Maternal and Child Health Services Title V Block Grant

Kentucky

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I. General Requirements

I.A. Letter of Transmittal

CABINET FOR HEALTH AND FAMILY SERVICES
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July 15, 2015

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Re: Kentucky 2014 Maternal and Child Health Block Grant Application/DUNS# 927049767

Dear Dr. Lu:

Please accept the enclosed application from the Kentucky Cabinet for Health and Family Services for the 2016 Maternal and Child Health Block Grant application and 2014 Annual report in response to HRSA Program Announcement 16-001.

The purpose of the grant is to fund support services administered by the Commission for Children with Special Health Care Needs and maternal and child health initiatives administered by the Department for Public Health and local health departments. The grant request is for (FA) financial assistance in support of these efforts.

If you have any questions regarding this application, please direct them to Shelley Adams, Title V Grant Administrator, at 502-564-2154 ext. 4405 or shelley.adams@ky.gov .

Sincerely,

Connie Gayle White md
Deputy Commissioner for SMG

Stephanie Mayfield Gibson, MD, FCAP
Commissioner

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Section 1.E. Executive Summary

The Kentucky Title V program is committed to assuring the health and well-being of Kentucky's maternal and child health (MCH) populations. The 2015 needs assessment process was used to identify emerging needs, evaluate progress, and explore opportunities for improvements in MCH programs. Topics were similar to 2010, but there were clear shifts in what consumers and stakeholders saw as most important. The priority topics, emerging needs, accomplishments and progress for each population health domain will be summarized in this executive summary.

Women/Maternal Health:

Substance abuse was the dominant emerging issue identified through Kentucky's (KY's) needs assessment process. This issue includes smoking during pregnancy, abuse of prescription medication, and use of illegal drugs. It affects every community with particularly devastating consequences to pregnant women and infants. Since this issue impacts all population health domains, it is discussed in more detail in the Cross-Cutting section of this summary.

The priority need for KY in this domain is maternal morbidity. Higher rates of pre-existing diabetes and hypertension are noted in KY compared to the Nation, and KY also has a higher percentage of first time cesarean sections compared to the national average. In order to address this priority need, KY will use National performance measure #2, the percent of cesarean sections among first time low risk births. This will align with our previous work on Early Elective Delivery (EED) through Healthy Babies are Worth the Wait (HBWW). Efforts will include increasing the number of hospitals with a hard-stop policy for EEDs, and continued participation in the Preterm (PT) and Early Term Births Collaborative Improvement and Innovation Network (CoIIN). With efforts so far, decreasing EED and C-section rates have contributed to a reduction in non-medically indicated EEDs among singleton term deliveries from 13% in 2011 to 10% in 2014. Although this is progress, much work remains to be done. Additional progress on MCH priority areas related to maternal morbidity include: From 2010-2014, the percent of singleton late PT infants declined from 8.8% to 7.9%; pre-pregnancy body mass index (BMI) in either the overweight or obese category declined from 50.6% to 46.6%; and the percent of women who smoked during the third trimester of pregnancy declined from 20.3% to 19.0%.

Improvements in maternal health are seen in the KY home visitation program, Health Access Nurturing Development Services (HANDS) and Maternal Infant and Early Childhood Home Visitation (MIECHV). Recent evaluation of the core HANDS program (first time parents) participants compared to similar risk families, showed higher adequate prenatal care, 49% less pregnancy-induced hypertension, and 40% fewer maternal complications in pregnancy. Improvements in the HANDS MIECHV projects (multigravida families) include increased percentage of HANDS participants with a medical home six months after delivery, reductions in the percentage of HANDS participants with a subsequent pregnancy at one year postpartum, increased referrals for positive depression screens, and increased

screening for domestic violence.

Perinatal/Infant Health:

Infant mortality continues to remain a priority need for the state. In 2012, Kentucky's infant mortality rate (IMR) per 1,000 live births was 7.3, compared to 6.0 in the Nation. KY will focus on two national performance measures: #4: improving breastfeeding initiation and duration rates, and #5: increasing the percent of infants who are placed to sleep on their backs. The emerging issue identified impacting the Perinatal/Infant health population is Neonatal Abstinence Syndrome (NAS), consistent with the cross-cutting concerns of substance abuse. This topic is described in the Cross-Cutting sections of this application.

Progress on Perinatal/Infant health includes: From 2010-2014, the percent of mothers who breastfed their infants at six months of age increased from 29.6% to 31.5%; and the percent of very low birth weight infants delivered at a Level III facility increased from 58.9% to 64.2%. The HANDS program has shown success in improving infant outcomes and reducing infant mortality overall with the latest outcome data showing 26% less premature births, 46% less low birth weight births, and 47% less child abuse and neglect than similar high risk families respectively; and infant mortality was 74% less likely than statewide.

MCH is continuing to improve data around safe sleep to better inform prevention efforts, including applying to the Centers for Disease Control and Prevention (CDC) to become part of the Sudden Unexpected Infant Death (SUID) registry. Local health departments (LHDs) address unsafe sleep using several MCH Evidence Informed Strategies. In addition, The External Review Panel for Child Fatalities and Near Fatalities recommended a statewide public awareness campaign on the dangers of co-sleeping, especially with an impaired caregiver. An MCH Safe Sleep Taskforce is developing the campaign with a target launch set for October 2015.

The Kentucky Infant Safe and Strong (KISS) program is a collaborative effort between Title V and Women, Infants and Children (WIC), endorsed by KY March of Dimes (MOD) and the KY Perinatal Association (KPA). It is a hospital recognition program which includes infant safety and breastfeeding. Hospitals applying for recognition must do both steps to improve infant safety and steps towards becoming Baby Friendly. The Baby Friendly Hospital Initiative is being supported across the state.

Child Health Domain:

Child abuse and neglect is the priority need in the Child Health Domain. Noted as an emerging issue in 2010 by our consumers, in this needs assessment it was a priority identified by the consumer survey, stakeholder survey, focus groups, and stakeholders in the prioritization meeting. Although deaths due to child abuse and neglect among children less than five years of age did decline over the past five years, there was a 28% increase in the rate of these deaths during the past year. In order to address this issue, Kentucky has chosen to work towards the national performance measure aimed at reducing the rate of injury-related hospital admissions per population ages 0-19; this will include hospitalizations for child abuse and neglect.

The increased awareness of child abuse as a public health issue, particularly abusive head trauma (AHT), has resulted in legislation and action at the highest levels. The creation of a state-level Child Fatality and Near Fatality External Review Panel in 2013, an independent, multidisciplinary body housed in the Justice Cabinet, is evidence of the growing support for addressing child abuse in the state. In addition, legislation now requires all professionals serving children receive training on child abuse and prevention of AHT. In developing our statewide safe sleep campaign, we intend to integrate messages about prevention of AHT, as new parents need information on both topics. We will continue to work on projects with KY Safety Prevention and Alignment Network (KSPAN), the Division of Pediatric Forensic Medicine at the University of Louisville (UL), Prevent Child Abuse Kentucky (PCAK), the KY American Academy of Pediatrics (AAP), and LHDs on these issues.

Progress on MCH priority areas related to Child Health include: Over the past five years, (2010-2014) the rate of KY children less than five years of age who died from child abuse/neglect declined from 8.9/100,000 population to 6.5/100,000 population; and the rate of all non-fatal injuries among children 14 and younger declined from 120.7/100,000 population to 100.0/100,000 population.

Adolescent Health Domain:

In Adolescent Health, substance abuse was again identified by our stakeholders as the top priority issue. It will be addressed under the Cross-Cutting section. The priority need chosen for this domain is obesity/overweight. In the 2010 needs assessment, obesity was identified as a children's issue, but in 2015, it emerged in adolescent health with stakeholders and consumers. According to the 2014 State of Obesity Report, KY ranked 8th in the obesity rate for 10-17 year olds at 19.7% and 1st in obesity for High School Students at 18%. In order to monitor progress towards improving this priority, KY has chosen national performance measure #8: increasing the percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day.

KY has seen progress in adolescent health in other areas of preventative and primary services. KY's teen birth rate has fallen to its lowest ever level at 38.7 per 1000 females ages 15-19. Although still above the national average, this is a huge improvement for KY. In addition, there are ongoing efforts to assure adolescents get immunized against HPV. These public health initiatives, though not led by Title V, have significant impact on the health of our adolescent population.

Through the Coordinated School Health Program (CSHP), a collaboration with the KY Department of Education (KDE), Title V is working on obesity prevention through school settings. These efforts include the KY School Health and Physical Education (SHAPE) Network. In addition, the CSHP team promotes the utilization of a Comprehensive School Physical Activity Program (CSPSP) in the school setting. As of 2015, the KY SHAPE Network has educated over 600 schools enrolled in Let'sMove! Active Schools. In school year 2013-2014, there was a 24% increase from the previous year in schools reporting proficiency in implementation of a CSPSP and a 17.4% increase in schools implementing their district wellness policy.

Training on the 5-2-1-0 program promoting healthy nutrition and physical activity, will continue with early childhood educators, staffs, LHDs, and communities. Kentucky plans to increase the number of communities with a pedestrian plan and encourage the development of more trail towns in communities.

Children and Youth with Special Health Care Needs (CYSHCN) Domain:

Kentucky's CYSHCN program faces challenges associated with completing the transition from a traditionally direct service role to an assurance role with regard to ensuring statewide systems of care and infrastructure building. The gulf between the number of children served in CYSHCN specialty medical clinics and the estimated population of CYSHCN in KY illustrates the issue, as does the fact that KY's rate of CYSHCN is the highest in the country. Findings have shown a lack of access to medical and supportive services in KY's communities. The development and promotion of a more integrated system will ensure that CYSHCN in KY are able to access services in their communities. Improvement of transitions services is a core outcome and continued priority from the most recent Needs Assessment cycle. While data capacity will not directly impact any child to achieve outcomes, KY considers that developing the expertise to properly measure and evaluate available data will allow the agency to ensure that progress is being made toward achievement of the goals.
The Commission for Children with Special Health Care Needs (CCSHCN) reports improvement in six of eight performance measures between 2009 and 2014. Healthy weight and obesity rose slightly in 2013 and 2014. The state's scores on the transition action plan improved to 92.3%, doubling the 2010 score.

Regarding the three priorities linked to projected State Performance Measures (access to care, adequate insurance coverage, and improved data capacity), CCSHCN will leverage technical assistance resources through the upcoming National Governor's Association (NGA) Learning Collaborative to turn preliminary ideas into robust plans to strengthen and better integrate the overall system of care for CYSHCN in KY. Available data from the National Survey of Children with Special Health Care Needs (NS-CSHCN) and National Survey of Children's Health (NSCH) supplements data and determines trends among the larger CYSHCN population. While the revised NSCH will provide a backbone for annual block grant reporting, CCSHCN is examining data collection efforts for the purposes of developing more accurate management information to guide program evaluation and program planning and development.

Cross-Cutting Life Course:

Substance abuse. The dominant issue impacting all population domains from our Needs Assessment was substance abuse. Kentucky is # 2 in the nation in overdose deaths. Rates of NAS have risen sharply. The consequences of this epidemic include pregnancy complications, increased risks of relapse, and overdose deaths in women; and for children, NAS, infant death from impaired bed sharing and deaths from pediatric AHT.

Accomplishments include legislation for mandatory reporting of NAS which will greatly enhance data quality related to NAS. The associated emerging issue identified in the client survey was Hepatitis C in these families. Kentucky's Viral Hepatitis Program has been tracking perinatal Hepatitis C Virus, and this reporting was codified by legislation as a reportable disease during this year's legislative session.

MCH has a leading role in addressing smoking. Legislation for a statewide smoke-free ordinance failed in the last legislature, but public opinion is now supportive. MCH has several activities aimed specifically at smoking in pregnant women, and will work toward the national performance measure aimed at reducing the percent of women who smoke during pregnancy and the percent of children who live in a household where someone smokes. Smoking in pregnancy in KY is gradually decreasing over time, from 24.1% in 2009 to 21.9% in 2013.

Oral health is another cross-cutting issue for KY. Dental caries is the most common chronic disease of childhood. MCH houses the KY Oral Health Program (KOHP) and State Dental Director. As a Governor's priority, many activities are in place to provide better access to preventative dental services, especially for children. To measure our continued progress, KY will use national performance measure # 13 aimed at increasing the percent of women who had a dental visit during pregnancy and the percent of children ages 1 through 17 who had a preventive dental visit in the past year.

An accomplishment for improving dental access was the creation of a new licensure category for public health dental hygienists, who will be able to provide preventative dental services to low risk patients without a dentist on site. The Governor designated funding for 10 pilot sites to establish a public health dental hygiene program; 5 were awarded in Fiscal Year (FY) 15 and 5 more will be started in FY 16. In addition, public health nurses across the state are trained to provide fluoride varnish treatments to children to prevent decay.

II. Components of the Application/Annual Report

II.A. Overview of the State

II. A. Overview of the State

Kentucky's health care delivery environment and the role of Title V

Kentucky's Title V agency is in the Division of Maternal and Child Health (MCH) which is organizationally located within the Kentucky Department for Public Health (KDPH), in the Cabinet for Health and Family Services (CHFS)in the state capital, Frankfort, KY. Kentucky operates a decentralized public health system, with independent and district health departments serving all 120 counties who are accountable to their local board of directors; the state health department operates the personnel and financial systems for LHDs and supports the LHD role in state and federally funded programs through allocations, standards of practice, training and technical assistance. As another CHFS entity, the KY CCSHCN is a sister agency to KDPH. CCSHCN is located in the state's largest city, Louisville, with regional sites in twelve (12) offices throughout the state. Significant changes in the health care landscape have occurred in KY with the implementation of Managed Care Organizations (MCOs) for Medicaid beneficiaries, the addition of provisions required by the Affordable Care Act (ACA) in the Medicaid State Plan, the implementation of the Kentucky Health Benefit Exchange (KHBE), and the expansion of eligibility in Medicaid.

Kentucky implemented Medicaid managed care statewide in 2011. There are currently five MCO providers throughout Kentucky. There were initial difficulties that are mostly overcome with an overall successful transition from traditional Medicaid. In the 2015 Needs Assessment focus groups, some families expressed difficulties in finding local providers depending upon which MCO they choose; network adequacy is improving. In January 2014, KY implemented provisions of the ACA requiring coverage for mental health and substance abuse services. Both of these came up often as needs for MCH populations in our needs assessment process. Previously the only mental health or substance abuse treatment paid for by Medicaid was through the state network of Community Mental Health Centers. However, the new State Plan amendment opened up the Medicaid provider network to add multiple mental health and substance abuse provider types. Since implementing the ACA requirements, more than 300 new behavioral health providers have enrolled in Medicaid and at least 13,000 individuals with a substance abuse disorder have received related treatment services (Deloitte Development LLC, 2015). This is a huge step forward for access to these critical services for MCH populations.

KYs Governor Steve Beshear was one of the first to call for and implement a state-based health exchange, which in Kentucky is known as "kynect". The exchange is a marketplace for individuals and employees of small businesses to shop for health insurance based on price and quality. In the first open enrollment period with 640,000 Kentuckians uninsured (October 2013 - April 2014), 413,410 Kentuckians enrolled in new health coverage through kynect. During the second enrollment period (November 2014 – February 2015), 158,685 individuals enrolled in health care coverage through kynect: 55,855 individuals who enrolled in Medicaid, 75,760 individuals who renewed their enrollment in a qualified health plan, and 27,070 individuals newly enrolled in a qualified health plan (kyhealthnow, 2015).

The Medicaid program in KY has historically focused on providing health care to subgroups of the lowest income individuals including the elderly, disabled, children, and pregnant women. In 2013, Governor Beshear announced his decision to expand Medicaid and to extend coverage to individuals with incomes up to 138% of the federal poverty level (FPL). KYs decision to expand Medicaid eligibility had three goals including: 1) reducing the number of low income residents in Kentucky who lacked health care, 2) improving the health status of Kentuckians – especially low income residents without prior access to health care coverage, and 3) boosting KY's economy. In the first year of Medicaid expansion (January 2014 – December 2014), 310,887 Kentuckians enrolled in the Medicaid expansion

which exceeded projections. Further, those individuals who enrolled with the expansion of Medicaid are accessing preventative services at a rate equal to or greater than the traditional Medicaid population (Deloitte 2013). Although this did not have a direct impact on Medicaid eligibility for pregnant women, which is at 185% FPL in KY, it will allow for more women to be covered in the preconception and interconception care periods. In Appalachian counties, the number of Medicaid enrolled citizens has exceeded 90% of those eligible. This will have a significant impact on the overall health of some of our most needy counties.

Efforts to expand Medicaid eligibility have been successful. National data indicates that KY experienced the second largest decrease of any U.S. state in its uninsured rate during calendar year 2014, dropping from 20.4% to 9.8% (Witters, 2015) . In addition, based on the 2014 enrollment data, approximately 60% of the SFY 2014 prior-eligible enrollees were children. The aggressive outreach and marketing efforts along with LHDs, CCSHCN, area development districts, community mental health centers, community action agencies, faith-based organizations, hospitals, clinics and other health care providers were likely responsible for the state exceeding targeted enrollment for Medicaid expansion (Deloitte 2015). The Title V program has been actively involved in these efforts. The CCSHCN regional offices and several LHDs have kynectors on staff (staff trained to facilitate customers accessing kynect for enrollment), and in other communities they know the locations to send families for this service. The Title V MCH program also provides funding and training for outreach through one of the MCH Evidence Informed Strategies that LHDs can choose to implement with their Title V Funds, "Affordable Health Care for KYs MCH Populations", based on the Health Resources and Services Administration (HRSA) funded "Peer-to-Peer Technical Assistance (TA) for State Title V MCH Programs on Implementation of the ACA."

CCSHCN sees involvement in Kentucky's Health Benefits Exchange ("kynect") and partnership with other organizations implementing ACA as part of the agency's mission as a Title V agency – a way to ensure that all families and CYSHCN have adequate sources of insurance. CCSHCN-affiliated kynectors have made nearly 3000 direct consumer contacts, assisting with the initiation of over 500 applications. Statewide survey data shows that CCSHCN respondents are less likely than others to experience problems with obtaining insurance via kynect than other groups. Further, the agency contracts with a trusted nonprofit, Patient Services, Inc., to provide insurance case management and premium assistance solutions for those with eligible conditions – specifically, bleeding disorders and cystic fibrosis. As insurance coverage is a cross-cutting issue among MCH populations, and as a disparity of adequacy exists in terms of CYSHCN, CCSHCN is working toward greater (appropriate) coverage by guiding and advocating for CYSHCN on an individual basis and on a state level, participating in ongoing dialogue with Medicaid and the managed care organizations to reach solutions to any issues. CCSHCN has participated in two learning collaborative opportunities with Medicaid partners (and is preparing for a third), and continues to work with state partners as well as national experts. Initial impacts of the transition to Medicaid Managed Care to CYSHCN included concerns about the breadth of provider networks and the ability to find contracted providers to meet the needs of families of CYSHCN, as well as required pre-authorizations for medical procedures for which CYSHCN may previously have been exempted.

State Health Agency Priorities

Although we did not write his script, our Governor describes his health priorities as follows: *"Governor Steve Beshear has made improving the health and wellness of Kentucky's children, families, and workforce one of his highest priorities. To significantly advance the well-being of Kentucky's Citizens, Governor Beshear is announcing the following health goals for the Commonwealth... These strategies will be implemented through executive and legislative actions, public-private partnerships, and through the success of enrolling Kentuckians in health care coverage."*(kyhealthnow, 2014)

Begun in February of 2014, the intent of the kyhealthnow initiative is to focus public and private, health, education and business sectors to all be working towards common health goals, instead of having siloed, disparate efforts. The

initiative oversight team reflects this diverse membership and is led by the Lieutenant Governor. The vice-chair is the Commissioner for Public Health, Dr. Stephanie Mayfield Gibson. This initiative outlines seven health goals to work toward achieving over five years; these goals are the current priorities for the KDPH. All of the kyhealthnow goals will impact MCH populations. The kyhealthnow goals are:

- Reduce KY's rate of uninsured individuals to less than 5%
- Reduce KY's smoking rate by 10%
- Reduce the rate of obesity among Kentuckians by 10%
- Reduce KY's cancer deaths by 10%
- Reduce cardiovascular deaths by 10%
- Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%
- Reduce deaths from drug overdose by 25% and reduce by 25% the average of poor mental health days of Kentuckians

These priorities are very consistent with the findings of our Title V Needs Assessment. MCH has a leading role in the strategies for obesity, smoking, and oral health goals, which will be described in detail later in this application. However, MCH also has a role in raising the awareness that these health issues, although viewed as adult health problems, all have roots in Adverse Childhood Experiences (ACEs):

- Uninsured: Most people access insurance through their jobs.In the ACEs study, people with 4 or more ACEs had more absenteeism and difficulty getting along with people on the job. (Felitti et al., 1998)
- Smoking: The higher the ACE score, the more likely a person will begin smoking before age 14.Ninety percent of adult smokers start as teens.ACEs are responsible for 39% of ever smoking and 26% of current smoking.
- Obesity: Risk of obesity doubles in people with 4 or more ACEs.
- Cancer: Kentucky is #1 in lung cancer, and Brown et al. showed a graded relationship between the ACE score and the risk of lung cancer.
- Cardiovascular: ACEs in childhood triples the risk of heart disease as an adult.
- Dental Disease: The presence of even one ACE in a child's life increased the likelihood of having poor dental health; multiple ACEs had a cumulative negative effect on the presence of dental caries (Bright et al., 2015)
- Overdose Deaths: Four or more ACEs more than double the risk of starting illicit drug use by age 15-18. A male with 6 or more ACEs has a 4,600% increased risk of IV drug use; 78% of IV drug use in females is attributable to ACEs.

- Mental Health: ACEs in childhood are responsible for 54% of chronic depression in adults, and 58% of suicide attempts in adults. Over half of women who have experienced 5 or more ACEs will have chronic depression as an adult.

We view all our work in MCH towards improving the health and well-being of our mothers and children, and specifically working to reduce ACEs, as directly impacting these health goals. Another Governor's Initiative, Shaping Our Appalachian Region (SOAR), co-led by Congressman Hal Rogers, targets many of our social determinants and challenges in delivering services to our MCH populations across the state. (Described below).

Challenges for Delivery of Services

Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage." In addition, Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people." "Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." In Kentucky, we see the effects of racial and ethnic disparity in all of our MCH indicators. In addition, our population is affected by economic and geographic disparities across the state.

While more Kentuckians have health insurance than ever before, coverage does not equal access. Based on 2010 Census data, 24% of Kentuckians live in rural areas compared to 6.3% in the U.S. (Price, 2011). This affects access to health care, higher education, employment, and services. The rural nature of KY poses barriers such as limited providers for primary care and dental services, and transportation issues. It is important to note that due to these factors, some communities in KY are still reliant on the LHD system for primary care services.

The overall poverty rate in KY in 2013 was 18.8% and 27.7% of Kentucky's children live below 100% FPL. Poverty is more prominent in our rural areas. There are 54 and 21 KY counties designated as Appalachian and Mississippi Delta regions, respectively, indicating populations where poverty rates and geographic challenges contribute to higher morbidity and mortality. The Appalachian Regional Commission (ARC) designates counties in the range of Appalachian Mountains according to their economic status. Overall, there are 408 ARC counties across 13 states designated as distressed, at-risk, or transitional. Twenty-two percent of those counties are distressed. However, in KY, 54 of our 120 counties are ARC counties, and 72% of them are distressed. Many of our indicators of poor health match the maps of the ARC/ economically disadvantaged counties.

KY has three major urban areas: Louisville, Lexington, and the Northern Kentucky metropolitan area. These urban areas have very different opportunities and challenges than the rural parts of the state.

According to the 2010 Census, KYs total population is 4,339,367 with a growth rate of 7.4% over the last ten years. As the population grows, it is becoming more racially and ethnically diverse. Overall, whites comprise 87.8% of the population, African-Americans represent 7.8%, and other groups comprise 4.4% of the population. Of KYs total population, 3.1% are Hispanic. The growth in racial and ethnic diversity is illustrated in the younger generation: among children, the population is 81.3% white, 9.2% black, and 4.7% Hispanic. In KY, our racial and ethnic populations tend to concentrate in specific areas, and health disparities are mostly addressed by place-based initiatives such as the Federal Healthy Start program in Louisville, and the Bluegrass Community Health Center in Lexington, a Federally Qualified Health Center (FQHC) that provides a medical home for many migrant families in central KY.

Acknowledging the long history of economic and geographic disparities that affect Appalachia, Kentucky Governor Steve Beshear and Congressman Hal Rogers joined in a bipartisan initiative to address the challenges facing Eastern Kentucky. "Shaping our Appalachian Region" (SOAR), began in 2013 to "expand job creation; enhance

regional opportunity, innovation, and identity; improve the quality of life; and support all those working to achieve these goals in Appalachian Kentucky." (SOAR 2015) This Initiative has drawn millions of dollars of investments from many state and federal agencies, including U.S. Dept. of Agriculture (USDA) Strike Force Designation, ARC, the Department of Labor, VISTA Volunteers, a designated CDC staff person, and President Obama's only rural designation of a Promise Zone. One of the first projects announced is to build broadband access to internet to all parts of Eastern KY. The initiative recognizes the link between health and economic disparity, and formed a health committee as one of its initial priorities. The state MCH director, Dr. Ruth Ann Shepherd, who has practiced neonatology in Eastern KY, was designated as the Cabinet's representative to SOAR.

The SOAR Health Committee began work in 2014 with a series of 16 "listening sessions" or town hall meetings in different parts of the region, attended by over 350 citizens. In addition, SOAR hosted a Health Impact Series with Dr. Tom Frieden and Congressman Hal Rogers hosting 4 sessions around the region, inviting health leaders from the area to present on issues and challenges. Over 1000 people attended those sessions. Information gathered at all these sessions were compiled into a report on Health, which prioritized the areas of most concern. MCH issues were prominent in these priorities. The issues prioritized for the final report were: Coordinated School Health; Environmental Health; Smoke-Free Initiatives; Substance Abuse; Wellness Initiatives (healthy eating & water first); a regional Health Clearinghouse; ACEs; Transportation/Access; Children's Oral Health; and Physical Education in schools. The Committee acknowledged existing MCH efforts and reinforced the need to promote them in Appalachia. Just as with kyhealthnow, these priorities reflect the needs we have determined from our Title V Needs Assessment process. More detail is provided later in the application.

Health disparities, including racial, ethnic, economic, and geographic disparities will continue to dominate the landscape for KY's MCH populations. In the national CoIIN, Kentucky MCH has chosen to participate on the Social Determinants CoIIN team to learn more specific strategies to address these issues and work towards health equity for all Kentuckians.

Process Description

For the Title V Block grant, we designed an extensive needs assessment process, with multiple levels of inputs; this work shows significant alignment between the Title V Needs Assessment and these major health efforts at the state level.

KY's Title V 2015 needs assessment process included a review of quantitative data on numerous indicators, consumer surveys that were conducted in LHDs and CCSHCN sites across Kentucky, focus groups with local staff from the LHD and CCSHCN, and stakeholder inputs. Potential priorities were identified for the five MCH population domains of women/maternal health, perinatal/infant health, child health, adolescent health, and children and youth with special health care needs. The ranking of those topics across the domains was assessed to determine their importance as cross-cutting. Each successive step in our process helped reinforce the issues identified as most important from our consumers and stakeholders. Since the steps in the process all included the MCH and CCSHCN together, a clear picture of the needs of our Title V populations emerged. These were aligned with the new Title V structure and the priorities of the state, as described above. (See Priorities section for more detail)

Several emerging issues have been identified through the ongoing needs assessment process. KY has worked for several years on reducing non-medically indicated cesarean sections, but overall, maternal morbidity is not yet a topic of concern from our stakeholders. With the emergence of this issue as a national priority, Title V will increase our efforts to address this issue. While substance abuse and NAS were identified in the 2010 needs assessment cycle, they have clearly moved to the top of the list of concerns for KY consumers, stakeholders, and politicians. The related need emerging is the high incidence of perinatal Hepatitis C associated with substance abuse; this was identified in our consumer survey, a bellweather of things to come. We are working with our KDPH Infectious Disease Branch on this issue. Child abuse and neglect were identified in the 2010 cycle Needs Assessment, but only by the consumers. In 2015 it came up as a priority for consumers and stakeholders alike. The establishment of

the External Panel for the Review of Child Abuse Deaths in statute points to the political will that now is behind that issue.

State statutes and other regulations that have relevance to Title V program authority

State statutes and regulations of relevance to KY's Title V program authority are described in this section to provide the basis for MCH programs and their required activities.

The foundational statute for KY MCH is within KY Revised Statute (KRS) 211.180 which gives the CHFS the responsibility and authority to formulate, promote, establish and execute policies, plans and programs relating to all matters of public health. It states that the Cabinet is responsible for "the protection and improvement of the health of expectant mothers, infants, preschool, and school-aged children" and "the protection and improvement of the health of the people through better nutrition".

KRS 211.180 authorizes MCH to protect and improve the health of expectant mothers. In addition, the legislature decades ago provided funding to MCH with the intent that no pregnant woman in KY will go without prenatal care due to lack of ability to pay. Thus KY Administrative Regulation (KAR) 902.4:100 established the public health prenatal program to administer these funds and set the financial eligibility for those in need of prenatal care at 185% and below of the Federal Poverty Level (FPL) who are not covered by Medicaid or any other funding source. The Prenatal Program serves as a core public health service and is the primary strategy for reducing maternal morbidity and mortality, as well as infant morbidity and mortality.

In addition to the nutrition provisions in KRS 211.180 (above), KRS 211.755 stipulates that a mother may breastfeed her baby or express breast milk in any location, public or private, where the mother is otherwise authorized to be.

Newborn Screening is required and the program is authorized to collect data for inborn errors of metabolism and other hereditary disorders by KRS 214.155. Expanded newborn screening was implemented in 2006, and the law allows the state to add any conditions to the panel that are recommended by the American College of Medical Genetics (ACMG). KY currently screens for 50 disorders. The program is currently adding severe combined immunodeficiency and the legislature in 2015 passed a bill to add Krabbe Disease to the panel. The Metabolic Foods and Formula program is established in KRS 304.17 to provide needed supplements and special foods to children with metabolic disorders. Medicaid and insurance companies are required to provide these for their enrolled patient population up to a cap of $25,000. The public health program then assists families of children with no insurance to obtain these items. KRS 211.192 was amended this year to direct KDPH to make available up-to-date information on spina bifida.

Universal Newborn Hearing Screening, overseen by the CCSHCN, is established in KRS 211.645, 211.647, and 216.2970.

The Kentucky Birth Surveillance Registry is authorized by KRS 211.651 to obtain data on all children up to the age of five years with congenital anomalies or disabling conditions. Reporting sources include acute care hospitals, outpatient records, and laboratory reporting.

In 2013, KRS 211.674 established the Perinatal Advisory Committee to review MCH data and make recommendations on infant mortality, perinatal substance abuse and NAS, and maternal mortality. KRS 211.676 required that NAS cases must be reported to the KDPH. Facilities in the state must report all cases diagnosed among newborn infants diagnosed at their facility. As public health surveillance, this data is managed by the MCH epidemiologists.

KRS 211.690 establishes HANDS as a voluntary home visitation for first time, at-risk parents as a primary service delivery strategy. 902 KAR 4:120 sets the definitions, eligibility criteria and provider qualifications for the HANDS program. HANDS is funded from the Master Tobacco Settlement and Medicaid funding, in accordance with 907

KAR 3:140. This administrative regulation stipulates charges to be fee-for-service.

KRS 200.654 allows MCH, as part of the CHFS, to designate state and federal funds to the First Steps Program (Part C of IDEA) to provide early intervention services for infants and toddlers with disabilities and their families. 902 KAR 30:150 defines personnel qualifications for participation as First Steps providers.

Multiple statutes pertain to childhood lead poisoning. KRS 211.900 defines at-risk populations. KRS 211.901 addresses the statewide program for the prevention, screening, diagnosis and treatment of lead poisoning. KRS 211.903 specifies the intervals of screening of at-risk children. KRS 211.904 states that the CHFS shall establish an educational program to inform parents, teachers, personnel of human resource agencies, owners of dwellings and dwelling units, health service personnel and the general public of the dangers, frequency, and sources of lead poisoning and the methods of preventing such poisoning.

In 1996, the Public Health Local Child Fatality Review (CFR) System was established through KRS 211.686. The purpose of the local teams is to assist the coroner in determining an accurate manner and cause of death. Grief counseling for families who have lost an infant to Sudden Infant Death Syndrome (SIDS) was initiated through LHDs after the SIDS program was established in KRS 213.161.

KRS 199.8945 establishes technical assistance for child care providers through the Healthy Start in Child Care Program. This statute mandates the training and education of child care providers in child health and safety and to increase awareness and education for parents of children who attend child care.

KRS 211.190 (11) requires the CHFS to provide public health services that include water fluoridation programs for the protection of dental health. 902 KAR 115:010 sets forth the requirements for the program. KY has the highest percentage of fluoridated water systems in the country, at 98%. A special licensure category for Public Health Dental Hygienists was established in KRS 313.040, which expands the scope of the preventative dental work that hygienists can do in a public health outreach under protocol without requiring the presence of a dentist on site. KRS 156.160 requires that all children entering public school have a dental assessment; while this is the responsibility of the KDE, the MCH State Dental Director provides training and technical assistance.

KRS 156.501 establishes a full time position in the KDE for a school nurse consultant, and MCH pays half her salary. The role of this position is to develop protocols for health procedures, quality improvement, and health data collection in schools. This position works collaboratively with MCH staff to develop this guidance for health management in schools. Most recently legislation has directed protocols be provided for administration of insulin in schools, and naloxone protocols were added this year.

Program authority for CYSHCN services derives from KRS 200.460-200.499. The authorizing statute reads in part: that CCSHCN “shall provide through contractual agreement, or otherwise, such services as may be necessary to locate, diagnose, treat, habilitate, or rehabilitate children with disabilities, and may include any necessary auxiliary services.” A biennial report to the Governor and General Assembly is mandated. A recent change to the organizational structure is the addition (by Executive Order) of an Office on Autism, which is currently attached to CCSHCN for administrative purposes. Expansion into the area of Autism Spectrum Disorders (ASD) marks an evolution for CCSHCN, and a good program fit. Along with other partners (universities, Kentucky Autism Training Center), CCSHCN held its first clinic in the fall of 2014. Patients are able to see several providers on the same day, and patient satisfaction was high. Clinics include consultation by developmental pediatrics, neurology, and psychiatry; diagnostic clinics also included psychology. CCSHCN’s billing ability for multiple managed care organizations allows the agency to contract with providers, and chips away at waitlists for services in the community. The agency plans to continue to build up infrastructure and envisions partners to take over the provision of services. The Office on Autism continues to staff the statewide Advisory Council on ASD, and advance solutions as per the 2013 Autism Needs Assessment.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Five Year Needs Assessment Summary

The 2015 KY Title V Needs Assessment was conducted by the KDPH MCH and KY CCSHCN with support provided by the University of KY College of Public Health (UK CPH). Throughout 2014, the planning committee gathered and analyzed information from LHD staff and consumers, CCSHCN clinic staff and families, and a diverse group of MCH stakeholders.

THE PROCESS

The planning committee had three goals for the 2015 MCH Needs Assessment process: to thoroughly examine the health status of the population health domains using quantitative and qualitative data; to identify priorities for the Title V program over the next five years; and to achieve this work with an unprecedented level of integration between the two agencies.

Quantitative and qualitative methods, data resources

To measure progress on current priorities and build evidence to identify new priorities, KY used quantitative and qualitative analysis techniques. The quantitative and qualitative data resources and a brief description of the process are described below. Selected results from the data resources will be presented under MCH Population Needs.

Quantitative Data Resources

MCH Fact Sheets: Sixteen MCH fact sheets (Attachment A) were developed from May to December in 2014 by Title V staff and practicum MPH students from the UK CPH. Using state-level data such as Vital Statistics, the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System as well as national surveys, fact sheets were developed as the foundation for needs assessment efforts.

National Survey of Children's Health (NSCH) & National Survey of Children with Special Health Care Needs (NS-CSHCN) Analysis: To enhance data capacity and review outcomes for KY CYSHCN, survey results for the 2011/2012 NSCH and 2009/10 NS-CSHCN were analyzed to compare KY outcomes to HRSA Region IV and the Nation. The results examined core performance outcomes, inequities between CYSHCN and non-CYSHCN, and the prevalence of select conditions (Attachment B).

Consumer/Family Survey Analysis: A consumer survey (English and Spanish) was distributed in county and district health departments and CCSHCN clinics across KY in May. A total of 3,361 surveys (813 from CCSHCN families) were returned. The UK CPH team examined statewide results and compiled LHD and regional CYSHCN reports for sites with at least 75 completed surveys. A detailed report on the survey is in Attachment C.

Stakeholder Survey: In October, a survey was developed to prioritize topics identified by the consumer survey. The criteria and weight (wt) used for prioritization included: seriousness of issue (wt=2); economic and social impact (wt =1); state's ability to prevent, improve, or impact the issue (wt =3); and overall importance of the issue to the rater (wt =2). The survey was distributed to all potential attendees of the stakeholder meeting as a "pre-meeting" assignment. One hundred and sixty-four responses were received, and weighted by domain and overall. Results were presented during the stakeholder meeting.

