



# MCH 2020: Perinatal & Infant Health

## State Priority

Families are empowered to make educated choices about infant health and well-being

## Performance Measures

- Percent of infants who are ever breastfed
- Percent of infants breastfed exclusively through 6 months
- Percent of Women, Infants, and Children (WIC) infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"
- Number of Safe Sleep (SIDS/SUID*) trainings provided to professionals

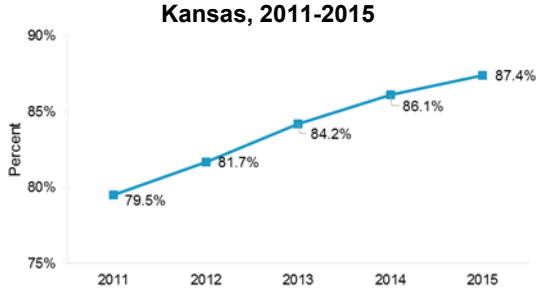
*Sudden Infant Death Syndrome and Sudden Unexpected Infant Death

## Data Highlights

- In 2015, 87.4% of Kansas infants were breastfed,[1] higher than the *Healthy People 2020* goal of 81.9%.
- Breastfeeding exclusively for six months supports optimal growth. In 2013, 23.4% of Kansas infants were breastfed exclusively for 6 months,[2] lower than the *Healthy People 2020* goal of 25.5%.
- Sudden Unexplained Infant Death (SUID) is the third leading cause of death for Kansas infants. The Kansas Infant Death & SIDS Network provides safe sleep training to more than 4,500 parents and providers annually.[3]
- Opportunity for Improvement: Disparities persist in perinatal/infant health based on racial, ethnic, socioeconomic and geographic factors.

## Spotlight on Improvement

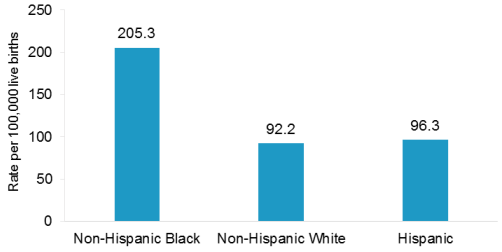
**Percent of Infants Ever Breastfed**
**Kansas, 2011-2015**




Source: KDHE Bureau of Epidemiology and Public Health Informatics

## Example of Health Disparity

**SUID Rate by Race/ Ethnicity**
**Kansas, 2011-2015**




Source: KDHE Bureau of Epidemiology and Public Health Informatics

## Next Steps

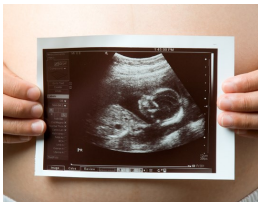
- Increase the number of communities that provide breastfeeding support across community sectors (i.e. hospitals, businesses, physician clinics, health departments, child care facilities).
- Increase the number of Baby-Friendly® hospitals participating in the Baby Friendly Hospital Initiative.
- Develop standardized education content on the importance of prenatal and postpartum nutrition and exercise for optimal infant feeding to support existing programs, including perinatal community collaboratives utilizing the March of Dimes Becoming a Mom® curriculum; home visiting; and Women, Infants, and Children (WIC).
- Implement a multi-sector safe sleep initiative to include safe sleep instructor training, expanded community baby shower (safe sleep, breastfeeding, smoking cessation), hospital bundle, and physician's toolkit.

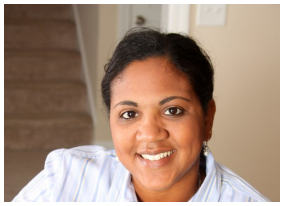
Kansas Department of Health and Environment

This fact sheet, created by the Kansas Department of Health & Environment Bureaus of Epidemiology and Public Health Informatics and Family Health, highlights the priorities and measures identified as part of the Title V MCH Services Block Grant Program five year needs assessment (*MCH 2020*). The Title V Block Grant was authorized in 1935 as part of the Social Security Act. Title V's mission is 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.

