobacco Use Initiation**
    - Increase the number of youth engaged in anti-tobacco activities.
- **Strategy- Increased restriction and enforcement of tobacco product sales, availability, and use.**
    - Increase the number of communities implementing tobacco retail strategies to reduce youth tobacco initiation.

Goal Area 2- Eliminate nonsmokers' exposure to secondhand smoke

- **Strategy- Create tobacco-free policies**
    - Increase the number of multi-unit dwellings with smoke-free policies
    - Increase the number of worksites with tobacco-free policies
    - Increase the number of parks with smoke-free policies

Goal Area 3- Promote quitting among adults and young people

- **Strategy- Increase establishment and use of cessation services**
    - Establish cessation referral systems for healthcare providers
    - Increase number of WorkWell Businesses with cessation referral systems
    - Establish cessation referral systems for mental healthcare providers
    - Promote the KDHE "Brief Tobacco Intervention" web-based provider training to healthcare providers in the community. (Cannot op-out)
- **Strategy- Increase coverage for Cessation Services**
    - Increase number of worksites that have insurance plans that reimburse for cessation services including Quitline referral, nicotine replacement therapy, medication, etc.

Goal Area 4- Increase access to healthy foods and physical activity

- **Strategy- Increase support for policies and programs that expand access to healthy foods and physical activity in worksites and communities**
    - Promote and support worksite CSA programs
    - Recruit employers to participate in WorkWell Kansas and coordinate trainings
    - Promote the adoption of food service guidelines/nutrition standards, that also include sodium (target locations may include venues where food is

provided or sold including, but not limited to, worksites, hospitals, schools and/or community vending, cafeterias, snack bars and meetings or events (e.g. conferences).

- **Strategy- Increase local food production and sourcing**
  - Establish new, and expand existing, farmers' markets
  - Promote and support access to and use of EBTs-SNAP at farmers' markets
  - Promote and support farm-to-school and farm-to-institution programs and policies
  - In counties with the Senior Farmers' Market Nutrition Program (SFMNP), recruit seniors for and promote SFMNP. Provide targeted nutrition education and farmers' market promotional materials to SFMNP check distribution sites.
- **Strategy- Increase access to breastfeeding friendly environments**
  - Provide access to professional and peer support for breastfeeding
  - Ensure workplace compliance with federal lactation accommodation law
- **Strategy- Increase the number of communities that adopt and implement healthy community design principles**
  - Adopt and/or implement/enforce Complete Streets policies in combination with community awareness activities and presentations to local boards of health and planning commissions on the evidence-base and opportunities to impact health.
  - Adopt and/or implement/enforce master bike/walk transportation plans in combination with community awareness activities and presentations to local boards of health and planning commissions on the evidence-base and opportunities to impact health.
  - Form bike/walk planning advisory committees to coordinate local community design policy efforts and awareness activities.

Goal Area 5- Increase the ability of those with chronic disease to manage their condition(s)

- **Strategy- Increase access to CDSME programming**
  - Promote and coordinate the expansion of CDSME programming opportunities and their reach

E. Communications and Promotions

Category E.1 Increase public and decision-makers' knowledge of chronic disease and generate buy-in.

Strategy E.1.1. Increase awareness and knowledge of chronic disease

Describe plan for meeting requirements listed under this strategy.

- Integrate Kansas Tobacco Quitline promotion into tobacco control activities
- Capitalize on local interventions, national reports/ data releases and current events to generate earned media
- Attend media and public relations training provided by TUPP to better publicly speak about the dangers of tobacco use and secondhand smoke exposure, the existence of tobacco-related disparities, and similar topics

Strategy E.1.2. Generate buy-in among the public and decision-makers

Describe plan for meeting requirements listed under this strategy.

- Perform public relations efforts geared toward decision-makers such as speaking engagement, fact sheets, meetings, and informational letters to local and state officials (content must be reviewed by KDHE Communications Coordinator).
- Complete one success story per approved program area per year: one for tobacco, one for PAN and one for CDSME, if applicable. Use the Success Story form.

F. Partnerships

Category F.1 Collaborate with local, state and national partners

Strategy F.1.1. Create and/or maintain a functioning chronic disease prevention coalition - subcommittees are encouraged; examples include: food policy councils, bike/ped committees, tobacco prevention committees, etc.

Describe plan for meeting requirements listed under this strategy.

- Ensure coalition meets at least quarterly
- Complete the CDRR Coalition Assessment to improve coalition planning and function
- Monitor and encourage attendance to coalition meetings
- Recruit additional coalition members as needed to ensure multi-sector communtiy representation
- Consult with regional Community Health Specialist to enhance coalition planning, capacity and infrastructure

Public Health Emergency Preparedness

Program Purpose

To protect the health of Kansans through efforts to mitigate, prepare for, respond to, and recover from disasters, infectious disease, terrorism, and mass casualty emergencies.