CYSHCN Prevalence Estimates for Select Conditions: In an attempt to better estimate the prevalence of five

chronic conditions (Asthma, Diabetes, Epilepsy, Allergies and Attention Deficit Hyperactivity Disorders [ADHD]) within the Commonwealth and CCSHCN Regions, staff at CCSHCN conducted a research project using KY Dept. of Education (KDE) data tracking condition and diagnosis data for students requiring health service accommodations. KDE provides information on the number of children with a specific condition at each of their public schools. These numbers were summed and then compared to county-level school enrollment statistics, allowing CCSHCN staff to estimate the proportion of children affected by county for each condition. This proportion was then applied to the total population of all children (ages 5-19) in each county and estimates of the true prevalence of each condition were extrapolated. These estimates were compared to CCSHCN electronic patient data system (CUP) to identify gaps, if they existed, at the state and CCSHCN regional office level.

Qualitative Data Resources

Focus Groups: In September and October of 2014, MCH LHD and CCSSHCN staff volunteered to participate in focus groups that were held in 10 KY sites with one Central pilot site: 2 Eastern, 4 Western, and 4 in North/Central KY. CYSHCN parent involvement was included where possible. The intent of the focus group process was to critically examine topics from the consumer survey and identify major themes of importance to communities. Four topics were discussed: Substance Abuse; Child Abuse/Neglect; Services and Resources for CYSHCN; Access to Care – Medical, Dental and Mental Health. Participants ranked these topics specific to their impact on the community, provided details about each problem based upon experience, and discussed what was working in their communities to address these issues. The focus groups had a total of sixty-six participants with an average of 6 per group. At least one CCSHCN staff member and/or parent representative was present at all sites. Group membership was primarily female with an average of nearly 14 years of public health experience. The fields of nursing, social work, public health and other areas represented. Focus groups were transcribed and recorded. UK CPH conducted the focus groups and completed the data analysis.

Hospital Community Health Needs Assessments (CHNA): The ACA requires non-profit hospitals to conduct a CHNA at least once every three years. Non-profit hospitals throughout KY were identified and a search was conducted for a CHNA document for each. Of 125 identified hospitals, 73 CHNA documents were identified and reviewed. Details within the CHNA documents varied substantially; however, MCH problems and needs were quickly identified with several topics raised as issues of critical importance to hospitals and their communities.

Stakeholder Meeting: Stakeholders registering for the November meeting were asked to select a domain area and then assigned, in small groups (8-10) to their selected area. Eight groups were formed in total – Women/Maternal (1); Perinatal (1); Child (3); Adolescent (1); CYSHCN (2). Each group included a facilitator and subject matter expert familiar with data available in the domain to assure that discussions focused on measureable, achievable targets.

With nearly 100 individuals in attendance, the meeting began with an overview of the Title V mission and evidence collected to date. KDPH and CCSHCN leadership used this time to set the stage for the work to come - challenging the participants to identify priorities for the domains. Those in attendance would discuss and vote during the small group work portion of the meeting.

Each small group was given 3-5 topics determined by consumer and stakeholder surveys, and was asked to select the two most important topics by voting. The two issues selected would determine their discussion for the remainder of the meeting. The discussion addressed what communities were currently doing to address the topic, what gaps exist, what participants wanted to see happen in communities, and action steps necessary to implement their ideas. Upon completion of the small group work, participants reconvened for a report out by each group. The three gaps identified for *each* of their two topical areas were reported, and these were the subject of the final vote of the day by all participants.

II.B.2. Findings

II.B.2.a. MCH Population Needs

MCH POPULATION NEEDS

Women's and Maternal Health

Overview: The statewide consumer survey identified the top issues for women as *overweight/obesity* (56.5%), *drug/marijuana use* (34.3%), *depression* (30.0%), w*omen who smoke* (23.1%) and *secondhand smoke* (22.6%), with other comments including *domestic violence, abuse, Hepatitis C* and *poverty*. **Prioritization by stakeholders resulted in the following ranked priorities for this domain: *substance abuse*, *overweight/obesity*, *pregnancy/health problems related to pregnancy*, and *mental health*.** The priority topics in KY have not changed since the 2010 needs assessment although the order has changed with substance abuse becoming the leading concern.

Strengths and Needs: Strengths that were identified include few reported problems obtaining family planning services, WIC vouchers, or seeing a doctor for care during pregnancy or yearly checkups based on the consumer survey. Regional differences were noted with concerns about drug use higher in the East (46.9%) than the West (22.9%). Concerns about mental health, problems related to pregnancy, and sexually transmitted diseases (STDs) were more common in Western KY.

Drug abuse was the top concern across KY hospital Community Health Needs Assessments with discussion of prescription and non-prescription drug addiction; lack of rehabilitation services and inpatient facilities as well as limited substance abuse counseling. Tobacco and alcohol abuse, domestic violence (and the need for shelters) were also common concerns. Availability of mental health services for all ages and obesity were also raised by community hospitals. Further, a need for specialists in obstetrics/gynecology and maternal fetal medicine, a need for coordinated obstetric care, and more resources to support chronic diseases (particularly diabetes) were also documented.

Needs identified based on stakeholder input included a lack of comprehensive substance abuse and mental health treatment options (residential and outpatient centers) and the need for prevention and early intervention services. Shortages of mental health providers and long wait times for substance abuse and mental health treatment, even during pregnancy, were primary concerns. A need for developing support groups outside of 12-step/referrals and treatment facilities available for those unable to pay were identified. Education about substance abuse and mental health issues for professionals across many disciplines was noted. Stakeholders also discussed a focus on youth and prevention, collaboration across service providers, continuity of care, and the need for stricter guidelines for medication-assisted treatment.

Successes, Challenges, and Gaps: Focus group participants noted that heroin is more prevalent in urban areas with methamphetamines and prescription drugs a wider concern in rural communities. They reported few treatment options are available and waits for in-treatment beds are long, an average of three months. Addicts are selling Subutex and Suboxone on the street and Hepatitis C is increasing, particularly in Northern KY.

Tobacco use during pregnancy is known to be a concern for families across KY. KYs rate of smoking during pregnancy has decreased 9% in the past five years from 24.1% in 2009 to 21.9% in 2013, but more work must be done. Stakeholders recommended that work towards a statewide smoking ban continue.

The concern about health problems related to pregnancy and PT birth continues to be an issue. KYs rate of PT birth

has been decreasing since 2007, in part due to efforts to reduce EEDs, particularly late PT births (34-36 weeks) through our Healthy Babies are Worth the Wait (HBWW) projects. In 2013, KYs PT birth rate is estimated to be 12.6%; nearing the US rate of 11.4% suggesting that the gap between KY and the US is beginning to close. In 2013, 30.6% of KY low-risk first births were delivered by cesarean section compared to 26.8% in the US. These cesarean sections were common among non-Hispanic Black women, and women over the age of 29.

Recognizing Preterm birth as a continuing problem for KY, stakeholders recommended increasing the birthing hospitals with hard-stop policies and stressed the importance of education for vulnerable populations about the risks of prematurity. They also noted that increased access to obstetric care, and extended Medicaid eligibility following delivery for both mother and baby, were important goals that would require legislative support to achieve. Finally, enhanced provider knowledge about progesterone therapy to reduce PT deliveries was considered optimal.

Programmatic Approaches: Programmatic approaches to improve the health of women and mothers include collaborative efforts with other state agencies to increase comprehensive treatment options, promotion of preconception and interconception health, and strategies to increase access to mental health services. HANDS, HBWW, and CoIIN activities should continue as well as efforts to promote smoke-free policies.

Perinatal/Infant Health:

Overview: The top issues identified by consumers for infants included secondhand smoke exposure, improper use of car seats, and preterm birth (born too early), and drug use by parents/children living in homes where drugs are used/ infants born addicted to drugs. Over half (54%) of the comments received were about some *exposure to drugs*. **Prioritization by stakeholders resulted in the following priorities for this domain: *NAS, Preterm births,* and *Breastfeeding*.**

Strengths and Needs: Overall there has been an increase in provider education regarding NAS with special emphasis on standardizing medical treatment for infants. Additionally it was noted by stakeholders that HANDS continues to have a positive impact on preterm birth as well as our collaboration with March of Dimes and the Kentucky Hospital Engagement Network (KHEN) that is working to implement hard stop policies in birthing hospitals to reduce elective deliveries less than 39 weeks gestation. These will continue as strategies in the maternal health domain.

The Hospital CHNA overview reflected issues associated with NAS and child abuse/neglect. Needs identified by stakeholders included improvement in post-discharge care for addicted mothers and their infants, need for medical homes and providers to see these patients. Additional suggestions from the group included the immediate identification of infants diagnosed with NAS followed by the use of risk-reduction interventions to support families as they work to break the cycle of addiction. The need for legislative support, including policy development, funding and accountability, was emphasized by participants.

Successes/Challenges/Gaps: Focus group members discussed their concerns about rates of NAS in their communities and the risks for infants raised by drug-addicted parents. Exposure to secondhand smoke, while recognized by members as a significant issue, was preempted by the severe and immediate influence that drugs had on the families under their care. The number of reported cases of child abuse and neglect were increasing exponentially and, in some communities, overwhelming the safety net systems established to address them.

Breastfeeding was identified as a larger issue in the 2010 Needs Assessment than in 2015. However, our data reflects that even though we have made significant progress in breastfeeding initiation rates, there is still room for improvement and thus have chosen to continue to focus efforts on improving breastfeeding rates in KY.

Although the issue of safe sleep was not a highly ranked priority by consumers or stakeholders, our data shows an increasing number of KY infants are dying due to unsafe sleep. In 2013, 90.5% of SUIDs had at least one sleep-

related risk factor documented, and over half (54.8%) of the sleep-related deaths in 2013 had bed sharing listed as a risk factor. Due to the overwhelming presence of this potentially preventable risk factor, KY has chosen to focus on safe sleep efforts in the upcoming years.

Programmatic Approaches: The Kentucky Perinatal Quality Collaborative (KPQC) has introduced an NAS quality improvement project with the goal of collecting information from partnering hospitals in KY. From there, information on best practices for treating infants with NAS will be disseminated to hospitals and maternal-infant health care providers. Initially, the focus will be on interventions for hospitalized newborns with NAS, including both medication and non-medical treatments. MCH is developing a hospital recognition program that promotes both breastfeeding and safe sleep (http://chfs.ky.gov/dph/mch/ns/KISS.htm). Continued participation in the National CoIIN efforts on Safe Sleep will remain an area of focus for KY.

Child Health:

Overview: Kentucky's children comprise nearly one quarter of the state's population. KY ranks 35th in overall child well-being according to the 2014 Kids Count. In that data, the health measures are beginning to show improvement, but measures of economic well-being and family and community are lagging. **Priority topics for children that came out of the Needs Assessment process were child abuse and neglect, pediatric obesity, and injury prevention.** Child abuse and neglect, influenced in part by substance abuse issues of parents and caretakers, was identified as a top issue for KY children.

Strengths and Needs: LHDs still serve as safety net providers, as health care networks expand across the state more children are able to access medical homes. However, particularly in rural areas, transportation remains a major issue. Two major contextual factors, substance abuse and poverty, impact the health and well-being of children in the state. In the 2015 Needs Assessment process, these topics were all prominent concerns for the children of the state.

LHD and CCSHCN consumers selected the top problems for KY children as: exposure to secondhand smoke (55.9%); child abuse or neglect (53.2%); babies born too early (prematurity) (20.5%); inadequate use of car or booster seats for infants and children (20.2%); and overweight/obesity (19.5%). Results of the 2010 consumer survey results were similar with an emphasis on secondhand smoke exposure and child abuse or neglect. On a positive note, the consumer survey also documented that few have problems obtaining immunizations for children or WIC vouchers. The stakeholder survey identified child abuse and neglect as the top priority for children, followed by obesity and developmental screening. Obesity will be dealt with in the Adolescent Health Domain. Developmental screening fell to a lower priority in the overall ranking of needs, but is noted in the discussions of child abuse in the stakeholder small groups (see below).

Successes, Challenges, Gaps: Stakeholders identified as strengths the increased awareness of child abuse and particularly the laws requiring education on pediatric Abusive Head Trauma (AHT), laws for child safety restraints, and places to check for proper car seat installation as positives that are currently helping address the problem. They noted that particularly in rural areas, many people were not aware of resources. This was compounded by lack of knowledge and siloed approaches by service providers. Lack of knowledge of parenting and child development came up frequently, as did lack of mental health and substance abuse treatment services. Lack of support for families was identified including difficulty accessing affordable child care, lack of family friendly work policies, lack of educational opportunities for parents, and concern about stigma as a deterrent to accessing needed services. Local CFR teams were seen as successful efforts to address injury prevention in their communities, but the need for more local data for local action was a gap.

Programmatic Approaches: Stakeholders identified a number of programmatic approaches as working well, including local CFR teams, the Strengthening Families initiative, and mandatory pediatric AHT education. They noted the HANDS home visiting program positive outcomes of HANDS, including reductions in child abuse and neglect, and encouraged the continuation and expansion of this program. Focus group participants also recognized

HANDS for the positive difference it was making in the Commonwealth.

In addition, stakeholders suggested efforts that included integration/co-location of mental health and physical health providers, reducing stigma for mental health and substance abuse treatment, making coping skills part of the school curriculum, more child care assistance, more coordination between substance abuse treatment providers and child protection workers, improving transportation, involving faith based groups, and promoting community health workers. While the Title V agency does not have direct authority over many of these, Title V is working to influence and impact all of these through partnerships and interagency collaboration.

Adolescent Health

Overview: The statewide consumer survey regarded *drug or marijuana use* (60%) the top issue for the adolescent population with *teen pregnancy* second at 55.4%. Concerns for *teen smoking* (28.9%), *exposure to STDs* (17.3%) and *overweight/obesity* (16.5%) followed. Survey results were similar to 2010, with overweight/obesity replaced by injuries or deaths associated with motor vehicle accidents. **Prioritization of the leading topics by stakeholders resulted in the following ranked priorities for this domain: *substance abuse*, *overweight/obesity*, and teen pregnancy.**

Strengths and Needs: Regional survey results included concerns about drug use being higher in Eastern and Central KY (63.9% and 63.2% respectively) compared to Western KY (51.3%). Eastern KY ranked motor vehicle accidents as a concern, while the risk of STDs and teen self-harm were more serious in Western KY.

Substance abuse exposure and use in adolescents dominated discussions throughout the needs assessment process, as did poor mental health, stress associated with bullying and lack of community-level resources for teens. Stakeholders discussed youth living with families addicted to drugs and the resulting depression and isolation that permeated their lives.

The CHNA hospital scan revealed the need for drug abuse prevention (including smoking) and more mental health services. Hospitals expressed concern about depression, anxiety, overweight, obesity and diabetes among youth in their communities.

Adolescent fatalities due to drug overdose now exceed those caused by motor vehicle crashes. Increased rates of Hepatitis C when injecting heroin with dirty needles were particularly high in Northern KY. Western KY reported families as fearful to discuss their child's weight with doctors they may not address this and just tell parents the child is fine. LHDs are not equipped to see teens for substance abuse, and referral to a community mental health center or private substance abuse provider usually has a long wait time. Western KY stated immunizations may not be given in private physician offices, or for certain types such as Varicella, they send patients to the LHD. One comment was if immunizations were solely handled through LHDs everyone would get the right ones at the right time. Central KY cited the need for more public education on substance abuse.

Successes, Challenges and Gaps: Teen pregnancy, although declining in KY, varies by race and region of the state. While KY's rate per 1,000 has declined 28% since 2008, the greatest impact is reported among Black women, with a 46% decrease in teen births, a greater decline than that observed in the U.S. (30%) over the same time frame. Yet KY's rate remains one of the highest, ranking 5th among all states and the District of Columbia.

Needs or gaps identified for teen substance abuse included lack of residential treatment centers, too few school-based services and drug counselors, lack of proactive treatment, and the need to educate teachers and other school employees on early signs of drug use. Suggestions include increased positive youth development, peer support, more local treatment options, and family support.

Obesity discussions included needed parent education and support by the school system, with such barriers as the cost of healthy foods and lack of knowledge about healthy eating. A reduction of physical education and activity in schools with increased media time at home increases the problem. Improvement ideas included regular health education and student wellness programs for all grades. Parental education on healthy lifestyles is needed along with

community agency engagement, and a statewide physical education requirement policy change.

The 2014 State of Obesity Report cites KY as the worst in high school student obesity at 18% and 8th worst in obesity among 10-17 year olds at 19.7%. Based on 2013 KY Youth Risk Behavior Surveillance System (YRBSS) data, 22.5% of high school students were physically active for at least 60 minutes per day on 7 of the past 7 days compared to 27.1% in the Nation. Non-Hispanic Black students were less likely to have this much physical activity (15.3%) compared to non-Hispanic Whites (23.6%), and only 15.4% of female high school students had this level of activity compared to 29.5% of male students.

Programmatic Approaches: The Coordinated School Health Program addresses obesity and overall youth well-being by increasing the number of schools with leadership trained in the SHAPE program, increasing the number of schools with a school wellness policy and CSPAP. The 5-2-1-0 campaign is designed to give parents, healthcare professionals and child care providers a memorable way to talk about the key evidence-based behaviors that reduce childhood obesity before the teenage years.

Children and Youth with Special Health Care Needs

CCSHCN saw *improvement* in 6 of 8 measures from 2009-2014. The number of infants screened for hearing revealed a slight decline, due in part to better tracking and an increase in home births. Obesity rose slightly in 2013 and 2014 although no trend is evident over the 5-year period. CCSHCN faces challenges associated with completing the transition from a traditionally direct service role to an assurance role with regard to ensuring statewide systems of care and infrastructure-building. The gulf between the number served in CCSHCN specialty clinics (approximately 9400) and the estimated population of CYSHCN (197,000) illustrates the issue, as does the fact that KY's rate of CYSHCN is the highest in the country. CCSHCN looks to fill gaps in services–not necessarily through provision of direct care, but by ensuring integrated services exist in communities where CYSHCN live. As 2015 progresses, CCSHCN intends to leverage partnerships, TA, and community resources to emerge with a robust plan to strengthen and enhance the overall system of care for CYSHCN in KY.

When asked about needs for CYSHCN, survey respondents said that their greatest concerns are ensuring the ability of families to receive services, ability to find insurance to pay for care, and availability of developmental, social, and emotional screening services. Training and support for children with behavioral issues, and finding doctors who can provide care were the last two priorities. When this category was examined using only data from families of CYSHCN enrolled in CCSHCN clinical programs, priorities varied slightly. The need to find insurance moved off the list completely and was replaced by concerns about finding doctors to provide care as the second issue. Training and support for children with behavioral issues moved to the third priority and the need for early identification of special health care needs was added to the list. When responses were examined by region, statistically significant variations occurred. Finding doctors who can provide care was of greater concern in Western KY than in Eastern, though the latter is known for provider shortages. Finding insurance to pay for care was more of an issue in Central KY and nearly a quarter of respondents from Eastern KY said early identification of CYSHCN was a high priority need. The need for transition services was thought to be greater in Eastern KY.

The analysis of NSCH and NS-CSHCN data compared KY outcomes to Region IV and national results overall, KY fared well; 2 outcomes are targeted for improvement: *access to community-based services,* and *Transition Services*.

When condition prevalence was examined, KY had more children living with Asthma; Arthritis; ADD or ADHD; Behavioral or conduct problems; Epilepsy/seizure disorders; heart problems; and Cerebral Palsy. KY fared better than either Region IV or the nation in autism prevalence and blood problems. Small sample sizes in the datasets present issues in accurately analyzing disparities within the state; it is noted that with the exception of Hispanic, males outnumber females in CYSHCN prevalence in every race/ethnicity. KYs population is significantly more rural than CYSHCN nationally.

Focus groups discussed issues pertaining to CYSHCN and their families. Access to resources and services was the primary topic. Specialized providers are not available in many rural areas of KY. The lack of pediatric dentists and pediatric mental health providers was noted as were barriers families faced as they traveled long distances for needed specialty care. Professionals report that families often struggle to navigate existing systems. Sometimes services are available but unknown. Parents may be overwhelmed by responsibilities and the need for respite was frequently mentioned.

The stakeholder meeting devoted 2 tables to CYSHCN issues. Gaps identified by stakeholders included provider shortages, transportation and complexity of system navigation for families. Too few providers accept Medicaid in KY, so enrollment does not equate with access to care. Multiple possible solutions were discussed, including education of medical societies regarding barriers, creation of a CYSHCN resource hotline, increased use of telemedicine, etc. Provider capacity issues explored included lack of specialists, too few clinics, and reimbursement issues. Ideas included collaborations to provide loan repayment support for young physicians as well as increased use of physician extenders. To improve provider reimbursement, negotiations with MCOs for bundled payments for multidisciplinary clinics and special rates for CYSHCN were suggested. Stakeholders acknowledged that often families did not know what services were available and that many lived in resource-poor regions of the state. Solutions included blended funding, expanded outreach and centralized resources to help families navigate services.

Cross-Cutting/Life Course:

The cross-cutting/life course domain was not a separate domain in the needs assessment process. Instead, all topics were considered in each of the population domains, and following prioritization were reviewed to determine those topics that crossed multiple populations. Priority topics that were considered in this domain include: adequate insurance coverage, adverse childhood experiences, oral health, overweight and obesity, and substance use including tobacco use. **The priorities in the cross-cutting/life course domain that were identified through the needs assessment process are substance abuse and oral health.**

Substance Abuse

Overview: Substance abuse was, by far, the most significant priority identified throughout the needs assessment process. This epidemic is having a devastating effect on all MCH population domains; a leading priority in 3 domains: women/maternal, perinatal/infant, and adolescent. Child abuse and neglect, a priority issue in child health is linked to substance abuse.

Strengths and Needs: A significant strength in this area is the collaborative efforts that have occurred to identify best practices for comprehensive treatment options for women with substance use disorder especially pregnant women who have substance use disorder. These efforts are described in the State Action Plan.

The needs are many, but an initial focus must be access to quality, evidence-based treatment programs for individuals with substance use disorder. Consistent data is needed across age groups with consistent definitions among agencies and stakeholders.

Successes, Challenges and Gaps: Successes related to the area of substance abuse is legislation requiring reporting of NAS to MCH, and a 2015 comprehensive Heroin bill. Focus group participants noted that heroin is more prevalent in urban areas with methamphetamines and prescription drugs a wider concern in rural communities. They reported few treatment options are available and waits for in-treatment beds are long, an average of three months. Addicts are selling Subutex and Suboxone on the street and Hepatitis C is increasing, particularly in the Northern portion of the state. Related specifically to tobacco, KY has documented some progress with a decrease of 9% from 2009 to 2013, but more work must be done.

Programmatic Approaches: Communities are fighting back. Activists in Northern Kentucky are responding to the heroin epidemic through a collective impact initiative (Drug Free NKY, 2013). In Eastern KY, Operation UNITE works

to empower communities and to raise awareness about drug addiction to change society norms. Efforts to improve the data related to substance abuse are important to understand its complete impact and monitor progress. Additionally, comprehensive treatment options are needed across the Commonwealth for all age groups. Stakeholders also supported comprehensive smoke-free legislation to improve the health of all MCH populations.

Oral Health

Overview: Oral health problems, and a lack of oral health services, continue to challenge KY families. Oral health was not a top priority from the 2015 Needs Assessment, but due to its inclusion as one of six focus areas in kyhealthnow, it has been chosen as a priority of focus for the next five years.

Strengths and Need: A major strength in oral health is the increased emphasis that it has received from all levels of leadership. State General funds have been provided to build infrastructure including additional personnel for water fluoridation, epidemiology, and program management, and to establish a public health dental hygiene program with a state-level hygienist program manager. During the Needs Assessment and MCH focus groups, it was reported that dental preventive services (oral exams, sealants and fluoride varnishes) provided in LHDs and school satellite clinics fill an important gap. Too few dentists will accept Medicaid, and those dentists who do accept Medicaid children are near capacity in the number of patients they can accept. Reports also included dentists are not comfortable treating children with cleft lip and palate and other special needs. In Western and Central KY, group input applauded the fluoride varnish program, especially access for consumers through school clinics.

Successes, Challenges and Gaps: KY ranks 41st in annual dental visits, 45th in the percentage of children with untreated dental decay (34.6%), and 47th in the percentage of adults 65+ missing 6 or more teeth (52.1%). In 2015, state general funds were provided to establish the public health dental hygiene program. The program allows hygienists to provide preventative services, but the most important service provided to this at-risk population is the referral of these patients to a permanent 'dental home' in their own communities.

Programmatic Approaches: Support for existing public health dental hygiene programs is ongoing and efforts will focus on increasing the number of LHD dental hygiene programs, and promoting fluoride varnish by public health nurses. To address access for children in rural areas, the KOHP has a training program that offers general dentists practical training in pediatric techniques so that they will see this young patient population (under six years of age).

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

ORGANIZATIONAL STRUCTURE

Governor Steven L. Beshear remains in office until December 2016. In his Executive Branch there are 11 Cabinets, the largest of which is the Cabinet for Health and Family Services (CHFS). KDPH and CCSHCN are organizationally located within CHFS. Other agencies located within CHFS include the Department for Aging and Independent Living, the Department for Community Based Services (DCBS), Department for Family Resource Centers and Volunteer Services, Office of Health Benefit and Health Information Exchange, Office of Health Policy, Department for Income Support, Department for Medicaid Services (DMS), and Department for Behavioral Health, Developmental and Intellectual Disabilities. KDPH is the state health agency; Title V is implemented through the Division of Maternal and Child Health.

The foundational statute for Kentucky MCH is within KY Revised Statute (KRS) 211.180 which gives CHFS the responsibility and authority to formulate, promote, establish and execute policies, plans and programs relating to all matters of public health. Legislation related to MCH is contained in the Overview document of the Title V Application.

The majority of Title V funding is provided to LHDs to implement MCH Evidence Informed Strategies based upon the priority needs of the MCH population. Other programs supported with Title V funds include maternal mortality, regionalized perinatal care, access to specialty care (Genetics, Developmental Evaluations) and infrastructure for the MCH effort including IT systems, university based trainings, MCH workforce, and pediatric injury prevention technical assistance.

As per the mandates and authorizations in state statute (KRS 200.460-200.499), services provided by CCSHCN include:

1. Direct care gap-filling clinics for those children with a diagnosis on the agency's eligibility list. Clinic visits include access to nutritional services, social services and transitions preparation, care coordination through a registered nurse, and care provided by contracted specialty physicians. Therapists are included in clinics for children with conditions such as orthopedic conditions, cerebral palsy, hearing loss or other conditions that affect speech and language development. Clinics in which complex conditions are treated offer the services of multiple physicians who provide a team approach to management. Clinical services offered via telehealth are a newly added method of service delivery.

2. Audiology services, which are easily accessible and includes hearing conservation, testing, hearing aid fittings, and programming for cochlear implants. CCSHCN administers the state Early Hearing Detection & Intervention (EHDI) newborn hearing screen surveillance program.

3. Foster care support programs, which support children with special needs in the child protective service system through collaboration with the DCBS. This involves a home visitation program to meet the needs of medically fragile children placed in foster care, and a nurse consultant program which provides consultation and assistance on medical issues through nurses stationed in regional DCBS offices statewide.

4. Support for those with Autism Spectrum Disorders, which includes a statewide Office on Autism created within CCSHCN, an advisory council of community partners and service providers, and direct services provided through pilot clinics in collaboration with the UL.

5. Family to Family Health Information Centers (F2F HICs), which provide assistance to families and professionals in navigating health care systems; information, education, training, support and referral services; outreach to underserved/underrepresented populations; guidance on health programs and policy; and collaboration with other F2F HICs, family groups, and professionals in efforts to improve services for CYSHCN.

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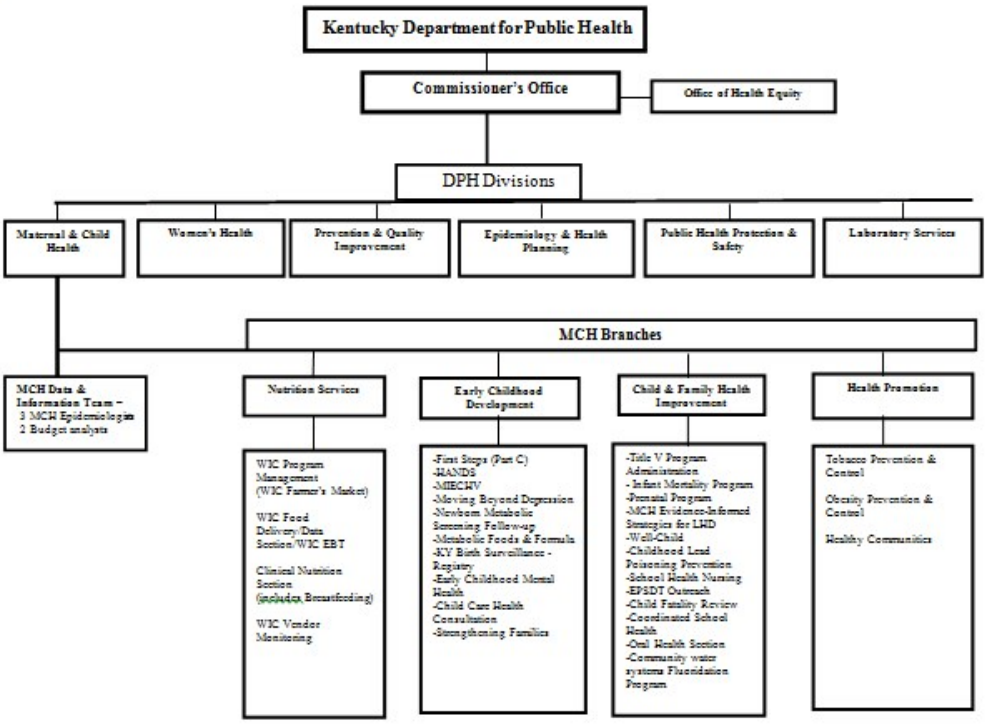
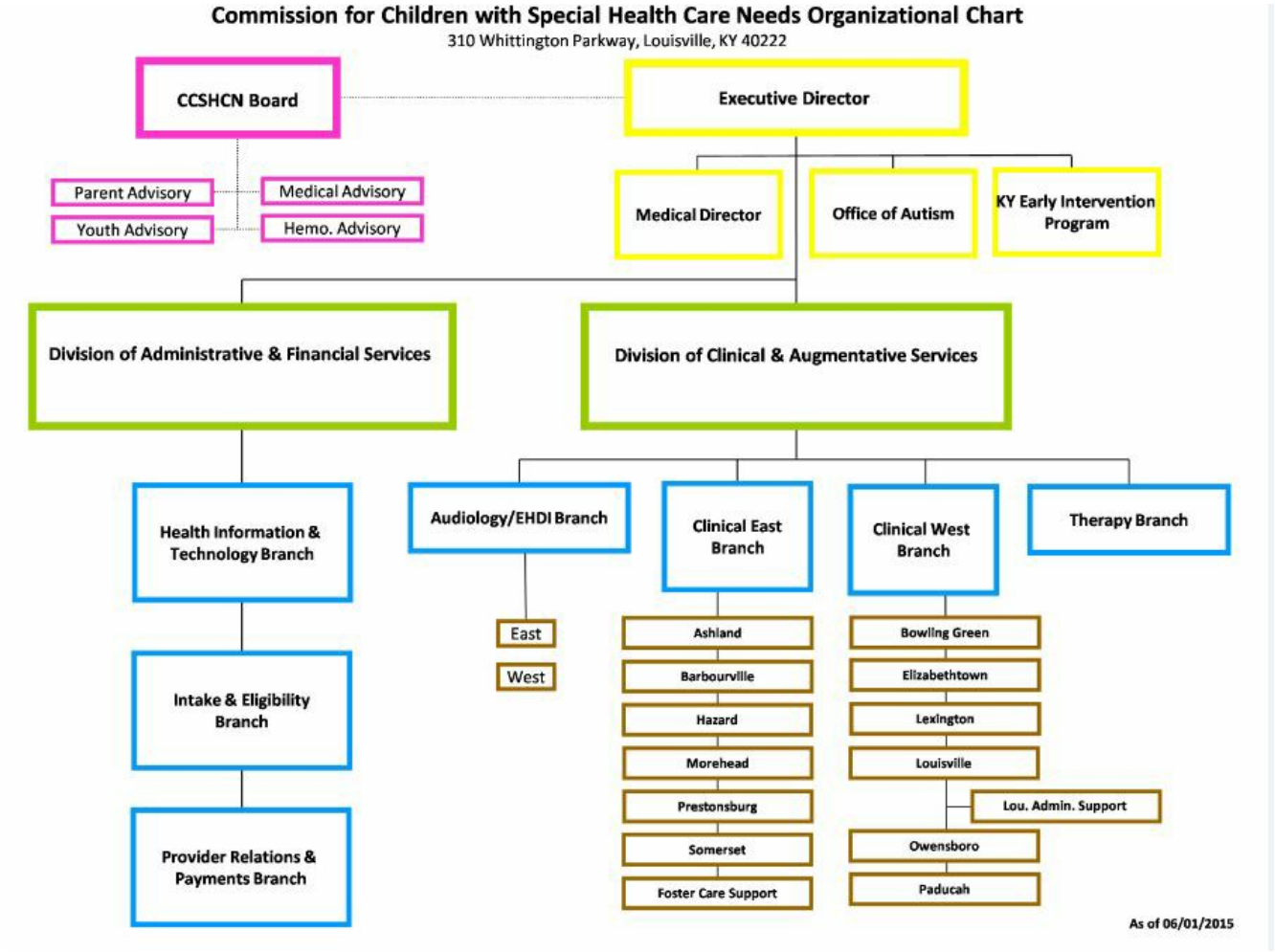

Kentucky Department for Public Health
Commissioner's Office
Office of Health Equity
DPH Divisions
Maternal & Child Health
Women's Health
Prevention & Quality Improvement
Epidemiology & Health Planning
Public Health Protection & Safety
Laboratory Services
MCH Branches
MCH Data & Information Team –
3 MCH Epidemiologists
2 Budget analysts
Nutrition Services
Early Childhood Development
Child & Family Health Improvement
Health Promotion
WIC Program Management
(WIC Farmer's Market)
WIC Food Delivery/Data Section/WIC EBT
Clinical Nutrition Section
(includes Breastfeeding)
WIC Vendor Monitoring
-First Steps (Part C)
-HANDS
-MIECHV
-Moving Beyond Depression
-Newborn Metabolic Screening Follow-up
-Metabolic Foods & Formula
-KY Birth Surveillance - Registry
-Early Childhood Mental Health
-Child Care Health Consultation
-Strengthening Families
-Title V Program Administration
- Infant Mortality Program
-Prenatal Program
-MCH Evidence-Informed Strategies for LHD
-Well-Child
-Childhood Lead Poisoning Prevention
-School Health Nursing
-EPSDT Outreach
-Child Fatality Review
-Coordinated School Health
-Oral Health Section
-Community water systems Fluoridation Program
Tobacco Prevention & Control
Obesity Prevention & Control
Healthy Communities



II.B.2.b.ii. Agency Capacity

AGENCY CAPACITY

Title V services are provided in all 120 counties to assure gap-filling services for the MCH population. Partnerships and collaboration are described later in this needs assessment summary. The basic preventive and assurance services that are provided by population health domain include:

Women's/Maternal Health: MCH assures the health of Kentucky's women and maternal population with direct services for prenatal, postpartum and interception care. The Prenatal Program provides gap-filling services and the statute intends that no pregnant woman in Kentucky should go without prenatal care. MCH collaborates with the Division of Women's Health (DWH) in KDPH on adolescent health, family planning & teen pregnancy prevention, and preconception/interconception care efforts.

Perinatal/Infant's Health: Perinatal and infant health in Kentucky relies upon preventative services, the promotion of nutrition and breastfeeding, and healthy beginnings for infants and young children. The newborn screening program assures that all infants born in Kentucky are screened for conditions recommended by the ACMG. The HANDS home visiting program promotes healthy birth outcomes and safe environments for KYs most vulnerable population.

Child Health: Child health programs utilize a holistic approach to promote child well-being including physical, mental, emotional, and oral health in children. Preventative services include well child exams, nutrition counseling, injury

prevention, and services provided in the school setting.

Adolescent Health: Adolescents receive gap-filling services including immunizations, physical exams, family planning, and STD screening. MCH partners with the Division of Women's Health on teen pregnancy prevention.

CYSHCN: CCSHCN has made continuous attempts to expand beyond the clinically eligible population and reach more of the estimated 197,000 CYSHCN through non-direct services. While there will always be a need for the provision of gap-filling direct services, in recent years, deliberate attention has been placed on assuming a place in a well-constructed service system. These attempts are institutionalized in the agency's strategic plan and draft standards of practice documents. CCSHCN programs are administered on a regional basis by staff located in twelve (12) offices throughout the state. Regional clinics operate with available area providers who contract with CCSHCN, and outreach and programs are based on the particular community's needs. While the formal needs assessment, program planning, and evaluation processes are functions of the central administration, CCSHCN relies on each regional office to identify solutions to localized issues and to participate in human service councils or other partnerships to advance those beyond the scope of one agency.

CCSHCN program collaborations with other agencies include formal memoranda of understanding with the KDPH for audiology referral services (as well as interpreter services) for the First Steps early intervention system, and the DCBS for foster care support and audiology services. The public health agencies collaborate through a variety of other initiatives as well, such as participation in healthy weight initiatives with the Partnership for a Fit KY and distribution of folic acid multivitamins as a preventative measure to the specific population of families of CYSHCN. Given the structure of CHFS and weekly leadership meetings, many partnerships may start at the management level (e.g. services for children with ASD, a collaboration with the state's behavioral health system), while others develop at a community level as pilot initiatives (e.g. foster care support services), originating to address an identified need in one community and expand statewide. As public programs are only one part of the array of KYs services, CCSHCN collaborates with private organizations as well, such as recently entering into an agreement with Health First Bluegrass, a FQHC, to assure medical home services for underserved populations in the Lexington area. Through a public-private partnership, CCSHCN therapy staff is housed at, and have access to the state-of-the-art equipment of the Home of the Innocents, a private facility specializing in the care of children with medically complex needs. CCSHCN's board and advisory councils include representatives from various private entities, and staff participates in committees and boards locally, regionally, and at the statewide level.