KANSAS MATERNAL & CHILD HEALTH

Data Sources: 1. KDHE Bureau of Epidemiology & Public Health Informatics. Kansas birth data (resident) 2. Centers for Disease Control & Prevention. National Immunization Survey
3. KIDS Network 2015 Annual Report





# MCH 2020: Women & Maternal Health

## State Priority

Women (ages 15-44 years) have access to and receive coordinated, comprehensive services before, during and after pregnancy

## Performance Measures

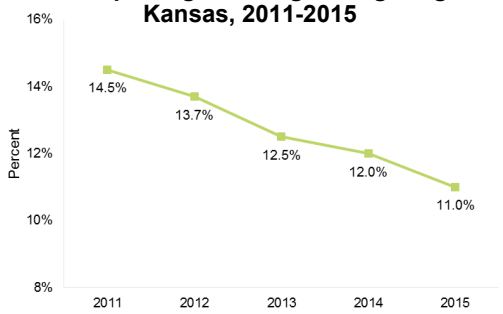
- Percent of women with a past year preventive medical visit
- Percent of women served by a Title V program that received education on the importance of a preventive medical visit in the past year
- Percent of preterm births (<37 weeks gestation)
- Percent of women who smoke during pregnancy

## Data Highlights

- In 2014, 63.7% of Kansas women (18-44 years) had a preventive medical visit.[1]
- In 2015, the Kansas preterm birth rate (8.8%) was higher than the March Dimes goal of 8.1% by 2020.[2]
- Kansas mothers who smoked anytime during pregnancy were almost two times more likely to have a baby die than mothers who did not smoke. In 2015, 11.0% (4,294 out of 39,050) of mothers reported smoking during pregnancy.[2]
- Opportunity for Improvement: Disparities persist in women/maternal health based on racial, ethnic, socioeconomic and geographic factors.

## Spotlight on Improvement

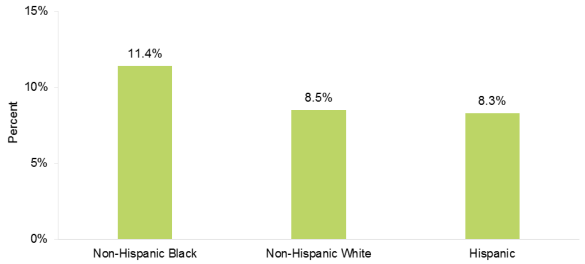
**Women Reporting Smoking During Pregnancy**
**Kansas, 2011-2015**




Source: KDHE Bureau of Epidemiology and Public Health Informatics

## Example of Health Disparity

**Preterm Birth (<37 Weeks Gestation) by Race/Ethnicity**
**Kansas, 2015**




Source: KDHE Bureau of Epidemiology and Public Health Informatics

## Next Steps

- Increase the number of women receiving a preventive medical visit (well woman visit) annually.
- Implement a standard prenatal/postnatal risk screening protocol, including screening for trauma, depression, and prior spontaneous preterm birth. Promote the appropriate use of progesterone therapy among pregnant women.
- Increase the number of established perinatal community collaboratives. The Kansas Perinatal Community Collaborative Model utilizes the March of Dimes Becoming a Mom® prenatal education curriculum. This public/ private partnership brings together prenatal education and clinical care.
- Increase the proportion of smoking women referred to evidence-based cessation services and increase abstinence from cigarette smoking among pregnant women.
- Increase the number of women/families receiving home visiting services through improved coordination and referral.

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KANSAS MATERNAL & CHILD HEALTH

Data Sources: 1. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System, 2014. 2. KDHE Bureau of Epidemiology and Public Health Informatics. Kansas birth data (resident).





# MCH 2020: Child Health

## State Priority

Developmentally appropriate care and services are provided across the lifespan (*children 1-11 years*)

## Performance Measures

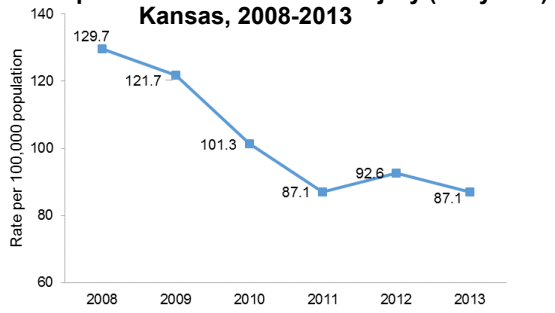
- Percent of children, ages 10 through 71 months, receiving a developmental screening
- Percent of Title V program providers using a parent-completed developmental screening tool
- Percent of children 6 through 11 years who are physically active at least 60 minutes per day
- Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 years
- Number of child safety seat inspections completed by certified technicians

## Data Highlights

- From 2011-2012, 37.0% of Kansas children ages 10 through 71 months received a developmental screening, higher, but not statistically significant, than the United States rate of 30.8%.[1]
- From 2011-2012, 36.0% of Kansas children ages 6 to 11 years were physically active at least 20 minutes a day.[1]
- Motor vehicle crashes are the number one cause of unintentional injury deaths for Kansans ages 0-14 years. In 2015, the Buckle Up program checked 1,695 car seats at 181 local events.[2]
- Opportunity for Improvement: Disparities persist in child health based on gender, race, ethnicity, and socioeconomic factors.