Eligible Applicants

Funding for the Preparedness Program is contingent upon the receipt of adequate funding by KDHE through federal grants. Each health department receives a base award amount and then additional funding based on population. Approximate funding allocations for preparedness will not be known until late spring/early summer with final award amounts being designated by July 1. Participating local health departments will receive a 25% advanced payment at the beginning of the grant year.

In the event that the local health department is unable to expend all of the funds allocated, the Fiscal Agent shall notify KDHE in writing of the amount of unspent funds. KDHE may request a refund of unspent funds at the end of the grant period.

Family Planning

Program Purpose

The goal of the Family Planning Program is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children, and to provide access to additional health services that would lead to the overall improvement in the health of those individuals, prioritizing services to low-income and high risk individuals.

Eligible Applicants

The Kansas Legislature established two priorities related to contracting for the delivery of family planning services: First priority is to be given to public entities (state, county, and local health departments and health clinics); and, if any moneys remain, then, second priority is to be given to non-public entities which are hospitals or federally qualified health centers that provide comprehensive primary and preventative care in addition to family planning services.

Funding

Based on the availability of State or Federal funds, the State Agency determines the base award to the Local Agency on the 3-year average of unduplicated number of Family Planning Users. Funding is also subject to legislative and policy priorities.

Local Agency continuation grants are funded equal to at least 80 percent of the previous year's base award and the remaining 20 percent of funds may be allocated based on performance data. The amount of funding a local agency requests in the grant application should be based on the cost to provide services.

Program Details

All program details, application requirements and program staff contact information can be found on the attached document Family Planning Program Guidelines

Family Planning Program Guidelines

Funding
Based on the availability of State or Federal funds, the State Agency determines the base award to the Local Agency on the 3-year average of the number of unduplicated number of Family Planning Users.

Funding is also subject to legislative and policy priorities. The Kansas Legislature established two priorities related to contracting for the delivery of family planning services: First priority to public entities (state, county, and local health departments and health clinics); and, if any moneys remain, then, Second priority to non-public entities which are hospitals or federally qualified health centers that provide comprehensive primary and preventative care in addition to family planning services.

Local Agency continuation grants are funded equal to at least 80 percent of the previous year's base award and the remaining 20 percent of funds may be allocated based on performance data. The amount of funding a local agency requests in the grant application should be based on the cost to provide services.

In the event additional funds are received at the state level, they will be distributed to local agencies based on performance/need data. At such time that the Local Agency's unduplicated number of Family Planning Users for a 3-year average falls below 50, the State Agency may discontinue funding the Local Agency. The State Agency reserves the right to modify in its sole discretion, the funding criteria used in the award process. Funding is also subject to legislative and policy priorities.

Match – Local Agency matching funds must be equal to or greater than 40 percent of grant funds awarded. Program revenues may be utilized to meet the match requirement.

Program Revenue – Local agencies must establish a schedule of fees for services and supplies based on guidelines contained in the Manual (see b. below). Funds generated from program revenue will be used to support the maintenance/expansion of family planning services. These funds will be carried forward from year to year. The grant application budget for family planning must reflect the total program budget including grant funds, projected fee collections, Title XIX, and third party reimbursements, donations plus any unexpended revenue carryover (prior grantees only) from the previous year's budget.

Specific Program Information
a. Application – Follow the KDHE "SFY2016 Grant Application Guidance" instructions. The application budget must include expenses for staff to attend education updates. In order to advocate for increased funds, documentation of pharmaceutical expenses must be included in the detailed budget.

b. Services – See the Department of Health and Human Services' DHHS "Program Requirements for Title X Funded Family Planning Projects," (http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf), Providing Quality Family Planning Services (http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf) and the "Kansas Health Services Manual, Family Planning/Women's Health."

(1) Each project must assure that skilled personnel, equipment and medical back-up services are available to provide the required services.

(2) Each project will have an advisory committee to review and approve family planning informational and educational materials, and provide guidance in the development, implementation and evaluation of the project.

(3) Each project must provide for community education programs to: a) enhance community understanding of the objectives of the project; b) inform potential clients of the availability of services; and c) encourage continued participation by persons to whom family planning may be beneficial. Community education and outreach activities should be based on an assessment of community needs, and have both implementation and evaluation components.

(4) Each project must handle Family Planning pharmaceuticals purchased through the Office of Pharmacy Affairs 340B Drug Pricing Program in compliance with that program's guidelines.

(5) For delegate agencies whose subcontractors are purchasing Family Planning pharmaceuticals for their clients through the Office of Pharmacy Affairs (OPA) 340B Drug Pricing Program there must be a mechanism in place that allows for allocating a proportional amount of the grant award to the subcontractor(s) in order to meet the OPA expectation that Title X Family Planning covered entities receive grant funds for clinical services.

c. SFY2016 Outcome Objective: All client records with Pap test results showing epithelial cell abnormalities (ASC or more severe) will have documentation of client notification, and appropriate referral and/or follow-up recommendations within 6 weeks of the date the Pap smear was read.