Cross-cutting/ Life Course : All MCH population domains are included in this domain. Strategies are developed to target individual population domains, but cross-cutting allows an opportunity to coordinate these strategies across the life span. This domain requires significant collaborative efforts with other agencies in order to develop a comprehensive approach for dealing with significant issues. Further details are provided in the State Action Plan.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH WORKFORCE DEVELOPMENT AND CAPACITY

MCH employs 80 public health practitioners focused on improving the physical, socio-emotional health, safety and well-being of all KY women, infants, children, adolescents and their families. MCH provides funds to the LHDs to implement Evidence Informed Strategies in alignment with MCH priorities to assure an identified person as MCH Coordinator at each local health department.

DPH/MCH Staff

Dr. Connie White, Deputy Commissioner for Clinical Affairs, is board certified in OB/GYN with emphasis on patient education and preventive medical care.

Joy Hoskins, RN, BSN is Director of Women's Health, serving DPH in MCH and WH, and the Director of Nursing for DPH.

Vivian Lasley-Bibbs, MPH directs the Office of Health Equity (OHE), and is a Health Disparities Epidemiologist and Healthy People 2020 State Coordinator, affiliated with national, state, civic and community based organizations.

Dr. Ruth Ann Shepherd directs MCH, and is Board Certified in Pediatrics and Neonatal-Perinatal Medicine, and has certificates in Business Administration, Non-Profit Management, and Healthcare Quality. She served on HHS Secretary's Advisory Committee on Infant Mortality and was a team co-lead in the initial HRSA COIIN.

Marvin Miller, MSW, Assistant Director for MCH was instrumental developing WIC, HANDS and many Well Child Programs. He is legislative liaison for MCH, and oversees the LHD plan and budget process.

Shelley Adams, MSN, RN manages Child and Family Health Improvement, Prenatal, Pediatric, and Oral Health Programs, and administers the Title V MCH Block Grant.

Frances Hawkins, RDLD manages Nutrition Services, WIC, MCH Nutrition Program, including state-wide WIC EBT, Breastfeeding Peer Counselor Program, and WIC Farmers' Market.

Paula Goff, MS manages Early Childhood Development, HANDS, First Steps and Newborn Screening. She was the Part C Coordinator in KY and Missouri, and serves on the Governor's Early Childhood Advisory Council.

Andrew Waters manages Health Promotions. He is an epidemiologist with experience in local health, tobacco prevention/control, and environmental health.

Julie McKee, DMD, State Dental Director, was previously the Director of WEDCO District HD and is instrumental in expanding KY Oral Health Program.

Joyce Robl, EdD, MS, CGC, MCH Data and Evaluation Officer, is a board certified genetic counselor that coordinates epidemiology, surveillance, and evaluation within MCH.

Tracey Jewell, MPH is the lead MCH epidemiologist for the MCH, with 17 years' experience in DPH and Title V.

Monica Clouse, MPH is a division level epidemiologist for the MCH, overseeing child fatality data and KBSR.

CCSHCN

With 155 employees in offices throughout the state, CCSHCN strengths include organizational structure, collaborative history, financial management, and affiliation with hospitals. Needs include limited supply of providers, wait time for appointments, and missing skill sets such as marketing and epidemiology/data.

CCSHCN Staff

Executive Director: Prior to appointment, Jackie Richardson served 18 years with the Louisville Metro Government in various roles, including Chief of Staff for Public Health and Wellness.

Medical Director: Judith Theriot served as director of a Pediatrics Clinical Research Unit and a multidisciplinary primary care clinic serving inner-city high risk children prior to appointment. Dr. Theriot is a certified physician executive and a professor of Pediatrics at UL.

Director, Administrative and Financial: Janaki Kannan has 12 years of government experience in various roles . She is a degreed Certified Public Accountant with a Fellowship of Cost and Executive Accountant.

Director, Clinical and Augmentative: Karen Rundall has over 22 years of experience as a nurse providing pediatric care for children with special needs, including 9 years at CCSHCN.

Director, Office of Autism: Amy Cooper-Puckett has 17 years of professional social work experience, 12 years with CHFS. Experience includes child protection, clinical therapy services, and program management.

Title V MCH Coordinator - Mike Weinrauch has 19 years of experience with CHFS, including 9 with CCSHCN. Other areas of focus include technical assistance with foster care support programs, and general policy guidance/analysis.

Family members on staff

The Parent Advisory Council (PAC) and Youth Advisory Council (YAC) each meet quarterly to provide input on how to better serve KY families. In addition to 96 trained family support parents, 16 PAC members, 9 YAC members, the agency's Executive Director, and participants on boards, the following family members of CYSHCN serve on staff:

Co-Director, F2F: Debbie Gilbert served on the Council on Developmental Disabilities for 6 years, having worked with many disability groups. She is currently State Coordinator for Family Voices, and state affiliate of Parent to Parent of KY.

Co-Director, F2F: Sondra Gilbert has 12 years experience writing Individual Education Plans for CYSHCN. Sondra has been a volunteer in the Owensboro school district, is appointed to the Council on Developmental Disabilities, and serves on the Regional Genetic Collaborative.

CULTURAL COMPETENCE

MCH partners with The Office of Health Equity (OHE) to promote activities to raise awareness on health inequities. This includes using the Bridges Out of Poverty and Bridges into Health curriculums as tools to enhance understanding of how our personal biases influence our health decision making. The OHE provides face-to-face training on all aspects of cultural competence for communities and programs. There are currently two modules on

TRAIN available when face-to-face is not available. The OHE prepares the biennial Minority Health Status Report to inform key decision makers about health disparities and inequities that affects Kentuckians. In addition, OHE collaborates with the Kentucky Behavioral Risk Factor Surveillance System (KyBRFSS) to ensure oversampling of the largest minority populations within the state as an additional data source to provide more focused programming efforts to address health disparities.
The OHE is instrumental in the use of the Community Health Improvement Plan to determine prevailing health and security needs of the community and representing the underserved and marginalized, such as the homeless, Lesbian, Gay, Bisexual, Transgender (LGBT), elderly, and Veteran populations.

OHE works with the faith based community and existing social networks along with spiritual leaders, to address disparities in churches, within the African-American community using faith based models. They also work with the Kentucky Functional Assessment Needs teams to collaborate with other community partners in addressing cultural and social norms specific to minorities and the underserved in the event of natural or man-made disasters.

OHE applies for grants to assist in adequately meeting the needs of culturally diverse groups. OHE conducts community based participatory research as one method used in capturing data from diverse populations to better understand barriers to care such as; access, service delivery and other social determinants of health. This data is used to enhance program development in addressing health inequities and social justice issues.

Academic partners collaborate with OHE to provide content area expertise to ensure holistic training and professional development of students in the health sciences. The areas covered include; cultural competency, health literacy and social determinants of health, and other social injustices related to health inequities.

The office provides a pipeline for racially diverse students and recent graduates who are interested in health disparity work by providing the opportunity to explore research interests and exposure to public health via interdisciplinary collaborations.

OHE is currently outlining guidance for health in an all-policies approach in addressing health inequities to be incorporated in the department strategic plan and infused throughout all state public health programs.

II.B.2.c. Partnerships, Collaboration, and Coordination

PARTNERSHIPS, COLLABORATION, AND COORDINATION

Partnerships with state agencies and community partners extend the reach and influence of MCH on behalf of mothers, infants, children and adolescents. Along with KDPH, MCH programs strive to work collaboratively with other federal partners and private organizations to help meet aligned agency goals and to address the priority needs of the MCH populations. In addition, the CCSHCN plays a critical role in coordinating partnerships to assure that the needs of this population group are met. The vision of the CCSHCNs is “To be the visible leader in supporting the highest quality of life for KYs children with special health care needs and their families through collaboration and creation of a more accessible community based system of support.” In accomplishing this vision, partnerships, collaboration, and coordination are essential values. The agency’s strategic plan includes specific sections on collaboration, as well as marketing and outreach (partially in the service of further collaboration). In addition to involvement on a care coordination level, several CCSHCN staff actively serve on boards and councils that further

the agency's mission. As a state agency with a 90 year history of service provision, CCSHCN has developed formal and working relationships with a variety of programs providing services to children. CCSHCN's contracted network of direct providers for clients numbers in the hundreds. CCSHCN strives to remain connected and relevant by remaining involved with outside organizations that are resources to families of CSHCN.

A more extensive discussion of partnerships and collaborations, including other MCHB, HRSA, and federal investments, as well as other government agencies, public and private partners, is found in the "Other Programmatic Activities" in the State Action Plan.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Maternal Morbidity	Continued	
2	Infant Mortality	Continued	
3	Child Abuse and Neglect	Continued	
4	Overweight and Obesity Among Teens	New	
5	Oral Health	Continued	
6	Substance Abuse	Continued	
7	Transitions Services for CSHCN	Continued	
8	Access to Care and Services for CSHCN	New	
9	Adequate Insurance for CSHCN	New	
10	Data Capacity for CSHCN	New	

Process for Development of State Priority Needs

Kentucky's state priority needs were determined through the 2015 needs assessment process that included multiple methods as describe in the Needs Assessment Summary. MCH and CCSHCN worked together throughout these activities.

With information developed from the consumer survey of over 3,000 consumers in LHD and CCSHCN sites, a prioritization survey was conducted with stakeholders. The criteria that were used for the prioritization included the seriousness of the issue; economic and social impact; ability to prevent, improve, or impact the issue; and their choice of a single most important issue. These results were then summarized and topics were rank ordered; these were further discussed in the stakeholder meeting. In this face-to-face meeting, the priority topics were reviewed and priorities ranked through small group work and multi-voting.

Through these processes, potential priorities were identified for the five MCH population domains. To determine the priorities for the cross-cutting domains, the rank priority of those topics in each of the five domains was considered. Through these multiple methods of collecting data from consumers, there were some clear priorities that stood out.

There were four additional considerations in determining the final priorities. First, priorities were compared to the agency priorities included in kyhealthnow, the Governor's health initiative. It was felt that if the political will was

already in place around a topic then additional consideration should be given to including that topic as a priority. The second consideration was whether or not MCH was the leader in a particular topic. A third consideration was alignment with the new Title V grant structure, aligning the needs to the population domains. The final step was to consider the programmatic activities that are currently underway that with focused attention over the next five years would have the greatest impact on the MCH population.

The priorities that were identified through this process by domain are:

Women/Maternal Health: Maternal Morbidity
Perinatal/Infant Health: Infant Mortality
Child Health: Child Abuse and Neglect
Adolescent Health: Overweight and Obesity
CYSHCN: Access to Care and Services; Transition Services; Adequate Insurance; Data Capacity
Cross-Cutting/Life-Course: Substance Abuse; Oral Health

The following narrative outlines by domain the priority topics that were considered and why they were not included as a priority topic. There will also be a discussion about whether priority topics are continued, replaced, or new.

Domain: Women/Maternal Health.
Priority Need (continued): Maternal Morbidity.

KY has chosen maternal morbidity as the priority need in the domain of Women/Maternal Health. Priority topics that were considered in this domain include: overweight and obesity, drug or marijuana use, mental health issues, tobacco use among women, secondhand smoke exposures for women, pregnancy and health problems related to pregnancy, and STDs. Based on consumer survey data and prioritization by stakeholders, the top three topic priorities were substance abuse (tobacco and drugs), overweight and obesity, and pregnancy/health problems related to pregnancy. Substance abuse has been chosen as a priority topic in the Cross-Cutting Domain as it was a leading priority for all MCH populations. The broad priority topic of maternal morbidity combines the two remaining priorities. The priorities identified in 2015 are very similar to those found in 2010 when the priority topics for women/maternal health included smoking in pregnancy, substance abuse in pregnant women, obesity in pregnant women, preconception care, and perinatal depression. In the previous grant cycle, pre-pregnancy body mass index (BMI) among first time births and late preterm births were state performance measures. For the coming cycle, these will be modified and EED and first time low risk C-section will become the measures. We consider the priority of maternal morbidity to cover all these issues. Substance abuse will be addressed as cross-cutting.

Domain: Perinatal/Infant Health
Priority Need (continued): Infant Mortality.
Data obtained through the Needs Assessment process revealed that infant health and safety continue to be a concern and an issue for our state. Infant mortality was identified in 2010 and will continue to be a priority need for KY. Efforts to address this need then consisted of developing a state performance measure on preterm birth that focused on reducing late preterm births, the target of our Healthy Babies are Worth the Wait (HBWW) project with March of Dimes that seeded the national discussion of EED. Progress on infant mortality was also monitored through various national performance measures, including racial disparities in infant mortality, and increasing the percent of very low birth weight infants born at facilities with appropriate levels of care.

In the 2015 needs assessment, prematurity came up as the # 3 priority for infants in the consumer survey and the # 2 priority in the infant domain of the stakeholder survey. Other needs that were identified for this domain included NAS (consumers and stakeholders), not putting infants in car seats (consumer survey) and breastfeeding (stakeholder survey). Preterm birth is addressed in the Women's and Maternal Health Domain with the focus on EED and C-sections there. Substance abuse has been identified as a priority need for the cross-cutting domain and NAS will be

addressed there. Infant safety (car seats) will be addressed as injury prevention in the child health domain. The other main concerns around infant mortality for our state come predominately from our data more than from our consumers and stakeholders. Data on both unsafe sleep and breastfeeding show major opportunities for impact. When using the broader category of SUID instead of SIDS, our analysis shows that 90% of these deaths had at least one sleep-related risk factor in 2013. Our priority focus for the perinatal/infant health domain will therefore include the national performance measures on Safe Sleep and Breastfeeding.

Domain: Children's Health
Priority Need (continued): Child abuse and neglect.

After substance abuse, child abuse was the next most significant issue identified for children. This showed up not only in the consumer survey, where over half identified child abuse and neglect as the major health issue for infants, but also in the stakeholder survey, and the stakeholder meeting small group work, where it was the highest rated issue for children. This shows a definite shift from the needs we collected in 2010. At that time, the consumers were the only group that even mentioned child abuse and neglect as an issue, and it did not come up with stakeholders or at community forums. The consumer survey continues to be the most valuable data collection tool in our extensive needs assessment process. The consumers also identified not using car seats/booster seats as a health issue for children, which will be covered in our choice of the new national performance measure on injury prevention for this domain. The other prominent topic for children from our consumers and stakeholders was pediatric obesity, which will be dealt with in the measures for the Adolescent Health Domain.

Domain: Adolescent Health
Priority Need (New): Obesity.

Adolescent obesity was selected as the priority need in this domain. According to consumer survey responses, community/professional focus groups and prioritization by stakeholders, overweight and obesity was a concern for both children and adolescent populations. Other leading topics of concern for adolescent health, in order of importance were drug or marijuana use, teen pregnancy, smoking, and exposure to STDs.

During the 2010 needs assessment, substance abuse and smoking were leading concerns for the adolescent population, but teen pregnancy was the real "hot topic" for nearly all the community needs assessment forums. Obesity was a high priority for children. In the 2015 needs assessment, however, obesity came up as a priority in the adolescent population for both consumers and stakeholders, so the importance in this population has been elevated. The 2015 needs that ranked higher for adolescents were substance abuse and smoking, and those will be addressed in the cross-cutting domain for the coming cycle. The interest in teen pregnancy has declined, although it still came up both in the consumer survey and with stakeholders as a much lower priority. Indeed, KY is seeing its lowest rates ever for teen pregnancy, even though we remain higher than the national average. Teen pregnancy initiatives are covered by the Division of Women's Health and continue to be important public health prevention activities.

Title V for the coming cycle will focus on obesity for the adolescent health domain. While continuing to address obesity through breastfeeding and early childhood work (birth to 5), much of the interest and activities around obesity prevention are now focused on schools promoting physical activity, as well as access to healthy foods.

Domain: CYSHCN
In selecting priority needs, CCSHCNs leadership team attempted to include as many expressed priorities as possible, taking into special consideration alignment with MCHs six core outcomes for an integrated system of care for CYSHCN. In addition to perceived and documented needs identified by stakeholders and observed trends in both national and state-generated data, the number affected by an issue, the issue's impact on families, and the extent of agency capacity for systems improvement were considered in selection.

Priority Need (New): Access to Care/Services.
Three (3) interrelated priorities were merged to form a selected priority of **easy access to care and services** – defined in this context as including

(1) Access to medical and specialty care,
(2) Assuring the availability of provider networks to reach CYSHCN; and
(3) Developing and promoting an easy to access system of supports and resources for CYSHCN and their families. This priority is inclusive of elements from CYSHCN outcome #5 for an integrated system of care – and was targeted for improvement in a study of NS-CSHCN results.

Priority Need (continued): Transition
The improvement of transitions services was the other core outcome (#6), which, despite being a priority in the most recent needs assessment cycle, showed a lack of statistical progress as measured in the NS-CSHCN and in fact regressed below both the regional and national averages. Due to the large number of CYSHCN affected (all), the effect on families (major), and the ability for the agency to undertake efforts to improve, transitions was selected as a focus.

Priority Need (new): Adequate Insurance
CCSHCN is poised to address the issue of adequate insurance to pay for needed services as a third priority, given consistent family and consumer survey results throughout all areas of the state.

Priority Need (new): Data Capacity
The final CYSHCN priority is the improvement of data capacity which was chosen as a result of the process itself. Despite an interest, the CYSHCN agency has not historically had the technical expertise necessary to analyze and incorporate non-clinical data. Of particular interest is bridging the gap between internal data regarding direct service enrollees and national data regarding all federally-defined and self-reported CYSHCN in KY, as well as studying available data regarding provider network adequacy in geographic areas of the state.

Domain: Cross-Cutting/Life Course
After the priority issues were identified, a review of common themes was completed to determine the factors that would be considered for the cross-cutting domain. Priority topics that were considered in this domain include: substance use, and tobacco use, oral health, adequate insurance coverage, overweight and obesity, and ACEs. Overweight/Obesity will be covered in the Adolescent Health Domain. The ACEs will be addressed in the Child Health Domain, as they are related to injury prevention/violence prevention. The priorities identified in 2015 are very similar to 2010 when the cross-cutting priorities were substance abuse, obesity, secondhand smoke, health insurance coverage, and oral health.

Priority Need (Continued): Substance Abuse
By far, in 2015 the leading issue reported for women, infants, and adolescents was related to substance use. For KY, tobacco use will be included as substance abuse; although it is legal, it is an addictive substance. While substance abuse was clearly identified in 2010 as a priority for women and teens, the needs assessment results in 2015 demonstrate that it has risen to the top concern for all MCH populations, including NAS now as a major concern for infants. Substance abuse is a continued priority; teen illicit drug use was a state performance measure in the last five year cycle.

Priority Need (continued): Oral Health

KY has long acknowledged the poor oral health of its citizens. According to kyhealthnow data, KY ranks 41st in

annual dental visits, 45th in the percentage of children with untreated dental decay (34.6%), and 47th in the percentage of adults 65+ missing 6 or more teeth (52.1%). The Governor has made Oral Health one of his priorities; the KY MCH program houses the State Dental Director and oversees oral health programming. While oral health did not come up as a priority in the consumer or stakeholder surveys in the 2015 needs assessment, it did come up in qualitative measures. Focus groups identified difficulties in finding dentists in their area, long wait times for appointments and visits once in the office, the distance, and cost of travel to the nearest dentist, as major concerns. The state agency priorities, as described in kyhealthnow strategies and measures, specifically target oral health for children: increasing pediatric dental visits by 25% by the end of 2015, and reducing the percentage of children with untreated dental decay by 25% by the end of 2019. In addition, the SOAR Health Committee identified children's oral health as one of its top priorities. This included avenues to reach out to children not currently receiving preventive dental care, partnering with school administrators toward innovative service models for screening and preventive dental care. Solutions were sought to encourage new dental graduates as future providers to stay in local areas identified with need (http://www.soar-ky.org/pdf/SOAR-Rupri-FullReport-092314.pdf). Therefore, KY has chosen oral health as a cross-cutting priority for Title V for the coming 5 year cycle. During the previous grant cycle needs assessment, oral health was cited as one of the top 5 cross-cutting priorities and one of the top 3 in children's health.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 2-Percent of cesarean deliveries among low-risk first births

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.2	30.2	30.0	30.0	29.5

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.0	62.0	63.5	63.5	64.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.5	14.5	15.0	15.0	15.2

NPM 5-Percent of infants placed to sleep on their backs

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.0	72.0	73.0	73.0	73.5

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	100.0	100.0	100.0	98.5	98.5

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	38.5	38.5	38.5

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	40.0	40.0	40.0	40.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.0	30.0	32.0	32.0	32.5

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	76.0	76.0	76.5	76.5	77.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	21.0	21.0	20.0	20.0	19.5

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	38.5	38.5	38.0

D. Linkage of State Selected Priorities with National Performance and Outcome Measures

Described below by population domain are the National Performance Measures (NPM) chosen by KY for the focus of our work in 2016-2020.

Women/Maternal Health Domain:

NPM #2: Percent of cesarean deliveries among low-risk first births to address maternal morbidity. In the prior cycle, KY has monitored these issues through our State Performance Measures (SPMs) on Late PT Birth (addressing EED) and pre-pregnancy BMI (increased risk of C-section with obesity). The new national performance measure is a natural fit for continuing our work in these areas. The two national outcome measures, rate of severe maternal morbidity per 10,000 delivery hospitalizations and maternal mortality rate per 100,000 live births are directly related to the priority issue of maternal morbidity. The strategies that will be developed for this measure should result in improvements in overall maternal health. In addition, from work on HBWW and work with the Region IV and VI CoIIN, KY has documented some improvement in EEDs, but the decline has not been as much as seen in other states. It was therefore felt that the opportunity to have a substantial impact on these measures was possible. An additional consideration is that focusing on this measure will have a positive impact on infant health.

Perinatal/Infant Health Domain:

NPM #4: Percent of infants who are ever breastfed and the percent of infants breastfed exclusively through six months; and
NPM #5: Percent of infants who were placed to sleep on their backs.

These NPM's were selected for the Perinatal/Infant Health Domain to address the priority need infant mortality. These two performance measures tie in closely with work that is currently underway within the state to reach the overall goal of reducing infant mortality and can have a direct impact on improving IMRs. The three national outcome measures, IMR per 1,000 live births, the post neonatal mortality rate per 1,000 live births, and the sleep-related SUID rate per 100,000 live births are all directly related to the priority issue of infant mortality. MCH now has better access to data for analyzing our sleep-related deaths to inform our work, including medical examiner reports. The work in progress includes developing a safe sleep campaign to increase the percent of infants placed to sleep on their backs, in which we hope to ultimately reduce infant mortality caused by unsafe sleep practices; and, gain community participation in the improvement of healthy outcomes for infants.

Breastfeeding is also a measure where KY has significant room for improvement, is related to reducing the risks of SUID, and also is a primary prevention strategy for obesity prevention. It is therefore believed that by focusing on these measures, KY will have the ability to positively impact the priority need of infant mortality. Work will continue on promoting Baby Friendly status of Kentucky hospitals.

Children's Health Domain

NPM #7: Rate of injury-related hospital admissions per population ages 0 through 19 years.
KY has chosen this measure because our top priority for this population is child abuse and neglect, which frequently presents through hospitalization for fatal or non-fatal injuries. In the previous cycle of the block grant, we developed a state performance measure specifically around child abuse deaths. Based on the recent work of our MCH Epidemiologists, we will continue to refine this and anticipate having a similar state performance measure on child abuse and neglect for this grant 5-year cycle. In selecting NPM #7, we will also continue to work on other injury prevention. Health Status Indicators from the previous grant cycle related to injury all were showing positive trends, especially related to motor vehicle accidents (MVA). Our consumer survey identified correct use of child safety restraints (infant car seats and booster seats) as one of the leading health issues for infants/children. The associated National Outcome measures for the NPM are about child mortality, teen deaths from MVA, and teen suicide, so we will continue to work on activities with a broader focus on injury prevention rather than just child abuse prevention. All of these areas are important to reduce child deaths.

Adolescent Health Population Domain

NPM #8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day. For the priority need in this domain of obesity, this measure will be used to reflect progress, particularly from our school-based initiatives. The National Outcome Measures related to this performance measure are percent of children in excellent or very good health and percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile). These outcome measures connect directly to the performance measure since both child and adolescent overweight and obesity and will be addressed through the strategies that promote policy and education on nutrition and physical activity in home, schools, and communities. Several of our advocate groups are already recognizing the CDC's new model of "Whole Child, Whole School, Whole Community". KY has been challenged by this issue for a long time. Ongoing work supported by the CDC, particularly promoting increasing physical activity in schools, is co-lead by MCH and will continue to be enhanced by making this a Title V priority. With more and more information linking physical activity to improved academic achievement, as well as the kyhealthnow priority for reducing obesity, momentum is building from the many strategies already being implemented around the state.

CYSHCN Domain:

NPM #12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
This is a continued initiative, as during the 2010 needs assessment cycle, KY has implemented multiple initiatives toward both a NPM and a SPM regarding improving transitions services.

As transitions impacts all CYSHCN, has a major impact on family, and CCSHCN sees in the agency the capacity for systems of care improvement, KY has chosen NPM #12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

Planning for the future, making positive health choices, managing health and healthcare, and understanding changes

are key tasks during the critical period of transition to adulthood. Provision of education and development of individualized transition plans in partnership with youth and families are ways that CCSHCN can provide support to CYSHCN as they assume more responsibility. Over the next few months, CCSHCN will be working to identify ESMs and performance objectives to address this measure.

National Outcome Measures associated with this NPM include:

- Percent of CYSHCN receiving care in a well-functioning system; and
- Percent of children in excellent or very good health.

Cross-Cutting Domain:

Substance Abuse

NPM #14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes to address substance use. The primary linkage to this performance measure is that the majority of women who have substance use disorder also use tobacco. Additionally, KY has almost double the national average for women who smoke during their pregnancy. Reductions in tobacco use could result in significant improvements in maternal, infant, child and adolescent health domains. The national outcome measures for this performance measure document the potential range of improvements from progress on this issue. There is overlap between several national outcome measures for this performance measure with other priorities in KY such as reductions in preterm births, early preterm births, late preterm births, perinatal mortality, infant mortality, neonatal mortality, post-neonatal mortality, preterm-related mortality, and sleep-related SUID. Additionally, the chosen NPM will also have an impact on the national outcome measure #11, the rate of infants born with NAS. It is likely that Kentucky will develop an additional state performance measure related to substance abuse and/or neonatal abstinence.

Oral Health:

NPM # 13: Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year. During KY's needs assessment, there was little discussion of oral health as a priority, but clearly the data shows that this is one of KYs worst health indicators. There are also links to improved learning in schools when dental needs are addressed. Since this is a Governor's priority area, Kentucky is already implementing strategies to address oral health with the expansion of the public health dental hygienist role in providing preventative services and referrals to dentists. The national outcome measures for this performance measure that will be impacted are: percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months and percent of children in excellent or very good health. These outcome measures indicate treatment for decayed teeth as a measure of the overall health state of an individual. Administrative claims data and improved oral health surveillance will show types and numbers of dental visits accessed by children. Children who have access to dental care should also have access to medical care, an indication of excellent or very good child health status. The related goal for the Governor's kyhealthnow initiative is: Reduce the percentage of children with untreated dental decay by 25%.

- Increase pediatric dental visits by 25% by the end of 2015

- Create public-private partnerships to increase to 75% the proportion of students in grades 1-5 receiving twice yearly dental fluoride varnish application.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

E. Linkage of State Selected Priorities with State Performance and Outcome Measures

At this time, KY has not determined the new SPMs. In the Women/Maternal Health Domain, substance abuse was the leading priority issue. It was also a leading priority topic for Perinatal/Infant Health and Adolescent Health Domains. It is likely that a state performance measure will be developed focused on this topic. While tobacco use has been selected as a national performance measure in the Cross-Cutting Domain, there is a great need to develop interventions for women using prescription and/or recreational drugs and the resulting effects on their infants. There is a national outcome measure on NAS, but we will want a more specific measure of progress.

A separate, related objective that is being considered is one related to deaths due to child abuse/neglect. Both NAS and child abuse/neglect were rated as a high priority from both consumers and stakeholders. Since there is not a NPM to specifically address either topic, both will be considerations for a SPM or state outcome measures. For children, we have also discussed using Developmental Screening as a SPM, since much of our early childhood work is towards building that capacity, and it is one of the protective factors that may build resilency and help reduce adverse childhood experiences.

CCSHCN will be considering state performance and outcome measures that relate to priority needs of Access to Care, Insurance Coverage, and Data Capacity. Agency leadership is involved in a number of learning collaboratives that will help move towards measures for these priority needs.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Maternal Morbidity	1. Decrease by 10% the proportion of non-medically indicated singleton early term births by September 30, 2020.	1.1 Increase the number of health departments implementing the MCH Evidence Informed Strategy: Healthy Babies are Worth the Wait 1.2 Increase the number of hospitals receiving the March of Dimes-KHA Banner for Early Elective Delivery Rates Below 3% 1.3 Increase the number of birthing hospitals with a hard stop policy 1.4 Increase provider educational opportunities related to cesarean sections and early elective deliveries 1.5 Implement recommendations from the Perinatal	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births	Percent of cesarean deliveries among low-risk first births		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		Advisory Committee 1.6 Targeted outreach to offer technical assistance to birthing hospitals with high cesarean section and early elective delivery rates 1.7 Expand the current team on the preterm CoIIN to include additional partners 1.8 Conduct quality improvement activities through the CoIIN to identify new strategies and activities to reduce early elective deliveries and preterm births				
Maternal Morbidity	2. Increase by 20 the number of community partners that utilize evidence-	2.1 Utilize MCH partners to distribute evidence-based materials	Rate of severe maternal morbidity per 10,000 delivery hospitalizations	Percent of cesarean deliveries among low-risk first births		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	based materials to educate the general public by September 30, 2020.	2.2 Promote text4baby to promote awareness through text messaging 2.3 Utilize media opportunities to educate about cesarean sections and early elective deliveries	Maternal mortality rate per 100,000 live births			
Maternal Morbidity	3. Increase the availability of Kentucky-specific data on cesarean sections and early elective deliveries by completing a minimum of three reports and/or presentations on this topic by September 30, 2016 with at least one additional report in each subsequent year to September 30, 2020.	3.1 Implement a quality improvement project to improve the accuracy of data on the birth certificate 3.2 Develop and distribute hospital-specific MCH reports that include data on cesarean sections and early elective deliveries 3.3 Establish a business case or return on investment document for Kentucky on early elective deliveries and preterm births	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births	Percent of cesarean deliveries among low-risk first births		

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

Women's Health Domain
Plan for the Coming Year

In the upcoming year, KY plans to focus activities on NPM #2: Percent of cesarean deliveries among low-risk first births. Based on federal-provided data, 30.6% of low-risk first time KY births were delivered by cesarean section in 2013. A great deal of improvement is needed to attain the Healthy People 2020 goal of 23.9% (U.S. Department of Health and Human Services, 2010). In order to address this measure, KY plans to implement strategies targeted to three objectives including: 1) Decrease by 10% the proportion of non-medically indicated singleton early term births by September 30, 2020; 2) Increase by 20 the number of community partners that utilize evidence-based materials to educate the general public by September 30, 2020; and 3) Increase the availability of KY-specific data on cesarean sections and EEDs by completing a minimum of three reports and/or presentations on this topic by September 30, 2016 with at least one additional report in each subsequent year to September 30, 2020.

In order to accomplish the first objective related to EEDs, KY plans to implement strategies through work with the LHDs, hospitals, and CoIIN activities. MCH funds options for two MCH Evidence Informed Strategies that can be used by LHDs to reduce cesarean sections in their communities. The first is called Prenatal Care Tracking, and the objective of the package is to assure entry into prenatal care in the first trimester, ongoing care throughout the pregnancy, and to assure insurance coverage throughout the pregnancy. The specific strategies include coordinating care for pregnant women with local providers, ongoing contact with pregnant women, and assistance with enrollment in presumptive eligibility and Medicaid, and referral of women who are denied Medicaid to providers for the Title V prenatal program. As health departments work with pregnant women, they are encouraged to use materials to prevent preterm birth from the ACOG, and the MOD. LHDs are also encouraged to educate women about the availability of text4baby. By assuring that women are obtaining early and ongoing prenatal care, there are many opportunities to educate these women about the risks associated with cesarean sections and EEDs.

The second MCH Evidence Informed Strategy is HBWW, and the objective is for the LHD to establish partnerships with local MOD representatives, prenatal providers, and hospital administrators to promote public awareness about ACOG recommendations to not induce labor or perform cesarean sections before 39 weeks unless there is a medical indication. Fewer early inductions will result in fewer C-sections. Specific activities include establishing a HBWW team, developing an implementation timeline and action plan, arranging for a grand rounds speaker for local health care providers to address preventable PT births, providing evidence-based materials to providers, and completing at least one presentation for a community group on PT birth.

Hospitals and providers have a significant role in the reduction of cesarean sections. Through collaboration with the KHA, birthing hospitals will be encouraged to develop and implement hard stop policies. The KHA is working with MOD to support hospitals that are still working to reduce their rates of EEDs to meet the Joint Commission and CMS requirements and recognize success for hospitals that have successfully met the goal with a banner. For receipt of the banner, hospitals must submit documentation of a hard stop policy that includes clearly defined medical indications for deliveries less than 39 weeks, a process to track and monitor non-medically indicated deliveries prior to 39 weeks, and provide data that supports having two quarters of deliveries with EED rates below 3%. To date, 16 of the 46 birthing hospitals in KY have applied for and received a banner. As part of KYs work on the PT and Early Term workgroup of the CoIIN, the ten hospitals that applied for the banner but did not meet the criteria will be offered TA. KY live birth certificate files will also be analyzed to identify hospitals with high rates of cesarean section and/or EED, and these hospitals will be offered TA as well.

The KY PT and Early Term workgroup of the CoIIN currently has representation from MCH, the DMS, the MOD, and the KHA. In order to reduce EEDs, this group will be expanded to include additional partners (such as KFAP and the Kentucky Chapter of ACOG) that can collaborate on efforts to reduce EED and first time C-section. This workgroup will also increase the educational opportunities that are available to providers on these topics. Additionally, quality improvement activities will be conducted to identify new strategies that are effective with reducing EED through participating on the CoIIN.

A final strategy related to reducing EED is to implement recommendations that are made from the Perinatal Advisory Committee. This committee has been provided extensive data on infant mortality and PT births along with other topics within their scope. The committee plans to focus on a handful of topics in which they could have a significant impact, and the prevention of EED may be a topic that is chosen.

The second objective to reduce cesarean sections involves education of the general public about the risks associated with cesarean sections. In order to increase awareness on this topic, MCH will collaborate with partners to distribute evidence-based materials. One avenue for this distribution is the KFAP. The partnership plan for the upcoming year includes activities to increase public awareness of the risks and risk factors associated with EEDs and PT birth, increase outreach to high risk populations, and increase the use of social media outlets to distribute information about PT births, and to promote awareness via text messaging (text4baby). All partners will utilize opportunities with the media to educate about cesarean sections and EED.

The third objective for reducing cesarean sections aims to increase the availability of KY-specific data on this topic. As mentioned previously, one barrier that exists is the discrepancy between hospital-reported data and live birth certificate files. In order to address this issue, a quality improvement project is being undertaken to determine if there are reporting issues with the birth certificate. MCH has met with the Office of Vital Statistics and received their approval to move forward with the project. Several birthing hospitals that are geographically diverse with different birth rates will be recruited to participate in the project. Hospitals will review the accuracy of the indicators on the birth certificate with emphasis on clinical variables such as those used in the CoIIN EED measure, as well as risk factors such as smoking in the three trimesters of pregnancy. Results will be compared to determine if there are inaccuracies in the birth certificate reporting. Education will be developed for birthing hospitals on variables that are commonly erroneously reported.

MCH also plans to distribute reports to birthing hospitals on MCH indicators to increase their awareness of birth outcomes in their facility. These reports will include data on first time, low risk cesarean births as well as EED. The reports provide an opportunity to increase awareness of decision-makers in the birthing hospitals on MCH issues. Birthing hospitals will also be offered the opportunity for technical assistance when the reports are distributed.

A final strategy that will be implemented in KY is to develop a return on investment or business case document using KY data on cesarean sections and EEDs. This information is important to raise awareness that KY needs to improve on these indicators, and to demonstrate the implications for mothers and infants related to these outcomes. The use of public health and Medicaid data in KY to develop this case can then be used to inform policy and program development in the future.

Women/Maternal Health - Annual Report

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	30.2	30.2	30.0	30.0	29.5

Women/Maternal Health Domain

MCH has collaborated with an extensive group of partners both internally and externally to address issues related to women/maternal health. The health care delivery system in KY has undergone numerous changes in the past few years. With implementation of the ACA, the number of individuals in KY without insurance has decreased dramatically. According to a progress report on Medicaid expansion based on the first years' experience, Medicaid expansion recipients are distributed evenly between males and females. This is in contrast to the traditional Medicaid receipts who were more likely to be female based on being the primary caretakers of low-income children (Deloitte Development LLC, 2015). Less than 50% of the Medicaid expansion population was between the ages of 18 and 35 in comparison to more than 70% in the comparative traditional Medicaid group (Deloitte Development LLC, 2015). These women who have health care coverage will now be able to access preconception and interconception care.