## Spotlight on Improvement

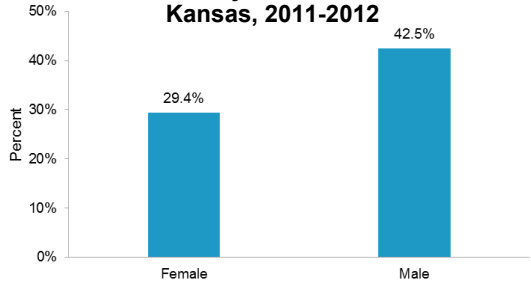
**Rate of Hospitalization for Non-fatal Injury (0-9 years)**
**Kansas, 2008-2013**




Sources: State Inpatient Database (SID); U.S. Census Bureau

## Example of Health Disparity

**Physically Active for 20 Minutes Everyday (6-11 years)**
**by Gender**
**Kansas, 2011-2012**




Source: National Survey of Children's Health, 2011-2012

## Next Steps

- Increase the number of children between 10 and 71 months that receive a developmental screening annually.
- Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.
- Support schools and communities in initiatives that promote daily physical activity among children and adolescents.
- Increase the number of families receiving education and risk assessment for home safety and injury prevention.
- Increase the number of children through age 8 riding in age and size appropriate car seats.

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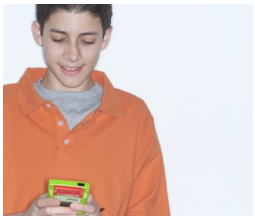
Data Sources: 1. Health Resources and Services Administration. National Survey of Children's Health, 2011-2012. 2. Safe KIDS Kansas. 2015 Annual Report.


# MCH 2020: Adolescent Health

## State Priority

Communities and providers support physical, social and emotional health *(adolescents 12-22 years)*

## Performance Measures

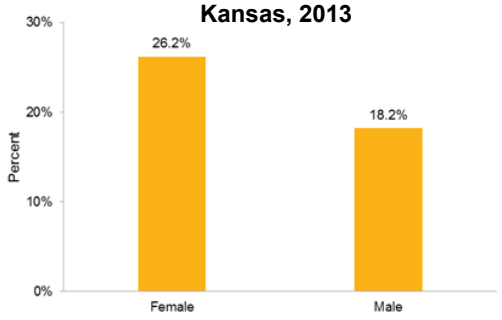
- Percent of adolescents, 12 through 17, who are bullied or who bully others
- Number of schools implementing evidence-based or informed anti-bullying practices or programs
- Percent of adolescents, 12 through 17, with a preventive medical visit in the past year
- Percent of adolescents, 12 through 22, that received education on the importance of a well-visit in the past year

## Data Highlights

- In 2013, 22.1% of Kansas youth in grades 9 through 12 reported being bullied on school property,[1] higher than the *Healthy People 2020* target of 17.9%.
- In 2016, the Kansas Department of Health and Environment had contracts with 15 schools to implement the Second Step Program, an evidence-based anti-bullying prevention program.[2]
- From 2011-2012, approximately 1 in 6 (16.6%) Kansas adolescents did not have a preventive medical visit in the previous 12 months.[3]
- Opportunity for Improvement: Disparities persist in adolescent health based on gender, race, ethnicity, and socioeconomic factors.

