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

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

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

This manual was developed specifically for use by entry level MCH KDHE grantees in the public health workforce.
100 - Overview of Maternal and Child Health (MCH) Services in Kansas

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

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

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

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

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

- prenatal care services, with a focus on increasing access and utilization of services and first trimester enrollments in prenatal care services;
- comprehensive prenatal and postnatal healthcare;
- follow-up services for the mother and infant up to one year post delivery;
- health, psychosocial and nutrition assessments through a collaborative effort between public health and private medical providers;
- reproductive health services and STD testing and treatment;
- pediatric health services, including well-child visits and immunizations, reduction of unintentional and intentional injuries in children, high-risk infant follow-up, smoking cessation efforts, perinatal mood disorders and identification and referral for substance abuse; and
- Multidisciplinary health professional teams, on site and/or through referral to the appropriate professional(s) within the community or grantee’s service area,
including but not limited to: a physician; registered nurse, including clinicians, practitioners and/or midwives; registered dietitian; and licensed social worker.

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

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

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

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

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

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

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

Resources
MCH Navigator: The MCH Navigator, 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/](http://www.mchnavigator.org/)

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

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

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

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

Core Public Health Competencies: The Core Public Health Competencies are a set of skills desirable for the broad practice of public health, reflecting the characteristics that staff of public health organizations need as they work to protect and promote health in the community. The competencies are designed to cover the essential services of assessment, policy development and assurance. [http://www.phf.org/resourcestools/Pages/Core_Public_Health_Competencies.aspx](http://www.phf.org/resourcestools/Pages/Core_Public_Health_Competencies.aspx)
107  **MCH Goal and Standards**
The following MCH goal and standards is the framework for services to women and their families. Each community has unique health needs and priorities. Each MCH grantee must determine the needs of their community through a local community needs assessment process and assure that consideration is given to address health priorities for Kansas.

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

**Standard 1: Community Needs Identification**
Specific MCH program services provided by local agencies are to be determined by the local grantees in collaboration with community partners/stakeholders of the MCH population using information from a community need and resource assessment as a basis for coordination, planning and evaluation. Once local needs are identified, it is desired to align needs with the state MCH priorities to determine how to allocate resources for greatest impact.

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

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

  To learn more about community needs assessments, go to:
  - Center for Disease Control and Prevention Implementing the Community Needs Assessment Process 1  
    http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning

- **Local agency grantees:**

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o Identify, define and prioritize specific interventions addressing the specific health care needs of the community.

o Ensure ongoing community involvement in the planning, implementation and evaluation of the program.

o Ensure involvement of representatives of the cultural, racial, ethnic, gender, economic and linguistic diversities within the community.

o Provide educational materials and services in a manner and format that best meets cultural, linguistic, cognitive, literacy and accessibility needs of the community.

o Move toward full compliance with the four mandated Culturally and Linguistically Appropriate Service standards (CLAS).

o Establish or maintain a committee of community partners/stakeholders, including family representatives, that advises on community MCH health issues. It is desired that at least 25% of committee membership be held by consumers served by local MCH programs.

o Work with other local, state and federal entities in the community to develop a network of complementary services.

o Make every attempt to employ staff that is representative of the population being served.

o Build systems of coordinated health care within your community and/or region.

o Provide Translation/Interpreter services or have bilingual staff available.

**Standard 2: Infrastructure**

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

- **Rationale:**

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

  The client record and data system 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:**
  o Employ adequate staff members to address the identified needs of the population to be served in the community.
  o Establish written fiscal management policies and procedures that include, but are not limited to: payment of debts, payroll, record keeping, auditing and receivables/expenditures.
  o Utilize sound accounting and business practices.
  o 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.
  o Establish and implement reporting and billing systems including a sliding fee scale for all clients receiving MCH billable services.
  o 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.
  o Establish and implement a sliding fee scale of discounted charges. Scale must include at least four levels of reduced billing using the federal Poverty Guidelines of income and number of people in the family. This scale meets the low income guidelines for those who are eligible for free or reduced charges for billable services. For information on Federal Poverty Guidelines³ go to http://aspe.hhs.gov/poverty/index.cfm
  o Establish a written fee collection policy which will be applied consistently for all clients. The policy will include a list of reasonable efforts made to collect outstanding client balances. Under no circumstances shall client confidentiality be jeopardized.