SFY2016 Process Objectives: In setting objectives for SFY2016, please review the latest data available from the state data system. The applicant must set objectives in each of the following areas:

(1) Provide family planning services to #___ Users.

(2) Increase the number of high-risk (age 19 & under) Users receiving services from #___ in Calendar Year (CY) 2014 to # ___ in CY 2015.

(3) Increase the number of low-income (at or below **100 percent** poverty) Users receiving services from #___ in CY 2014 to #___ in CY 2015.

(4) Remain in compliance with clinical indicators on semi-annual reporting forms.

d. Program Protocols: The Local Health Agency will develop and have on file, written local program policies and procedures for services to be provided based on program standards and guidelines contained in the Manual in b. above. As appropriate, the Local Health Agency will have on file current APRN protocols and authorization for collaborative practice as required by the Kansas State Board of Nursing.

e. Other:

(1) The Local Health Agency will provide for orientation and training of new staff. Staff will participate in the annual KDHE Family Planning update.

(2) Onsite monitoring and technical assistance visits are conducted by the State Agency. A corrective action plan for issues identified during the said visit will be established and implemented.

(3) For multi-agency grants only, the delegate agency shall provide each agent/subcontractor with a completed grant application, contract, and reporting instructions, and will have on file a signed memorandum of agreement with each agent/subcontractor which includes provisions for record keeping and providing matching funds if required. A copy of the signed memorandum of agreement with each agent/subcontractor shall be on file with the State Agency.

(4) For the Local Agency and its agents or subcontractors who are providing required core Family Planning services off-site, a copy of the signed agreement between the provider(s) and the Local Agency shall be on file with the State Agency.

Reporting Requirements
Refer to the KDHE “SFY2016 Grant/Contract Reporting Instructions.”

Program Contact Persons

Family Planning Director - Vacant

Christina Flyntz, Family Planning Administrative Consultant
(785) 296-1205 cflyntz@kdheks.gov

Family Planning Clinical Consultant - Vacant

Maternal and Child Health (MCH) Services

Program Purpose

- 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.
- To provide and 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
- To increase the number of low income children receiving health assessments and follow-up diagnostic and treatment services
- To promote the health of mothers and infants by providing prenatal, delivery and postpartum care for low income, at-risk pregnant women
- To promote the health of children by providing preventative and primary care services for low income children
- To 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. Maternal/women's health
2. Perinatal/infant health
3. Child health
4. Children with Special Health Care Needs (CSHCN)
5. Adolescent/young adult health
6. Crosscutting or life course (public health issues that impact multiple MCH population groups)

Priority Areas:

- All women receive early and comprehensive health care before, during and after pregnancy
- Improve mental health and behavioral health of pregnant women and new mothers
- Reduce preterm and low birth weight births, and infant mortality
- Increase initiation, duration and exclusivity of breastfeeding
- All children and youth receive health care through medical homes
- Reduce child and adolescent risk behaviors relating to alcohol, tobacco, and other drugs
- All children and youth achieve and maintain healthy weight

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

MCH program activities are provided in community, clinic, school and family home settings. Healthy Start Home Visiting (HSHV) for pregnant women, mothers, and infants up to one year of age to provide education and promote healthy/safe decisions is one example of service provision in the home. MCH services complement KanCare medical assistance programs. MCH programs serve as a safety-net provider for the MCH population by providing gap-filling health care services.

Eligible Applicants

- Organizations with the capacity to provide quality services to Kansas families 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. 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.

Funding Information

Grants will be awarded annually on a competitive basis. Priority for services should be given to those with low income or limited availability to health services. 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.

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.

Program Details (For application guidance)

For more information on program goals, guidance, reporting requirements, refer to the following documents, attached:

MCH Manual

Maternal and Child Health (MCH) Program Guidance

Maternal and Child Health (MCH)
Program Details
Application Guidance

General Information:

- The KDHE MCH Manual must be used in the development of the MCH grantee's policy manual.
- Healthy Start Home Visitor (HSHV) and Home visiting services provided locally must follow KDHE program and training requirements.
- The local grantee must use evidence-based practices in their work.
- The local grantee must engage in public awareness activities and develop a referral network.
- The local grantee will develop a program evaluation process that uses client satisfaction survey and community needs assessment information to assess their program and make changes to services based on responses.
    - The local grantee may use the current MCH Survey card or develop another survey form. These will be used internally to enhance or improve services and inform future activities. These surveys will not be sent to KDHE. Client satisfaction will be assessed as part of the site visit monitoring process.
- For multi county/agency grantees only, the designated lead organization must maintain the letters of commitment from participating organizations.
- At least one person from your agency is required to attend technical assistance calls and webinars provided by KDHE.
- All new MCH program staff and administrators are required to complete MCH training.
- The MCH Program Manager from your agency will participate in any scheduled site visits provided by KDHE.
- The local grantees must submit client encounter data using electronic means at least once a month. Paper Client Visit Record (CVR) will be accepted only if electronic means are not available.
- Income and family size of all MCH 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.
- A penalty will be assessed for delinquent reports.