## Example of Health Disparity

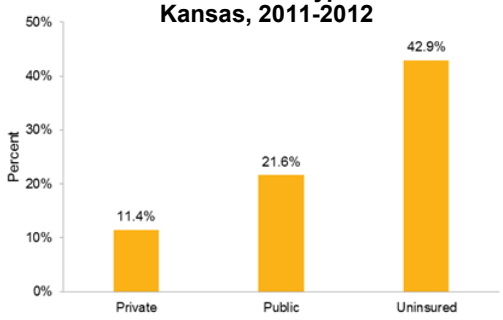
**Bullied on School Property (grades 9-12) by Gender**
**Kansas, 2013**




Source: Youth Risk Behavior Survey, 2013

## Example of Health Disparity

**No Preventive Medical Visit (12-17 years) by Insurance Type**
**Kansas, 2011-2012**




Source: National Survey of Children's Health, 2011-2012

## Next Steps

- Increase the number of adolescents, 12 through 17 years, accessing positive youth development, prevention, and intervention services and programs.
- Increase the number of schools that are implementing programs that decrease risk factors associated with bullying.
- Develop a replicable model for the establishment of school-based health centers around the state to increase access to preventive care/well-visits for adolescents.
- Increase the number of adolescents receiving immunizations according to the recommended schedule.
- Improve knowledge of parents and teens as to the importance of making informed health decisions.
- Increase youth-focused and -driven initiatives to support successful transition, self-determination, and advocacy.

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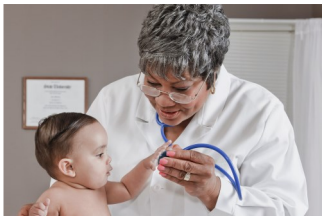
KANSAS MATERNAL & CHILD HEALTH

Data Sources: Centers for Disease Control and Prevention. Youth Risk Behavior Survey, 2013 2. KDHE Bureau of Health Promotion. Sexual Violence Prevention Education Program
3. Health Resources and Services Administration. National Survey of Children's Health, 2011-2012




# MCH 2020: Children & Youth with Special Health Care Needs

## Definition

Those who have, or are at risk for, a chronic physical, developmental, behavioral, or emotional condition and also require health and related services of a type or amount beyond that required by children generally.

## State Priority

Services are comprehensive and coordinated across systems and providers

## Performance Measures

- Percent of children with or without special health care needs having a medical home
- Percent of families who experienced an improved independent ability to navigate the systems of care

## Data and Program Highlights

- One in five (19.4%) Kansas children (0-17 years) has a special health care need.[1]
- Majority (59.1%) of Kansas children have a medical home. There was no statistical difference between children with a special health care need (53.8%) and children without a special health care need (60.4%).[1]
- Every quarter, the Kansas Special Health Care Needs Program provides free care coordination trainings for families with a special needs child.
- Opportunity for improvement: Disparities persist for children with special health care needs to access medical care based on adequacy of insurance and geographic factors.

## The Medical Home

A medical home is not a physical location but rather an approach to comprehensive primary care that is seen as the ideal model of care for all children.

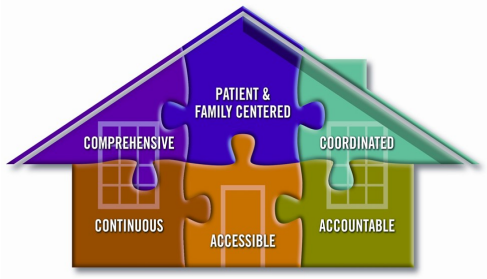
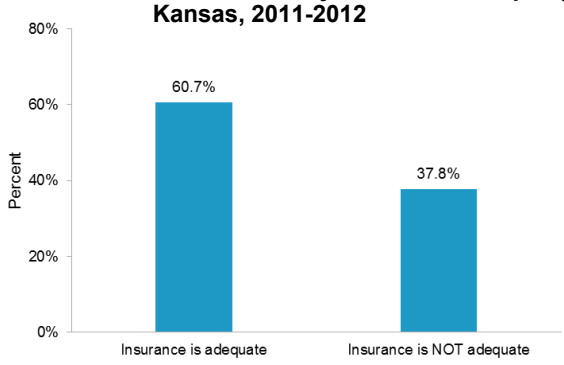



Image from www.oregon.gov/oha/pcpch/Pages/standards.aspx

## Example of Health Disparity

**CYSHCN* with a Medical Home by Insurance Adequacy Kansas, 2011-2012**




Source: National Survey of Children's Health, 2011-2012

## Next Steps

- Increase family satisfaction about the communication among their child's doctors and other health providers.
- Increase the number of families who receive care coordination support through cross-system collaboration.
- Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes.
- Increase opportunities to empower families and build strong Maternal and Child Health advocates.
- Train and education providers to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

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Data Source: Health Resources and Services Administration. National Survey of Children's Health, 2011-2012