KY Title V continues to provide safety net clinical services to women without insurance coverage. Over the past five years, the number of women receiving maternity services through the LHDs has declined dramatically from 8,518 in 2010 to 2,720 in 2014. These numbers reflect both the increased number of women with coverage through the health benefits exchange, and the transition of many LHDs from clinical services to population-based services. In areas that lack providers, health departments still provide some in-house prenatal care. The public health prenatal program is the payment source in many communities for those women who do not have insurance. The number of women for whom prenatal services are paid by Title V has also declined from 3,641 in 2010 to 1,350 in 2014.

Annual Report Activities:
The priority need of maternal morbidity will be discussed within the current year activities to highlight achievements and challenges that will be addressed in the plans for the upcoming year. This discussion will focus on activities related to the prevention of PT births and EEDs. The programmatic activities for which MCH has a leadership role that will be highlighted include HBWW, the Kentucky Folic Acid and Perinatal Partnership (KFAP), the Perinatal Advisory Committee, and the CoIIN to Reduce Infant Mortality. Additional Title V activities related to maternal morbidity that will be discussed include the maternal mortality review program.

HBWW. KYs prematurity prevention activities began through a pilot project named HBWW in 2007 with funding from the MOD and Johnson & Johnson Pediatric Institute. This community-based, multi-layer approach to prematurity prevention in three intervention communities with a range of health care settings was successful in showing that as hospitals, health departments, and communities work together rates of PT birth could be reduced. KY demonstrated success in the program as results indicate a statistically significant 12 percent decline in the PT birth rate in the intervention sites. KY now has 9 active sites along with 8 additional hospitals as members of the HBWW Collaborative for a total of 17 hospitals. Partnerships involved in the Collaborative include the MOD, state and LHDs, hospitals, and community organizations. All sites participate on monthly calls to share information and strategies. In addition, in-person meetings occur three times a year, once in conjunction with the MOD Prematurity Summit that is held for a wider audience of professionals. Creating the HBWW Collaborative made it possible for all hospitals and health department in the state to participate. KY promotes the use of the CMQCC/MOD toolkit, *Elimination of Non-medically Indicated (Elective) Deliveries before 39 Weeks Gestational Age*, as well as the NQF *Playbook for the Elimination of EED* (KY American Congress of Obstetricians and Gynecologists (ACOG) President Dr. Divya Cantor was on the committee that developed this tool). MCH is partnering with MOD and KY

Hospital Association (KHA) in continued efforts to reduce EED in the state through quality improvement methods. (see COIIN section)

KFAP. The KFAP began in December 1998 as the Kentucky Folic Acid Partnership with the original purpose to involve as many organizations as possible in the effort to educate Kentuckians about the US Public Health Preventative Task Force recommendation that all women consume 400 mcg of folic acid daily to prevent serious birth defects of the brain and spine. In January 2006, the KFAP voted to expand the partnership's scope to also include other perinatal health issues in addition to folic acid, and for the name of the group to reflect that change. This partnership currently has 76 agencies and over 90 members who work collaboratively to address perinatal health issues in KY. Work is accomplished through evidence-based strategies targeting professionals, the community, and media. In the past year, the KFAP has been restructured to focus on seven topics including Preconception/Interconception and the Life Course Model, Prematurity and PT Birth Prevention, Folic Acid and Nutrition, Smoking Use in Pregnancy, Substance Use in Pregnancy, Breastfeeding, and Safe Sleep.

Perinatal Advisory Committee. The Perinatal Advisory Committee was established by legislation in June 2013. This committee is appointed by the Governor and led by the MCH Director. They are to make recommendations for the improvement of the following statewide health status indicators that relate to pregnancy and prenatal care: 1) Infant mortality; 2) PT birth; 3) Substance abuse during pregnancy; 4) Neonatal withdrawal syndrome, also called NAS; and 5) Maternal mortality. According to legislation, the committee may make recommendations on evidence-based guidelines and programs to improve the outcomes of pregnancies, including ways to improve coordination of existing programs operated by the KY CHFS and private organizations. The Perinatal Advisory Committee meets on a quarterly basis, and reviews data related to the topics above. One of the several tasks of the Perinatal Advisory Committee is to address infant and maternal regionalized care. The Perinatal Advisory Committee members reviewed and provided comments to the proposed amendments to the State Health Plan for facilities and services when they were updated to align with the most recent recommendations of the AAP and ACOG.

CoIIN. As a Region IV state, KY was one of the original states who worked with the Maternal and Child Health Bureau (MCHB) to develop the CoIIN to Reduce Infant Mortality. The HBWW project discussed earlier was the inspiration for Dr. David Lakey's Association of State and Territorial Health Officers (ASTHO) President's Challenge to reduce PT births. When every state accepted the challenge, ASTHO approached other agencies and national organizations to get involved in infant mortality work, and the COIIN was HRSA's response. In the original CoIIN, Dr. Ruth Ann Shepherd, Title V Director, was a co-lead for the EED Workgroup. Other members of the team included a neonatologist from a tertiary care center, Dr. Scott Duncan and a data lead, Dr. Joyce Robl. Dr. Duncan worked with the KHA EED Project with the Kentucky Hospital Engagement Network (KHEN). KHEN was part of the Centers for Medicare and Medicaid Services (CMS) Strong Start Initiative through the Partnership for Patients. In Kentucky, 16 of 45 eligible KY birthing hospitals participated in the KHA-HEN collaborative. The KHA Board of Trustees signed an EED Resolution in 2013 committing to establishing a new standard for KY hospitals and ensuring a continued focus on improved patient care. KHEN provided resources on developing and implementing an EED policy to hospitals. KY is continuing to work on the PT and early term workgroup in the national expansion of CoIIN, and continuing to partner with MOD in their recognition program for hospitals that achieve an EED rate of <3%.

Maternal Mortality Review. MCH contracts with the UL to support a maternal mortality review committee through the Kentucky Medical Association (KMA), comprised of 14 members that are obstetricians/gynecologists, including maternal-fetal medicine specialists. Cases for review are ascertained from review of death certificates occurring to women ages 13 to 50 years. Any death to a woman who was pregnant within the year prior to death, identified by a check box on the birth certificate, is eligible for review. Homicides, suicides and MVAs where death occurs at the

scene are not reviewed. Committee members are geographically distributed throughout the state, and cases are assigned to members for review based on location. The committee meets once a year in conjunction with the KMA and reviews the cases. A final report is developed that is de-identified and includes whether the death was pregnancy-related or pregnancy associated. Maternal mortality review findings are monitored over time for changing trends. In conjunction with KY ACOG, the maternal mortality review team is developing a patient safety bundle for obstetrical hemorrhage which is designed to provide standardized treatment protocols. KYs investment of Title V funds for maternal mortality review is important to identify and review trends in maternal mortality and morbidity so that actions can be taken to improve practice and reduce such events in the future.

Accomplishments/Progress:

Previous SPM #1 monitors the percentage of infants who are first time births whose mother had a pre-pregnancy BMI in the overweight or obese categories. KY has demonstrated a decline in this measure from 51.4% in 2013 to 46.6% in 2014. On a broader scale, there are numerous activities occurring to promote healthier lifestyles in KY; one of the goals of the Governor's kyhealthnow initiative is to reduce obesity among Kentuckians. In order to reduce obesity, strategies are targeting all age groups from early child care through adulthood. Numerous activities of the CSHP also target obesity. (see the Adolescent Health Domain)

KY reduced the percentage of non-medically indicated early term deliveries among singleton term deliveries from 13% in the first quarter of 2011 to 10% in the second quarter of 2014. These improvements were accomplished through the collaborative work of CoIIN, KHEN, MOD, KFAP and other prematurity prevention partners who all worked together to address EED.

Previous SPM #3 monitors the percent of singleton live births to KY residents that are born late PT at 34-36 weeks gestation. From 2013 to 2014, the percent of late preterm infants declined from 8.5% to 7.9%. These data reflect the prematurity prevention efforts within the state including HBWW and KFAP. With the restructuring of KFAP in the past year, the Prematurity and PT Birth workgroup has developed a consistent message that can be used by all partners. Three documents were developed to assist with consistency including talking points, frequently asked questions, and a resource list.

KY has also shown tremendous progress related to maternal morbidity through its home visitation programs, HANDS and MIECHV. HANDS began in 1998 as KYs voluntary home visitation program designed to assist overburdened expectant and first-time parents, at critical development points, prenatally through age two. Most families enter HANDS during the pregnancy. HANDS focuses on fostering early childhood development and learning and serves more than 10,000 families annually in all 120 counties across KY. It has become one of the largest early childhood home visitation programs in the nation. The HANDS program paraprofessional and professional visitors build relationships with the parents of these young children, and work on strengths-based skills for both the child and parent. These protective factors build resilience and positive outcomes. Recent evaluations of HANDS have focused on several maternal outcomes. A comparison of HANDS participants to similar high risk families that did not participate in the program found that HANDS participants had increased adequacy of prenatal care (14% higher), reduced pregnancy-induced hypertension (49% lower), and reduced maternal complications during pregnancy (40% lower).

KY was a recipient of formula and competitive grant funds through the MIECHV funded as part of the ACA. The program goals for KY MIECHV include: 1. Expand HANDS to all at-risk families, not just first time parents; 2. Build Systems of Care for home visiting in communities to promote health and well-being for all pregnant women, children and their families; and 3. Provide in-home perinatal depression treatment through local mental health agencies. At full implementation, 78 counties were covered with the grant expanded services (in addition to the core HANDS

program, which is in every county). The benchmark results from this program found improvements in maternal health including: increased percentage of HANDS participants with a medical home six months after delivery (61.5% in year 1 versus to 81.4% in year 3), reductions in the percentage of HANDS participants with a subsequent pregnancy at one year postpartum (13.8% in year 1 versus 9.3% in year 3), increased referrals for positive depression screens (78.3% in year 1 versus 91.9% in year 3), and increased screening for domestic violence (35.7% in year 2 versus 60.5% in year 3).

Challenges:

Previous NPM #18 monitors the percent of infants that are born to women who have received prenatal care beginning in the first trimester. Data on this indicator demonstrates a decline from 75.4% in 2013 to 73.9% in 2014. While the 2014 data is preliminary and numbers may change, this decline will be closely monitored to determine if this is a continuing trend. Further analysis of this measure will be conducted to determine if there are any demographic characteristics (such as payment source for delivery, urban/rural or geographic location of county of residence) associated with later entry into prenatal care.

While KY decreased the percentage of non-medically indicated early term deliveries among singleton term deliveries, the decline was below the average decline for all states that participated in the original CoIIN. Nationally, less than 3% is achievable so there are opportunities for improvement in this area. One strong challenge regarding EED is the inconsistency between the data available from the birth certificate and that provided by hospitals through hospital discharge data, Joint Commission measures, and chart reviews. An additional challenge in this area is that many hospitals and providers have voiced that they feel they have already made the quality improvement changes needed to influence EED. KYs data, however, does not reflect that sentiment. It is possible that the changes needed to influence EEDs are not receiving ongoing attention to maintain reductions in this measure. Some of the efforts in the upcoming year will focus on addressing these barriers.

Over many years, the KFAP has been an effective means to disseminate perinatal health information throughout KY due to the large number of agencies committed to the partnership. With a large partnership, the ongoing engagement of members can be difficult especially with competing priorities for time. It is hoped that the restructuring of the KFAP into multiple workgroups will facilitate renewed energy among existing members and stimulate recruitment of new partners.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Infant Mortality	1. Increase to 25% the proportion of Kentucky infants born in either a	1.1 Educate the general public and health care providers on the	Post neonatal mortality rate per 1,000 live births	A) Percent of infants who are ever breastfed and B) Percent		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	baby friendly designated hospital or a hospital that has implemented the 10 steps towards becoming baby friendly by September 30, 2020.	importance and benefits of breastfeeding 1.2 Partner with WIC to assist birthing hospitals in implementing Kangaroo Kare and working towards baby friendly designation 1.3 Encourage birthing hospitals to participate in the KISS hospital recognition program	Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	of infants breastfed exclusively through 6 months		
Infant Mortality	2. Implement a PRAMS like surveillance system by September 2017.	2.1 Model the PRAMS protocol to collect state specific data on safe sleep practices	Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		
Infant Mortality	3. Increase by 5	3.1 Analyze				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	the number of local review teams that integrate SUID data to develop targeted interventions by September 30, 2016 with 1 additional team added each year to September 30, 2020.	SUID data from all sources to identify program target areas and inform interventions 3.2 Develop a data fact sheet on SUID deaths 3.3 Increase the percent of infant deaths that are reviewed by a mulit-disciplinary review team				
Infant Mortality	4. Increase to 50% the proportion of infants born in a hospital with a policy/certification that models safe sleep by September 30, 2020.	4.1 Increase the number of hospitals that have received a star rating through the KISS program 4.2 Increase the number of Kentucky hospitals that have received National Safe Sleep Hospital Certification by Cribs for Kids®				
Infant Mortality	5. Reduce by 15% the proportion of parents' and caregivers with perceived	5.1 Implement a state-wide safe sleep campaign to educate the general public				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	barriers/resistance to creating and using a safe sleep environment by September 30, 2020.	on safe sleep 5.2 Educate child care providers on the current recommended safe sleep practices and implement policies related to safe sleep in child care facilities 5.3 Work with community partners to identify families who are unable to provide a safe sleep environment in their home and provide them with a Cribs for Kids package, safe sleep education, and follow up services 5.4 Continue participation in the Collaborative Improvement and Innovation Network for safe sleep				

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

Plan for the Coming Year:

In an effort to build upon and improve existing data infrastructure that supports the data collection for these two focus areas, KY will work toward implementing a Pregnancy Risk Assessment Monitoring Survey (PRAMS)-like survey to be conducted statewide. KY has completed two prior PRAMS pilot projects successfully, but is not yet a PRAMS funded state through the CDC. However, we have found the information collected to be valuable, and KY plans to implement PRAMS following the national PRAMS methodology and protocol utilized by funded states.

Previous Title V indicators for KY show improvements have been made in the percent of mother's breastfeeding their infants at six months of age, therefore, KY will continue to build upon this success and continue to focus on breastfeeding as a priority. Measurement will shift to focus on the percent of infants who are ever breastfed and the percent of infants breastfed exclusively through six months of age.

In working towards this transition, efforts will continue to increase breastfeeding initiation and duration rates through continued education, promotion and support. Funding will be maintained and continued for the eleven Regional Breastfeeding Coordinators. These coordinators will continue to provide assistance in promoting and supporting breastfeeding through public outreach, community events, health services planning, and organizing continuing education opportunities. Breast pumps (hospital grade, single user, and manual) will continue to be provided to WIC mothers. Efforts will be focused on increasing the number of hospitals trained on breastfeeding promotion and support and the number of hospitals that have implemented Kangaroo Care moving towards becoming baby friendly. The goals of the Baby Friendly Hospital Initiative will continue to be supported and promoted in the state through the KISS hospital recognition program. Online education modules on breastfeeding and nutrition will continue to be developed for LHD staff training. The Business Case for Breastfeeding and the Breastfeeding Worksite Toolkit will continue to be promoted throughout the state. Collaboration will continue with the MCH Obesity Team and Partnership for a FIT KY. The staff will continue to promote and support breastfeeding and nutrition through participation in health fairs and conferences with displays and education materials. The Strategic Plan to Increase Breastfeeding Rates in KY strategies will continue to be implemented across the state. The seven strategies include: Maternity Care and Hospital Practice, Support for Breastfeeding in the Workplace, Peer Support, Educating Mothers and Families, Early Childcare Education, Healthcare Professional Support and Media and Social Marketing. Collaboration with Partnership for a FIT KY, UK, and UL and other public and private partners will be continued.

Educating the general public on the dangers of an unsafe sleep environment for infants will be the focus of a state-wide media campaign with a target launch set for October 2015. Campaign messages are currently being developed by Image West, Western Kentucky University's School of Journalism marketing firm in conjunction with the KY Safe Sleep Task Force. This work is funded from an Association of Maternal and Child Health Programs (AMCHP) Birth Outcomes grant. Pre-and post-surveys of knowledge, attitudes, and beliefs about safe sleep will be used to monitor the overall campaign effectiveness. Recommended messages will be tested through a series of targeted focus groups across the state that are set to take place over the summer months. Messages will be modified based on feedback received during the focus group sessions and then prepared for release in various media format (i.e. public service announcements, billboard ads, website, Facebook, Twitter etc.). Image West will conduct a formal evaluation of the effectiveness of the campaign.

Promoting safe sleep practices by all community partners will prevent infant deaths due to bed-sharing and other potentially dangerous sleeping environments. A target group for this package includes nurse managers of local birthing hospitals including the labor and delivery units. By engaging birthing hospitals to model safe sleep in the newborn nurseries and educating parents on safe sleep practices while in the hospital, this will help to reduce the

number of infants that are not placed in a safe sleep environment. Hospitals that take steps to implement evidence-based practices that will increase infant safety and reduce the risk of infant morbidity and mortality will be recognized through the KISS program. Efforts to educate child care providers will also be promoted. Staff will work with local child care providers through education and demonstration to assure that the most current, evidence-based safe sleep practices and policies are implemented in the child care facility. Staff will also assist providers with locating professional staff development opportunities which are consistent with current recommendations for safe sleep practices and will provide safe sleep educational information for the families of infants receiving care in the facility. Health department staff will also work with community partners (including hospitals, health care providers, and social workers) to identify families who are unable to provide a safe sleep environment for infant(s) in their home and provide them with a Cribs for Kids package, safe sleep education, and follow-up services.

KY will continue to participate in the national Safe Sleep CoIIN in order to improve our practices and learn from other states. KYs Safe Sleep Action Plan included activities to: a. to increase the number of providers and community organizations educated on AAP recommended safe sleep practices; and b. decrease/eliminate infant deaths in KY related to unsafe sleep practices using consistent safe sleep messaging as recommended by AAP. The work of the Safe Sleep Task Force will include these goals.

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.0	62.0	63.5	63.5	64.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.5	14.5	15.0	15.0	15.2

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.0	72.0	73.0	73.0	73.5

Perinatal/Infant Health Domain:

Infant mortality has been identified as a priority need for the perinatal/infant health domain. Title V continues to provide gap filling services for women and children in need. In the perinatal health domain, one such service is maternity care for pregnant women who do not have health insurance coverage. Prenatal care as a direct service

provided by the LHD has declined over the past few years. A dozen local health departments still provide “in-house” prenatal care services where there is a lack of providers in their communities. LHDs not providing prenatal services in-house are required to provide assurance that women can access prenatal care in their community, whether by referral to local obstetricians or contracts with local providers. For assuring risk-appropriate care for high risk infants and mothers, MCH has worked with the Cabinet Office of Health Policy to include the most recent recommendations from Guidelines for Perinatal Care in the State Health Plan. Since the state requires a Certificate of Need for Neonatal Intensive Care Unit (NICU) beds, any new NICU beds in the state will have to comply with the guidelines.

KY MCH activities to reduce infant mortality, in addition to the efforts to improve birth outcomes associated with the Maternal Health Domain, will be focused around two primary objectives: improving breast feeding, and reducing unsafe sleep.

Annual Report Activities:

Breast Feeding Promotion. KY has worked with stakeholders to develop a statewide Strategic Plan for breastfeeding. Continuing assessment and analysis of the Strategic Plan to Increase Breastfeeding Rates in KY are being led by the MCH WIC and Nutrition Branch. The Strategic Plan has gone through a mid-point revision to reevaluate and add more objectives to increase breastfeeding rates including early childcare centers. The KY WIC Program State staff and Regional Breastfeeding Coordinators are working to support and increase the number of hospitals that implement Kangaroo Care in their facilities. The Baby Friendly Hospital Initiative is being supported across the state. WIC participants receive hospital grade, single user and manual breast pumps to support breastfeeding duration. New education modules are being made available to local agency staff on breastfeeding promotion, breastfeeding education and three-step counseling. KY continues to promote the Business Case for Breastfeeding in collaboration with Partnership for a FIT KY and the obesity team, who included breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping KYs Future Policies to Reduce Obesity. The Breastfeeding Peer Counselor Program is continuing in 23 agencies and will be increasing. WIC and obesity staffs work with the statewide breastfeeding coalition.

KISS Program. The KY Infants Safe and Strong (KISS) Program is a program for recognizing hospitals that are taking steps to implement evidence-based practices that will increase infant safety and reduce the risk of infant mortality and morbidity and move towards implementation of the Ten Steps for Successful Breastfeeding. A hospital will be awarded one (1) star by implementing one (1) infant safety step and two (2) steps towards successful breastfeeding. The KISS Program will award up to five (5) stars to hospitals; a five (5) star hospital will have implemented at least five (5) of the infant safety steps and completed all Ten (10) Steps To Successful Breastfeeding. The MOD and the KPA have agreed to co-sponsor this program. This is the first year of accepting applications.

Safe Sleep Surveillance and related activities: KY began an in-depth investigation of sleep-related infant deaths through a project for the Health Resources Services Administration (HRSA) Graduate Student Epidemiology Program (GSEP). In 2012, GSEP student, Manza Agovi, under the guidance of our MCH epidemiologists, conducted a review of all SUID cases from death certificate records and medical examiners reports to identify the presence of risk factors including the sleep environment. An MOU specific to this project was developed between the DMCH and the Office of the Medical Examiner (ME). This opened the door for a separate MOU, which continues today, to allow MCH program staff to review and copy pertinent records from all ME cases in children under the age of six years thereby improving surveillance efforts and data capacity for child death review in Kentucky. Data from 2013 shows that 90% of our infant SUID – including SIDS, Accidental Suffocation and Strangulation in Bed (ASSB), Undetermined, and Unspecified Threats to Breathing – have at least one sleep-related risk factor. This is consistent with national data.

Safe Sleep Task Force. We are continuing to update this study and provide more specific data to stakeholders.

Over half of these deaths are associated with bed-sharing. In parallel to our MCH Data analysis, Kentucky's External Panel for the Review of Child Fatalities and Near Fatalities which was established by legislation in 2013, has noted an alarming number of deaths from co-sleeping/bed-sharing, often with the caregiver being impaired by drugs, alcohol, or marijuana. The Panel's recommendation for a statewide safe sleep awareness campaign is further described in Plan for the Coming Year.

Safe Sleep CoIIN. In addition, KY currently participates in the CoIIN for safe sleep aimed at promoting infant safe sleep practices with the overall goal of reducing infant mortality. The establishment of a data tracking system has enabled staff to monitor the timeliness of all data sources received and has served as a foundation for the discussion of a quality improvement project on the accuracy of the data reported. Integration of multiple data sources will facilitate a more prompt and thorough review of child deaths in the state.

MCH Evidence Informed Strategies at LHD's. With Title V Funds, LHDs are offered options of MCH Evidence Informed Strategies to select those best suited to their community's need. LHDs are required to choose at least one infant mortality strategy: Period of Purple Crying (AHT Prevention) for Community Partners; Safe Sleep (National Institute of Child Health and Human Development [NICHD] materials) with Community Partners and agencies; Safe Sleep (NICHD materials) for Child Care; and Cribs for Kids.

Accomplishments/Progress:

The HANDS program has continued to show success in improving infant outcomes and reducing infant mortality overall in the families that it serves. The latest outcome data show that for those families participating in the HANDS program premature births were 26% less than similar high risk families that did not participate; low birth weight births were 46% less than similar high risk families that did not participate; child abuse and neglect was 47% less than similar high risk families that did not participate; and infant mortality was 74% less likely than statewide. In addition, families served through our MIECHV grant continue to show improvement in the number of families with suspected child maltreatment and the number of families with substantiated child maltreatment.

The Federal Healthy Start program in Louisville, KY is the only federally funded site in the state. For sixteen years, Louisville's Healthy Start Program has supported the community by reducing infant mortality, low birth weights, and premature births. Program employees consisting of professionals, paraprofessionals, and peer counselors have served over 8,000 families. The program has been successful and impacted the neighborhoods served by lowering the rate of prematurity by 26%, reducing low birth weight deliveries by 41% and lowering the IMR to 7.4/1,000 live births compared to a rate of 14.4/1,000 live births of non-participants in the areas served. Both safe sleep and breastfeeding are addressed in Healthy Start.

The rates of mother's breastfeeding their 6 month old babies have increased from 25.3% in 2005 to 31.5% in 2014. This represents a 24% increase over the nine year period. During 2014, breastfeeding initiation and duration rates were maintained through training, education, promotion, and support. The 5th Annual breastfeeding summit held in April 2014 provided updates on the statewide breastfeeding coalition and the Strategic Plan to Increase Breastfeeding Rates in KY. Continuing assessment and analysis of the Strategic Plan to Increase Breastfeeding Rates in KY are being performed by the State Plan Committees. The Strategic Plan has gone through a mid-point revision to reevaluate and add more objectives to increase breastfeeding rates including early childcare centers. The KFAP has developed standardized materials including talking points, FAQ's, and a resource list for memberships to use in breastfeeding promotional activities. The KISS Program is now accepting applications and providing TA to several hospitals.

The Breastfeeding Peer Counselor Program consists of paraprofessionals who have successfully breastfed at least one infant and was a WIC participant. These peer counselors provide basic breastfeeding information and encouragement to WIC pregnant and breastfeeding mothers. This program is currently offered by WIC in 23 sites

and plans to increase to other sites.

In implementing the MCH Evidence Informed Strategies, LHDs across the state became Cribs For Kids providers and gave out 263 cribs to needy families in FY 2014. They also worked with over 400 community partners, including child care centers, parenting classes, and community service organizations to assure they were educating families on safe sleep and using the most recent materials from the National Safe to Sleep Campaign at NICHD.

Challenges:

In 2012 in KY, 71 infants died suddenly of no immediately obvious cause. These deaths are categorized as SUID, and they account for about 22% of all infant deaths in an average year in KY. In the United States, there are about 4,000 SUIDs annually, which accounts for about 16% of all infant deaths. In 2012, KYs SUID rate was 1.33 deaths per 1,000 live births, which is much higher than the national rate of 0.90 per 1,000 live births. Completeness of data reported continues to be a challenge in reporting of SUID deaths.

Even though improvements in breastfeeding have been made over time, KY still remains well below the Nation (49.0%) in terms of the percent of mother's who breastfeed their infants at six months of age. KY currently only has two (2) Baby Friendly hospitals which deliver 18% of the babies born in KY. Breastfeeding is fully supported in those hospitals that implement the Ten Steps to Successful Breastfeeding and become Baby Friendly. Kentucky has a limited number of International Board Certified Lactation Consultants (IBCLCs). With this limited number of IBCLCs, moms may have a difficult time finding help if a breastfeeding problem arises. In KY, not all workplaces are fully supportive of our breastfeeding mothers. This creates barriers for our moms that are breastfeeding when they return to work.

There is a considerable amount of controversy among breastfeeding advocates around bed sharing to promote breastfeeding, which contradicts recommendations for room-sharing but not bed sharing for infant safe sleep. Addressing these issues will be part of the MCH safe sleep campaign.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Child Abuse and Neglect	1. Develop a comprehensive surveillance system for child maltreatment and abusive head trauma by September 30, 2020.	1.1 Create data definitions for child maltreatment and abusive head trauma 1.2 Improve the completeness of data on child maltreatment and abusive head trauma	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000			
Child Abuse and Neglect	2. Increase by 3 the number of evidence-based injury prevention materials for health care providers by September 30, 2016 with an additional 1 each year to September 30, 2020.	2.1 Implementation of abusive head trauma education in birthing hospitals 2.2 Development of standardized Kentucky-specific evidence-based materials on childhood injuries 2.3 Collaboration with injury prevention partners and health care providers to disseminate materials 2.4 Utilize evidence-based materials in programs for young children (i.e. home visitation, early				

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		intervention services, well child)				
Child Abuse and Neglect	3. Decrease by 10% the rate of hospitalizations related to motor vehicle accident injuries among children ages 0 to 19 years by September 30, 2020.	3.1 Increase the number of car seats that are installed and used appropriately 3.2 Reduce distracted driving among the teen population				
Child Abuse and Neglect	Increase by 5 the number of child serving agencies that implement the Strengthening Families Protective Factors Framework by September 30, 2020.	4.1 Provide SF training and materials to child serving agencies 4.2 Develop community-based projects to implement Strengthening Families Protective Factors/Safe, Stable and Nurturing Environments				

Child Health

Child Health - Plan for the Application Year

Plan for the coming year

Our first objective is to develop a comprehensive surveillance methodology for child maltreatment and AHT, so that

we can monitor the effectiveness of our work. In the prior block grant reporting, we had developed a state performance measure on the proportion of children less than age 5 that die from child abuse. We anticipate that we may develop a similar measure when State Performance measures are added to the new block grant format. It is difficult to measure progress if we do not have consistent surveillance numbers, and, as pointed out in the child welfare literature, this is no small task (Richmond-Crum, Joyner, Fogerty, Ellis, & Saul, 2013). One goal for the coming year is to submit for publication what we have learned so far from our surveillance data work.

Our second objective is to increase the number of evidence-based injury prevention materials/toolkits for family serving agencies. In order to inform data-driven practices, the CFR Program will continue working with the state Coroner's Association to encourage development of active CFR Local Teams. MCH Epidemiologists will work with the DCBS, the agents who investigate child abuse and neglect, to improve data collection on deaths from child maltreatment. With PCAK and the KSPAN Committee on Child Maltreatment, we will work on expanding community-based prevention strategies for Pediatric AHT and continue to provide prevention training and materials. In developing our statewide safe sleep campaign, we intend to integrate messages about prevention of AHT, as new parents need information on both topics. (see Perinatal Domain for further details). We will continue to work on projects with KSPAN, the Division of Pediatric Forensic Medicine at the UL, PCAK, the KY AAP, and LHDs on developing materials for specific groups of providers.

Our third objective is to address hospitalizations from MVAs, which affects all the Title V populations. For the coming year, the Title V CFR program, through our contracted partners at KIPRC, will continue TA towards promoting rural motor vehicle crash prevention, sustaining the existing certified child passenger technicians in those areas, and helping rural health departments to organize networks of local/regional Certified Passenger Safety (CPS) technicians who can work together. The CFR program continues to support Safe Kids Chapters and assist them in maintaining skills through statewide planning process for updates and technical education. LHD CFR Coordinators and CPS technicians will continue to initiate and maintain dissemination efforts for new AAP/Safe Kids/National Highway Traffic Safety Administration (NHTSA) recommendations for rear facing until age 2 and booster seats until reaching adult height. CFR Coordinators will promote more Safe Kids and KY Office of Highway Safety child passenger seat check events in communities to continue a decrease in deaths among children 14 years and younger from motor vehicle crashes.
Our fourth objective is to continue our cross-agency work to build protective factors and strengthen families. For the next year, KYSF will focus on developing assessment tools for agencies, staff, and families to identify how they/their practices align with protective factors and values, as well as tools for systems integration, policy change, and evaluation of impact. Additional trainings will be developed for specific audiences and technical support will be promoted through Virtual Learning Communities. Specific plans include developing a statewide Help Me Grow call line to enhance the protective factor "Knowledge of Child Development" by making developmental screening available to all parents statewide. Additionally, we plan to pilot projects for communities to work on building resilience and counter ACEs, using the "Community Resilience Cookbook" produced by the Health Federation of Philadelphia (RWJ Funded).

Child Health - Annual Report

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	100.0	100.0	100.0	98.5	98.5

Annual Objectives					
	2016	2017	2018	2019	2020

Child Health Domain

KY has been fortunate in that children's health and well-being has been supported by all levels of KY leadership through the Governor. Our current Governor, even during the height of the recession, made a strong and successful drive to get eligible children enrolled in Medicaid and Kentucky Children's Health Insurance Program (KCHIP), so that 94% of Kentucky's children have health care coverage, public or private. The role of Title V, through LHDs, has been to provide safety net services and assure all children have access to well child, nutrition, and immunization services. Funding from the Title V Block Grant supports a university-based training program for LHD nurses to learn pediatric assessment, which certifies them to perform well-child examinations. The protocols follow AAP Bright Futures recommendations. The Title V program also contracts with the universities for biannual continuing education updates for LHD nurses that review common topics for pediatric preventative services as well as school health topics. The need for these pediatric safety net services appears to be trending downward following the expansion of Medicaid. More health departments are linking children to care in a medical home with community partners instead of providing direct services at the LHD. While still supporting basic safety net services, the Title V program is focusing more on population-based activities. Injury is the leading cause of death among KY children over the age of one, and came up frequently in our statewide needs assessment. Title V funds infrastructure in LHDs in all 120 counties to provide support for the CFR program and other injury prevention activities.

Annual Report Activities:

Surveillance and Related Activities: The Title V MCH Program is working to improve the quality and timeliness of data is in our Public Health CFR program. MCH is the lead for this program, which was established in 1996 by statute. The program supports and encourages reviews of child deaths by local multidisciplinary teams to assist the coroner in determining an accurate manner and cause of each child death. Kentucky's Child Fatality and Injury Prevention Program currently receives notifications of any child death occurring in the state of Kentucky from multiple data sources. In order to manage this data, the program has developed a tracking system in Epi Info to track the receipt and timeliness of all data (i.e. Rapid Reporting Forms, electronic death registration system data, Hard Copy Death Certificates, Coroner's CFR Reports, Local CFR Team Reports, MEs Reports, SUID Investigation Reporting Form, obituary scans, and grief counseling forms) received related to a child death. More recently, the Epi Info system was modified to track information pertaining to the review, such as whether a review is planned, reasons for not reviewing (coroner chose not to review, does not meet review requirements of local team, the death occurred in the hospital or hospice, or no local CFR team), the actual review date, timeliness of review, and number of contacts by the CFR program to initiate a review. As of January 1, 2015, KY has implemented an electronic death registration system. The MCH epidemiologists receive a weekly data transfer of all child deaths that are registered in the system since the previous transfer.

MCH provides Title V funds to the LHDs to support local CFR review teams and to implement evidence-informed programs in alignment with state priorities. As a component of this funding, there are 61 designated CFR coordinators based at the LHD level. An annual report of Child Death data from the Public Health system is required by legislation to be submitted to the Governor, the Legislative Research Commission, and the Chief Justice of the Kentucky Supreme Court by November 1 each year. The most recent report can be found at http://chfs.ky.gov/nr/rdonlyres/8d033d5f-8b4d-4cb1-b5f9-5849386b7f54/0/2014publichealthcfrreportfinal.pdf

In the needs assessment process, both consumers and stakeholders were particularly concerned about injury related to child abuse. While Title V does not have the leading role in child abuse prevention, surveillance is an area where

MCH can provide leadership. In an effort to determine the actual incidence of AHT in the state, the MCH Epi team reviewed the scientific literature and CDC definitions, but found no standard methodology. After this review and examination of all existing data sources available to MCH, the process was undertaken to examine Medicaid claims data for patterns of coding related to AHT for the development of a state specific case definition for AHT within administrative data. Given that our hospital discharge data is de-identified, a methodology was developed using Administrative Claims data from the Kentucky Medicaid Management Information System. This coding scheme was focused on infants up to 1 year of age, tested on historical data and compared with recent year's data. The results were assessed for accuracy and consistency using other available data sources. Based off of this comparison, we have a consistent algorithm to capture AHT cases. The next step is to do validation studies using data from the Division of Pediatric Forensic Medicine at the UL, which is the only pediatric forensic center in the state. The Division of Pediatric Forensic Medicine has been working collaboratively with MCH on this project and has agreed to partner with us on the validation studies.

In addition to working on surveillance data and process, MCH Title V program partners with the Kentucky Injury Prevention Research Center (KIPRC) at the UK, the bona fide agent for injury prevention for the KDPH. Title V funds a contract with KIPRC for pediatric injury prevention training and TA from a pediatrician with expertise in injury prevention and other staff. This person serves as our state Safe Kids coordinator. KIPRC applies for and coordinates the CDC Injury and Violence Prevention Cooperative Agreement for KY. MCH partners on prevention activities with KIPRC's statewide coalition and state injury prevention plan. The state-wide coalition is the KSPAN, a network of public and private organizations, and individuals, dedicated to promoting safety and preventing injuries throughout the Commonwealth of KY. KSPAN is specifically working to improve the state's capacity to conduct injury prevention and control activities across a wide range of injury causes, types and risk factors, and to increase the reach, efficiency and effectiveness of existing prevention efforts through greater coordination and alignment of resources. There are five major prevention emphasis areas for the KSPAN coalition: Young Driver & Child Passenger Safety, Prevention of Drug Abuse, Preventing Falls Involving Older Adults, Residential Fire Safety and Prevention of Child Maltreatment. These emphasis areas were chosen voluntarily by Kentucky in the Kentucky Violence and Injury Prevention Plan (KVIPP) as areas of focus to work towards improvement. MCH staff serves on three of the five different subcommittees that relate to the focus areas.

Primary Prevention Activities: KYs HANDS is our statewide home visiting program for first time parents. One goal for the program is that children live in healthy/safe homes, so the home visitors emphasize child safety checklists for appropriate ages, as well as teaching parents about child development, which is important in child abuse prevention. In addition, the program works on family self-sufficiency, including goal setting, resource development, positive parenting, and even anger management if needed, so that families are less likely to use harsh discipline or have violence in the home. In SFY 2014, there were almost 150,000 home visits provided to at-risk parents in Kentucky. HANDS evaluations continue to show success at reducing child abuse and neglect in this population of high risk families. The most recent outcome evaluation studies have found that HANDS participants experience 47% less child abuse and neglect than similar high risk families that did not participate in the program. This is consistent with earlier studies, which also showed a 50% reduction in child emergency room visits among HANDS participants compared to children statewide.