Attachments:

- A.1 - Attach an Organizational Chart
    - Name the attachment [Applicant Agency Name] Organizational Chart
- D.2 - Attach a Summary of your Community Needs Assessment
    - Name the attachment [Applicant Agency Name] Summary of Community Needs Assessment
- D.7 - Attach a Healthy Start Home Visitor Services Work Plan
    - Name the attachment [Applicant Agency Name] Work Plan

Program Contacts:

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

Barbara Kramer
Maternal/Family and Early Childhood Health Consultant
785-296-1308
bkramer@kdheks.gov

Kansas Maternal and Child Health Service Manual

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

Revised January 2015

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, 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

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, youth 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 94 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

Through MCH grants, 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. In addition, reproductive health, 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. Clients have access to multi-lingual translator services and a culturally oriented, multidisciplinary health professional team, including, at a minimum, a physician, registered nurse (including clinicians, practitioners and/or nurse midwives), registered dietitian and licensed social worker, on site and/or through referral to the appropriate professional(s) within the community or grantee’s service area.

Local MCH grantees should make every effort to inform clients of the services available from KanCare (Kansas Medicaid). The local agency staff assists clients in completing the eligibility application. 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

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) associated with poor pregnancy outcomes (e.g. premature labor/delivery, low birth weight and infant death) and improvement in quality of life for the mother, infant and family. Services include, but are not limited to the following and are available during the first year post-delivery and beyond if indicated:

- 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 and services for 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
- 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

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

The MCH Navigator, an online learning portal for MCH professionals funding 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/*

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

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/

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/*

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 appropriate 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 [1] *http://www.cdc.gov/policy/ohsc/chna/index.html*
  - Healthy People 2020. "A Guide to Using Healthy People 2020 in Your Community."[2] *http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning*

- **Local agency grantees:**
  - Identify, define and prioritize specific interventions addressing the specific health care needs of the community.
  - Ensure ongoing community involvement in the planning, implementation and evaluation of the program.
  - Ensure involvement of representatives of the cultural, racial, ethnic, gender, economic and linguistic diversities within the community.
  - Provide educational materials and services in a manner and format that best meets cultural, linguistic, cognitive, literacy and accessibility needs of the community.
  - Move toward full compliance with the four mandated Culturally and Linguistically Appropriate Service standards (CLAS). *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53* (standards and fact sheet)

[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

- Establish or maintain a committee of community partners/stakeholders that advises on community MCH health issues.
- 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 MCH population's 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 practice.
- 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 Guidelines[3] 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 encounters and submit data electronically to KDHE via KIPHS public health software, WebMCH internet-based program associated with the KSWebIZ immunization registry, or create a detailed flat file for electronic submission of required client visit record (CVR) encounter data elements utilizing an alternate data collection software system.
- Provide adequate automation of data transmission systems to ensure direct and timely communication to KDHE.
- Notify KDHE of any issues, concerns or questions regarding the MCH program.

Standard 3: Outreach

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

[3] Federal Poverty Guidelines http://aspe.hhs.gov/poverty/.

- 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

- **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.
  - Utilize the Pregnant Women's Medicaid birth list that is sent to the local health department monthly by KDHE to outreach high risk pregnant women.
  - 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.

Standard 4: Care Coordination

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

- **Rationale:**

  Care coordination is 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 their accessing those services.

  Nurses and social workers are particularly suited to provide care coordination and case management to high risk pregnant women, children 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.

Case management is 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 case manager serves as a liaison between the client, the physician, other providers and the insurer/payer to identify what services might also be needed and assists to coordinate all services and resources necessary to promote the best level of well-being and enhance communication between all parties including the insurance company or health care payer.

Many families are unfamiliar with how to navigate the health care and community service systems. Care Coordinators and Case Managers 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.

- **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 the Comprehensive Health Risk Assessment as a template 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.
  - 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 intervention[4]

[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.

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 the pregnancy for women, infants, children, adolescents and family life.

- **Local agency grantees:**
  - Show evidence that the agency employs or contracts for MCH services from staff with expertise in health, nutrition and psychosocial areas to provide such professional expertise for assessment, evaluation and facilitate client entry into the system of care for the three core areas.
  - Show evidence that new hires receive orientation and that all staff are given periodic on-going and annual professional development opportunities regarding Title V concepts and services. Make revisions to job descriptions as applicable.
  - Provide staff with required training and opportunities to acquire professional competencies to meet the needs of their MCH clients.
  - Provide an initial nutrition (basic nutrition services) and on-going nutrition assessments (at least one per trimester and one post-partum) to all pregnant women with referral to a registered/licensed dietitian if determined to be nutritionally at high risk.
  - Provide nutritional assessments and provide guidance to all children, adolescents and their parents with referral to registered/licensed dietitian if determined to be nutritionally at high risk.
  - Provide an initial psychosocial screen for depression, 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 are unable to take full responsibility for 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 including breastfeeding and nutrition, physical activity level 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 what affects one member of the family impacts other members of the same family in some way. Each family exists in the context of a greater community and fosters 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 and assist families through the completion of the KanCare (Medicaid) 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 enables a woman to learn the warning signs and symptoms of impending preterm delivery.