- Utilize electronic data collection of client visits and capture all required data elements via the web-based shared measurement system, DAISEY (Data Application and Integration Solutions for the Early Years). See more under Section 311 (Data Collection).
  o Provide adequate automation of data transmission systems to ensure direct and timely communication to KDHE.

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

**Standard 3: Outreach**

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

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

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

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

• Utilize the Kansas Resource Guide as a referral tool for families.

**Standard 4: Care Coordination**

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

- **Rationale:**

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

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

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

Many families are unfamiliar with how to navigate the health care and community service systems. Care Coordinators help families feel more comfortable accessing services by modeling how to make appointments and get needed services by phone, assure that they arrive at their appointed time and reinforce that they follow the care instructions provided by the medical provider. Positive health outcomes are possible with equipped families who can advocate for needed services, direct their services and care, and engage as a partner with their providers.
• **Local agency grantees:**
  o Work with local prenatal medical care providers to assure early entry (first trimester) into early and adequate prenatal care.
  o Use the results of a comprehensive health risk assessment as a tool to link families with available resources to address their identified needs.
  o 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.).
  o Reinforce and assess client understanding of provider’s recommendations or care and treatment instruction following appointment.
  o Identify and problem-solve with the client any barriers they may have in following provider recommendations.
  o 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\(^4\) including health education and risk reduction counseling; and initiate connection with appropriate health and human services and links to resources, as indicated by the assessment and family’ choice. The individual components of care should not be provided in isolation, but collaboratively planned and provided. Risk assessment, health promotion and development of a plan of care, early intervention and linkage into systems of care with follow-up are activities that should increase detection and/or prevention of risk factors that could negatively affect the outcomes of pregnant women, infants, children and adolescents, including those with special health care needs and family life.

• **Local agency grantees:**

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\(^4\) 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.
o 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.

o 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.

o Provide staff with required training and opportunities to acquire professional competencies to meet the needs of their MCH clients.

o 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.

o 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.

o 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.

o Provide developmental and psychosocial assessments, ATOD exposure and child abuse or maltreatment assessment of all children and adolescents. Provide anticipatory guidance regarding health and safety issues to all children, adolescents and their parents with referral to a licensed social worker for additional assessment and interventions based on individual identified risks.

Standard 6: Family-Centered Care
Provide MCH services with a family-centered focus of care and develop a Family Care Plan (FCP) with the family in collaboration with the MCH team.

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

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

- Identify appropriate frequency of primary care visits within a Medical Home for all family members/talking points that involve the family in their own care
- Identify the family’s social, emotional and physical health goals
- Identify the family’s goals around nutrition, physical activity and family activities.
- Recognize each family is on an ever-changing journey of life-long learning that begins with pregnancy and birth continuing through adulthood, where the cycle starts again.
- Recognize that all families are independent of one another and services must be individualized to a certain extent to support that family.
- Recognize that what may affect one member of the family will impact other members of the family in some way.
- Recognize that families impacted by a situation will react differently than another family, even if in the exact same situation.
- Recognize each family exists in the context of a greater community and engage these communities as resources for supports and services.

- Local agency grantees:
  - Respect that every family has their own unique culture and MCH honors the values of each family’s neighborhood, community and extended family.
  - Tailor support and services to each family to meet its own unique needs and circumstances.
  - Work as equal partners with each family and with the people and service systems in the family’s life.
  - Assist families in identifying a Medical Home that consists of a provider for and a payer for any services rendered by the provider.
  - Inform of KanCare (Medicaid) services and assist families through the application process.

Standard 7: Health Risk Assessment and Screening

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

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

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

*Bright Futures, 3rd Edition Guidelines*, 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

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

Critical strategies to improve the health care provided children and adolescents, including those with special health care needs, are to meet parents' informational needs and elicit their concerns in a systematic, standard way. A primary component of well-child care is Anticipatory Guidance and Parental Education (AGPE). Bright Futures Anticipatory Guidance Cards help "cue" health professionals and families to review key developmental goals for children and adolescents: confidence, success in school, responsibility and independence. Other topics range from safety and healthy eating to fitness and family relationships. 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 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/](http://www.aap.org/)
American College of Obstetricians and Gynecologists (ACOG) www.acog.org/
Association of State and Territorial Health Officials (ASTHO) www.astho.org/
Bright Futures, Georgetown University, promoting and improving the health, education and well-being of the children and adolescents and their families.
www.brightfutures.org/
Center for Disease Control and Prevention (CDC) www.cdc.gov/
Maternal and Child Health Bureau (MCHB) www.mchb.hrsa.gov/
National Academy for State Health Policy (NASHP) www.nashp.org
National Association of County and City Health Officials (NACCHO) www.naccho.org/topics/infrastructure/index.cfm
150 - MCH Background