In a more socio-ecologic, preventative approach to injury prevention, MCH Title V is leading the KY Strengthening Families (*KYSF)* Initiative in collaboration with the Governor's Office of Early Childhood. KYs initial focus is children prenatal to five years and their families. This initiative follows a collective impact model, and is similar to the CDC "Safe, Stable, and Nurturing Environments" work. KY is now an affiliate of the national Strengthening Families Network, developed by the Center for the Study of Social Policy. KYs initiative is somewhat unique, in that we are intentionally trying to develop a cross-sector, cross-agency, public-private framework so that families will be supported in strengths-based environments no matter what systems they access within their community. It is an intentional approach to systems change and common messaging to respond to the science of toxic stress and early

brain development. MCH has taken the lead in raising awareness of ACEs and Toxic Stress, which fit perfectly in the Life Course Perspective model, and lay the groundwork for why Strengthening Families and building protective factors are critical to children's health and well-being. The ACEs and epigenetics also help explain the multigenerational issues related to poor outcomes, and the KYSF leadership team is promoting the "two generation" approach. Audiences have been eager to receive this information, and have included Kids are Worth It (Statewide Conference of Prevent Child Abuse Kentucky), Kentucky School Board Association meetings, Ready Kids (statewide school readiness conference), statewide Systems of Care Academy (Behavioral health staff), Administrative Office of the Courts statewide meeting, Victory over Violence conference, the Early Childhood Advisory Council, HANDS Academy (statewide Home Visiting conference), and many smaller venues.

Accomplishments/Progress

In reviewing the Health Status Indicators from the past Title V grant years, all of the injury indicators appear to be improving in Kentucky. The decline in motor vehicle deaths is particularly notable, as it coincides with legislative efforts:

In the 2015 legislative session, KY improved its booster seat bill to meet national recommendations, increasing the height requirement to 57 inches and the age requirement to 8 years. Title V funds can be used to allow LHDs to send staff for training to become a certified car seat installation technician if there are none available in their area.

The increased awareness of child abuse as a public health issue, and particularly AHT, has resulted in legislation and action at the highest levels. The creation of a state-level Child Fatality and Near Fatality External Review Panel in 2013, an independent, multidisciplinary body housed in the Justice Cabinet, is evidence of the growing support for addressing child abuse in the state. The panel consists of a diverse team of professionals from across the state, including members from medical, social services, mental health, legal, and law enforcement fields. MCH serves on the panel, and has been instrumental in developing the data collection forms so that the panel can accurately record determinations and patterns from the cases reviewed. In addition, MCH has developed a process for local coroners and CFR teams to refer cases to the External Panel if they have any concerns about child abuse in the case and the local teams do not have enough information or expertise to make a determination.

Preventing AHT has been a priority for several legislators. KY has passed two laws, one requiring staff of all child serving agencies to be trained, including law enforcement, social workers, first responders, nurses, owners and staff of childcare centers, guardian ad litem attorneys. Last year, this requirement was extended to health care professionals including pediatricians, radiologists, family practitioners, trauma physicians, emergency room physicians, and Urgent Care staff. The training is done by Dr. Melissa Currie, the chief of Division of Pediatric Forensic Medicine at UL. MCH supports this by making the training available on the Public Health Web-based Training system, TrainingFinder Real-time Affiliate Integrated Network (TRAIN), so that it is available without charge. However, there is currently no legislation requiring hospitals to use the evidence-based practice of teaching new

parents about prevention of AHT.

This year, working through the KIPRC Child Maltreatment Subcommittee, the MCH Program, along with PCAK, the Division of Pediatric Forensic Medicine at UL, a pediatrician Champion from the KY AAP, and representatives from the two children's hospitals in KY, worked to promote evidence-based parent education on AHT in hospitals. A survey of birthing hospitals in the state, despite contacting them through the KHA, did not produce a sufficient number of responses to accurately determine which hospitals are following the evidence-based model for teaching parents of newborns about AHT prevention. Nonetheless, the group developed a packet of information with all the necessary tools for implementing an evidence-based program, trained the committee members to have capacity to go out to hospitals and do training, and sent the packet to all birthing hospitals at the start of Child Abuse Prevention Month (April). The introductory letter was signed by the Commissioner for Public Health, the Director of KIPRC, and the Medical Directors for both Kentucky Children's Hospitals. To date, no hospitals have requested training, materials, or more information, so there are still challenges for implementing this strategy despite the collaborative approach.

KYSF has maintained a stable leadership team and continued to engage partners despite the fact it is entirely a voluntary effort. While there is no specific funding for the initiative, it has gained enough recognition that several grants are finding ways to incorporate Strengthening Families into their grant projects. These include Early Childhood Comprehensive Systems, KY Race to the Top (RTTP) Early Learning Challenge, and the Behavioral Health Systems of Care Grant. Strengthening Families has been included as an initiative in the Cabinet's Children's Leadership Team; a cross-agency group established to communicate the multiple ways agencies are working to improve services for children and their families.

The workgroups of the initiative have been very active. A Train the Trainer Strengthening Families Overview has been developed and well-received, with over 100 trainers from various disciplines and agencies trained. Messaging and materials have been developed for professionals (Phase I). The Family Workgroup has developed a resource guide, a network of existing family groups in the state, a Parent Café training, and is working on a common family leadership ladder that many of the groups can contribute to and become involved.

MCH has partnered with the KY Chapter of the AAP on a pilot project in Corbin, KY for *"Help Me Grow",* an evidence-based, national program model for promoting developmental screening. Two other Help Me Grow sites in KY urban areas are affiliated with United Way – 211. We are exploring ways to expand the Help Me Grow system to the entire state, either in partnership with a 211 system (under development) or separately if needed. The KY Chapter of the AAP continues to be supportive of this project.

Challenges

Given that there is still no national standard for surveillance of child maltreatment from public health data, developing a consistent methodology so that we can track trends remains a challenge. The CFR System is challenged by the constant turnover of local coroners with every election cycle, and the lack of understanding of the importance of local reviews.

A major challenge to improving outcomes for children in KY is the number of children experiencing ACEs. These are potentially traumatic events that can have a lasting impact on the health of an individual once they are experienced. Based on data from the 2011/2012 NSCH, 44.7% of KY parents reported no adverse family experiences compared to 52.1% nationally (National Survey of Childrens Health). In KY and the Nation, 25.3% experienced one adverse family experience, while two or more adverse experiences were reported among 30.0% of children in and 22.6% of children in the nation (National Survey of Childrens Health). When the KY data is analyzed by age groups, the percentage of children experiencing two or more adverse family experiences increases from 20.1% among children up to the age of five to 32.5% among children 6-11 years, and 37.3% among children ages 12-17. The table below

compares KY data on ACEs from the 2011/12 National Survey of Children's Health to the nation.

Adverse Child or Family Experience	KY Prevalence	National Prevalence
Extreme economic hardship	29.6%	25.7%
Family discord leading to divorce or separation	28.9%	20.1%
Having lived with someone who had an alcohol or drug problem	14.4%	10.7%
Having been a victim or witness of neighborhood violence	9.3%	8.6%
Having lived with someone who was mentally ill or suicidal	11.1%	8.6%
Witnessing domestic violence in the home	9.7%	7.3%
Parent served time in jail	13.2%	6.9%
Treated or judged unfairly due to race/ethnicity	3.7%	4.1%
Death of parent	4.2%	3.1%

These data demonstrate that on all but one indicator, KY has a higher prevalence than the Nation. In order to have an impact on the long term health and wellness of children, it is imperative that ACEs be better understood in Kentucky and that children in need of trauma-informed care are identified as early as possible. The ACEs module is being incorporated into KYs Behavioral Risk Factor Surveillance System this year.

Inherent in the KYSF cross-agency approach for integrating protective factors into systems, are a number of challenges as each agency has its own constraints and specific purposes. For example, integration into Child Protective Services will look much different than integration into a United Way agency. Evaluation of this cross-agency, multi-layered effort is also challenging, as measures and measurement are quite different across agencies, and depend on whether you measure agency outcomes, front-line staff changes in behavior, or outcomes for families.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Overweight and Obesity Among Teens	1. Increase by 20% the number of participants attending the	1.1 Provide one (1) free physical activity leadership training and one (1) free KY SHAPE training to school district staff and administrators	Percent of children in excellent or very good health	Percent of children ages 6 through 11 and adolescents		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	Kentucky SHAPE (School Health and Physical Education) and/or Physical Activity Leader professional development workshops by September 30, 2016 with an additional 3% increase each year until September 30, 2020.	annually	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	12 through 17 who are physically active at least 60 minutes per day		
Overweight and Obesity Among Teens	2. Decrease by 10% the number of children ages 2 to 4 that are obese or overweight by September 30, 2020.	2.1. Provide one (1) 5-2-1-0 Toolkit Training of Trainers workshop annually to Early Childhood Educators in the state of Kentucky to train childcare staff throughout the state on the importance of daily intake of five servings of fruits and vegetables, limiting screen time to two hours a day for children 2 and older, one hour a day of physical activity, and zero sugary drinks 2.2. Provide ongoing communication to child care centers and preschools regarding the accessibility of the 5-2-1-0 Toolkit materials and resources available online 2.3. Record and archive one (1) webinar on TRAIN for use	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		by local health departments, child care centers and families to provide an overview of the 5-2-1-0 Toolkit 2.4. Measure the number of child care centers participating in Nutrition and Physical Activity Self Assessment for Child Care (NAPSACC)				
Overweight and Obesity Among Teens	3. Increase by 20% the proportion of schools in Kentucky that have implemented a school wellness policy and a comprehensive school physical activity program (CSPAP) by September 30, 2020.	3.1. The DPH Coordinated School Health administrator will encourage the local health department staff to participate in at least three (3) school wellness committees within their school district per school year 3.2. The local health department staff will provide ongoing education to the Wellness Committee throughout the school year on the importance of implementation and periodic assessment of their local wellness policy 3.3. The School Wellness Committee will provide an annual assessment of the school wellness policy to assure that it includes goals for nutrition promotion and education, physical activity, and other school-based activities that promote student wellness (USDA Department of Agriculture, Team Nutrition- http://www.fns.usda.gov/tn/local-				

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		school-wellness-policy-requirements)				
Overweight and Obesity Among Teens	4. Increase by 5 each the number of Farm to School programs and trail towns in Kentucky by September 30, 2020.	4.1. Partner with state and community agriculture resources to increase Farm-to-School programs and Farmer's Markets 4.2. Increase walkable communities and "trail towns" across the state				

Adolescent Health

Adolescent Health - Plan for the Application Year

Plan for the coming year:

For the coming year KY will be centering activities to address adolescent obesity around NPM #8: the percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day. One of the main objectives to be addressed is to increase training for school educators on health physical activity by providing at least one free KY SHAPE workshop.

To address Objective #2: Decrease by 10% the number of children ages 2 to 4 that are obese or overweight, the CSH Team provides statewide education on the importance of utilizing a District Level Wellness Policy to reflect practices in nutrition and physical activity within the school district. Local wellness policies are an important tool for parents, local educational agencies and school districts in promoting student wellness, preventing and reducing childhood obesity, and providing assurance that school meal nutrition guidelines meet the minimum federal school meal standards. In Fall 2015 the new proposed rule implemented by USDA Food and Nutrition Service will require the following guidelines for school districts; annual progress reports, triennial assessments, minimum content of the district wellness policy include specific goals for nutrition promotion, nutrition education, physical activity, and other school-based activities that promote student wellness. Training on the 5-2-1-0 program will continue to be provided to early childhood educators, staffs, LHDs, and communities to address Objective #2.

Addressing Objective #3: Increase by 20% the proportion of schools in KY that have implemented a school wellness policy and a comprehensive school physical activity, the KY SHAPE Network will continue to focus on ongoing TA and education to school districts and staff on the implementation of a CSPAP and the importance of outlining nutrition, physical activity, and staff wellness standards in a District Wellness Policy. Results from the Practical Living/Career Studies Monitoring revealed that in school year 2013-2014 there was a 24% increase from the

previous school year, in schools reporting proficiency in the implementation of a CSPAP. There was also a 17.4% increase in school year 2013-2014, in schools implementing their district wellness policy via a school level wellness policy.

Objective #3: Increase by 5% each year the number of farm to school programs and trail towns in KY, critical partnerships will continue to work to increase access to healthy foods and activity for adolescents, families and communities to decrease overweight and obesity. The goal is to increase the number of farmers' markets in underserved areas and the number of farmers' markets that accept Supplemental Nutrition Assistance Program (SNAP), WIC and Senior Famers' Market Nutrition Program (SFMNP). A Farmers Market Committee was formed to include Kentucky Department of Agriculture (Farmers' Market Program and SFMNP), KDPH's WIC Farmers' Market Program, KDPH's Food Safety Program, Community Farm Alliance, UK Cooperative Extension and other food and economic development advocates. Farmers' market stakeholders on the local and state level were interviewed to identify assets, needs and barriers. Information gathered help developed the Access to Healthy Foods Vision for Farmers' Markets. This vision document outlines three strategies needed to support farmers' markets: Supportive Infrastructure, Training, TA and Networking Opportunities and Community Engagement. KDPH Obesity Program and the Farmers' Market Committee will help promote the vision document and three strategies to engage stakeholders.

The Community Farm Alliance is funded to provide training and TA to local farmers' markets to improve infrastructure, promotion activities, acceptance of nutrition benefits and the Double Dollar incentive. Recipients of nutrition benefits (SNAP, WIC, and SFMNP) can use the Double Dollar incentive to double their benefits up to $10; doubling their buying power and supporting local farmers.

To increase access to physical activity, KY plans to increase the number of communities that have a pedestrian plan. A Community Physical Activity Committee was formed to include the Federal Highway Administration, Kentucky Division, Foundation for a Healthy Kentucky, Kentucky Association for Economic Development, KDPH, KDE, Kentucky Office of Adventure Tourism, KIPRC, KSPAN, Kentucky Office of the Americans with Disabilities Act, Kentucky Rails to Trails Council, Kentucky State Parks, Kentucky Transportation Cabinet, Kentucky Youth Advocates, National Park Service, and UK Cooperative Extension. Committee and local stakeholders were interviewed to identify assets, needs and barriers. Information gather help developed the Access to Physical Activity Vision Document (http://www.fitky.org/wp-content/uploads/sites/2/2015/04/PA-Vision-Slidedoc.pdf). This document outlines three strategies that needed to develop pedestrian plans: community engagement, easy to use resources, and training, TA and resources. Eleven communities were funded $500 mini-grants to attend pedestrian plan training with local stakeholders and visit communities with a pedestrian plan that have implemented projects. Each community will work on developing a pedestrian plan with community input and support.

Another strategy KY is employing to provide access to physical activity is the creation of trail towns in communities. A Trail Town is part of an extensive trail system linked through a series of trails that may be for hiking, exploration and may be on land, on water or by rail. These trails serve to provide access to physical activity, recreation for all ages and can attract visitors from outside the local community to enhance commerce. Communities apply to the Office of Adventure Tourism to become a Trail Town (Office for Adventure Tourism Kentucky Trail Town Program). There are currently four Trail Towns in KY located in the cities of Dawson Springs, Livingston, Morehead, and Olive Hill.

Adolescent Health - Annual Report

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	38.5	38.5	38.5

Adolescent Health Population Domain

Primary and preventive clinical services safeguard the health and wellness of all children and adolescents and are provided through LHDs across the state. The LHD School Health Program promotes access to preventive health services for school age children and adolescents, and improves access to health information at critical times for influencing health behaviors. Depending on local needs, LHDs collaborate with local school districts for the provision of pediatric preventive health services in satellite clinics within the school setting. Services may include preventive health services, education, emergency care, referrals, and management of acute and chronic conditions in a school setting. Services are provided for children aged pre-school through adolescence (up to age 21). Public Health encourages children and adolescents to have a medical home, and where possible for schools to develop a school based health center, over and above just a school nurse. Data from the National Survey of Children's Health demonstrate that the percentage of children ages 12-17 years with no preventive medical care visits in the past twelve months has remained fairly consistent from 15.7% in 2007 to 16.7% in 2011/2012. Similarly the percentage of children ages 12-17 years with one or more unmet needs for care was 7.1% in 2007 and 7.8% in 2011/2012.

Among the primary and preventative services accessed by youth at LHDs are immunizations. The Kentucky Immunization Program (KIP) distributes vaccines to LHDs and private providers enrolled in the federal Vaccines for Children Program. The vaccines distributed include: diphtheria, tetanus, polio, Haemophilus influenzae type B, hepatitis A, hepatitis B, human papilloma virus (HPV), measles-mumps-rubella, meningococcal, pertussis, pneumococcal, rotavirus, and varicella. The HPV vaccine is strongly encouraged in adolescents 13 to 17 years of age. KY female adolescents receiving the vaccine was 26.8%, compared to 37.6% for the nation in 2013 (Elam-Evans et al., 2014). The national prevalence rate for HPV, despite low vaccine coverage in the U.S., decreased from 11.5% in the pre-vaccine era (2003–2006) to 5.1% in the vaccine era (2007–2010) among females aged 14–19 years, the age group most likely to benefit from HPV vaccination (Centers for Disease Control and Prevention, 2014).

Another health service accessed by adolescents at LHDs is family planning. Services to adolescents for contraception, pregnancy, or childbirth can be accessed without parental consent per KRS 214.185 Diagnosis and treatment of disease, addictions, or other conditions. KYs teen birth rates are high compared to US teen birth rates. There is a high correlation between poverty and teen birth rates in KY and across the Nation. Traditionally, KYs rates have been at least 10 points higher than the national rates. KYs teen birth rate for 2013 was 38.7 per 1,000 females ages 15-19. This is a 30.6% drop from the KY 2008 rate of 55.8 per 1,000 females ages 15-19. While we are encouraged by this decrease in our teen birth rates, it is still 12 points higher than the national teen birth rate. In addition, the teen birth rates for the Appalachian counties continue to be significantly higher than the state's overall rate. This may indicate that teens in more urban areas of the state have easier access to services.

Adolescent obesity was identified as the priority topic for the adolescent health population domain from the 2015

Needs Assessment. KY has chosen NPM # 8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day to address this need.

Annual Report Activities:

Across KY, numerous initiatives are in place to address the issue of child and adolescent obesity. These activities range from well child assessments in LHDs and school-based clinics, to the CSHP and its alliance with the many early childhood programs in MCH as well as with the KY Department of Education (KDE). The OHE is involved in most MCH areas, especially those populations most affected by disparity of race, education, gender, and age. Members of this office have been addressing adolescent overweight and obesity through the Partnership for a Fit Kentucky educating youth on the importance of, and ways to access healthy foods, and how to gain access to physical activity.

According to the 2014 State of Obesity Report, KY ranked 8th in the obesity rate for 10-17 year olds at 19.7% and 1st in obesity for High School Students at 18% (the State of Obesity, Better Policies for a Healthier America). Data from the KY 2013 YRBSS reports that 31.6% of middle school students were active for at least a total of 60 minutes per day on 7 of the past seven days. The 2013 YRBSS data further reads that 22.5% of high school students were physically active for at least 60 minutes per day on 7 of the past seven days. In addition, the percentage of high school students who are obese increased from 2003 to 2013, from 14.5% to 18.0%, according to the 2013 YRBSS for KY.

Adolescent Health Program. MCH collaborates with the DWH and their adolescent health programs such as Teen Pregnancy Prevention, the Young Parents' Program and family planning. The Adolescent Health Program continues to receive federal funding to prevent teen pregnancy through the Abstinence Education Grant Program (AEGP) and the Personal Responsibility Education Program grant. DWH uses the AEGP to provide age-appropriate education to fifth through eighth graders in accordance with the KDE program of studies for sexual health education. Reducing the Risk or the Teen Outreach Program primarily targets disengaged youth at high risk for poor healthy decision making, academic failure and poor adulthood outcomes and is a curriculum in local schools or community based organizations. A total of 6,065 students in 51 counties across the Commonwealth were educated in the last school year. The program primarily targets disengaged youth at high risk for poor healthy decision making, academic failure and poor adulthood outcomes.

Coordinated School Health (CSH). CSH is a major vehicle in schools across the state, as well as the nation, to address obesity and overall youth well-being. CSH ties together adolescent services provided through the LHDs, schools, and school-based clinics. CSH consists of an eight-component model that recognizes how health, wellness, environment and learning are related. This national CDC CSH Eight Component Model is comprised of health education, physical education/physical activity, health services, nutrition services, family and community involvement, staff wellness, healthy and safe school environment and counseling, psychological and social services. By using this model, KYs goal is to promote preventive best practices around nutrition and physical activity. CSH collaborates with KDE to assist schools in providing an environment where children have the opportunity to learn, achieve, and be successful in a healthy environment.

Kentucky participates in the YRBSS Program through the CDC. Middle and high school students are surveyed in KY biennially in the areas of Nutrition, Physical Activity, Injury and Violence, Tobacco Use, Alcohol and Drug Use and Sexual Activity. Kentucky's CSHP is an effort funded by the CDC's 1305 State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity & Associated Risk Factors & Promote School Health Grant also known as the 1305 QUAD grant.

Policy change in Early Care and Education. In KY, we know that one in three children is obese or overweight before they start kindergarten. This increases the importance of ensuring the physical and nutritional health of our early childhood population, so that throughout elementary and latent education children and adolescents remain healthy. The vision for KYs Early Care and Education training program is that all children in KY will have access to high quality healthy foods and beverages, screen time limits, physical activity opportunities and breastfeeding support in early care and education settings. The MCH program works with Child Care providers using the CDC Nutrition and Physical Activity Self Assessment for Child Care (NAPSACC) and provides TA for implementing policy changes in the child care that promote better nutrition and more physical activity. Model policies for early care and education have been developed and trainings are provided. Since 2011, 122 child care centers completed NAPSACC training. An additional 65 centers were trained in 2014 through the intense Early Care and Education Learning Collaborative (ECELC) with funding from a Nemours Grant.

Through early childhood education and funding, the 5-2-1-0 program is promoted statewide to licensed childcare programs, LHDs, and communities in order to decrease the number of children ages 2 to 4 that are obese or overweight. The 5-2-1-0 program encourages parents and childcare staffs to serve five fruits and vegetables a day, limit screen time to two hours or less a day, provide one or more hour of physical activity daily, and serve no sugary drinks, just water, non-fat milk or 100% juice with meals daily.

*Kentucky Action on Childhood Obesity (KACO).*The KY Chapter of the AAP has an Obesity Task Force, which is a small group of pediatricians from varying backgrounds and locations that have special interest and expertise in pediatric obesity. Kentucky AAP, with the help of the Obesity Task Force powers KY Action on Childhood Obesity (KACO), which is an initiative to support providers around the state who are dealing with patients with obesity. All members of KY AAP receive communications from KACO and can receive support from KACO when requested. The group provides monthly pearls, provides a back-up network of experts and resources, and recruits advocates to provide help with preventing and managing obesity for pediatric medical providers in KY.

Accomplishments/Progress:
The KY SHAPE Network is a cadre of professionals developed through the partnership of KDPH and KDE CSH teams that educates school district staff and district administrators on the importance of providing physical activity opportunities in the school setting. Other partners include the Alliance for a Healthier Generation, Action for Healthy Kids regional representatives and State Coordinator, school district administrators, LHDs, Humana Vitality, and additional representatives from private foundations working toward a healthier school environment for children.

The CSH team promotes the utilization of a CSPAP in the school setting. A CSPAP is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally-recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime. A CSPAP reflects strong coordination and synergy across all of the components: quality physical education as the foundation, physical activity before, during, and after school, staff involvement, and family and community engagement.

The CSH team provides regional summer professional learning opportunities for school district staff and administrators focused on the implementation of a CSPAP in the school setting and the alignment of physical activity opportunities to what is required in the Practical Living/Career Studies Program Review at KDE. Because there is not a mandated requirement for physical activity for KY students, the CSH team provides education and resources on the importance of creating and implementing sustainable district and school level policies surrounding a requirement for physical activity in the school environment. In April 2015, KY expanded the network efforts to include 16 Health and Physical Education teachers who were selected to serve as regional liaisons between school districts and the state level CSH team. These 16 specialists receive ongoing training in the areas of Physical Activity,

Nutrition, and Staff Wellness in the school setting.

In addition, the KY SHAPE Network provides professional development trainings statewide promoting the utilization of Alliance for a Healthier Generation's Best Practices framework and Let's Move! Active Schools physical activity standards. In 2013, it was reported by Alliance for a Healthier Generation that 284 schools were enrolled in Let'sMove! Active Schools. As of May 31 2015, that number has increased to over 600 schools in the state of KY. Fourteen schools in the state of KY have qualified for recognition by the National Alliance for a Healthier Generation in their efforts around their physical activity and school nutrition environment.

Among some of the changes in school nutrition that is supported by the KY SHAPE Network is the SmartSnacks program. SmartSnacks builds on the already published practical, science-based nutrition standards for snack foods and beverages sold to children at school during the school day. The standards, required by the Healthy, Hunger-Free Kids Act of 2010, allows schools to offer healthier snack foods to children, while limiting junk food. The purpose of SmartSnacks is to heighten nutrition standards for any food consumption during the school day, including classroom celebrations, in-school fundraisers, and any food sold during the day including snack shops.

Challenges:

According to the 2014 State Obesity Report, KY ranks 1st in obesity for high school students drawing a keen focus to the issue of teen obesity (Trust for America's Health and Robert Wood Johnson Foundation, 2014). In the 2014 Title V Annual Report, NPM 14 measured little to no progress in the percentage of children ages 2 to 5 years receiving WIC services with a BMI at or above the 85th percentile. Between 2009 and 2013, the decline was 2% (31% to 29% respectively). The growing concern is that if young children are this overweight, we cannot expect adolescents to have lower rates of overweight/obesity.

During the 2015 Needs Assessment, discussions about obesity revolved around the education of parents and the need for support by the school system as a whole. Barriers included the cost of healthy foods and a lack of knowledge about healthy eating. A reduction of physical education and activity in the schools coupled with increased media time at home only increased the problem. Ideas for improvement included regular health education in the schools and student wellness programs from Kindergarten through 12th grade. Participants stressed that parental education about the benefits of healthy lifestyles had to go hand-in-hand along with community agency engagement; communities investing in their youth through increased activities and outlets.

Some obstacles faced by the CSH team in the effort to decrease adolescent obesity are obtaining administrative buy-in at the district level. We are now seeing more research around the correlation between healthier children and higher academic performance, however, there is inconsistency in this message and the practices surrounding physical activity opportunities and enhancing nutrition settings in schools. Local/statewide data collection across all grade levels in KY could prove to be a useful tool, but is not consistently recorded. It is required that student records be on file in schools, however, regulations do not specify the content of the files and is only available for district students entering Kindergarten and Sixth Grade. This information is not consistently entered by all school districts in the KDE Infinite Campus database. This would help our team collect local BMI numbers, and assist us in better aiming our efforts in preventing childhood obesity.

State Action Plan Table						
Children with Special Health Care Needs						
			National	**National**		

State Priority Needs	Objectives	Strategies	Outcome Measures	Performance Measures	ESMs	SPMs
Transitions Services for CSHCN	1. By 2019, achieve an increase from 37.1% to over 40% (current national average) of Kentucky families of CYSHCN reporting that the youth has received services needed for transition to adulthood (CYSHCN Outcome #6), as measured in the National Survey of Children's Health	1.1 Develop Evidence-Based or Evidence-Informed Strategy Measures (ESMs), in conformity to CYSHCN standards, recent research, and technical assistance/ guidance available from National Resource Centers 1.2 Consider development of formal written policy for transition preparation to document current and desired processes 1.3 Continue transition preparation activities for direct services populations (including use of transition checklist tool, in partnership with youth and family, to track and update completion of transition	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		process and assess readiness; preparation of portable medical summaries to assist with transfer from pediatric care to adult medical home or provider; outreach to youths upon 14th, 16th, and 18th birthdays; provision of assistance and consultation with adult medical home or provider as needed, and follow-up post-transfer)				
		1.4 Expansion of activities beyond direct services populations (including development of transition processes for contracted programs; maintaining community lists of available adult medical homes or providers				

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		accepting CYSHCN as patients; and cultivating awareness on available resources through website and social media, through active involvement of Youth Advisory Committee, agency staff, and F2F program)				
Access to Care and Services for CSHCN	2. By 2019, achieve a 5% increase, (from 63.8%) in Kentucky families of CYSHCN reporting community-based services are organized for easy use (CYSHCN Outcome #5), as measured in the National Survey of Children's Health	2.1 Access to medical and specialty care efforts (eligibility and discipline expansion, clinic flow, targeted outreach, telemedicine, etc.) 2.2 Assuring the availability of provider networks to reach CYSHCN (contract with community providers, provide training and capacity building, support				

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		KHIE, university partnerships, etc.) 2.3 Development and promotion of an easy to access system of supports and resources for CYSHCN and their families (Spanish support group and monitoring of gaps in system for diverse populations, funding innovative strategies per SNAP mini-grant program, Autism work to connect and develop system, EHDI Early Intervention initiatives, foster care services, etc.)				
Adequate Insurance for CSHCN	3. By 2019, achieve an increase to over 70% (from 66.8%) in families of	3.1 Develop strategies, in conformity to CYSHCN standards, recent research,				

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	CYSHCN reporting that the youth has adequate insurance to cover needed services (CYSHCN Outcome #3), as measured by National Survey of Children's Health (supplemented internally with CUP or other patient survey data to capture subset of CCSHCN-affiliated CYSHCN families)	and technical assistance/ guidance available from National Resource Centers 3.2 Coordinate with agency partners, both in-state and through learning collaborative opportunities, to address gaps in covered services and provider networks, streamline processes in Kentucky (such as contract modifications, rate and requirement negotiations) 3.3 Assist CYSHCN and other MCH populations through assistance with state health benefits exchanges and education about system navigation				

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Data Capacity for CSHCN	4. Achieve phased implementation of CCSHCN's Data Action Plan, with improvement of at least 10% each year.	4.1 Develop formal plan for bridging the gap between internal service data regarding CCSHCN direct service enrollees (~9000) and national data regarding all federally-defined and self-reported CYSHCN in Kentucky (~200,000), as well as studying available data regarding provider network adequacy in geographic areas of the state.				

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

CCSHCN - Application Year (FY 2016)

For many years, CCSHCN agency leadership has been maneuvering to move public health services offered to CYSHCN down the MCH pyramid; for example, identifying offsite and low-census clinics where there are no longer barriers to care and asking whether direct gap-filling services are necessary and whether those services should be transitioned to community providers. KYs CYSHCN program faces challenges associated with completing the transition from a traditionally direct service role to an assurance role with regard to ensuring statewide systems of care and infrastructure-building. The gulf between the number of children served in CCSHCN specialty medical clinics (approximately 9400 in SFY 2014) and the estimated population of CYSHCN in KY (approximately 197,000

per the 2009/2010 NS-CSHCN) illustrates the issue, as does the fact that KYs rate of CYSHCN is the highest in the country. CCSHCN looks to fill gaps in services – not necessarily through the provision of direct care, but by ensuring that services exist in the communities where CYSHCN live, and determining what role CCSHCN needs to play in improving access. Within the structure of a Strategic Plan, and in the context of ongoing Needs Assessment, CCSHCN continues to deliberately expand needed services to previously un-enrolled CYSHCN, most significantly through partnerships to meet the needs of underserved populations e.g. those with ASD around the state, Muscular Dystrophy in Louisville, and Pediatric Urology patients in the East. Statewide multidisciplinary Cerebral Palsy and Myelomeningocele clinics are being considered as possible partnerships as well. In the past, CCSHCN may have attempted to provide the new services directly; however, the agency now seeks to work with universities, hospitals, and other resources by providing enabling services such as care coordination or family support roles. While this approach takes careful planning up front, the agency feels that the healthcare system as a result is more coordinated and integrated, duplication is eliminated, and patients receive increased access and quality care. CCSHCN is currently in the selection process for candidates for a newly created leadership position of Assistant Director with a responsibility to focus on growth and coordination of non-direct services.

The promise of telemedicine continues to be a viable option for ten non-urban sites where there is a significant proximity to provider problem. Waiting lists have decreased, access to care has improved, and cost per patient is competitive. Patients report satisfaction at a rate of 98.9%. CCSHCN is currently exploring other pediatric sub-specialty clinics for introducing care via telemedicine. To date, neurology has been the discipline of the pilot program; an autism clinic is also to be piloted.

Reaching more CYSHCN takes outreach and marketing, culturally competent strategies, as well as tweaking procedures and trying new avenues. CCSHCN has revised eligibility for the YAC (which has resulted in participation of new members previously unaffiliated with CCSHCN), participated in the formal statewide network of volunteers who help Kentuckians become educated about and enrolled in insurance coverage through the KHBE, and begun serving in supportive roles for various underserved groups such as those in the child welfare system and those families of CYSHCN with Limited English Proficiency (LEP). The agency is currently reviewing responses from both CCSHCN-contracted physicians as well as the wider KY medical community to a substantive survey touching on how to better assist CYSHCN and engage partners. A goal is to connect with AAP, family practice physicians, hospital associations, and other stakeholders, to survey existing programs.

As the 90 year-old agency's evolution continues, CCSHCN looks forward to participating in strategic and deliberate partnerships with peer agencies in a way that will transform Kentucky's pediatric care landscape, particularly in the area of enhanced access. Recently, CCSHCN applied for (and the application has been accepted) targeted TA through the NGA opportunity, which also involves 5 other national organizations. With the assistance of partners (Medicaid, AAP, MCH, etc.) in the Learning Collaborative opportunity, it is hoped that KYs CCSHCN will emerge with a robust plan to leverage TA resources to strengthen and better integrate the overall system of care for CYSHCN in Kentucky. KY also participates in other cross-agency TA efforts related to standards development and insurance coverage and hopes that the NGA opportunity will pave the way toward a coherent road map for development and infrastructure building.

An area of need which has been explored in some depth during past reports is to accurately measure data beyond the provision of direct services. While the revised NSCH will provide a backbone for annual block grant reporting, CCSHCN is examining data collection efforts for the purposes of developing more accurate management information, and to guide program evaluation and program planning and development. During the most recent cycle, CCSHCN substituted consumer- and agency-generated data in place of national survey data, in order to measure year-to-year changes in progress or lack of progress toward indicators, and to connect results to programs. However, this approach suggests a clinical focus, and pertains to a subpopulation of the larger population of CYSHCN in KY. A GSEP proposal was accepted for the purpose of reengineering the data collection system;

however, no appropriate student match could be identified. CCSHCN will work with other resources on the project; meanwhile, the performance measure data reporting processes have remained the same for this year for consistency.

In conjunction with the strategies listed on the preliminary action plan table, CCSHCN submits the following updates – currently organized around the most recent performance measures:

NPM 2 – Satisfaction & Partnership

- Two separate physician surveys (one for CCSHCN providers, another to connect with existing community providers, AAP, family practices, hospital associations, etc.) were developed and initiated to explore provider satisfaction and aimed to engage doctors as partners (in addition to families), and to gauge community needs regarding lack of access. As of early June, a combined 65 responses have been received, with substantive comments and recommendations
- New efforts at outreach to the provider community and development of educational modules – including grand rounds, school health nurse presentations, and medical school morning reports
- While the GSEP project envisioned did not materialize, CCSHCN will work to re-engineer the data collection system to include not only CCSHCN enrollees, but non-enrolled CYSHCN, to capture additional dimensions of outcomes and process, and to conform to and supplement national data sources
- The CCSHCN transitions administrator will follow up with families of aged-out CYSHCN to assist with overcoming barriers, conducting quality assurance regarding transitions efforts and gauging how much families are understanding
- F2F is training support parents who partner with FQHCs and Spanish-speaking practices to provide parent care coordination support in-office
- Family presentations to branch managers will take place regularly, as well as regular meetings between F2F and CCSHCN staff, and the development of family-based proposals/wish list for executive team
- F2F to train Spanish support group facilitators

NPM 3 – Medical Home

- CCSHCN staff will continue to advocate for the concept of medical home, and provide support to existing providers in communities
- CCSHCN will consider the feasibility of providing CMEs to community physicians, pediatric offices, and health departments

NPM 4 – Insurance

- Rate negotiations with MCOs and Medicaid will continue
- As mentioned above, CCSHCN and partners continue participation in the AMCHP Standards Action Learning Collaborative towards greater access to insurance
- While the ACA assists with expanding coverage, this does not ensure adequacy or access to care. CCSHCN clinical staff will continue, on an individual and family level, to educate to assure adequacy of insurance, and specific strategies will be developed toward adequate insurance as a priority need and SPM
- CCSHCN front-line staff will continue participation with KYs state health benefit exchange as Certified Application Counselors – though funding was stopped for “kynectors”, agency sees continued involvement as necessary

NPM 5 – Ease of Use of Community Based Services

- CCSHCN's further autism expansion to improve timely access to services includes another Parent Summit (bringing the total to 2 – 1 each in Eastern and Western parts of the state), participation in LEND grant application, and ensured cultural diversity in autism screening
- As described above, and in accordance with specific strategies to be developed toward a SPM, CCSHCN will continue to build infrastructure, allow partners to take over direct services where possible, and supplementing efforts (for example, new pediatric urology outreach in Morehead and Somerset)
- Participation in the State Innovation Model (SIM) Population Health Improvement grant through the Kentucky Office of Health Policy and Medicaid toward integrated and coordinated care, and increased access (workgroups)
- Consider well-planned telemedicine expansion possibilities into other disciplines
- CCSHCN will be administering "First Steps" (early intervention) point of entry services in the Louisville area, receiving referrals, facilitating eligibility determination through the coordination of developmental evaluations and assessments, and coordinating the development of the initial Individualized Family Service Plan
- Establishment of a position specifically responsible for the growth of non-direct services
- Implementation of improved processes to improve clinic flow
- Continued assurance ofservices for medically fragile youth in foster care as well as population in or at risk of placement outside the home – and evaluation of the service quality/quality improvement efforts
- Replication of the "Una Mano Amiga" support program outside of the pilot area for Spanish-speaking families
- Administration of the F2F, care coordination, and social work programs to assistwith navigation of services
- Initiation of the Special Needs Access Projects mini-grant program.