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

Critical strategies to improve the health care provided children and adolescents 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 relationships[6]. 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.

  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

[6] http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

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's/Maternal Health
2. Perinatal/Infant Health
3. Child Health
4. Children 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 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.

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 Health[7]

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.

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

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

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 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

[8] Maternal and Child Health Bureau. http://mchb.hrsa.gov/

- 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/*

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) 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 most current state plan "MCH 2015" includes the following priorities for the five-year period 2011 through 2015.

GOAL: To enhance the health of Kansas women and infants across the lifespan

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

GOAL: To enhance the health of Kansas children and adolescents across the lifespan

5. All children and youth receive health care through medical homes
6. Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs
7. All children and youth achieve and maintain healthy weight

GOAL: To enhance the health of all Kansas children and youth with special health care needs across the lifespan

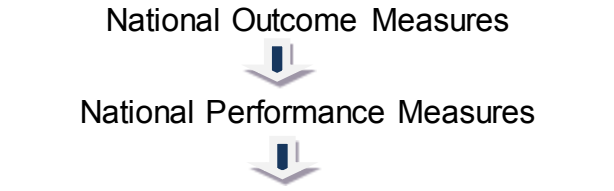
8. All CYSHCN receive coordinated, comprehensive care within a medical home
9. Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work and self-determined independence
10. Financing for CYSHCN services minimizes financial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

MCH2015 represents only the first steps in a cycle for continuous improvement of maternal and child health. Between 2010 and 2015, 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, infants and children. The process will be repeated beginning in 2014 to plan for actions and strategies for 2015-2020. To view the complete MCH 2015 Final Report and results, go to www.datacounts.net/mch2015/default.asp. 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.

Performance Measure Framework



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.

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

157 National Outcome Measures (FFY2016 proposed)

	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	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 85th 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 (FFY2016 proposed)

	National Performance Measures (NPMs) ***Kansas will select, monitor, and report on 8 of 15***	**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

159 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.

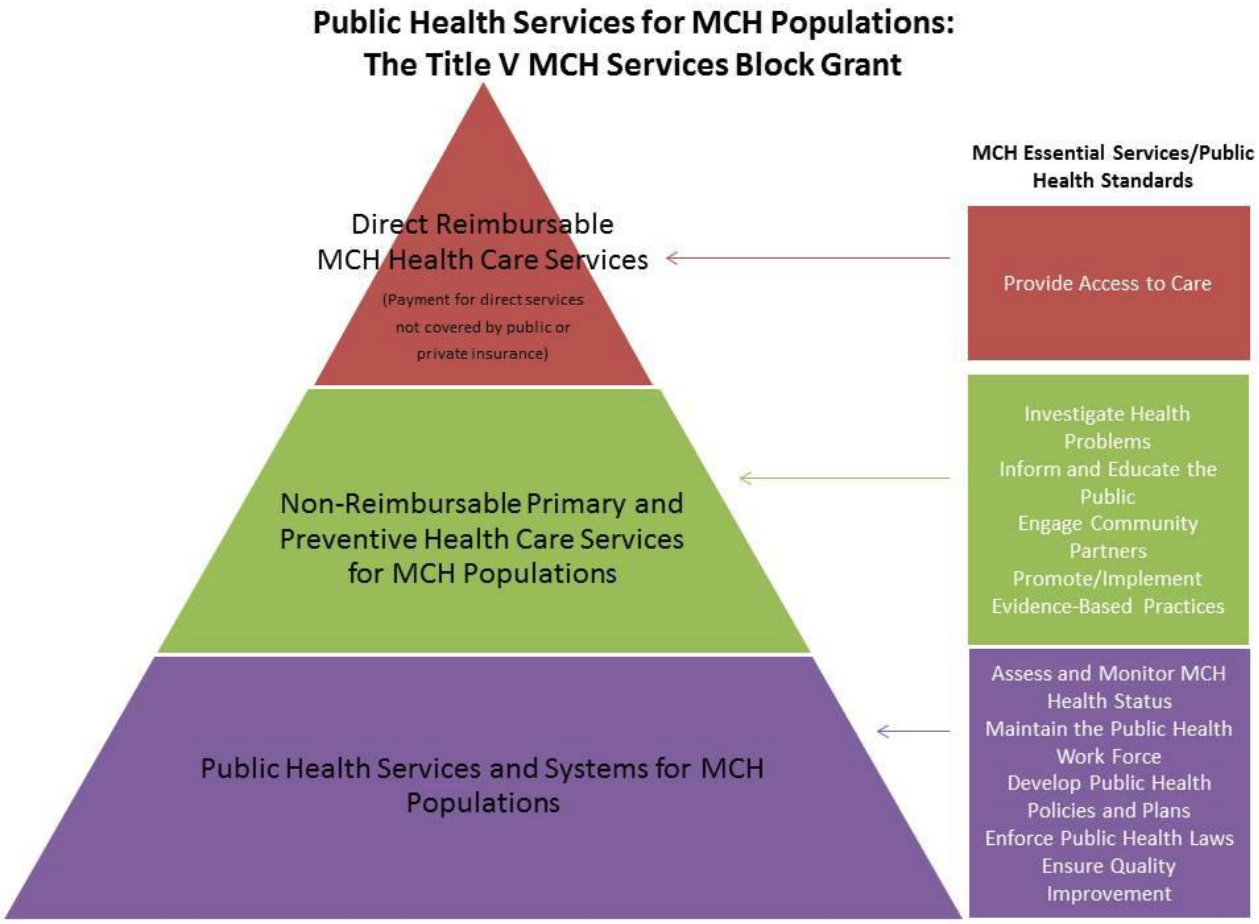
Performance measures help to quantify whether:

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

State MCH Performance Measures (SPMs) *(as of July 2014; to be updated July 2015)*	Population Health Domain
1. The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age (added 2013).	Perinatal/Infant Health
2. The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.	Women/Maternal Health
3. The percent of live births that are born preterm less than 37 weeks of gestation.	Perinatal/Infant Health
4. The percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of medical home.	Child Health
5. The percent of high school students who had at least one drink of alcohol during the past 30 days.	Adolescent Health
6. The percent of children who are obese.	Child Health
7. The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self-management skills.	Children with Special Health Care Needs

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.



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 where 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 specialist pediatrician 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 purpose of 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 HCP 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, 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

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*

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*

> ***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*

- 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 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.

- 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 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 affidavits 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

The key criteria for funding consideration will be proposals based on children in poverty per county.

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. It may also include a "wish list" within it. The second budget or what is called the "Final Budget," will be completed after you received the Notice of Grant Award letter with the actual MCH grant amount will 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

<u>Fringe Benefits</u>

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.

Affidavits of Expenditure

Follow the KDHE ATL reporting process and utilize the required Affidavit.

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 "OTHER" category on the affidavit must be itemized. "MISC" or "OTHER" responses will not be accepted.
7. 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.

307 Reporting and Payment Schedule

Grant Payments	Documentation/Reports Due	Due Date
July 1		
October 1	First Quarter Reports • Affidavit of Revenues and Expenditures • Narrative Report • Aggregate Client Data	October 15
November 15		
January 1	Second Quarter Reports • Affidavit of Revenues and Expenditures • Narrative Report • Aggregate Client Data	January 15
February 15		
April 1	Third Quarter Reports • Affidavit of Revenues and Expenditures • Narrative Report • Aggregate Client Data	April 15
May 15		
	Fourth Quarter/Final Reports • Affidavit of Revenues and Expenditures • Narrative Report • Aggregate Client Data	July 15
August	Final payment if funds have been withheld from prior payments.	

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, affidavits, 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
- 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. The deadline is June 20 in order to process the budget adjustment.

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. Excess program income may be retained to build a three-month operating capital. Program income must be used during the current or following fiscal year. 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 affidavit 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 Quarterly Affidavit. 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

To meet federal reporting requirements, minimum data elements must be collected and reported by each local agency.

Data requirements run on a calendar year from January 1 to December 31 each year. January 15 is the deadline to submit December's data to KDHE.

Agencies are to submit client encounter data to KDHE as part of the MCH grant requirements by:

- Paper Client Visit Record (CVR) collection/electronic submission
- KIPHS using PH Clinic
- WebMCH database (via WebIZ)

Paper CVRs

If a local agency is using a paper-based data collection method (completing the paper CVR), the contractor is required to input the data from each CVR into a spreadsheet, database or other means approved by KDHE that is usable for aggregate reporting. The data shall be submitted to KDHE electronically.

KIPHS, Inc. www.kiphs.com
Public Health Software Developers can be reached toll free at 877-905-4747.

WebMCH is an online data system that can be used to enter CVR data. Data is collected at least monthly. When submitting large amounts of data (> 50), it is helpful to submit data at least twice a month.

General Enrollment Process for WebMCH

1. Must currently be using WebIZ
2. Must have a security token (devices that ensure extremely secure sign-on to the system)
3. A User Security and Confidentiality Agreement must be completed and on file with KDHE, Bureau of Family Health, Children & Families Section
4. KanPhix - Personal Health Information Exchange – new users must register at this website: https://kanphix.kdhe.state.ks.us/newuser/
5. Attend training and practice on the training site

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:

- Affidavit not received.
- Semi-Annual Narrative report not received.
- DATA (due monthly) is not received.
- A response to a site visit is past due.
- Healthy Start Home Visitor did not attend a required Statewide Conference.
- Healthy Start Home Visitor did not attend the required Fall Regional training.
- Any other requested information 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 may result in a decrease in the contract amount or termination of the contract.