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151 Title V Block Grant to States

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

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

Legislatively-Defined State MCH Population Groups
1. pregnant women, mothers, and infants up to age 1;
2. children; and
3. children with special health care needs.

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

Title V legislation and the MCH Services Block Grant Program enables states to:
- provide and assure mothers and children access to quality MCH services;
- reduce infant mortality and the incidence of preventable diseases;
- provide rehabilitation services for blind and disabled individuals; and
- provide and promote family-centered, community-based, coordinated care, and facilitate the development of community-based systems of services.

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

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

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

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

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

152 Maternal and Child Health

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.

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7 Adapted from the Introduction to MCH 101 in-depth module at the HRSA MCH Timeline. www.mchb.hrsa.gov/timeline/.
The MCH program is required by law to serve as a gap-filling provider for families served through the Medicaid program. A partnership exists between the Maternal Child Health Services and Medicaid to serve high risk families. The Maternal and Child Health (MCH) Services Block Grant and Medicaid, authorized by Title V and Title XIX of the Social Security Act (SSA), serve complimentary purposes and goals. Coordination and partnerships between the two programs greatly enhance their respective abilities, increase their effectiveness and guard against duplication of effort. Such coordination is the result of a long series of legislative decisions that mandate the two programs to work together.

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

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

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

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

Applications for funding must include:
- Needs assessment and priorities
- Measurable outcomes
- Budget accountability
- Documentation of matching funds
- Maintenance of efforts
- Public input

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

https://mchdata.hrsa.gov/TVISReports/

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 image below depicts the state Title V MCH program needs assessment, planning, implementation and monitoring process.

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

### State MCH Priorities*

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

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

### National Performance Measures (NPMs)*

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Population Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Well-woman visit (Percent of women with a past year preventive medical visit)</td>
<td>Women/Maternal Health</td>
</tr>
<tr>
<td>2. Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)</td>
<td>Perinatal/Infant Health</td>
</tr>
</tbody>
</table>
3. Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool) | Child Health

4. Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9) | Child Health

5. Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others) | Adolescent Health

6. Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year) | Adolescent Health

7. Medical home (Percent of children with and without special health care needs having a medical home) | Children with Special Health Care Needs


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

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

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

National Performance Measure Framework

National Outcome Measures

National Performance Measures

State-Initiated Structure/Process Measures

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

### National Outcome Measures

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

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

**Population Domain**

- **Adolescent Health**
- **Child Health**
- **Child Health and/or CSHCN**
- **CSHCN**
- **Perinatal/Infant Health**
- **Population Domain**
- **Women/Maternal Health**

**158 National Performance Measures**

| 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                  |
11. Percent of children with and without special health care needs having a medical home*  
   Children with Special Health Care Needs

12. Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care  
   Children with Special Health Care Needs

13. A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year  
   Cross-Cutting/Life Course

14. A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes*  
   Cross-Cutting/Life Course

15. Percent of children ages 0 through 17 who are adequately insured  
   Cross-Cutting/Life Course

*Kansas selection

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

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

Performance measures help to quantify whether:
- Capacity was built or strengthened
- Processes or interventions were accomplished
- Health status was improved

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

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

160 MCH Pyramid
As depicted on the MCH Pyramid, the working framework for the Title V MCH Block Grant to States Program aligns with the 10 MCH Essential Services and consists of three levels. In developing systems of care, States should assure that they are family centered, community based and culturally competent.
Direct Services
Direct services are preventive, primary, or specialty clinical services to pregnant women and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. Direct services include, but are not limited to:

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

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

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

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

**Public Health Services and Systems**

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

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

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

**161 Essential Public Health Services to Promote Maternal and Child Health**

The 10 Essential Public Health Services were cross walked with the MCH Block Grant to States Program resulting in the following strategies:
• Mobilize partners, including families, at the federal, state and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services and developing supportive policies;
• Integrate systems of public health, health care and related community services to ensure access and coordination to assure maximum impact;
• Conduct ongoing assessment of the changing health needs of the MCH population (as impacted by cultural, linguistic, demographic characteristics) to drive priorities for achieving equity in access and positive health outcomes;
• Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and efficient use of resources;
• Inform and educate the public and families about the unique needs of the MCH population;
• Promote applied research resulting in evidence-based policies and programs;
• Promote rapid innovation and dissemination of effective practices through quality improvement and other emerging methods; and
• Provide services to address unmet needs in healthcare and public health systems for the MCH population (i.e. gap-filling services for individuals.)

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

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

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

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

Local Core MCH Public Health Services for Child Health

- **Direct Services**
  - Well child care for uninsured children (gap filling)
  - Immunization (gap filling)
  - Developmental screenings (including social/emotional)
  - Vision and hearing screenings

- **Enabling Services**
  - Health education regarding fitness, nutrition, motor vehicle safety, emergency preparedness, immunization, pregnancy prevention, substance abuse
  - Providing Medicaid/KanCare information and eligibility requirements to families with young children
  - Resources, referrals and/or care coordination
  - School readiness activities
  - Providing information regarding quality childcare and after school activities

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

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

- **Direct Services**
  - Well child care for uninsured children (gap filling)
  - Immunization (gap filling)
  - Developmental screenings (including social/emotional)
  - Vision and hearing screenings
  - Provision of Specialty Care in Specialty Clinics (gap filling)
  - Diagnostic Services in Diagnostic and Evaluation (D&E) Clinics (gap filling)

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

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

- Primary care,
- Habilitative and rehabilitative services,
- Other specialty medical treatment services,
- Mental health services and
- Home health care
166 Local Core MCH Public Health Services for Adolescent Health

- **Direct Services**
  - Adolescent well visit for uninsured children (gap filling)
  - Immunization (gap filling)
    - HPV (male and female)
    - Flu shot
  - Vision and hearing screenings
  - Sexual and reproductive health (gap filling)

- **Enabling Services**
  - Health education regarding fitness, nutrition, motor vehicle safety, pregnancy prevention, substance abuse, sexual and relationship behaviors, unintentional and intentional injuries
  - Providing Medicaid/KanCare information and eligibility requirements
  - Resources, referrals and/or care coordination
    - Suicide prevention hotline
    - Abstinence education
    - Counseling services

- **Public Health Services and Systems**
  - Public education and outreach related to:
    - Injury Prevention and risky behaviors
    - Teen pregnancy prevention
  - Collaborating with schools to improve health, nutrition and fitness to include:
    - Administration of medication
    - School screening and entry examinations
    - Providing health related assistance to school nurses

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

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

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

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201 - Description of Social Determinants and Health Disparities
202 - Health Disparities Defined
203 - Public Health and Disparities
201 Description of Social Determinants and Health Disparities

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

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

http://www.healthequityks.org/

202 Health Disparities Defined

There are many definitions of health disparities.

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

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

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

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

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

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

1. Increase quality and years of healthy life among all ages of people living in the United States.
2. Eliminate health disparities among different segments of the population by specifically targeting the segments that need to improve the most.
These goals are maintained by Healthy People 2020.
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).
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301 - Grant Applications
302 - Contracts and Subcontracts
303 - Contract Revisions
304 - Budgets
305 - Documentation of Local Match
306 - Financial Accountability
307 - Reporting and Payment Schedule
308 - Fiscal Record Retention
309 - Inventory or Capital Equipment
310 - Income
311 - Data Collection
312 - Monitoring
313 - Client Satisfaction/MCH Survey Cards
301 Grant Applications
The Maternal and Child Health (MCH) program grant application is part of the Aid-To-Local (ATL) process within the Kansas Department of Health and Environment. In January of each year, the Grant Application Guidelines and Grant Reporting are available on the KDHE ATL website. [www.kdheks.gov/doc_lib/index.html](http://www.kdheks.gov/doc_lib/index.html)

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

To apply for funding, fill out an application in Catalyst. [www.catalystserver.com](http://www.catalystserver.com) **Note:** Existing/previous grantees will receive a Catalyst user name and password in advance. New applicants should contact the Catalyst Operations Support Team at support@shpr.org.