NPM 6 – Transitions

- As Transitions will continue to be a priority need and selected as an NPM, CCSHCN will develop evidence-based or evidence-informed strategy measures over the next year to implement strategies aimed at reversing the downward trend in national survey outcomes, ensuring conformity with Got Transition and AAP guidelines/best practices
- CCSHCN staff will continue to stress transition, including development of transitions content for hemophilia and sickle-cell patients at the UL and autism population

NPM 12 – Early hearing screening

- Collaborate with state and national partners to implement or expand on a number of quality improvement initiatives aimed at reducing loss to follow up at each of these critical junctures:1) between referral on universal newborn hearing screen (UNHS) and outpatient re-screen or diagnostic audiology and 2) between diagnosis of permanent hearing loss and enrollment in early intervention.
- Activities will include increasing the knowledge base of physicians and Medical Homes regarding the impact of failed UNHS and the importance of ongoing monitoring of hearing throughout childhood to detect progressive, late onset or acquired hearing loss; reducing LTF by building effective referral pathways for hospitals, physicians, health departments and medical homes; continuing work with early intervention to ensure the exchange of individually identifiable information regarding children with permanent hearing loss; improving services for children diagnosed with unilateral and mild bilateral permanent hearing loss and improving the dissemination of statewide resources and supports for infants and children identified as deaf and hard of hearing and their families.
- KYs EHDI Advisory Board has been reorganized and members have expressed a commitment to assist KY EHDI in short and long term planning to better serve children that are deaf and hard of hearing, and their

families. CCSHCN will rely on their vast knowledge, experience, vision and focus to propose strategies for improvement that can be trialed, adapted and, if deemed successful, implemented at each level of the KY EHDI process.

- CCSHCN's aim is to decrease our LTF between UNHS and diagnostic audiology by age 3 months from 18% to less than 15%. Meeting the national benchmark of 85% of enrollment in early intervention by 6 months is a challenge complicated by the fact that unilateral and mild bilateral hearing loss are not currently established risk conditions for the First Steps program (CCSHCN is gathering additional data and advocating for inclusion). Ascertaining that children with unilateral and mild hearing loss receive warranted follow up, including appropriate diagnostic testing to identify developmental delays and referral to First Steps when indicated, is an approach that is being implemented by CCSHCN audiologists. KY EHDI hopes to generalize this approach statewide through the use of Audiology Scorecards.

SPM 7 – Healthy weight

- CCSHCN will focus on how to collect data with an ever-changing population, possibly initiating chart reviews of individual longer-term patients to determine whether the agency's processes positively, negatively (or neither) affect outcomes in any way
- Continue to refine efforts as guided by the agency's Health Weight Plan
- Continue to collaborate with coalitions locally and statewide

SPM 8 – Transitions Action Plan

- As described in NPM 6, CCSHCN will continue to expand on transition efforts as part of agency's 5-year plan and beyond, and develop evidence-based and –informed measures
- Implement transitions piece for hemophilia and sickle cell patients through UL

Children with Special Health Care Needs - Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40	40	40	40	40

<u>CYSHCN Domain</u>

Annual Report (FY 2014)

Annual Report Activities

CCSHCN submits the following updates organized around the most recent performance measures:

NPM 2 – Satisfaction & Partnership: 97.9% - CCSHCN's continuing challenge is to obtain meaningful stakeholder involvement at a policy level. However, new efforts are being made toward engagement and hearing the input of those CYSHCN served in clinics and those not currently affiliated with the agency.

- 2100 clinic comment cards received during the reporting period
- Nurse care coordination and multi-professional team approach continues
- Nurse care coordinator now present at muscular dystrophy clinic in Louisville
- F2F Health Information Centers assisted nearly 2000 individuals
- CCSHCN social work staff and F2F staff/support parents served as “kynectors” – part of a network of individuals trained to provide information and assistance with enrollment in the state’s health benefits exchange
- F2F participation in Kentucky Infants Sound Start program to encourage newborn hearing rescreening follow up
- Family participation through PAC and YAC avenues, as well as Strategic Planning retreat
- Peer mentoring program through D70 grant
- Parent participation in AMCHP Action Learning Collaborative – Standards – as well as other planned initiatives

NPM 3 – Medical Home: 96.0% - with the low census, the retirement of a physician, and the fact that another agency emerged, CCSHCN has transitioned out of the role of gap-filling direct medical home service provision in the Lexington area, partnering with local accredited medical home provider to ensure enhanced services, including behavioral health and pharmacy, are available for foster children and others needing services

NPM 4 – Insurance: 96.8% - work toward assuring coverage has shown progress. Public policies including the ACA, and KYs Medicaid expansion and development of a state-based health benefits exchange have led to increasing numbers of those insured. While coverage has increased, the ACA in and of itself does not ensure adequacy or access to care. This will continue to be addressed as a performance measure. Strategies are in development.

- 27 agency-affiliated kynectors assisted approximately 3000 people during reporting period (participation began 10/13), and started over 500 applications during that time
- PSI premium assistance program continued for Hemophilia and cystic fibrosis populations, contracted through Patient Services, Inc. (PSI)
- Avesis (MCO dental administrator) special rate negotiated for patients with Cleft Lip & Palate in need of complex and phased orthodontia treatment – attracted more providers and resulted in increased access to care
- Prior authorization requirements for hearing aids and therapy services through one MCO have been reduced
- Current Medicaid cost settlement agreement in place for care coordination services

NPM 5 – Community Based Services: 96.2% - while this NPM is retired, activities will continue as before, and with new strategies under the access to care and services priority. A wide variety of initiatives are planned, especially with regard to non-direct services.

- While the data measure is perhaps not a helpful or valid measurement, care coordination continues in and outside of specialty medical clinics
  CCSHCN continues to provide F2F and social work system navigation and resource-brokering assistance
- CCSHCN’s foster care support program has grown, with nurses out-stationed in child welfare offices now convening individual health planning meetings and reviews, as well as conducting monthly home visits to approximately 150 medically complex children placed in out of home care throughout the state
- CCSHCN expansion of provision of gap-filling direct services – where waitlists exist, services are not otherwise available, or need for multi-disciplinary clinics exists – and in partnership with existing providers

- Autism services include
    - Pilot for ongoing medical care and diagnosis has begun in 4 offices
    - Convened Autism Advisory Council, which CCSHCN Executive Director co-chairs as per Governor's appointment
    - Partnership with KY Autism Training Center to develop specialized ASD training
    - Modification of wait rooms and exam rooms to accommodate needs of patients on spectrum

- Telehealth partnership – this option has been in all offices where there is a significant proximity to provider problem

NPM 6 – Transitions: 68.8% - CCSHCN's transition program, established in 1998, has expanded beyond the current 13-point plan (SPM 8) into new initiatives involving affiliated families to the point where transitions preparation is the rule and an established part of the array of services offered. Among the challenges this past year has been connecting youth with mentors from different parts of the state – logistical issues with non-face to face contact. Some of the activities of the transitions program include:

- One on one discussions with families enrolled in CCSHCN programs – based on transition checklist which documents what skills have been accomplished, are in progress or part of future expectations
- Morehead pilot activities part of process statewide – outreach expectation to assist youths with handoff to adult care, knowledge, and preparation assurance – portable medical summary in use
- CCSHCN is still actively involved in the KY Interagency Transition Council for Persons with Disabilities and the 9 Regional Interagency Transition Teams ("RITTs") across the state
- Staff and F2F support parent participation in fairs, conferences, school events and shared information with families and professionals
- Youth forum bringing together young adults (21-35) to identify barriers and opportunities for successful transition
- Partnership with UK Human Development Institute to train and match mentors and mentees (16-20)

NPM 12 – Early hearing screening: 96.8% - CCSHCN has been making overall progress during the past year in addressing loss to follow up at every critical juncture. EHDI continues to struggle with the home birth population, many of whom are resistant to medical interventions and/or governmental collaboration, and who sometimes seek services from lay midwives, who are not sanctioned by state law.

- KY has maintained a very high screening rate for newborns prior to hospital discharge.
- Hospital Scorecards have been developed and implemented, and in conjunction with annual hospital visits have assisted CCSHCN staff in holding hospitals to account for timely submission and improved accuracy of data files, and in increasing the numbers of newborns who receive warranted follow up to 89%.
- To better allocate staff time for outreach and education to medical homes and community audiologists, CCSHCN's EHDI program reduced annual hospital visits by 10% in FY 2014 and will continue to do so for the next three years.
- The management information system (CUP) collects and reports unduplicated, individualized demographic data for all newborns and tracks progress through the three components of the EHDI process-Screening, Diagnosis and Intervention. Feedback is provided to hospitals on a monthly, semiannual and annual basis to improve hospital hearing screening programs. KY EHDI has developed a report that lists each hospital

rescreen and KY EHDI staff review each one for completeness. An existing report was modified to include follow up test date and follow up provider. As a result, hospitals are contacted quickly when a baby is discharged without a follow up appointment scheduled and hospital staff assist KY EHDI in getting babies scheduled resulting in improved Loss to Follow Up (LTF) numbers.

- Eleven (of twelve) of the CCSHCN district offices continue to provide infant ABRs-the preferred follow up diagnostic test for infants who refer on one or both ears on the newborn hearing screen. A new query has been designed to track testing protocol and timeliness of data submission by community audiologists. The results obtained from this report are forming the basis for an "Audiology Scorecard" which will be shared with pediatric audiologists statewide to demonstrate compliance with best practice standards.
- CCSHCN receives quarterly reports that lists any child with a diagnosis of unilateral hearing loss and provides pertinent information regarding degree of loss, use of amplification, date of last hearing test, and status in terms of enrollment in Early Intervention. Since unilateral hearing loss is not an "established risk" for enrollment in the KY First Steps, KY EHDI aims to take a proactive role is assuring these children receive warranted follow up, including periodic hearing tests, speech–language evaluations and referral to First Steps if a developmental delay is identified. Children who have been diagnosed by CCSHCN audiologists as having unilateral or mild bilateral hearing loss have been contacted to assure that warranted follow up is provided on an on-going basis.
- The success of the ACA in Kentucky has reportedly resulted in a decrease in the number of infants receiving well baby care LHDs, negating the effectiveness of the MOU that we had initiated with Kentucky River Health Department (and were planning to launch at other health departments) to provide hearing screening equipment in an effort to reduce our LTF numbers.
- CCSHCN is aiming to increase collaboration with Medical Homes and Primary Care Providers (PCPs) to improve knowledge and reduce loss to follow up/loss to documentation which stands at 18% for FY 2014.
- EHDI has recently received equipment ordered for visiting physician practices and demonstrating various hearing screening options. The first medical practice has been approached and efforts are underway to schedule an outreach visit and to recruit other medical practices that would benefit from this hands-on approach for staff in service training.
- KYs EHDI program sponsored an educational session prior to the National EHDI meeting (held in Louisville in March, 2015). KY EHDI also scheduled a presentation for pediatric residents at UL School of Medicine. Future presentations will be planned for residents at the UK School Of Medicine.

SPM 7 – Healthy weight: 36.5% - CCSHCN's formal Healthy Weight Plan addresses prevention, identification/assessment, and intervention/treatment among the CYSHCN population – a group who often find it more difficult to control weight and remain healthy. Many barriers exist; lack of time during clinic appointments, family lack of readiness to make changes, or families not accepting that overweight/obesity is a legitimate concern; families who are more concerned with their children's special health care need(s) than they are about the risks of overweight or obesity. CCSHCN makes gentle efforts to overcome these barriers, and works with others to advance solutions to community concerns beyond the scope of the agency

- CCSHCN staff continued participation in 5-2-1-0 initiative for CCSHCN direct service enrollees
- Training by dietitians on accuracy of height and weight measurements, review of BMI status data
- Participation in the Partnership for a Fit Kentucky – a collaboration among network partners, where best practices are shared; local council involvement

SPM 8 – Transitions Action Plan: 92.3%

- See NPM #6

Significant progress was made with regard to social media presence and assistance with transition to adult health care providers; CCSHCN is nearing completion of 5-year plan to improve agency capacity to provide transitions services

Accomplishments and Progress

It is noteworthy that, as measured, CCSHCN reported improvement in six of the eight performance measures between the period of 2009 and 2014. The number of infants screened for hearing before hospital discharge revealed a slight decline (likely due in part to better tracking and an increase in home births), and the measure involving healthy weight and tracking childhood BMI, rose slightly in 2013 and 2014 although no discernible trend is evident over the five year period.

Challenges

As the Application Year section alludes to, CCSHCN has up to now used state-generated data for performance measures regarding the direct services sub-population. As part of the annual report and needs assessment, staff also studied available data from the NS-CSHCN and NSCH to supplement data and determine trends among the larger CYSHCN population. During the reporting year, CCSHCN continued to carry out statutorily-defined responsibilities to the CYSHCN population in KY. However, the pivot from direct services to a defined subpopulation to the full cohort of CYSHCN has begun and will require new methods of measurement. Going forward, KY will be reporting using revised NSCH outcome measures as soon as the data is available. (To achieve progress on the expected SPM regarding data capacity, KY is considering several specific action steps as detailed on the Action Plan Table – with so many resources available, CCSHCN is looking to take better advantage and build skills in this area.)

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Substance Abuse	1. Refine the methodology for surveillance of neonatal abstinence syndrome (NAS) by September 30, 2020.	1.1 Collaborate with the Department for Medicaid Services to develop a consistent methodology for reporting cases of NAS	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		1.2. Utilize the consistent methodology developed with Medicaid to report cases of NAS from hospital discharge data	Percent of low birth weight deliveries (<2,500 grams)			
		1.3. Collaborate with the Kentucky Perinatal Quality Collaborative to improve care for infants with NAS	Percent of very low birth weight deliveries (<1,500 grams)			
		1.4. Collaborate with the Department for Community Based Services, Medicaid, and the Department for Behavioral Health to improve access to treatment services for pregnant women with substance use disorder	Percent of moderately low birth weight deliveries (1,500-2,499 grams)			
			Percent of preterm births (<37 weeks)			
			Percent of early preterm births (<34 weeks)			
			Percent of late preterm births (34-36 weeks)			
			Percent of early term births (37, 38 weeks)			
			Perinatal mortality rate per 1,000 live births plus fetal deaths			
			Infant mortality rate per 1,000 live births			
			Neonatal mortality rate per 1,000 live births			

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health			
Substance Abuse	2. Increase by 5% the proportion of women who report that a health care provider discussed smoking cessation during pregnancy by September 30, 2020.	2.1. Incorporate more extensive smoking cessation materials in existing MCH programs 2.2. Increase the number of local health departments that implement the MCH Evidence Informed Strategy: Baby and Me are Smoke Free 2.3 Explore				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		opportunities to make the GIFTS smoking cessation program available to a broader audience 2.4 Increase the availability of information on Quit Now Kentucky to MCH stakeholders 2.5 Increase the number of educational presentations and materials on smoking cessation available to health care providers 2.6 Implement a PRAMS-like survey to obtain data to establish the baseline and monitor progress				
Substance Abuse	3. Increase by 10 the number of smoke-free policies implemented in	3.1. Increase the number of local communities with smoke-free laws and/or				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	Kentucky by September 30, 2020.	ordinances 3.2. Increase the number of 100% Tobacco Free Schools				
Oral Health	1. Decrease by 25% the proportion of children with untreated dental decay by September 30, 2020.	1.1 The KOHP will continue to train LHD nurses in the procedures required for a successful varnish application through the KIDS Smile curriculum 1.2 Promote public health dental hygiene program and referrals to dentists 1.3 Promote and encourage LHD selection of the MCH Evidence Informed Strategy: Fluoride Varnish for Children through the Fifth Grade 1.4 Increase the number of local health departments that	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	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		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		have a public health dental hygiene program				
Oral Health	2. Increase by 10% the number of fluoride varnish applications provided by public health registered dental hygienists by September 30, 2020.	2.1 Expand the number of funded public health hygiene pilot sites 2.2 Increase effectiveness and efficiency of preventive service delivery through data evaluation and observational audit tools				
Oral Health	3. Develop and refine methodologies for ongoing oral health surveillance among children by September 30, 2020.	3.1 Develop methodologies for service data from the Department for Medicaid Services to reflect oral health services for children 3.2 Continue to work with University of Kentucky and University of Louisville Schools of Dentistry to create				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		surveillance on dental services for children under six years of age				

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

Cross-Cutting
Substance Abuse
Plan for the Coming Year

KY has chosen NPM #14: Percent of women who smoke during pregnancy and the percent of children who live in households where someone smokes in the cross-cutting domain. Based on the fact that the majority of women with substance use disorder use tobacco and the fact that substance abuse was the leading priority issue for pregnant women, infants and teens in the 2015 needs assessment, an objective related to NAS has been included. It is likely that in the future a SPM will be developed to further tackle this issue, but the need to focus efforts in the coming year on this topic is great. The objective that will be addressed is to refine the methodology for surveillance of NAS by September 30, 2020.

The strategies that will be used to address NAS in the upcoming year include collaborating with the DMS to develop a consistent methodology for reporting cases of NAS. Part of this process will be attempting to better understand why different codes are used for this diagnosis. The methodology that is developed will then be replicated with hospital discharge data. MCH will continue to collaborate with the KPQC to improve care for infants with NAS. Title V will also continue to collaborate with other departments to improve access to treatment services for pregnant women with substance use disorder.

In the upcoming year, MCH plans to focus activities on NPM #14: Percent of women who smoke during pregnancy and the percent of children who live in households where someone smokes. Based on federal-provided data, 21.6% of pregnant women in KY smoked during pregnancy in 2013. In order to address this measure, Kentucky plans to implement strategies targeted to three objectives including: 1) Increase by 5% the proportion of women who report that a health care provider discussed smoking cessation during pregnancy by September 30, 2020; and 2) Increase by ten the number of smoke-free policies implemented in KY by September 30, 2020.

In order to accomplish the first objective, KY has several strategies targeting increased availability of smoking cessation programs for pregnant women. MCH will plan to incorporate more extensive smoking cessation messages in existing programs. Two programs within MCH that have a broad reach with high risk populations for smoking during pregnancy are WIC and HANDS. Increased efforts will be placed on distributing materials through these programs as well as increasing the knowledge of programmatic staff on the best ways to approach women

who are smoking during pregnancy.

The MCH Evidence Informed Strategy: Baby and Me are Smoke Free has LHDs use evidence-based support and educational materials to engage pregnant and postpartum women to take a proactive role in modifying their smoking behaviors including smoking cessation and reductions in exposures to secondhand smoke. The objective of this strategy is to implement a smoking cessation program for pregnant women using individualized counseling and resources. Activities include use of the brief smoking cessation intervention, 5 A's, screening for co-morbidities (depression, social support, domestic violence) with appropriate referrals, individualized educational materials, and carbon monoxide screening.

In January 2015, Kentucky MCH received a grant from the Anthem Foundation to implement Giving Infants and Families Tobacco-free Starts (GIFTS) 2.0 in three counties. Two counties are focused on providing smoking cessation services to women served by any program in the LHD. The third county is implementing the program along with their Centering in Pregnancy© prenatal care program at the local hospital. Women are offered a small incentive to enroll in the program. Program components include the 5A's, screening for co-morbidities, carbon monoxide screening, motivational interviewing and support, and educational materials. Upon completion of the postpartum visit, a small reward in the amount of approximately $10 is provided to the women. Efforts focus on having a visit in each trimester of pregnancy as well as one postpartum visit. When possible, one visit is completed as a home visit to assess secondhand smoke exposures.

The second objective will focus on increasing the number of smoke-free policies that are in place. There are currently 24 KY communities with comprehensive smoke-free ordinances. As of April 1, 2015, 32.5% of Kentuckians are protected by comprehensive smoke-free workplace laws (University of Kentucky, Kentucky Center for Smoke-free Policy, 2015). MCH will collaborate with other partners to promote comprehensive ordinances in more KY counties.

In addition, the MCH Evidence Informed Strategy: 100% TFS is available for LHDs to implement. The objective of this strategy is that LHDs will promote 100% TFS by assisting the District Board of Education and other community stakeholders with the development and implementation of a policy for 100% TFS for all of the schools within their district. Activities for this package include the establishment of baseline data, meeting with key gatekeepers, stakeholders, and potential partners within the school district, and surveying school personnel, students and the community for measures of their support. The package also supports collaboration with appropriate student groups and distribution of survey results and information about policies to key stakeholders. When policies are adopted, this package can also be used to assist with implementation of the policy.

Oral Health

Plan for the coming year:

KOHP will be working diligently to retain community water fluoridation while updating the applicable regulations that reflect the new HHS/CDC Recommendations released in April, 2015 and will continue to support our existing public health dental hygiene programs and work to establish them in areas that are interested in this focus of public health. This program serves the MCH grant targeted populations, but work is being done to make these programs fiscally sustainable solely through Medicaid reimbursement.

MCH created an Evidence Informed Strategy that LHDs can choose to utilize Title V funds that will increase the application of fluoride varnish services for children through the fifth grade. This service is available in LHDs and school based clinics. The fluoride varnish used for this strategy is supplied to MCH though a contract with the UK

College of Dentistry.

To address Objective #3, develop and refine methodologies for ongoing oral health surveillance among children, the KOHP is working to fund and establish a survey of children's oral health status; KY has not conducted a comprehensive survey since 2001. We are engaging our two state dental schools in these plans as well as our established public health dental hygienists. As we work to establish this survey of children's oral health status, we will also be working to design an ongoing and sustainable surveillance system to be able to have up-to-date data of which better policies and programs can be developed.
Currently, the best data to which we have access is the Kentucky's Medicaid Claims Data and the CMS Report Number 416, which includes measurements parallel to Title V Performance Measures. While these two vehicles are not comprehensive point-in-time status reports, Medicaid is the largest insurer to the Title V targeted populations, thus giving us information about this population. The data will be important in determining trends in changes of oral health status in all segments of Kentucky's population but specifically the National Outcome Measure #14: Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.0	30.0	32.0	32.0	32.5

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	76.0	76.0	76.5	76.5	77.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	21.0	21.0	20.0	20.0	19.5

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	38.5	38.5	38.0

Annual Objectives					
	2016	2017	2018	2019	2020

Cross-Cutting Domain

The cross-cutting domain allows KY to focus on critical issues that affect individuals across the entire course of their life. Further, the concept of life course recognizes that there are critical periods from before the time a child is born and throughout the entire life span that influences the health of individuals. The clinical and preventive services previously described in the other domains are relevant within this domain as those population groups are provided services within this domain. The topics that are of vital importance in KY for the cross-cutting domain are substance abuse, including tobacco use, and oral health; all of which will be discussed below.

Substance Abuse

Annual Report Activities:

Substance abuse is having a devastating effect across all MCH populations in KY as evidenced in the 2015 needs assessment process and quantitative data analysis. It is an issue in every community in KY, and the consequences of this epidemic have been particularly devastating to pregnant women and their infants. These consequences include pregnancy complications, increased risks of relapse, and overdose deaths in women; and for their children, NAS, infant death from impaired co-sleeping, and deaths from pediatric AHT. The areas that will be highlighted for the annual report include the Perinatal Advisory Committee, NAS surveillance, and collaborative activities with other state agencies.

Perinatal Advisory Committee. Substance abuse during pregnancy and NAS are two of the topics for which the Perinatal Advisory Committee may make recommendations on evidence-based guidelines and programs to improve the outcomes of pregnancies. The committee receives updates on NAS data as well as smoking during pregnancy at their quarterly meetings.

NAS surveillance. In KY, data from hospital discharge records indicate the number of cases of NAS has increased 15-fold in the last decade (67 in 2001 compared to 1016 in 2014). The rate of NAS among infants covered by Medicaid in KY has more than doubled from 263 cases in 2008 to 728 in 2014. Mandatory reporting of NAS to DMCH was instituted in July 2014. From August 1, 2014 to March 31, 2015, there have been a total of 647 unduplicated symptomatic KY residents reported with NAS. The rate of NAS during this time period is 21.5 cases per 1,000 live births. Opiates are the most commonly reported substances accounting for 87.5% of all reported cases of NAS during this time period. Along with rising rates of NAS, there has also been an increase noted in the number of children with hepatitis C. Kentucky's Viral Hepatitis Program initiated a voluntary reporting pilot project for Hepatitis C Virus (HCV) in January, 2014 for pregnant women, children under the age of six years, and infants born to Hepatitis C positive women. Through mid-April 2015, there were over 650 pregnant women voluntarily reported with HCV infection. Based on this concern, HCV was approved by legislation as a reportable disease among these populations.

Collaborative Activities with Other State Agencies. KYs Title V agency has invested significant time working collaboratively with the Department for Behavioral Health, Developmental and Intellectual Disabilities and the DMS to identify best practices for comprehensive treatment options for women with substance use disorder, particularly during the pregnancy and parenting period. These agencies have worked together to develop the Medicaid State Plan Amendment to implement Health Homes focusing on individuals with substance use disorders and at risk of

blood-borne infections, a subpopulation of which is pregnant and postpartum women with opioid addictions.

KY has also participated in the National Center on Substance Abuse and Child Welfare In-Depth Technical Assistance (IDTA) initiative. The aim was to build a sustainable, family-focused, integrated system that will strengthen, stabilize and unify families with co-occurring parental substance use disorders and child maltreatment who are involved with the courts.

MCH also collaborates with the Office of Drug Control Policy on issues related to substance abuse. In 2015, a comprehensive bill was passed in the KY Legislature to address the heroin epidemic. The bill includes stronger penalties for dealers and traffickers and better treatment options for those seeking help. The addiction treatment system will receive an immediate $10 million boost followed by $24 million annually. A portion of those funds are designated towards NAS. The bill also increases the availability of naloxone, and allows for clean needle exchange programs if the local jurisdiction approves.

Accomplishments/Progress:

Recognizing the serious issue of NAS, legislation was passed that required facilities making the diagnosis of NAS to report Kentucky resident birth cases to KDPH. The legislation also requires that KDPH publish on at least an annual basis de-identified statistical data on the reports of NAS. In July 2014, a guidance document and form were distributed to all birthing hospitals in the state, with a revision distributed in January 2015. A database system has been developed to track the reports received. The first report on the data will be released in December 2015.

MCH has also taken a leadership role in work groups established to address NAS. In May 2013, a forum on NAS was held to set an agenda for further work on NAS. From this workgroup, four critical opportunities for intervention and breaking the perinatal substance abuse cycle were identified including the prenatal period, hospital period, post-discharge period, and community prevention. At the end of the forum, participants prioritized the topics that were most important to address NAS. The three priority areas included: 1) Post-discharge treatment/case management programs that support mother and baby together, address bonding and infant development, and extend for 12-24 months after the birth; 2) State guidelines/evidence-based practices/Best practices; and 3) Universal drug screening for pregnant women and infants. Four committees developed out of these topics and draft recommendations have been made. The four committees are universal screening, guidelines for the hospital period, post-discharge to age three, and policy and community.

MCH has also been working with the KPA on a Kentucky Perinatal Quality Collaborative (KPQC) that is focused on NAS. Two NAS meetings have occurred in the past six months to provide education to participating hospitals on NAS and quality improvement strategies. Hospitals began reporting data in January 2015. The aim of the project is to improve the care of infants with NAS through standardizing NAS scoring and medical guidelines for treatment of NAS infants by July 2015. The measurable goals include decreasing the average length of stay by 10% for NAS admissions, decreasing the number of infants with NAS referred for higher level of care, and decreasing the number of NAS infants requiring pharmacologic treatment.

Challenges:

The widespread nature of the substance abuse epidemic in Kentucky is a challenge. When focusing efforts on treatment options for pregnant and parenting women, the need far outweighs capacity. From a data standpoint, there are also challenges to obtain accurate numbers using administrative data sources. The NAS reporting form captures the ICD-9 code that is being used at the hospital for all reported infants. This data has demonstrated that some of the babies with the diagnosis of NAS are not receiving a specific code related to the diagnosis, and that

some babies are receiving codes outside the two typically used for this diagnosis (779.5 and 760.72). Additionally, there is no consistent method between agencies to report consistently on the prevalence of this issue. Another significant concern is that some babies with NAS may be discharged from the hospital before onset of symptoms, resulting in a potentially high-risk situation for the infant.

Tobacco Use

Annual Report Activities:

Tobacco use remains a significant public health problem in KY with 26.5% of adults reporting tobacco use according to the KY BRFSS. Among high school students in KY, 17.9% report tobacco use. Due to the widespread health implications from tobacco use, this is a priority goal in kyhealthnow. The aim is to reduce KYs smoking rate by 10%. Specific strategies to achieve this goal include increase the use of smoking cessation therapy by 50% and supporting tobacco-free schools and campuses. The areas that will be highlighted for the annual report include the KFAP, CoIIN, and collaborative activities with the Tobacco Control and Prevention Program.

KFAP. KFAP includes Smoking Use in Pregnancy in the restructured partnership. The KFAP received a grant from the MOD to implement a project entitled "Use of the "What's in a Cigarette" Informational Tool for Education on the Dangers Associated with Smoking During Pregnancy and to Discourage Use of E-Cigarettes." In this project, KFAP has developed two-sided colorful cards where one side demonstrates what is contained in a traditional cigarette while the other side demonstrates the contents of an electronic cigarette. These materials are being laminated and will be distributed to health care providers to assist them in educating patients about the adverse effects of smoking during pregnancy.

CoIIN. As a Region IV state, KY participated on all of the work groups in the CoIIN to Reduce Infant Mortality including the Smoking Cessation Work group. Participants in this work group were Dr. Joyce Robl from MCH and Ms. Bobbye Gray from the Tobacco Prevention and Cessation Program. A PDSA cycle to increase calls to Quit Now KY was conducted, and the results are discussed below in the challenges section.

Collaborative Efforts with Tobacco Prevention and Cessation Program. The Tobacco Prevention and Cessation Program is organizationally located within the DMCH which leads to increased collaborative efforts regarding the MCH target population and tobacco issues. A statewide comprehensive smoke-free bill was proposed during the 2015 legislative session. For the fourth year in a row, it passed out of the House Health and Welfare Committee, and for the first time, in a historic vote it passed the House. A companion bill was sponsored in the Senate, bur rather than referring it to the Senate Health and Welfare Committee chaired by the bill's sponsor, it was referred to the Veteran's Affairs and Public Protection Committee, where it died without a committee hearing. A poll released in January 2015 by the Foundation for a Healthy Kentucky found that 66% of Kentuckians now support a comprehensive statewide smoke-free law.

Tobacco efforts have also focused on adolescents. By the end of 2014, the number of public school districts with a 100% Tobacco-Free School (TFS) policy had grown to a total of 39, or 23% of KY school districts. Among KY students, 38% are protected from secondhand smoke. Additionally, the Tobacco Retailer Underage Sales Training (TRUST) program which was launched in July 2012 continued to experience significant growth in 2014 by adding nearly 600 retailers by the end of December 2014. A postcard to promote TRUST availability was developed and revised with input from a focus group of tobacco retail leadership and store managers. An initial mailing was sent out in June of 2014, and ads placed within grocer and retail target publications more than doubled the previous year.

As of April 30, 2015, TRUST has reached a total of 1,667 retail staff since its launch.

Quit Now KY has a pregnancy/postpartum protocol that is available to all KY residents 15 years of age or older who are currently pregnant. In this protocol, there is a designated female coach assigned to each pregnant woman. There are also rewards in place for completion of completed calls. During pregnancy, women receive $5 per completed call up to $25, and postpartum they receive $10 per completed call up to $40.

Accomplishments/Progress:

Previous NPM #15 monitors the percent of women who smoke in the third trimester of pregnancy. KY has made slow but steady progress on this outcome over the past ten years with the percent declining from 23.4% in 2005 to 19.0% in 2014. The decline from 2013 was small with 19.3% of mothers reporting smoking in the third trimester in that year. The KFAP Smoking Use During Pregnancy work group has developed materials including talking points, frequently asked questions (FAQ's), and a resource list to promote consistency in messages among the partners. In addition, all pregnant women enrolled in the Public Health Prenatal Program are to be assessed at each prenatal visit about the use of alcohol, tobacco, secondhand smoke exposure, and other drug use. Staff is to provide appropriate education and referrals such as Quit Now KY.

Challenges:

While KY has made some progress in decreasing the number of women who smoke during pregnancy, the rates of smoking during pregnancy in KY remain almost double that of the Nation. KY is consistently one of the worst states on this indicator. The CoIIN activities that were completed in the original CoIIN attempted to increase Quit Line usage among pregnant women enrolled in a home visitation program. HANDS is a voluntary program for first time at-risk parents that is available in all 120 counties. Three counties were identified to participate in a quality improvement project to increase the number of pregnant smokers who contacted the Quit Line. Home visitors in these three counties were trained on completing the 5 A's (Ask, Advise, Assess, Assist and Arrange) for smoking cessation, motivational interviewing, and the specific activities of KYs Quit Line, Quit Now KY. In the quality improvement project, calls to Quit Now KY were monitored for referrals from the HANDS program. Unfortunately, there were no increased number of referrals from this program, and the counties implementing the project did not have a change in their referrals either. The Quit Line does not appear to be an effective manner of increasing smoking cessation among pregnant women in KY.

Oral Health

Oral health in KY ranks very poorly and is a subject of concern for all ages in the cross-cutting health population domain. Although it did not rate as a top priority in the needs assessment process, it appeared as an issue from consumers and professionals alike. Poor oral health is on the Governor's list of concerns and is a goal of kyhealthnow to reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%. According to the latest statistics from the DMS, only 43% of KYs children with Medicaid accessed at least one dental service in 2013 (KY Medicaid Data Warehouse; Claims database Year 2013).

KOHP is concerned with the oral status of all Kentuckians and houses programs that target that goal. The Community Fluoridation Program works with municipal and private water systems to assure compliance with KYs statewide law that requires fluoridation at optimal levels to reduce decay rates in the state. KY has the highest rate of

municipal system customers having optimally fluoridated water than any other state in the country.

Annual Report Activities:

Fluoride varnish and the application of dental sealants are preventive health strategies used to meet the needs of our youngest Kentuckians who live in pockets of the state without pediatric dentists or where providers do not accept Medicaid or treat uninsured populations. We continue to use state general fund allocations to fund sealants that are placed by dentists in the state through contracts with their LHDs. The target audience for this outreach is children that do not have a payment source for sealants.

Fluoride Varnish Program. KOHP supports LHDs for the provision of fluoride varnishes to their clinic- and school-based patients through trained public health nurses. Fluoride Varnish is one of the MCH Evidence Informed strategies that LHDs can implement with Title V funds. Fluoride varnishes have been provided by public health nurses for the population of birth to 6, and now will be expanded to providing varnishes to children through the fifth grade. This is based on the "Smiling Schools" project (see accomplishments). This project will be repeated for the FY 15-16 school year. Up-to-date training in dental development and disease prevention is provided to public health nurses throughout the state. As a leading oral health preventive service, the varnish training program continues to encourage interested physicians, including pediatricians and their nurses, to provide fluoride varnish treatments for very young children in their clinical settings, which are now reimbursable through Medicaid.

Oral Health screenings for school entry. The KY Legislature has acknowledged the importance of oral health in children by passing a requirement for all children to have an oral health screening at school entry (kindergarten or first grade). The MCH State Dental Director has assisted in developing the form with the KDE and is providing trainings to LHD and schools nurse to be able to do the screening.

Public Health Dental Hygiene Program. In order to provide more access to preventative dental services, especially in rural areas, the legislature established a new licensure category for public health dental hygienists. These hygienists can provide preventative dental services to low risk populations, operating under protocols rather than the direct oversight of a dentist. The first year, public health hygiene teams were established in five health departments to provide primary preventive services to the underserved. Although they provide a comprehensive range of primary preventive services, our clinical focus is on the placement of sealants on erupting molars (previous MCH NPM). But, clearly, the most important service provided to this at-risk population is the referral of these patients to a permanent dental home in their own communities. Additional dental hygiene teams will be added in the coming year.

Oral Health Outreach. Through a contract, KOHP supports and partially funds preventive and restorative outreach services of the UK College of Dentistry to underserved children through their mobile dental vans and remote clinics/teaching sites. The application of dental varnish, the dental sealant and the placement of fillings will impact the Performance Measure related to the number of preventive dental visits and Outcome Measure related to the percentage of children ages 1-6 with untreated dental decay.

Accomplishments/Progress:

To address access for children in rural areas, the KOHP has made available a training program that offers general dentists practical training in pediatric techniques so that they will see this young patient population (under six years of age). The development of this curriculum was funded by HRSA, yet received an enhancement grant from ARC to target participation by the dentists in the ARC geographic area. This increased access to dental care for children in

need. Medicaid showed a slight increase in utilization for this targeted patient group, a positive step to meeting the goal of increasing by 25% the number of pediatric dental visits.

With the support of the Governor's office and funding from ARC, the KOHP developed a school-based fluoride varnish program. “Smiling Schools”, for elementary children in 30 of KYs highest need counties. This two-year project had significant results when we provided two varnishes for each of the two years for over 14,500 students. But the most impactful of the evaluation results was the finding that active decay had reduced by 20% in this population over the course of the project. Because of this finding, our MCH Title V plan expanded to support the provision of fluoride varnish to elementary students. Current data collection is limited to Medicaid Claims data.

The 2014-16 biennial budget provided additional funding for the state oral health program. This has enabled the KOHP to establish four new positions that will be dedicated to the improvement of the state’s oral health status, rather than relying on grant funding.