313 Client Satisfaction/MCH Survey Cards

Grantees are to use a client satisfaction survey to assess their program and make changes to services based on responses. They can use the current MCH Survey card or develop another survey form. These will be used internally to enhance or improve services and inform future activities. These surveys do not need to be sent to KDHE. Client satisfaction will be assessed as part of the monitoring process.

350 - Guidelines for Records Management

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351 Scope of Records Management

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

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

352 Statutes and Laws for Records Management

Practitioners are directed to the Kansas Legislature website when seeking statutes related to records management. This website accesses bills and statutes by searching with specific bill or statute numbers or using key words. *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 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.

403 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. In addition, the top three priorities for pregnant women and infants identified during the Maternal and Child Health (MCH) 2015 Statewide Needs Assessment (MCH 2015) were:

1. All women receive early and comprehensive health care before, during and after pregnancy
2. Improve mental health and behavioral health of pregnant women and new mothers
3. Reduce preterm births (including low birth weight and infant mortality)
4. Increase initiation, duration and exclusivity of breastfeeding
   www.datacounts.net/mch2015/mothers_and_infants.asp

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

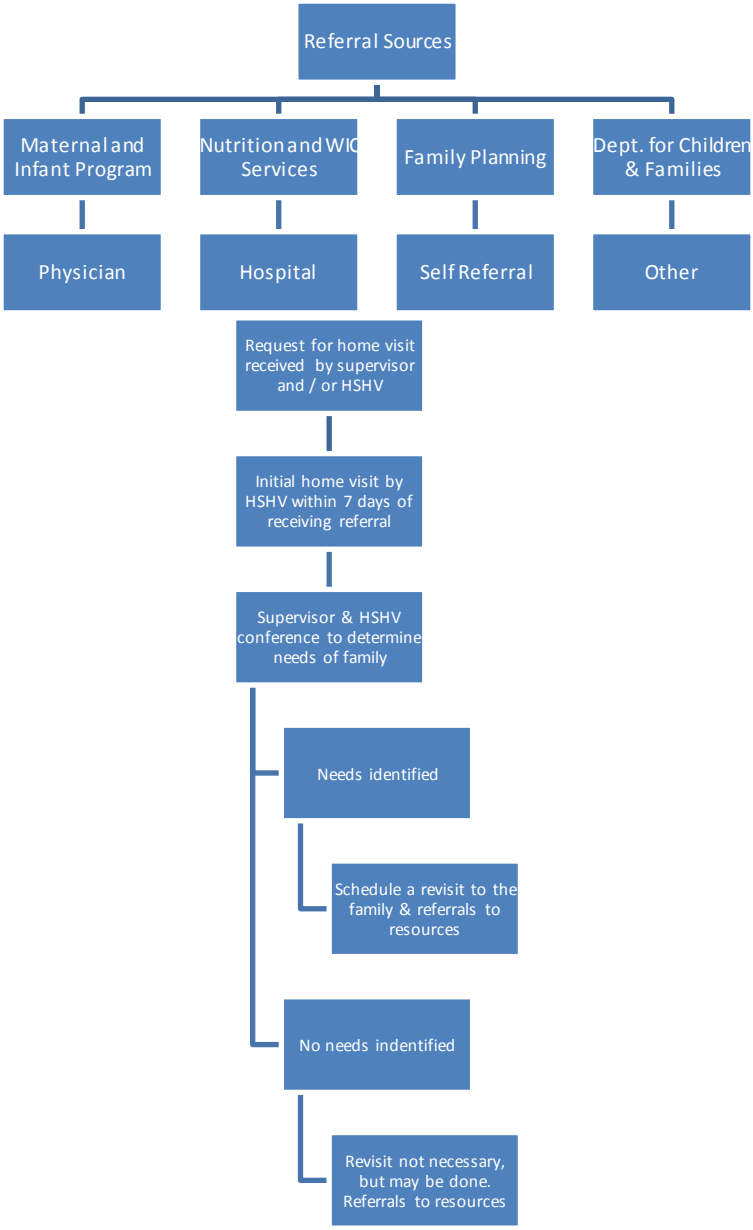
417 Responsibilities of Home Visitors

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 Share information on reason and purpose of visit with family
2. Pre-visit phase	Initiate contact with mother/family Establish shared perception of purpose with mother/family Determine mother/family's willingness for home visit Schedule home visit Review referral and/or family record
3. In-home phase	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, 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 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.

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 on the CVR for the HSHV outreach and family support services to the mother shows the following:

- Where the service was provided
- What referrals were made with the mother
- Number of mothers served prenatal and postnatal (Users)
- Number of visits made overall (Encounters)

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
- Be 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 may also work with the other program.

STI/HIV Prevention Program

Program Purpose

This program is designed to support Comprehensive HIV Prevention Programs in accordance with the Centers for Disease Control and Preventions (CDC) National HIV/AIDS Strategy (NHAS). This funding is provided to nonprofit community-based organizations and local health departments to support prioritized HIV testing and HIV prevention services to reach at-risk populations. Based on recent HIV epidemiologic data, the priority at-risk populations for HIV prevention in Kansas are currently identified as: men who have sex with men (MSM), African-American heterosexual women, injection drug users (IDU), youth ages 15 to 24, and other high risk individuals (those with a recent STD, TB, or hepatitis infection and the incarcerated population).