Before starting the application, complete the following training courses on Kansas TRAIN: [https://ks.train.org/DesktopShell.aspx](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 and special health care needs populations, and develop a work plan and budget that aligns with the MCH priorities and measures. Generally, preference will be given to applications which indicate a collective impact approach and coordination with other programs, including food and nutrition, education, developmental/children and family services, family planning and other health and community service programs.

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

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

Single or multi county/agency applications will be accepted. Multi county/agency applicants must designate a lead organization for application. The lead organization will serve as the fiscal agent and grant management entity. Each participating county/agency must provide a letter of commitment that includes agreement with designation of the lead organization.
• Contracts are issued for one-year periods based on review of the application, contract agency performance and compliance with both general and special conditions of the contract.

• The MCH grantee shall notify KDHE in writing within ten (10) working days of any change of key personnel.

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

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

• A request for approval of program adjustments must be submitted in writing to the Bureau of Family Health, Children & Families section if there is a ten (10) percent or more variance in the line item of the current budget. Approval must be granted before changes are implemented. The request should indicate what portion of the narrative or budget will be changed along with justification.
  o Adjustments less than ten (10) percent of a line item may be made within the budget without prior approval. This includes moving less than 10 percent of the total budget amount for a program within the budget, revisions to the “other funds” categories and changes in a single category of personnel of less than .20 FTE. Examples include replacing one full-time nurse with two part-time nurses.

• Amendments - A contract amendment is in order when an actual increase or decrease to the grant award amount is made. These are typically initiated by KDHE. KDHE and local agencies monitor expenditures to assure budget allocations are adhering to contract agreements.

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

• **Notice of Grant Award Amount and Summary of Program Objectives.**
  Grantee will be asked to submit a revised final budget for the amount awarded.

**Awarding Funds**

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

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

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

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

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

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

Routine Adjustments - Adjustments less than 10 percent of a line item may be made within the budget without prior approval. This includes moving less than 10 percent of the total budget amount for a program within the budget, revisions to the "other funds" categories and changes in a single category of personnel of less than .20 FTE. Examples of routine adjustments include replacing one full-time nurse with two part-time nurses or adjusting time between two programs.
Routine adjustments must be made in the approved budget. Notify the Bureau of Family Health by submitting a cover letter with applicable narrative outlining the change on the budget form. Year-end expenditures will be compared against the revised line item amount.

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

**Process**

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

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

**304 Budgets**

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

**305 Documentation of Local Match**

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

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

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

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

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

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

**Financial Status Report (FSR) / Affidavit of Expenditures**
Follow the KDHE ATL reporting process and utilize the required FSR through Catalyst.

1. The State Fiscal Year begins on July 1 each year.
2. 25 percent of the total grant amount shall be available to the local agency for the period July 1 through September 30.
3. Agency must spend the grant money and 40 percent match dollars by the end of the fiscal year, June 30.
4. All salary amounts charged must be supported in your agency accounting records and by the individual employee time sheets.
5. Fringe benefits may only be requested on that portion of the employee’s salary supported by the MCH contract and must be based on the salary rate specified in the MCH application.

6. The “TRAINING” category on the FSR should include expenses related to fees, accommodations, mileage, etc. Travel costs directly tied to training should go in this category instead of “TRAVEL”.

7. The “OTHER” category on the FSR must be itemized. “MISC” or “OTHER” responses will not be accepted. This category could include phones, internet charges, etc.

8. At least half (50 percent) of your grant award should be spent and reported by December 31. At least half (50 percent) of the required match amount should be spent and reported by December 31.