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Established community oral health coalitions continue to provide solutions to barriers regarding the lack of access to dental services for the MCH targeted populations. As expected, sustainability of the coalition lies in training and implementing strategies to increase the awareness of oral health knowledge and advocacy skills to create social change towards oral health. These coalitions were funded through grants from the federal HRSA and the quasi-federal ARC. Although the funding has ended for these coalitions, many of them (about 15) still carry on with goals to improve the dental health status of their community and most of the coalitions target children’s access to care. The statewide Kentucky Oral Health Coalition has reinvigorated itself through a private foundation grant to assist in the improvement of dental health status. Their goals include the increase of utilization of dental services for the at-risk children in the state: the uninsured and Medicaid-insured child.

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Challenges:

During KYs Needs Assessment, oral health did not come up in the consumer or stakeholder surveys. It remains a challenge to have KY families value good oral health for their children. However, oral health did come up in focus group discussions as access to dental care resonated as a major concern, either in distance to travel to a dentist, or lack of pediatric dentists overall. The burden for families to travel distances because of lack of transportation or cost is another issue, as well as long wait times to be scheduled for care, or to actually be seen once in the office.

Other Programmatic Activities

Other Programmatic Activities

KYs State Systems Development Initiative (SSDI) is involved with all of the MCH domains. The purpose of this grant is to enhance the data analytic capacity within MCH in order to address three goals: 1) Build and expand KYs MCH data capacity to support Title V efforts and the utilization of data for MCH programmatic decisions; 2) Improve the timeliness and availability of data related to infant mortality in support of Kentucky's efforts with the CoIIN to Reduce Infant Mortality; and 3) Increase utilization of the minimum and core data sets in KYs MCH programs. The SSDI grant provides KY an opportunity to build on our existing data infrastructure and enhance the quality of our data. SSDI program staff, comprised of MCH epidemiologists, has participated on the 2015 Needs Assessment team, prepared fact sheets on selected topics, assisted in the determination of state priorities, and assisted in the development of action plans for the selected NPMs. They have also provided analytic support for the data reported in this block grant application and participated in the development of the annual report. In the upcoming year, SSDI staff will participate in ongoing needs assessment activities, assist in the development of SPMs, assist in the

development of structural and process measures for the selected measures, and provide ongoing evaluation of selected measures. SSDI staff will also coordinate a PRAMS-like survey for KY. This survey will be used to access high quality data of selected maternal behaviors and experiences. The collected data will fill gaps in existing MCH data in KY, and will be used for monitoring progress on selected Title V performance measures. While KY is not a CDC grantee for PRAMS, staff have conducted two previous PRAMS pilot projects (2007 and 2009/2010) in Kentucky.

KY MCH epidemiologists have also mentored two HRSA GSEP students in the past few years. In 2012, Dr. Joyce Robl was the preceptor for Ms. Manza Agovi who conducted a review of all SUID cases from death certificate records and ME reports to identify the presence of risk factors such as the sleep environment. In 2014, Ms. Tracey Jewell mentored Ms. Caitlin Dunworth who completed an internship with the CCSHCN. She completed an assessment of data from the NS-CSHCN and compared that to internal Commission data in order to assess gaps in services for specific conditions.

Other MCHB Investments: Kentucky has a longstanding history of a state-wide home visiting program for first time parents (HANDS). MIECHV has allowed us to expanded home visitation program to include multi-gravida families, and to implement in-home depression treatment (Moving Beyond Depression). In addition, in Louisville, The Federal Healthy Start program addressed infant mortality disparities in high risk zip codes in this urban area. It is currently the only federally funded Healthy Start site in the state. For sixteen years, Louisville's Healthy Start Program has supported the community by reducing infant mortality, low birth weights, and premature births. Program employees consisting of professionals, paraprofessionals, and peer counselors have served over 8,000 families. The ECCS grant has provided infrastructure and staff to help support Kentucky Strengthening Families (KYSF), This initiative represents a multi-disciplinary partnership of more than 20 public and private national, state and local organizations dedicated to promoting six research-based protective factors into services and supports for young children and their families across agencies and promoting early childhood systems at the state and community levels.

Other Federal Investments: MCH currently houses and oversees the federal Kentucky Birth Surveillance Registry Grant funded through the CDC and the Childhood Lead Poisoning and Prevention grant also funded through the CDC. The WIC program is in the Nutrition Branch of MCH, and includes breastfeeding promotion. MCH also partners with family planning, and immunization programs to ensure that specific needs of the MCH population are addressed through programmatic activities. The federal Part C program, called First Steps, is managed in MCH and has 12 regional Points of Entry across the state. Through partnership with the DCBS, the state's child welfare agency, CCSHCN provides support to child welfare clients, caseworkers and foster parents through development of individualized health plans and monthly nurse home visits to medically fragile children in foster care for condition-specific education and support; and co-location of dedicated nurse consultants in regional child welfare offices across the state for consultation on medical needs of children in or at-risk of foster care placement.

Other HRSA Programs: The HRSA Bureau of Primary Care has a significant impact in KY, as KY is predominantly a rural state with about half of the population living in rural areas and 98 of 120 counties categorized as non-metropolitan. Access to care is a problem for many due to poverty, transportation and cultural isolation. The state's Health Professional Shortage Areas (HPSA's) are based on the county as the service area. Kentucky currently has 65 counties with a primary care HPSA, 32 counties with a DPSA (dental) and 98 counties with a MPSA (mental health). These include whole counties, partial counties (census tracts) or combined counties and can be geographic, with high needs or population/low income. The shortage area designations provide counties the opportunity for better recruitment and retention of providers through programs such as the National Health Service Corps and J1 Visa Waiver Programs. Kentucky has 22 Health Center Grantees (FQHC) with 159 sites across the state. Kentucky has 132 Primary Care Centers, private, non-profit corporation of community health centers, rural health clinics, primary

care centers and other organizations and individuals concerned about access to health care services for the state's underserved rural and urban populations. Three centers focus on homeless and seasonal/migrant farm workers. LHDs partner with federally qualified health centers in many places to address specific health needs of the community and provide resources for outreach and education.

State and local MCH Programs: CCSHCN considers KDPH a key partner and the agencies continue to support one another's missions. LHDs are resources embedded in local communities throughout KY, and some CCSHCN staff are co-located with health departments. However, the Needs Assessment focus groups served to bring those in some communities together for the first time. In addition to working together on block grant applications, CCSHCN interfaces closely with MCH programs such as First Steps through referrals and follow-up, CCSHCN serving as the preferred audiological assessment provider for First Steps, and providing a network of foreign language interpreters for both agencies, as well as exchanging data and information regarding EHDI referrals and follow-up. As of July, 2015, CCSHCNs partnership with First Steps includes administering point of entry services in the Louisville area. CCSHCN supports, through daily operations, larger cross-cutting MCH goals within the CYSHCN population (e.g. counseling children with regard to teen pregnancy as part of the care coordination, transitions and life skill building process; providing folic acid access and education to those of childbearing age who come into contact with agency staff; and parallel participation in larger initiatives alongside KDPH – such as "kynect" and 5-2-1-0, etc.).

Other Programs within the State Department of Health: MCH is working jointly with the Hepatitis C and HIV/AIDS programs within the Division of Epidemiology and Health Planning to address the rising rates of drug use among women of childbearing age and subsequent NAS rates among infants. The MCH Title V program partners with the Kentucky Injury Prevention and Research Center (KIPRC) at the University of Kentucky, the bona fide agent for injury prevention for the KDPH. KIPRC applies for and coordinates the CDC Injury and Violence Prevention Cooperative Agreement for Kentucky. MCH partners on prevention activities with KIPRC's statewide coalition and state injury prevention plan. MCH works closely with the Division of Women's Health on a number of efforts, including adolescent health, teen pregnancy, family planning, and folic acid.

Other Governmental Agencies: There is currently an unprecedented level of activity in KY State Government around services that directly impact our MCH populations. Challenged by the Cabinet Secretary, multiple departments within the CHFS have engaged in intentional efforts to eliminate silos and work together to meet the needs of children and families. The Secretary established a Children's Leadership Team, led by the Deputy Secretary, as a forum for communication to assure coordination among all these efforts. Both the MCH Director and the CCSHCN Executive Director are members of this team. In addition, there are representatives from Behavioral Health, Substance Abuse, Medicaid, Child Protective Services, Family Resource Centers (FRYSC), data analysts, and grant-specific program managers. There has developed a close connection between this group and the State InterAgency Council (SIAC), which also includes Juvenile Justice, the Administrative Office of the Courts, and Education. SIAC is charged in statute with overseeing services for children with behavioral and emotional issues, but now is providing the oversight structure for many of the cross-agency children's initiatives. These include:

- Kentucky Initiative for Collaborative Change (KICC): Children's Behavioral Health Redesign and Expansion of Systems of Care. This Substance Abuse and Mental Health Services Administration (SAMSHA) funded grant builds on a previous grant for establishing systems of care in communities for children with Behavioral Health Needs. Many MCH programs have been involved, including HANDS, Child Care Health Consultation, Early Childhood Mental Health, First Steps (Part C), WIC, and Strengthening Families. The KICC grant promotes family-driven, culturally and linguistically appropriate, and community based services. KICC teams designed a framework for addressing a "new and modern children's behavioral health system" and those now have become standing committees for SIAC.
- In the last legislative session, a bill redesigning Juvenile Justice was passed, and the SIAC partners are overseeing the implementation of this change.

- Trauma-informed care is being promoted across systems including behavioral health, child protective services and family preservation, KDE, and the Governor's Anti-Bullying Task Force. MCH has a key role in presenting ACEs to these audiences.
- Family Resource Centers are overseeing a pilot of behavioral health screening in schools, using the GAIN-SS, to identify children with externalizing, internalizing, substance abuse, or violence issues and get them into treatment. Family Resource Centers are also the base for Born Learning Academies, an initiative of the Governor's Office of Early Childhood as part of the Race To the Top (RTT) Early Learning Challenge grant awarded to KDE in 2014.
- Child Protective Services is currently implementing a Title IV-E waiver project to improve services and supports around domestic violence and substance abuse. This includes expanding the START program, an evidence-based, intense substance abuse treatment and support approach for families who face removal of their infant due to substance abuse issues.
- DMS and the Cabinet Office of Health Policy were awarded a CMS Planning grant for Health Homes, a concept of coordinated, comprehensive care for chronic disease. The chronic disease chosen by Kentucky's workgroup is Substance Abuse, and they are focusing on creating a more intense case management payment for pregnant and parenting women with substance abuse. The Medicaid Medical Director, Behavioral Health Medical Director, and MCH Director have made many field trips to explore what treatment for pregnant and parenting women is available in our state and best practices from surrounding states.
- These discussions have also been part of KYs invitation to attend a SAMHSA Policy Academy on Substance Abuse, an award of an In-Depth TA grant with the National Center for Child Welfare and Substance Abuse, and a new grant opportunity from SAMHSA to develop Medication Assisted Treatment opportunities in the context of comprehensive treatment modalities for pregnant and parenting women with substance use disorder. The MCH Director serves on the team for these initiatives.
- The DMS has received a CMS Innovations Grant to develop a State Innovation Model, an extensive planning grant to change the way we deliver and pay for health care. This is a large effort involving public and private partners, providers and business leaders from across the state, facilitated by Deloitte, to redesign the ways Medicaid could do business differently and impact the triple aim of better health, better patients experience, and lower cost.
- The DMS is also pursuing the development of the Kentucky Health Data Trust Initiative, an all-payor claims database that will integrate all health care data to support analytics, impact policy, and improve health in the state. The MCH Epidemiologists are participating in the planning development of this initiative due to our surveillance projects and use of data to support program and policy.
- The KDE received a RTT Early Learning Challenge grant, and MCH has been involved in the planning and implementation of RTT activities. The RTT grant embraced our Strengthening Families initiative as a model for parent engagement.
- KYSF is an initiative co-led by MCH and the Governor's Office of Early Childhood. It has no specific funding stream, but components are funded through the Race to the Top/Early Learning Challenge Grant Program and the MCH Early Childhood Comprehensive Systems Grant Program.

CCSHCN is connected and involved with outside organizations that are resources to families and in turn make CSHCN known to the agency. CCSHCNs own governing board is representative of the community and includes governmental, university and private sector entities.

CCSHCNs cooperative relationship with the DMS is unique and significant - as sister agencies under the umbrella of the state's CHFS, CCSHCN and DMS leadership interact regularly in the interest of better serving their respective populations. While CCSHCN had minimal involvement in the development of DMS's master agreement with the five MCOs, the contract did make provisions for cost reporting as a way of ensuring reimbursement for the Title V

agency. After the awarding of the contracts to the MCOs, CCSHCN initiated discussions with the individual MCOs to offer an opportunity for the MCOs to learn about the Title V agency and its role with CYSHCN. Although CYSHCN are mentioned in the master agreements for the MCOs, none knew of the Title V agency's exact role. As the Title V agency is a Medicaid provider, CCSHCN leadership has established and maintains working relationships with representatives from each of the MCOs and is able to renegotiate existing contracts accordingly. CCSHCN receives funding from DMS through cost-based reimbursement for direct services provided in a clinic environment, targeted case management, outpatient therapies and audiological testing, and fee-for-service reimbursement from MCOs.

Public Health and University Collaboration: KDPH maintains an on-going partnership on many levels with the UK CPH. Staff from MCH continue to guest lecture in MCH courses offered at UK. Universities provide expertise for CYSHCN and vice versa include CCSHCN contracting to operate Hemophilia Treatment Centers through UK and U L, specialty providers who have become active with CCSHCN due to their affiliations with KYs teaching hospitals; provision of educational opportunities at CCSHCN for medical residents and internships/externships for a variety of pre-professional programs (audiology, nursing, OT, PT, SLP, social work, etc.); collaboration to ensure the availability and continuity of services not available elsewhere (e.g. when UL disbanded their cochlear implant clinic, services were folded into CCSHCN); and collaborating to provide itinerant pediatric clinics in rural and underserved communities.

Family/Consumer Partnership and Leadership Programs: Refer to section on Family and Consumer Partnerships

Other State and Local Public and Private Organizations: Additionally, MCH collaborates with a number of advocacy organizations. Grass roots efforts around eliminating EED are obtained through March of Dimes events. Kentucky Youth Advocates, the Kids Count vendor for KY, hosts the Kentucky Oral Health Coalition. Prevent Child Abuse Kentucky hosts the annual Kids are Worth It Conference. The Pritchard Committee for Academic Excellence promotes early childhood home visiting and pre-K. The Foundation for a Healthy Kentucky focuses work on Coordinated School Health. These groups partner with MCH on advocacy for MCH issues as well as program planning.

II.F.2 MCH Workforce Development and Capacity

F.2. MCH Workforce Development and Capacity

Kentucky's health care workforce has been extensively studied in preparation for the KHBE and Medicaid expansion. A Health Care Workforce Capacity Report (Deloitte Consulting, 2013) was completed in 2012. This report found that the current supply of physicians in 2012 was 10,475, and the need at that time was 3,790 full time equivalents (FTEs). In 2012, there were 1,711 dentists with an overall need of 612 additional FTEs, or 36% of the current supply. Maldistribution of providers is also an issue, as KY is primarily a rural state. These findings demonstrate the continued need in some areas for LHD's to provide direct MCH services, as described in this application.

The Education and Workforce Development Branch (EWD) within KDPH is responsible for ensuring a well-trained competent public health workforce at the state and local level. EWD provides training opportunities via a national public health web-based training system [TRAIN], used by MCH programs. In 2012, EWD conducted a statewide public health workforce assessment in collaboration with the Kentucky and Appalachia Public Health Training Center. The survey included the eight competency domains that are being used on a national level to assess public health workforce. (Knight, 2012) The percentage of participants with a score of "Competent" or higher is documented in the table below.

	Directors and Senior Leaders	Managers and Supervisors	Professionals and Support Staff
Communication	83.1%	77.2%	77.2%
Community Dimensions of Practice	68.6%	66.2%	65.1%
Cultural Competency	73.7%	65.9%	71.3%
Policy Development/ Program Planning	67.7%	57.3%	52.2%
Public Health Sciences	64.0%	50.3%	42.9%
Analysis and Assessment	59.5%	52.6%	52.8%
Financial Planning and Management	61.9%	50.6%	45.5%
Leadership and Systems Thinking	67.7%	69.7%	56.1%

The results suggest that areas of strength for KYs public health workforce include communication, cultural competency, community dimensions of practice, and leadership and systems thinking. Based on the survey results, critical workforce development needs for state Title V staff include policy development/program planning, public health sciences, analysis and assessment, and financial planning and management. To address these needs, with the support of MCH and CCSHCN, UK CPH is partnering with the graduate education program at the University of Alabama at Birmingham School of Public Health for their MCH training grant. This project will develop a plan to address our workforce education needs both individually and in collaboration with other Title V programs in the region. The CCSHCN looks forward to its possible alignment with and inclusion of CYSHCN areas.

MCH employs 80 public health practitioners focused on improving the health, safety and well-being of all MCH populations. MCH supports local MCH professionals with trainings and technical assistance; funds assure an MCH coordinator at each of the 61 LHD administrative units. The public health MCH workforce at the state and local level access workforce development trainings via several modalities including federal, regional, and state face-to-face meetings, webinars, and virtual learning networks such as the HRSA CoIIN to Reduce Infant Mortality. MCH programs that provide state-wide services, such as HANDS and Kentucky's Part C Early Intervention System (First Steps) have training coordinators dedicated to ensuring that all providers within their program have the critical competencies to complete their work. MCH also contracts with university partners for specialized trainings such as in-depth clinical training for well child assessments and prenatal services for LHD staff.

In order to improve MCH workforce capacity for the state, MCH contracts with the UK CPH to administer a Graduate Certificate in MCH. This is the only graduate training program in the state focused on public health expertise in MCH. The goal of the Graduate Certificate is to prepare public health workers to address multifactorial MCH issues

in their communities. The Certificate has four objectives including 1) To provide participants with theoretical, practical, and relevant educational experiences in MCH using the life course approach; 2) To use population data to assist in determining the needs of MCH populations for the purposes of designing programs, formulating policy and conducting research or training; 3) To describe health disparities within MCH populations, offer strategies to address them and respond appropriately to needs based on sensitivity to and respect for diverse cultural and ethnic backgrounds and socioeconomic status; and 4) Demonstrate the use of a systems approach to explain the interactions among individuals, groups, organizations and communities to improve health outcomes of MCH populations. The program began in fall of 2009 and there have been 22 graduates. One graduate has been hired in MCH as an Epidemiologist I. Five students from the program have been accepted for the GSEP. The development of this curriculum has increased the number of students completing practicums and internships in MCH, providing an opportunity for staff to mentor the next generation workforce.

MCH also participates in a workforce project led by the Division of Epidemiology and Health Planning called Building Epidemiology Capacity in KY, or BECKY. One subcommittee of BECKY is focused on academic/university collaboration with public health. State and university partners train current public health students so that they can provide assistance on state projects. For example, these students have assisted MCH epidemiologists in data entry projects in the past year. This subcommittee also works to provide trainings based on identified needs. This subcommittee is currently developing trainings on Geographic Information Systems (GIS) and interpreting laboratory reports.

CCSHCN employs approximately 155 staff, including 38 who are funded through Title V. Consistent with the Title V Mission, CCSHCN has historically provided gap-filling services. Currently, CCSHCN's primary source of care is direct care. CCSHCN is working towards expanding non-direct services to include more population based services and build better infrastructure. CCSHCN is in the process of hiring an Assistant Director, who would be instrumental in achieving this goal. Some of the non-direct services that CCSHCN envisions are building community partnerships throughout the State, expanding the outreach plan, coordinating expansion of telehealth program to other programs within CCSHCN such as autism and cardiology, acting as subject matter expert for MCH, strengthening family partnerships, strengthening support services for the non-English speaking immigrant population, strengthening Youth Advisory and Parent Advisory Committees, accessing existing programs for quality improvement, collecting data for existing and new programs, growing and promoting family centered care.

Beginning with participation in the 2014 GSEP summer program, and continuing in the coordination as part of the Needs Assessment process, CCSHCN has increasingly partnered with the UK CPH and one of the Title V MCH epidemiologists to assist in developing data capacity. For example, UK CPH initiated and completed a set of survey briefs (see attached) corresponding to CCSHCN's regional office map. These individualized 4-page briefs have been brought to the attention of regional nurse administrators for the purposes of education, planning, and outreach on a local level.

The opportunity to coordinate the consumer survey with MCH revealed a large number of children and youth with special health care needs (CYSHCN) not enrolled in CCSHCN services. This revealed what leadership was already aware of – the apparent need for further outreach and marketing (a skill set needed by the agency) beyond those efforts initiated by the agency's strategic plan. By bringing together CCSHCN and health department personnel both in follow up focus groups and at the statewide stakeholder meeting, CCSHCN hoped that working relationships at the local level will assist both sets of personnel with knowledge of resources and programs for the benefit of MCH populations.

CCSHCN makes every effort to improve the capacity of the MCH workforce. New employee orientation includes

required trainings - using materials available on the MCH Navigator as guidance, leadership staff created an MCH Primer which is posted on the staff intranet and is incorporated as a required training for new employees. Core Competencies training is provided through TRAIN National, a free service of Public Health Foundation. Staff is provided with a training budget to pursue personalized opportunities for growth in their field as pertained to job duties. For example, social workers may choose to attend trainings related to resource brokering or advocacy; nurses may pursue training in case management. CCSHCN staff also receives informal training on important issues (such as Transitions, Medical Home, Insurance, care coordination issues, billing/claims/prior authorization issues, etc.) through presentations at monthly Branch Managers meetings. Executive Staff attend the annual conference conducted by AMCHP and other relevant opportunities to stay abreast and learn about the programs from other States. CCSHCN reviews all TA opportunities, such as learning collaboratives, and attempts to learn wherever possible to expand the knowledge base of staff. Ultimately, the goal is to develop and promote systems of care and improve access for CYSHCN, and CCSHCN accepts advice from those who offer it. For example, CCSHCN is pleased to be participating in the NGA Learning Collaborative on Focusing on Accelerating Statewide Improvements in MCH alongside our partners over the next year.

CCSHCN maintains a strong commitment to enhancing the quality of life for KYs children with special health care needs through direct service, leadership, education and collaboration. Direct medical services are provided to children with defined medical conditions throughout the state through 12 regional offices. Through a diversity of staff (nurses, therapists, nutritionists, transition coordinator, social workers, medical directors, audiologists, parent liaisons), CCSHCN provides family-centered, community based care by sending treatment teams including nurses and pediatric specialty physicians to clinic sites throughout the state. Clinics for specific complex conditions that require multi-physician treatment teams are held only in Louisville and Lexington due to availability and coordination of providers, although telemedicine offers new possibilities to those areas where there is a provider shortage and/or waitlists. To assure cultural and linguistic needs of clients are met, foreign and sign language interpretive services are available in each region to assure effective communication that is easily understood by families of diverse cultures including those with hearing impairments.

II.F.3. Family Consumer Partnership

Kentucky's Title V program is committed to partnering with families and consumers in all aspects of MCH programming. These partnerships provide a unique perspective that strengthens the quality and effectiveness of MCH programs. Title V envisions that services will be provided in a culturally competent manner that extends beyond medical interpretation due to language barriers to an understanding of the health beliefs and behavior patterns of various cultures. Further, it promotes the delivery of information in a manner that is easily understandable by those of limited English proficiency, those with low literacy skills, and those with disabilities.

While CCSHCN attempts to be reflective of the population served, greater cultural representation is sought in order to broaden the reach of programs and services. Geographic diversity has increased due to the implementation of video conferencing for council meetings. Support groups have been implemented which reach the Hispanic population, and the agency is looking to add representation on groups which could cross the language barrier. Parents of all perspectives are solicited to become involved, including those from varying racial and socioeconomic backgrounds.

The strategies and activities that have been used to support family and consumer partnerships in advisory committees, strategic and program planning, quality improvement, workforce development, block grant development and review, materials development, and advocacy are described below.

Advisory Committees

Established CCSHCN advisory committees include the Hemophilia Advisory Council, the Parent Advisory Council, the Youth Advisory Council, and the CCSHCN Board of Commissioners, which provide opportunities for family leadership. Eligibility for the Youth Advisory Council was recently expanded to all CYSHCN (rather than CCSHCN enrollees), which increased and energized membership. CCSHCN includes parent representatives on ad hoc groups (such as the Healthy Weight committee, the strategic planning committee, Kentucky's delegation to AMCHP's Action Learning Collaborative, etc.) but is attempting to grow parent involvement beyond a committee presence and toward front-end collaboration. The more family members are involved and the more they are prepared, the more they can contribute. Training is provided as needed or requested, and efforts have been made to better orient interested parents and youth to agency operations. An active Family to Family (F2F) program has funding available for training, and peer-to-peer parent match program provides mentoring. CCSHCN attempts to help families understand what is going on with their child's care, and, beyond that, to empower families in leadership roles to strengthen their abilities to advocate for their own and other CYSHCN. Leadership attempts to ensure a family perspective at the state level and invites F2F co-directors to present at bimonthly statewide managers meetings.

Stipends are available for F2F and Parent Advisory Council members. CCSHCN reimburses for travel and provides a child-care stipend and has recently begun to offer food at Youth Advisory Council meetings. Technical assistance to the advisory councils includes staffing, guidance, orientation, logistical planning, and hosting of meetings. Opportunities are sought to provide F2F support parents with the ability to attend national conferences and other training events and opportunities. Partial reimbursement may be provided, subject to available funding. For example, multiple parents of CYSHCN were provided with training regarding care coordination and medical homes and services available for children with genetic disorders. Through this partnership with Michigan's Genetics Collaborative, as well as participating families from neighboring Indiana, stipends were given to cover gas, childcare, and time. Meals were provided.

CCSHCN invites Parent Advisory Council members to staff training events, which are of a limited frequency agency-wide. Orientation training document for new providers does discuss mission/vision of family involvement. Inasmuch as training is offered, an attempt is made to provide a parent perspective when possible. F2F support parents received the same training as agency social workers and other staff in preparing for roles as navigators for the state-based health benefits exchange ("kynect"). Co-directors of F2F are parents of CYSHCN. These co-directors are valued and hard-working CCSHCN staff who are involved in a variety of aspects of agency operations on behalf of the CYSHCN population. Further, a network of capable support parents assist with statewide initiatives, such as the implementation of kynect, the state-based health benefit exchange. The executive director of the agency is also a parent of two CYSHCN.

The Kentucky Strengthening Families (KSF) Leadership Team includes agencies that serve families, family organizations, and family advocates who are committed to promoting strength based, family driven values and principles in agencies who adopt the Kentucky Strengthening Families Framework. Kentucky Strengthening Families has a parent advisory board/group that is a virtual network of parents who have experienced Kentucky's system. These parents provide the voice of parents to the program, assure relevance, and provide KSF a mechanism to communicate back to families. This group sponsored a forum on the Parent Café model facilitated by Be Strong Families Illinois. It was a two-day experiential and highly interactive training that prepared parents and providers to convene and conduct Parent Cafés and serve as table hosts at Parent Cafés. Participants learned the basic structure and elements of the World Café process. Areas covered included the anatomy of a Parent Café, the philosophical foundations and research underlying Parent Cafés as a parent education and parent engagement strategy, how to create an ambiance conducive to maximizing the effectiveness of the Parent Café process, and how to build on the Parent Café experience to enhance programming for parents.

Kentucky's Early Intervention System has six parent representatives on the Interagency Coordinating Council (ICC). The mission of the ICC is to maximize the potential of infants and toddlers (birth through two) having, or at risk of having developmental delays, to do so through a comprehensive statewide system; and to provide services that are: available as soon as it is possible to identify the need, family centered, coordinated, community-based, normalized, accountable, culturally competent, individualized, accessible, quality, timely, interdisciplinary, and linked to services outside of the early intervention system. Additionally, First Steps has a parent consultant as a staff person to assure family perspectives on service delivery and programming.

Strategic and Program Planning

KSF Family Informed Systems Work Group hosted the first Parent and Family Forum on December 3, 2014. Approximately 30 participants representing different parent and family organizations and programs attended. Participants volunteered to share information about their organization's family ladder or spectrum of family involvement. The group identified common themes and language that could serve as the foundation for developing a common family ladder as well as other tasks of this work group. The participants were highly interested in having a more formal forum where all partners collaborate to strengthen family-driven care.

Quality Improvement

In November 2013, the Governor established a new KY Advisory Council on Autism Spectrum Disorders, attached to CCSHCN that includes appointees from DPH and seeks to offer a collaborative multiagency approach to making recommendations to the Governor. Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities and Department for Public Health sought to identify challenges to early identification, diagnosis and intervention for children up to eight years with an autism spectrum disorder. Partnering with the Center for Systems Change, 14 regional forums were hosted to gather feedback from the community. At those forums, each region formed the beginnings of a task force, who then completed the Regional Assessment and Planning tool. The assessments were collected, summarized and have been reported to Kentucky's leadership in April 2014. Five follow-up meetings were held regionally in which data was presented, as well as a presentation within the Cabinet's interdepartmental meeting. In May 2015, a Parent Summit brought together over 70 family members and individuals with ASD (as well as 15 professionals), and only positive evaluations were received.

MCH is partnering with the Kentucky Perinatal Association to launch the first Kentucky Perinatal Quality Collaborative project on NAS. This involves 20 hospitals and teams, all using PDSA cycles to improve care for this population.

Workforce Development

The Office of Health Equity (OHE) provides training to state and local public health professionals on cultural competency sensitivity including vulnerable populations. Training is provided in person and TRAIN modules are available. The TRAIN modules are being updated with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care that are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Block Grant Development and Review

Families and consumers had numerous opportunities to provide input on the 2015 Needs Assessment as well as the Title V application in Kentucky. Two key components of the needs assessment were consumer surveys that were

distributed through LHD and CCSHCN sites. These surveys were available in both English and Spanish. Additionally, focus groups were conducted with local MCH staff to obtain feedback. A complete discussion of the efforts to promote consumer input is described in the Public Input section of this document.

Materials Development

The Early Childhood Comprehensive Systems (ECCS) leadership identified a gap for social and emotional resources by conducting an intensive survey sent to approximately 40 Social and Emotional consultants, trainers, and experts across the Commonwealth. Based on suggestions and needs assessment data from these audiences, ECCS staff created a three hour Social and Emotional training module modified for three different audiences: 1) Preschool teachers; 2) Infant-toddler teachers; and 3) Parents of children birth to 5 years. This social and emotional training, "Connect the Dots," concentrates on three aspects: 1) increasing adult awareness about why children exhibit challenging behaviors; 2) building social and emotional skills of the adults who work with children birth to age 5; and 3) providing tangible, quick reference tools that serve as reminders to teachers and parents about how to continue building these social and emotional skills in young children. Professionals are currently piloting this training. Family participants of the Kentucky Partnership for Families are going to be involved in the testing during the month of July 2015.

HANDS solicits valuable input from the perspective of parents and service providers through completion of two different satisfaction surveys that are completed on an annual basis. Each March the HANDS Parent Satisfaction Survey is distributed to participants actively receiving services and those who have exited from the program over the past twelve months. This survey gathers information from the families about the quality, duration, frequency, and impact of services. The second survey, the HANDS Site Satisfaction Survey, is distributed at the end of each state fiscal year to each HANDS site to gain input from program staff about the frequency and benefits of support received from technical assistance services, the value of training opportunities, areas of program implementation that need additional support, and the value and benefit of HANDS materials and resources.

MCH is currently working on a safe sleep campaign. To assure that materials are appropriate, focus groups are being conducted with consumers representing the target populations for the message. Focus group feedback will be utilized to refine the messaging and materials for the campaign.

In order to assure that all families and consumers are adequately informed, interpreters and translators are available throughout all MCH & CCSHCN programs. Materials are developed with attention to reading level to address the needs of consumers with low literacy.

Advocacy

The Early Childhood Advisory Committee (ECAC) appointed by the Governor, provides advice to the Governor's Office of Early Childhood regarding a variety of initiatives in early childhood. The ECAC oversees the early childhood funding provided through the Tobacco Master Settlement and provides support to the Governor's Office of Early Childhood on the implementation of the priorities of the Race to the Top Early Learning Challenge Grant. DPH is represented on this council. The ECAC is comprised of early childhood professionals, networks, and advocacy groups. There are two work groups focused on community-based efforts. The Community Collaboration Work Group aligns Community Early Childhood Council funding with local collaboration goals and promotes collaboration competencies. The Community Engagement Work Group establishes tools and processes for engaging citizens in advocacy for early childhood.

Additionally, MCH receives input from a number of advocacy organizations. Grass roots perceptions of early elective delivery are obtained through March of Dimes events. Kentucky Youth Advocated, the Kids Count vendor for KY, hosts the Kentucky Oral Health Coalition. The Pritchard Committee for Academic Excellence promotes early

childhood home visiting and pre-K. The Foundation for a Healthy Kentucky has focuses work on Coordinated School Health. These groups partner with MCH on advocacy for MCH issues as well as program planning.

II.F.4. Health Reform

F.4. Health Reform

Title V Role

The decision to implement a state-based exchange was based on a survey of stakeholders that demonstrated strong support for state rather than federal control (CHFS Office of Health Policy, 2012). The Kentucky Health Benefit Exchange (KHBE) has been branded as kynect. A Gallup poll in February 2015 reported a 10.6 percentage point drop in uninsured rates in Kentucky from 20.4% in 2013 to 9.8% in 2014, the second greatest state decrease (Witters, 2015).

The primary role of Title V in support of health reform has been outreach and enrollment. Kynectors are individuals who have been trained to provide information and assistance with enrollment. LHDs participated in these activities, and MCH Title V staff assisted consumers in a kynect retail store in the second enrollment period.

CCSHCN pursued inclusion with the KHBE ACA navigator program as a means to assist families during the open enrollment period and beyond. An agency “in-person assister administrator” oversaw 27 regionally located kynectors. CCSHCN sees involvement and partnership with KHBE as part of its mission - to ensure that CYSHCN have adequate insurance. While the funding of CCSHCN-affiliated kynectors has ended, CCSHCN continues participation in a similar capacity with a different name: Certified Application Counselors.

Services that advance implementation of ACA

One MCH Evidence Informed Strategy, Affordable Healthcare for KYs MCH populations was developed to improve access to health insurance. LHDs will provide education about the ACA, its benefits, and how to enroll. One strategy requirement is participation in a training developed by Kentucky Voices for Health and Get Covered Kentucky entitled *The ACA: What It Means for Kentuckians*. This training outlines ACA eligibility, enrollment, and dissemination to the public with discussion of possible barriers (culture) and best practices/resources.

In addition to Certified Application Counselors and CCSHCN staff working with enrollees to assess insurance adequacy, the agency also contracts with Patient Services, Inc., to provide insurance case management and premium assistance solutions for those with eligible conditions (bleeding disorders, cystic fibrosis). Policies have been refined to assure objective criteria for assistance to those with greatest need.

Title V Gap Filling Services

The Title V program continues to provide gap filling services. Many areas of rural KY have limited health and dental care providers making access difficult. Transportation may also be a barrier. LHDs fill that gap as they are in all counties, have flexible hours, and coordinate services to minimize visits.

KYs CCHSCN recognizes the effect that the relatively recent shift to managed care has had on CYSHCN, with changes in the way care is financed. The agency has worked with an existing MCO in one Medicaid region since its inception in 1997. Through discussions and an initial orientation period with the more recently established MCOs,

CCSHCN was able to educate on services provided, allowing for partnerships and integrated practices. For example, nursing assessments were developed to align documentation with MCO needs, and nursing care plans were created to demonstrate an individualized care plan developed with the patient and family. Documentation of case management provided by CCSHCN is shared with MCOs to avoid service duplication. The entrance of multiple MCOs has affected CYSHCN enrolled in multi-specialty clinics, as all providers are not enrolled in every MCO. This has the potential to fracture the team approach when providers are substituted on teams. An example of cooperation is CCSHCNs work with the dental administrator for 3 MCOS to create a policy specifically for CYSHCN enrolled in craniofacial and cleft lip/palate clinics to go beyond a once-in-a-lifetime orthodontia benefit and permit phased treatment.

Another success was negotiating with 2 MCOs to assure that no pre-authorization for therapy services would be required. For other MCOs requiring pre-authorizations, therapists are educated on consistently documenting medical necessity. Additionally, variability exists among the MCOs in terms of authorizations required for durable medical equipment. When facing such barriers to securing prescribed interventions, CCSHCN staff and parent peer consultants work diligently with families to resolve issues or obtain Medicaid waivers where appropriate.

Cultural & linguistic competence

The Office of Health Equity was invited to partner with the KHBE at the time of its inception to ensure that all aspects of the exchange were culturally and linguistically appropriate. Kynect was refined to be user-friendly with consideration for reading level capacities, diverse cultures and languages, and varied technology capacity. The system is available in English and Spanish with a toll free number for others with an interpreter available at no cost. A strategy in kyhealthnow is to increase kynect access in other languages.

In branding kynect, animated characters were developed representative of different types of Kentuckians. These characters were used in the marketing campaigns and education/outreach materials. The KHBE is required to provide culturally and linguistically appropriate outreach and educational materials to the public.

II.F.5. Emerging Issues

KY's Emerging Issues:

Several emerging issues have been identified by KY through the needs assessment process, not just by what was identified, but also the issues that were not identified by stakeholders.