Eligible Applicants

Applications to support Comprehensive HIV Prevention Programs should be submitted for continuation of current contracts only.

Funding

Applicants for nonprofit community-based organizations must demonstrate the ability to have achieved a 0.25 percent positive for calendar year 2013 to successfully be awarded funding. Applicants for local health departments must demonstrate the ability to have achieved a 0.10 percent positive for calendar year 2013 to successfully be awarded funding. Award amounts will be contingent on federal funding availability and amounts. Awards will be initiated upon receipt of an amended budget based on the actual amount of the award unless award is equal to the requested amount. At this time, matching funds are not required for grants with the STI/HIV Section. The STI/HIV Section reserves the right to require grantees to provide matching funds in the future.

Immunization Action Plan (IAP)

Program Purpose
Reduce the incidence of vaccine preventable disease by increasing immunization rates across Kansas.

Eligible Applicants
Funding will be provided for Local Health Departments and Community Health Services who were previously awarded funds

Funding Information
Awards will be based on county population, availability of funding from State General Fund and the Federal, CDC Immunization Grant. Applications will be considered based on implementation of strategies, completion of objectives and timely submission of progress reports.

1. Awardee funding match is not required
2. Funds may not be used to supplant or replace existing agency funding sources
3. Funds may not be used for vendor systems license or maintenance fees for immunization documentation, vendor sub-contacting fees, vaccine purchase or food.

Program Contact:
Tim Budge
Immunization Section Chief, CPM
Bureau of Disease Control and Prevention
Kansas Immunization Program | KDHE
Phone: 785-296-1021 | Cell: 785-925-1990
Fax: 785-291-3142 | tbudge@kdheks.gov

Reporting Requirements
Submit Quarterly Certified Affidavit of Expenditures and Bi-Annual Progress Reports of activities toward targeted goals.

IAP Reporting Schedule SFY 15		
Grant Reporting Period	**Due Date**	**Form Due**
7/1 to 9/30	October 15	Affidavit of Expenditures & Progress Report
10/1 to 12/31	January 15	Affidavit of Expenditures
10/1 to 3/31	April 15	Progress Report
1/1 to 3/31	April 15	Affidavit of Expenditures
4/1 to 6/30	July 15	Affidavit of Expenditures

Applications are available on January 15, 2015 and are due on March 16, 2015.

Women, Infant & Children (WIC)／ Immunization Collaboration Project

Program Purpose
Expand existing collaboration between Women Infant and Children Programs and Immunization Services to increase age-appropriate immunizations for children less than 5 years of age who are accessing WIC services.

Eligible Applicants
Cherokee, Finney, Ford, Saline, Seward, Sedgwick, Shawnee and Wyandotte county health departments

Funding Information
Funding sources are State General Fund and the Federal, CDC Immunization Grant. Applications will be considered based on implementation of strategies, completion of objectives and timely submission of progress reports.

1. Awardee funding match is not required
2. Funds may not be used to supplant or replace existing agency funding sources
3. Funds may not be used for vendor systems license or maintenance fees for immunization documentation, vendor sub-contacting fees, vaccine purchase or food.

Program Contact:
Tim Budge
Immunization Section Chief, CPM
Bureau of Disease Control and Prevention
Kansas Immunization Program | KDHE
Phone: 785-296-1021 | Cell: 785-925-1990
Fax: 785-291-3142 | tbudge@kdheks.gov

Reporting Requirements- Submit Quarterly Certified Affidavit of Expenditures and Bi-Annual Progress Reports of activities toward targeted goals.

Grant Reporting Period	Due Date	IAP Reporting Schedule SFY 16
7/1 to 9/30	October 15, 2015	Affidavit of Expenditures & Progress Report
10/1 to 12/31	January 15, 2016	Affidavit of Expenditures
10/1 to 3/31	April 15, 2016	Progress Report
1/1 to 3/31	April 15, 2016	Affidavit of Expenditures
4/1 to 6/30	July 15, 2016	Affidavit of Expenditures

Personal Responsibility Education Program (PREP)

Program Purpose

The Personal Responsibility Education Program (PREP) is for the provision of evidence-based effective programming to adolescents on STIs, HIV/AIDS, Teen Pregnancy Prevention and Adulthood Preparation subjects. The fidelity of each program model must be maintained.

Reporting Requirements

Funded agencies are to submit progress reports at least bi-annually as requested and specified by the grantor and a quarterly financial affidavit. Data from program models should be entered using the database provided by KDHE.

Program Contact Person

Jennifer Vandevelde
PREP Data and Evaluation Coordinator
785-296-6544
jvandevelde@kdheks.gov

Form Required:
Certified Affidavit of Expenditures