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

307 Reporting Schedule

Quarterly – Submit in Catalyst by October 15, January 15, April 15 and July 15:
- Financial Status Report (FSR)
- Quarterly Progress Report

<table>
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<tr>
<th>Quarters</th>
<th>Grant Reporting Period</th>
<th>Due Date</th>
<th>Forms Due</th>
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<tr>
<td>1</td>
<td>7/1 to 9/30</td>
<td>October 15</td>
<td>• Financial Status Report (FSR)</td>
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<td>• MCH Quarterly Progress Report</td>
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<td>2</td>
<td>10/1 to 12/31</td>
<td>January 15</td>
<td>• Financial Status Report (FSR)</td>
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<td>• MCH Quarterly Progress Report</td>
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<td>3</td>
<td>1/1 to 3/31</td>
<td>April 15</td>
<td>• Financial Status Report (FSR)</td>
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<td>• MCH Quarterly Progress Report</td>
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<tr>
<td>4</td>
<td>4/1 to 6/30</td>
<td>July 15</td>
<td>• Financial Status Report (FSR)</td>
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<td>• MCH Quarterly Progress Report</td>
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308 Fiscal Record Retention

State/KDHE

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

Local

Retention policies for individual organizations may vary. Please check with the lead agency/applicant’s legal department to determine the requirements.
309  **Inventory or Capital Equipment**
When listing inventory or capital equipment on the budget, the following must be approved in advance:
- Items costing $500 or more;
- Items with a useful life greater than one year; and
- Items purchased from State (grant) funds.

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

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

310  **Income**

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

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

Program income cannot be carried over from year to year. As program income is earned, it must be utilized to enhance the program, either as cash match or additive, resulting in a zero balance on the final financial report of each fiscal year.
Cash Donations
- Cash donations are allowed as optional - but not required - for persons served.
- No person should be denied service from a MCH Grant-funded program for not offering a cash donation. Donations should not be solicited from an individual who is covered by Medicaid.
- Cash donations are program income and should be so reflected on the Financial Status Report (FSR). Donations must be re-invested in the MCH Grant-funded program as cash match or additive.

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

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

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

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

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

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

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

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

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

**Sliding Fee Scale**
A Sliding Fee Scale is required with a minimum of four increments and implemented for all MCH services provided. [http://aspe.hhs.gov/poverty/](http://aspe.hhs.gov/poverty/)

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

**311 Data Collection**
In order to KDHE to fulfill obligations under Kansas Public Health Law (K.S.A. 65-101 ) and meet state and federal reporting requirements, minimum data elements must be collected and reported by each local agency.
Authority to collect the data is pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and Kansas Law as follows: HIPAA provides that a covered entity may disclose protected health information to a public health authority that is authorized by law to collect such information for the purpose of preventing or controlling disease, injury, or disability. 45 C.F.R. § 164.512(b)(1)(i). KDHE is a public health agency that is authorized by state law to investigate the causes of disease, and is charged with the general supervision of the health of the state. K.S.A. 65-101

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

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

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


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

2. Watch the Getting Started in DAISEY webinar for an overview of DAISEY Implementation tools and resources.
3. Check out DAISEY Implementation at a Glance.
4. Request User Access

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

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

**Audit or Examination of Records**

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

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

**Grant Compliance**

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

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

\textbf{Withholding of Support}
Temporary withholding of funds does not constitute just cause for the MCH grantee to interrupt services to clients.

\textbf{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.

\textbf{Contract Termination}
Failure to comply with the contract may result in reduction of funds or loss of contract.

\textbf{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.

\textbf{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.

\textbf{Changes in Service}
Changes in the services to be provided by the MCH grantee as outlined in the contract require prior written approval by KDHE. Discontinuation of any service requires an amended work plan and may result in a decrease in the contract amount or termination of the contract.
313  Client Satisfaction/MCH Survey Cards
The local grantee must develop a method to receive input on client satisfaction. Input should not be sent to KDHE, rather used internally at the local level to enhance or improve services and inform future activities. Client satisfaction is assessed as part of the monitoring process. The local grantee must develop and implement a program evaluation process that utilizes client satisfaction responses and community needs assessment information to assess the program and results in improvements or changes to services based on input.
350 - Guidelines for Records Management

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351 - Scope of Records Management
352 - Statutes and Laws for Records Management
353 - Resources
351 Scope of Records Management
Records management is crucial in provision of health services to families. Practitioners must be knowledgeable of the standard of practice for documentation of services and maintenance of records in health care delivery settings, including protection of patient information/confidentiality.

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

352 Statutes and Laws for Records Management
Practitioners are directed to the Kansas Legislature website 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](http://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](http://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](http://www.kshs.org/government/index.htm).

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# 400 - Maternal and Infant Health

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

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

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

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

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

411 Description of Services
The Kansas Title V MCH program is an integrated delivery of services to the MCH population, providing services to families and children in a variety of settings including the home setting. In order to provide outreach and family support services, MCH grantees may opt to implement Healthy Start Home Visitor (HSHV) services. A HSHV works in tandem with, and is supervised by, professional nursing and/or social work staff as part of the constellation of maternal and child health promotion and prevention services to improve birth outcomes and healthy infant development. Through home visits and other contacts, the HSHV provides outreach, support, and referrals to other community services to pregnant women and families with infants up to one year postpartum. The HSHV services are not independent of other MCH services, but are to complement and assist with MCH services to pregnant women and families with infants. The program is universal in approach, available to all without additional eligibility limitations. HSHV services are short-term, providing just one to a few visits, and are distinct from other longer-term, intensive home visiting programs.

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

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

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

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

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

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

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

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

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

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

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

**415 Responsibilities of Supervisors**
1. Supervise the activities of the HSHV
2. Include home visitors in appropriate agency staff meetings
3. Consult with the home visitor on a regular and as needed basis, specifically to review client records and to discuss services needed for the family
4. Determine which families require a nurse visit after consultation with the home visitor
5. Have a thorough understanding of the role of the HSHV and the requirements to be met for the MCH grant
6. Assist the HSHV in identifying learning needs
7. Complete an annual written personnel evaluation
8. Periodically accompany home visitors on home visits to evaluate content of visits and effectiveness of the home visitor
9. Ensure that the registered nurse/social worker will make follow-up visits to families when the home visitor observes current or potential problems
10. Ensure that the home visitor has appropriate supervisor access and support in the event of client crises or emergencies
11. Promote effective interagency cooperation with community resources/programs
12. Consult with other professionals who have provided referrals to HSHV services
13. Promote outreach activities in the local community to promote HSHV services
14. Ensure that all reports are completed and forwarded timely and accurately
15. Review/sign documentation of the home visitor

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

417 Responsibilities of Home Visitors
The role of the HSHV is to provide support and information to each mother/family visited, serving as a screener in identifying potential problems to be referred to the professional supervisor. Services are ideally provided in the client’s home; however, services can be provided in a variety of settings including the hospital, clinic, group settings, community and any other setting a mother may choose. It is recommended that no transportation, child care, or errands be provided by the home visitor.
1. Visit families to provide nonthreatening, friendly support
2. Visit each mother/family currently expecting a baby or with an infant < 12 months of age within seven (7) days of referral
3. Provide a resource list to families for local service options such as transportation, child care, DCF, health and medical services, social services including other longer-term home visiting programs, etc.
4. Refer to local resources as indicated, facilitate successful linkages, and follow up
5. Follow-up with needed and appropriate educational information
6. Observe families for any current or potential problems
7. Alert supervisors of existing or potential problems
8. Conduct return visits for ongoing as necessary and determined with supervisor
9. Seek client referrals from local health department programs, hospitals, physicians, DCF and all available local resources to initiate visits to a client prior to and during the hospitalization period
10. Participate in outreach activities in the local community to promote HSHV
11. Complete reports in a correct and timely manner
12. Participate in required training provided by KDHE

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

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

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

Phases and Activities of a Home Visit

**Phase** | **Activity**
--- | ---
1. **Initiation phase** | Clarify source of referral for visit  
Clarify purpose for home visit  
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](http://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
   - Confidentiality related to the Health Insurance Portability and Accountability Act (HIPAA) [www.hhs.gov/ocr/hipaa/](http://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
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](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

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

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

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

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

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

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

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

430  **Do’s and Don’ts of Successful Home Visitation**

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

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

Some “don’ts” to avoid:
• Don’t impose values
• Don’t bring other visitors without the parent’s permission
• Don’t socialize excessively during the visit
• Don’t exclude other members of the family from the visit
• Don’t talk about families in public
• Don’t be the center of attention
• Don’t expect perfection from the parent

431  **Federal Healthy Start Programs Serving Kansas**

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

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

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

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

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

452 **Eligibility for Services**
All participants must meet the following eligibility criteria:
- Be a Kansas resident
- Meet age requirements (based upon diagnosed condition)
- Diagnosis meets medical eligibility (treatment services and care coordination only)

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

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

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

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

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

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

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

**454 Local Agency Grantee Responsibilities:**
Assist in efforts to expand SHCN community-based services by:

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

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

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

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

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