Maternal morbidity was defined recently by the World Health Organization as ''any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing'' (Curtin, 2015). In 2013, KY had a maternal mortality rate almost 1.5 times that of the Nation (25.2/100,000 live births vs. 17.8/100,000 live births). African American women in KY have a maternal mortality rate 3 times that of White women. Clinical factors that have been associated with the rise in maternal morbidity include the increased cesarean delivery, induction and augmentation of labor (Bateman, Mhyre, Callaghan, & Kuklina, 2012). KY has a higher percentage of cesarean sections low risk women (31.8%, 2013) compared to the nation (26.9%, 2013). Despite the significance of this data, our stakeholders do not yet recognize maternal mortality and morbidity as a problem for KY women.

The emerging issue for children related to child abuse and neglect is the life-long impact of adverse childhood experiences, the need for trauma-informed practices by professionals, and the development of safe, stable, and nurturing environments in communities. Although violence prevention has always been an MCH issue, it now takes on added significance for the health and well-being of children.

Substance abuse is now an epidemic, not just in KY but across the nation. In 2013, KY had the second highest age-adjusted drug overdose death rate in the Nation at 23.7 deaths per 100,000 population compared to 13.8 per 100,000 in the U.S. (Slavova, 2015). Pharmaceutical opioids were the primary cause of KY resident drug overdose deaths as they were involved in 58% of deaths for which the drug was listed on the death certificate (Slavova, 2015). The many long term consequences of drug use for pregnant women include increased risks of assault and abuse, miscarriage, contracting hepatitis or human immunodeficiency (HIV), delivering infants with physical and behavioral problems, postpartum depression, and potential loss of custody of their children (Wilder, Lewis, & Winhusen, 2015). Perinatal Hepatitis C (HCV) was noted by our consumers as an emerging issue. Through mid-April 2015, there have been over 650 pregnant women voluntarily reported with HCV infection. This is more than 4X the number of women reported with Hepatitis B, and mandatory reporting of HCV was approved by legislation in 2015.

II.F.6. Public Input

The completion of the 2015 Needs Assessment in Kentucky provided several opportunities to solicit input from the public. Our experience in conducting the 2010 Needs Assessment was convincing that more than any other group, consumers had the greatest insight into emerging needs of the MCH population. For example, in 2010, consumers identified substance abuse and child abuse/neglect as key issues, but they were not identified by other stakeholders. It was therefore decided that consumer and input would drive the development of priority topics for the application and annual report in 2015.

A key component of the needs assessment was a consumer survey that was distributed through LHDs and CCSHCN clinics throughout Kentucky. CCSHCN placed special emphasis on reaching Spanish-speaking families; translations of the surveys were available in clinics and presented to the Una Mano Amiga support group for families of CYSHCN. A total of 3,361 consumers completed the survey and the findings were used to develop the initial list of potential priority topics. These findings were also used to identify the strengths and needs of the MCH population.

In order to gain a deeper understanding of several issues (substance abuse, child abuse/neglect, services and resources for CYSHCN, and access to care for medical, dental and mental health needs) that arose from the survey, focus groups were conducted with 66 public health practitioners from LHDs and CCSHCN sites throughout Kentucky. These regional meetings provided an opportunity to obtain input from the front line of MCH service provision, and to increase the dialogue between these two organizations on the local level.

Stakeholder feedback was used to refine the priorities in Kentucky. A diverse group of stakeholders (164) completed a survey to rank the importance of potential priorities by population domain. Proposed priorities were then identified for each domain and over 80 individuals participated in a stakeholder meeting where the Title V Needs Assessment and Annual Report development was reviewed and data was provided on proposed priorities. Stakeholders provided additional feedback as they ranked topics by population health domain in small groups and then provided input on current strengths, gaps, and strategies for selected topics. Stakeholders will continue to be updated on the process after submission of the application and annual report.

CCSHCN received an early comment from a CCSHCN support staff member that the needs assessment document was too complicated in its language, so an “at-a-glance” summary with more images and simplified language was prepared to “get to the point” quicker. CCSHCN attempted to strike a balance between readability for families with busy lives, while still containing enough substance to summarize the needs assessment process and priorities accurately. During presentations, more emphasis was placed on the priorities and plans than the process itself. While more information is contained in the Family/Consumer Partnership section, it should be mentioned that an

emphasis has been made during 2015 to strengthen engagement with families and integrate meaningful family partnership into CCSHCN's process as it pertains to the needs assessment and annual report/application. To that point, a standing weekly meeting occurs between the CCSHCN Title V Administrator and F2F Co-director with the purpose of greater stakeholder involvement and inclusion in the process.

Kentucky conducted additional activities beyond the needs assessment to solicit public input. No activities were completed via public hearings, as historically, this has not been a successful means of obtaining public input. Additional activities to solicit public input were conducted through web posting, advisory council review, social media, electronic distribution lists, and outreach to specific stakeholders. These activities are summarized below along with plans for continued input following submission of the application and annual report.

Web Posting

A formal comment period followed posting of a draft of the CYSHCN portion of the needs assessment, application, and annual report on the CCSHCN staff intranet, the CCSHCN website, and Facebook page. Comments were invited via phone, anonymous survey, and Facebook posts. MCH posts the entire annual report and application on its website each year after submission of the block grant. The Needs Assessment document will also be posted this year as it is the first year of the five year grant cycle. MCH plans to utilize the website to solicit additional public input in the upcoming year. The website may be utilized to survey consumers for feedback on priority topics and activities.

Advisory Council Review

CCSHCN staff presented overviews of the Needs Assessment process to both the Parent and Youth Advisory Councils throughout the process and invited input, questions, and active participation. It is the agency's goal to increase families' comfort level with this process so that they may ask questions and provide feedback. The CCSHCN Board of Commissioners was also notified when the draft documents were posted on the CCSHCN website.

Social Media

As mentioned previously, CCSHCN posted their draft materials to Facebook, and encouraged comments via Facebook posts. No substantive feedback was received other than "likes".

Other Use of Media

Consumers and stakeholders were notified of the posting of CCSHCN draft materials through messages on well-populated e-mail distribution lists pertaining to CYSHCN. MCH uses electronic distribution lists as a mechanism to distribute information and obtain information from stakeholders for specific issues, such as the stakeholder survey for the needs assessment. Currently these distribution lists are being utilized in the development of the state-wide Safe Sleep campaign. For the future, MCH plans to refine this practice to promote distribution of evidence informed strategies and best practices, that may improve the services and resources that are available to all MCH consumers.

Outreach to Specific Stakeholders

CCSHCN is a heavy user of Survey Monkey, and all visitors to clinics receive a comment card. Over 11,500 surveys have been received during the current Needs Assessment cycle with regard to the direct services experience. As is mentioned elsewhere in this report, CCSHCN aims to expand data-gathering to non-enrolled CYSHCN in the near future, with regard not only to clinical care, but also access to care and the system of services for CYSHCN. On an ongoing basis, CCSHCN staff participating in the planning committee updated staff at all levels of the agency (most frequently, through presentations at statewide manager and regional nurse administrator meetings), and input was sought via in-person or phone questions, e-mail, and an anonymous Survey Monkey link.

MCH plans to continue outreach to local staff through use of distribution lists and regional meetings. Focus group feedback demonstrated that local staff are eager for more interaction with state staff as well as other MCH providers in their area. LHD staff used to be able to participate in state-wide meetings such as the Kentucky Public Health Association to get updates on MCH issues. With reductions in staff and budget in recent years, the ability to travel has been curtailed. In the future, regional meetings will be conducted to continue soliciting feedback from consumers and staff in the field.
See also the input from consumers noted in Family/Consumer Partnerships.

II.F.7. Technical Assistance

A technical assistance need in the domain of women and maternal health is analytic support for the development of a business case or return on investment document on early elective deliveries and preterm births in Kentucky. As expected, an analysis of preterm births has demonstrated that many of these births occur to women with a previous preterm birth. Kentucky is also interested in identifying the extent of progesterone use in this population of women among the Medicaid population.

In order to better understand geographic disparities in infant mortality, a spatial analysis including detailed maps of Kentucky's infant deaths would be useful. Assistance in conducting the spatial analysis and various mapping techniques would be necessary. This would be useful for better understanding of a number of MCH indicators, and help us identify place-based initiatives.

In 2013, Kentucky had 84 SUID deaths. Of these infant deaths, 76 or 90% had at least 1 unsafe sleep risk factor present. In addition, the External Panel for the Review of Child Abuse Deaths has noted many infant deaths due to impaired co-sleeping, and recommended public health develop a statewide Safe Sleep Campaign. Kentucky is currently working with a task force to develop this campaign. With the experts on the task force and the input of stakeholders, messages have been developed for testing. Focus groups will occur during the summer, and the campaign will be released in the fall of 2015. We continue to seek the advice of subject matter experts in this area from NICHD, CDC, HRSA and AMCHP Best Practices. Our technical assistance need is to support keynote speaker for the Prematurity Summit in November, where we are partnering with March of Dimes and featuring breast feeding and safe sleep. We requesting Barb Himes, IBCLC, Director of Education and Training for First Candle and co-lead for SUID/Safe Sleep Collaborative Improvement and Innovation Network. We need her expertise to address the issues around safe sleep, bed sharing, and breastfeeding as well as safe sleep with impairment.

In the Cross-Cutting/Life Course domain, a significant need related to substance abuse is improvements in the availability of consistent data on infants with neonatal abstinence syndrome (NAS). Kentucky implemented mandatory surveillance for NAS in July 2014. Technical assistance is needed to develop consistent methodologies for reporting this data from different data sources. Kentucky would also be interested in collaborative efforts with other states who are working on this topic. Assistance in developing a multi-state work group to refine data analysis around this topic would be helpful.

CCSHCN areas of needed technical assistance at this time relate to development of ESMs for Transitions and specific action steps regarding the three State Performance Measures. Stronger collaboration with partners such as DPH and UK CPH is expected towards data capacity specifically, and CCSHCN is excited about being chosen to participate in the opportunity to collaborate with federal and state partners on the project entitled "Learning Collaborative on Focusing and Accelerating Statewide Improvements in Maternal and Child Health: Round 1". Kentucky's goals for the Learning Collaborative include working with the assembled partners to assist in refining CCSHCN's objectives, approaches, and planned actions to implement progress on priority issues for the CYSHCN

population - of primary interest are assuring, enhancing, and integrating services, and fleshing out State Performance Measures of access to care, adequate insurance coverage, and data capacity; however, focus may also be considered for improvement of transitions services and youth preparation for adult health care. CCSHCN relies on expertise from National Centers and AMCHP, as well as other TA providers, and will not hesitate to take advantage of any further opportunities that present or are recommended.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 11,354,415	$ 8,954,614	$ 11,131,292	$ 6,615,556
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 39,540,300	$ 35,296,534	$ 36,355,790	$ 35,451,756
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 18,592,000	$ 17,767,268	$ 17,976,900	$ 17,549,087
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 69,486,715	$ 62,018,416	$ 65,463,982	$ 59,616,399
Other Federal Funds	$ 143,818,400	$ 118,772,750	$ 142,853,466	$ 131,098,398
Total	$ 213,305,115	$ 180,791,166	$ 208,317,448	$ 190,714,797

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 10,649,600	$ 8,890,360	$ 10,637,166	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 36,549,700	$ 28,653,411	$ 35,788,000	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 17,200,300	$ 24,456,589	$ 17,108,200	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 64,399,600	$ 62,000,360	$ 63,533,366	$
Other Federal Funds	$ 132,906,100		$ 152,586,559	$
Total	$ 197,305,700	$ 62,000,360	$ 216,119,925	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 11,029,949	$
Unobligated Balance	$ 0	$
State Funds	$ 28,672,600	$
Local Funds	$ 0	$
Other Funds	$ 139,767	$
Program Funds	$ 21,651,933	$
SubTotal	$ 61,494,249	$
Other Federal Funds	$ 129,434,229	$
Total	$ 190,928,478	$

III.A. Expenditures

III. Budget Narrative

Kentucky maintains and provides budget and expenditure data as required under the Title V Section 505(a) of the Social Security Act. Available budget and expenditure data reflects the overall federal application and the breakdown of primary and preventive care for MCH children, children with special health care needs, maintenance of effort, and administrative cost.

A. **Expenditures**

Block Grant funding and expenditures are provided by the state as are explanations for significant variations of 10% or greater in the expenditure data compared to the previous year, as reported in Forms 2 and 3. Expenditures for this section are based on actual expenditures for state fiscal year 2014 which ended June 30, 2014 while the budget is based on state fiscal year 2016. Reporting of actual expenditures may differ from the reported budget due to state fiscal year carryover and grant year amount variations. Kentucky's state fiscal year begins on July 1st and ends on June 30th, which is different from the federal grant year of October 1st through September 30th. The variance in budgeted vs. expended for FY14 was $2,139,589. Those funds unused within the State Fiscal Year will be spent in the first quarter of the new state fiscal year, July – September, which is the 4th quarter of the federal fiscal year. Other differences may include additional expenditures from other revenues and budget adjustments made throughout the year, but these are generally minor. The Commonwealth of Kentucky requires a balanced budget at the end of each fiscal year.

MCH has funded total expenditures using 51% from the State General Fund, 12% from Federal Funds and 37% from Agency Funds. Maintenance of effort and match are made up of total State General Funds and Agency Funds**.** Details of these sources are found in Form 2.

Local Health Departments in every county deliver the Title V services for their community MCH populations. More than half of the MCH Title V funds go directly to expenditures for services at the LHD's. We try to assure some level of flexibility to meet community needs with accountability for the Title V funding. The entire Title V program is seeking to balance the direct service needs of our populations with enabling, population-based, and systems services within the changing healthcare landscape. We have encouraged LHD's to build more partnerships with community providers, especially primary care providers, to assure basic MCH services are available. If they do not have other resources in their community, then the LHD provides the safety net services, acknowledging that Title V will be the payor of last resort. Title V Federal Funds to LHD's are managed through allocations from KPDH and monitored by the system-wide financial structure, which captures all LHD expenses and activities. MCH staff regularly monitor the cost centers for their programs and review monthly reports of expenditures by LHD.

Expenditures for Federal MCH Title V Program Services are broken down by types of MCH services provided:

- 15% Direct Health Care for preventive and primary care for all pregnant women, mothers and infants up to age 1.
- 11% Direct Health Care for preventive and primary care services for children.
- 34% Enabling services
- 40% Public health Services and Systems

The numbers provided are estimates based on what data is available from our systems, since our accounting systems do not specifically identify these types of services. These percentages do not include MCH activities funded by other federal funding sources.

Direct services for pregnant women include Title V funds used by LHD's who have in-house prenatal programs. Title V funds also support face-to-face medical nutrition therapy by dieticians for pregnant women and mothers. Title V is the payor of last resort for direct services. With expanded Medicaid and aggressive outreach from the Health Benefits Exchange, it is now rare for LHD's to have to pay for deliveries. However, still serving as the safety net, several LHD's have to either contract with local providers & hospitals or provide in-house prenatal care and related direct services. Title V funds are not used for inpatient services, as hospitals have an obligation to serve the uninsured. It should be noted that KY's largest non-federal investment in encounter-driven primary and preventative services for pregnant women, mothers, and infants, is the $8.5 M it dedicates for the core HANDS home visiting program for first time parents, providing assessments, professional visits, and paraprofessional visits to nearly 10,000 families each year, from prenatally until the child turns two. Eighty-five percent of these families enter the program during pregnancy. This investment is not included on the Title V budget forms because it is used for the MOE requirement for MIECHV, but the investment should be noted as significant part of the Title V program.

For children, direct services are provided by the LHD's, both at the LHD and at school sites. These are billed to Medicaid when the child is Medicaid eligible and to insurance when appropriate, but may not be covered, and Title V becomes the payor of last resort. Public Health nurses provide well child exams, screenings, health education, and other preventive and primary services. They also are trained to provide fluoride varnish services for this population, and Title V pays for some of these services. Title V funds are used to assure specialty services for comprehensive developmental evaluations at a university-based, multidisciplinary child evaluation center. Non-federal MCH funds also support direct services including access to specialty visits for Genetics, oral health services, and the Part C Early Intervention services (that are not covered by Medicaid). From non-federal funding, medical foods and formula for children with metabolic disorders are paid for children with no ability to pay, so that they are not denied this life-saving specialized nutrition.

Enabling services also support the legislatively-defined MCH Populations. With Title V funding, some 35 LHD's are providing case management services for pregnant women in their jurisdiction, to improve access and promote early entry into prenatal care. As part of our safe sleep initiatives, Title V funds are being used to provide cribs for needy families who have no safe place for their infant to sleep in over 30 LHD's. Non-federal funding supports the Newborn Screening Program, as well as the local case management and prevention services for elevations of lead in children (not covered by the federal grant or Medicaid).

The largest part of both federal and non-federal funding in MCH goes towards Public Health Services and Systems. Title V funding supports workforce development through trainings for MCH prenatal and pediatric programs, as well as a broader effort to develop the MCH workforce across the state through an MCH certificate program at the UK College of Public Health. Surveillance activities include maternal mortality and child fatality review. Systems supported are Regionalized Perinatal Care and select pediatric specialty services. Locally, Title V Funding supports LHD's building public health capacity through programs and partnerships with schools, child cares, and local providers, using MCH Evidence-Informed Strategies.

CCSHCN has funded total expenditures using 31% from the State General Fund, 22% from Federal Funds and 47% from Agency Funds. During FY14, the total expenditures of CCSHCN are broken down as follows:

- 63% on Direct Services such as personnel, physician contracts, Care and support.
- 8% on Foster Care Program
- 7% on Augmentative services such audiology and therapy services
- 4% on First Steps Interpreters services
- 18% on Administrative expenses

CCSHCN has achieved the following service efficiencies and improvements during FY14.

- Implemented telemedicine program for neurology patients. Offers faster and easier access to a subspecialist.
- Partnered with Health Benefit Exchange to train CCSHCN staff and parents as Kynectors to assist families with selecting insurances from the Health Benefit Exchange.
- Partnered with University of Louisville and La Casita Center to achieve shared outcomes for Spanish speaking children and youth with special health care needs and their families.

CCSHCN has continued with some of the prior efficiencies and improvements such as establishing mail order for Pharmacy Assistance Program, Collaboration with University of Louisville and University of Kentucky to provide specialty physician services, and reduction of uninsured population.

III.B. Budget

III. Budget Narrative

B. **Budget**

The Kentucky Title V Block grant is spent in compliance with the federal requirements for utilization of those funds. In KY, by statute, 34.9% of the Block Grant funds go to the Commission for Children with Special Health Care Needs. Less than 10% of the block grant goes to administrative costs. The remainder (58.8% in FY14, 62.2% budgeted for FY 16) goes to support primary and preventative care for mothers and children through MCH activities, exceeding the 30% requirement.

The total required match ($4 federal/ $3 state) for KY is $8,272,462, which includes the CCSHCN and MCH. The CCSHCN is responsible for their portion of the match (34.9%, or $2,887,089) and the remainder ($5,385,373) is the responsibility of MCH. Both agencies have more than adequate funds just from state general funds to meet the match requirement. KY's total maintenance of effort from 1989 is $22,552,700. As is evident on Form 2, KY's MCH

effort far exceeds the match and MOE requirements. Maintenance of effort and match are made up of State General Funds and Agency Funds.

MCH's total budget for FY2015 has decreased 0.95% since FY2014. MCH expects to fund the total FY 16 budget from 13% State General Funds, 4% from Federal MCH Block Grant, 74% from other Federal Funds and 8% Agency Funds. MCH feels certain that the state and agency funds required for the 1989 maintenance of effort level of $14.382.300 and the match of $5,385,373 will continue to be available in the foreseeable future.

For the FY 16 budget, $4,696,150 of the MCH Title V allocation will go directly to LHD's to provide the direct, enabling, and public health services/system-building, depending on needs of the local MCH populations. The state assures these funds will be used appropriately through a select list of MCH Evidence-Informed Strategies as options, and some of the funding remains categorical. The remainder of the MCH Title V allocation is budgeted for public health services and systems. These include surveillance (maternal mortality, CFR); workforce development and trainings; IT systems for data collection; regionalized perinatal care; and technical assistance to LHD's and other agencies for pediatric injury prevention.

Other Federal funding MCH receives includes:

Federal Grants	Grant Amounts
State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPP)	$386,136
ACA Maternal, Infant and Early Childhood Home Visiting Program	$16,816,178
Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$171,685
State Systems Development Initiative (SSDI)	$65,374
Women, Infants and Children (WIC)	$106,163,100
Early Identification and Intervention Infants/Toddlers (Frist Steps)	$5,801,747
TOTAL	**$129,434,229**

Non-Federal program funding MCH receives includes:

Non-federal Programs	Amounts
Maternal and Child Health (SJBA)	$6,088,200
Oral Health (SJB4)	$1,885,100
KEIS (SJPA/SJPB)	$12,221,500
Genetics (SJPF)	$269,200
Newborn Screening (SJPL)	$265,300
Nutrition (SJRA)	$41,800
HANDS (S2TC)	$0 (reported with MIECHV for MOE)
Healthy Start (S4TA)	$1,000,000
ECD Mental Health (S8TA)	$1,000,000
ECD Oral Health (S9TA)	$500,000
TOTAL	**$23,271,100**

CCSHCN's total budget for FY2015 has increased by 3.83% from FY14. CCSHCN expects to fund the total budget from 32% State General Funds, 24% from Federal MCH Block Grant, 3% from other Federal Funds and 41% Agency Funds. The CCSHCN feels certain that the state and agency funds required for the 1989 maintenance of effort level of $8,170,400 and the match of $2,887,089 will continue to be available in the foreseeable future.

The focus of CCSHCN's budget is to effectively use its funding resources to provide quality services. The highlights of the FY15 budget are:

- Continue to achieve the service efficiencies and improvements from the past years.
- Collaboration with community and state partners to limit duplication and fragmentation of services.
- Networking with CHFS agencies and community partners in order to expand the patient population that would benefit from Commission specialty clinic care.
- Increase efforts with Telemedicine in order to reduce provider travel and patient wait time.
- Strengthen family involvement to ensure provision of comprehensive coordinated care.
- Strengthen workforce capacity by training and education

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Final Preventive Health FY 15 16 PO2 748 1400006375.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Attachment A- Needs Assessment Fact Sheet.pdf

Supporting Document #02 - Attachment B - KY CCSHCN MCH Attachments.pdf

Supporting Document #03 - Attachment C - Consumer Survey Final Report.pdf

Supporting Document #04 - Attachment D - Acronyms.pdf

Supporting Document #05 - Attachment E - References.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Kentucky

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 11,029,949	$ 8,890,360
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 6,874,497	$ 5,052,075
B. Children with Special Health Care Needs	$ 3,849,452	$ 3,298,057
C. Title V Administrative Costs	$ 306,000	$ 540,228
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 28,672,600	$ 28,653,411
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 0	$ 0
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 139,767	$ 24,456,589
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 21,651,933	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 50,464,300	$ 53,110,000
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 22,552,700	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 61,494,249	$ 62,000,360
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 129,434,229	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 190,928,478	$ 62,000,360
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 10,649,600
A. Preventive and Primary Care for Children	$ 5,966,900
B. Children with Special Health Care Needs	$ 3,716,700
C. Title V Administrative Costs	$ 966,000
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 36,549,700
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 17,200,300
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 53,750,000

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs);	$ 386,136
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 16,816,178
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	$ 171,685
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 95,374
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 106,163,109
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers;	$ 5,801,747

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Amounts are based on state fiscal year. Remaining funds are used for 1st quarter of the following year.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Amounts are based on state fiscal year. Remaining funds are used for 1st quarter of the following year.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Amounts are based on state fiscal year. Remaining funds are used for 1st quarter of the following year.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Amounts are based on state fiscal year. Remaining funds are used for 1st quarter of the following year.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Amounts are based on state fiscal year. Remaining funds are used for 1st quarter of the following year.	
6.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**

Column Name:	Annual Report Expended

Field Note:
Amounts are based on state fiscal year. Remaining funds are used for 1st quarter of the following year.

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Kentucky

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 1,698,001	$ 1,247,863
2. Infants < 1 year	$ 1,711,750	$ 1,257,967
3. Children 1-22 years	$ 2,302,956	$ 1,692,445
4. CSHCN	$ 3,849,452	$ 3,298,057
5. All Others	$ 1,161,790	$ 853,801
Federal Total of Individuals Served	$ 10,723,949	$ 8,350,133
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 11,313,324	$ 12,270,057
2. Infants < 1 year	$ 11,389,508	$ 12,405,718
3. Children 1-22 years	$ 12,760,820	$ 13,839,964
4. CSHCN	$ 12,372,300	$ 11,743,642
5. All Others	$ 2,628,348	$ 2,850,619
Federal Total of Individuals Served	$ 50,464,300	$ 53,110,000
Federal State MCH Block Grant Partnership Total	$ 61,188,249	$ 61,460,133

Form Notes For Form 3a:

Numbers are estimates. See budget narrative for more detail

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: On Form 3a Lines 1, 2, 3, and 5 equal the total on Form 2 Line 1a.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: NOTE: Does not include administrative expenses/budget	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: On Form 3a Lines 1, 2, 3, and 5 equal the total on Form 2 Line 1a.	

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Kentucky

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 5,716,381	$ 4,809,418
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,077,074	$ 889,036
B. Preventive and Primary Care Services for Children	$ 789,855	$ 622,325
C. Services for CSHCN	$ 3,849,452	$ 3,298,057
2. Enabling Services	$ 2,441,369	$ 1,760,558
3. Public Health Services and Systems	$ 2,872,199	$ 2,320,384
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 4,809,418
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 4,809,418
Federal Total	$ 11,029,949	$ 8,890,360

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 18,845,560	$ 18,819,942
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 3,807,800	$ 4,131,332
B. Preventive and Primary Care Services for Children	$ 2,665,460	$ 2,891,933
C. Services for CSHCN	$ 12,372,300	$ 11,796,677
2. Enabling Services	$ 12,184,960	$ 13,220,264
3. Public Health Services and Systems	$ 19,433,780	$ 21,069,794
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 18,819,942
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 18,819,942
Non-Federal Total	$ 50,464,300	$ 53,110,000

Form Notes For Form 3b:

These are estimates. See budget narrative for details

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Kentucky

Total Births by Occurrence 54,150

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	53,878 (99.5%)	0	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	53,878 (99.5%)	3	1	1 (100.0%)
Methylmalonic acidemia (cobalamin disorders)	53,878 (99.5%)	0	0	0 (0%)
Isovaleric acidemia	53,878 (99.5%)	1	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	53,878 (99.5%)	5	1	1 (100.0%)
3-Hydroxy-3-methyglutaric aciduria	53,878 (99.5%)	0	0	0 (0%)
ß-Ketothiolase deficiency	53,878 (99.5%)	0	0	0 (0%)
Glutaric acidemia type I	53,878 (99.5%)	0	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	53,878 (99.5%)	13	2	2 (100.0%)
Medium-chain acyl-CoA dehydrogenase deficiency	53,878 (99.5%)	11	6	6 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	53,878 (99.5%)	4	1	1 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	53,878 (99.5%)	0	0	0 (0%)
Trifunctional protein deficiency	53,878 (99.5%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Argininosuccinic aciduria	53,878 (99.5%)	0	0	0 (0%)
Citrullinemia, type I	53,878 (99.5%)	1	1	1 (100.0%)
Maple syrup urine disease	53,878 (99.5%)	2	1	1 (100.0%)
Homocystinuria	53,878 (99.5%)	0	0	0 (0%)
Classic phenylketonuria	53,878 (99.5%)	7	4	4 (100.0%)
Tyrosinemia, type I	53,878 (99.5%)	0	0	0 (0%)
Primary congenital hypothyroidism	53,878 (99.5%)	362	37	37 (100.0%)
Congenital adrenal hyperplasia	53,878 (99.5%)	89	1	1 (100.0%)
S,S disease (Sickle cell anemia)	53,878 (99.5%)	10	7	7 (100.0%)
S, βeta-thalassemia	53,878 (99.5%)	3	0	0 (0%)
S,C disease	53,878 (99.5%)	8	5	5 (100.0%)
Biotinidase deficiency	53,878 (99.5%)	31	15	15 (100.0%)
Critical congenital heart disease	50,823 (93.9%)	41	15	15 (100.0%)
Cystic fibrosis	53,878 (99.5%)	121	15	15 (100.0%)
Hearing loss	52,937 (97.8%)	2,396	65	65 (100.0%)
Classic galactosemia	53,878 (99.5%)	77	4	4 (100.0%)

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	52,937 (97.8%)	2,396	65	65 (100.0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

After referral from the State Lab, the University partners conduct the confirmatory testing and provide the long-term follow-up care and treatment of the infants.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Newborn Hearing - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Referred	
2.	**Field Name:**	**Newborn Hearing - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Diagnosed Hearing Loss	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Kentucky

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,720	49.0	0.0	1.9	47.9	1.2
2. Infants < 1 Year of Age	53,795	48.2	0.0	43.7	3.2	4.9
3. Children 1 to 22 Years of Age	243,934	59.7	0.0	2.9	37.2	0.2
4. Children with Special Health Care Needs	20,064	62.5	0.0	25.3	2.4	9.8
5. Others	33,740	45.0	0.0	7.9	46.1	1.0
Total	354,253					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Not all infants will be elligible for services provided by Title V; however, all infants do receive a newborn metabolic screen and this is a Title V program, so we have included all live born infants receiving a newborn screen in the infant total row. The information regarding payment source for infants was obtained from the live birth certificate payment source field.	
2.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: 8660 CCSHCN + 11,404 First Steps Unknown = First Steps (Early Intervention) includes those in referral stage	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Kentucky

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	12,720
2. Infants < 1 Year of Age	53,795
3. Children 1 to 22 Years of Age	580,384
4. Children with Special Health Care Needs	53,514
5. Others	33,740
Total	734,153

Form Notes For Form 5b:

There will be duplicatioin of individuals on this form as there will be some that receive education and outreach and may also receive a direct service.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: Not all infants will be elligible for services provided by Title V; however, all infants do receive a newborn metabolic screen and this is a Title V program, so we have included all live born infants receiving a newborn screen in the infant total row. The information regarding payment source for infants was obtained from the live birth certificate payment source field.	
2.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Not all infants will be eligible for services provided by Title V, nor will they be CYSHCN; however, nearly all infants receive a newborn hearing screen reported to and followed up on by CCSHCN, and this is a Title V program, so we have included all live born infants receiving hearing screens.	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Kentucky

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	53,795	44,997	4,769	56	503	6	0	3,464
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	38,277	31,993	4,548	142	323	124	0	1,147
2. Total Infants in State	56,788	46,477	5,457	179	736	80	2,351	1,508
Title V Served	58,274	47,278	6,561	115	589	101	3,630	0
Eligible for Title XIX	33,145	25,802	4,041	88	226	93	0	2,895

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	51,065	2,673	57	53,795
Title V Served	0	0	0	0
Eligible for Title XIX	35,283	2,261	733	38,277
2. Total Infants in State	51,810	3,470	1,508	56,788
Title V Served	54,374	3,900	0	58,274
Eligible for Title XIX	30,853	1,596	696	33,145

Form Notes For Form 6:

Data Sources: For Deliveries: Total Deliveries in State: KY vital statistics files, live birth certificate files, occurence births for year 2014. Title V served: CDP reporting system, PSRS database, year 2014 Eligible for Title XIX: KY Medicaid Management Informaiton System, Medicaid data warehouse, Year 2013; Currently there are issues with the race/ethnicity fields in the data warehouse for year 2014 the issue is currently being addressed however at time of form completion the issue was still not resolved, therefore, data reflects year 2013. For Infants: Total infants in state: US Census Bureau, state specific populaiton estimates by race and ethnicity from the 2012 census. Title V served: CDP reporting system, PSRS database, year 2014 Eligible for Title XIX: KY Medicaid Management Informaiton System, Medicaid data warehouse, Year 2013. Currently there are issues with the race/ethnicity fields in the data warehouse for year 2014 the issue is currently being addressed however at time of form completion the issue was still not resolved, therefore, data reflects year 2013. Data for this indicator does contain duplicate records, therefore, the total number of infants served will be greater than the total number of infants in the state. Local health departments are no longer providing direct clinical care services related to maternity and therefore there were no deliveries funded by Title V in year 2014. Data entered actually reflects year 2012 since the TVIS would not accept a 0 as the number of deliveries served by Title V.

Field Level Notes for Form 6:

None

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Kentucky

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 462-6122	(800) 462-6122
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Information Toll Free Li	Maternal and Child Health Information Toll Free Li
3. Name of Contact Person for State MCH "Hotline"	Shelley Adams	Shelley Adams
4. Contact Person's Telephone Number	(502) 564-2154	(502) 564-2154
5. Number of Calls Received on the State MCH "Hotline"		2,919
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

Callers on the MCH Information Toll Free Line were trying to access services for WIC, SNAP, Community Based Services, and Medicaid, these callers were transferred or given the phone number for these agencies. A number of callers were looking for the number to their local health department. These callers were given the number and transferred. Over 50 calls were received trying to access KYNECT Health Insurance for every Kentucky. These calls were referred to the KYNECT Website and the Toll Free Number for the Cabinet's KYNECT Office. This Fiscal Year saw an increase in calls that required the assistance of the Cabinet's Language Access Staff for Spanish interpretation. A total of six calls were assisted by the Cabinet's language access section. One call was for WIC Services and the caller was directed to the Nutrition Services Branch for assistance, the other five calls were for Medicaid and SNAP Benefits. These were referred to these agencies within the Cabinet.

Form 8
State MCH and CSHCN Directors Contact Information

State: Kentucky

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Ruth Ann Shepherd
Title	Title V Director
Address 1	275 E. Main Street, HS2W-A
Address 2	
City / State / Zip Code	Frankfort / KY / 40621
Telephone	(502) 564-4830 x4391
Email	ruth.shepherd@ky.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Jackie Richardson
Title	Executive Director
Address 1	310 Whittington Parkway, Suite 200
Address 2	
City / State / Zip Code	Louisville / KY / 40222
Telephone	(502) 429-4430 x2071
Email	jackie.richardson@ky.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Kentucky

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Maternal Morbidity	Continued	
2.	Infant Mortality	Continued	
3.	Child Abuse and Neglect	Continued	
4.	Overweight and Obesity Among Teens	New	
5.	Oral Health	Continued	
6.	Substance Abuse	Continued	
7.	Transitions Services for CSHCN	Continued	
8.	Access to Care and Services for CSHCN	New	
9.	Adequate Insurance for CSHCN	New	
10.	Data Capacity for CSHCN	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Kentucky

Form Notes for Form 10a NPMs and NOMs:

None

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	75.8 %	0.2 %	40,711	53,732
2012	75.6 %	0.2 %	40,509	53,595
2011	75.3 %	0.2 %	39,973	53,069
2010	73.7 %	0.2 %	39,324	53,370
2009	71.8 %	0.2 %	39,743	55,321

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

2012	143.9	5.3 %	737	51,212
2011	140.7	5.3 %	718	51,020
2010	150.2	5.4 %	769	51,212
2009	140.5	5.2 %	743	52,873
2008	124.2	4.8 %	658	52,973

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

NOM-3 Maternal mortality rate per 100,000 live births

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	25.2
Numerator	14
Denominator	55,572
Data Source	Kentucky vital statistics files, live birth and death certificate files, year 2013; data are preliminary and numbers may change
Data Source Year	2013

NOM-3 Notes:

Note: Pregnancy-related mortality is defined as a death of a woman up to one year post delivery whose cause of death was coded between ICD10 O00 – O99.

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.7 %	0.1 %	4,845	55,674
2012	8.7 %	0.1 %	4,823	55,752
2011	9.1 %	0.1 %	5,040	55,350
2010	9.1 %	0.1 %	5,044	55,762
2009	8.9 %	0.1 %	5,141	57,537

Legends:
🚩 Indicator has a numerator <10 and is not reportable
ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.5 %	0.1 %	833	55,674
2012	1.6 %	0.1 %	892	55,752
2011	1.6 %	0.1 %	861	55,350

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010	1.6 %	0.1 %	903	55,762
2009	1.5 %	0.1 %	858	57,537

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.2 %	0.1 %	4,012	55,674
2012	7.1 %	0.1 %	3,931	55,752
2011	7.6 %	0.1 %	4,179	55,350
2010	7.4 %	0.1 %	4,141	55,762
2009	7.4 %	0.1 %	4,283	57,537

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	11.1 %	0.1 %	6,149	55,653
2012	11.0 %	0.1 %	6,151	55,730
2011	11.3 %	0.1 %	6,226	55,328
2010	11.7 %	0.1 %	6,521	55,757
2009	11.6 %	0.1 %	6,648	57,488

Legends:
🏴 Indicator has a numerator <10 and is not reportable
ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.0 %	0.1 %	1,658	55,653
2012	3.0 %	0.1 %	1,648	55,730
2011	3.0 %	0.1 %	1,668	55,328

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010	3.1 %	0.1 %	1,731	55,757
2009	3.0 %	0.1 %	1,712	57,488

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.1 %	0.1 %	4,491	55,653
2012	8.1 %	0.1 %	4,503	55,730
2011	8.2 %	0.1 %	4,558	55,328
2010	8.6 %	0.1 %	4,790	55,757
2009	8.6 %	0.1 %	4,936	57,488

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.2 %	0.2 %	15,692	55,653
2012	30.5 %	0.2 %	16,993	55,730
2011	30.7 %	0.2 %	17,007	55,328
2010	32.1 %	0.2 %	17,888	55,757
2009	34.3 %	0.2 %	19,728	57,488

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	9.0 %			

Legends:
Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.7	0.4 %	376	55,884
2012	7.2	0.4 %	402	55,955
2011	5.9	0.3 %	326	55,527
2010	5.6	0.3 %	313	55,960
2009	6.0	0.3 %	346	57,732

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.4	0.3 %	356	55,686
2012	7.2	0.4 %	401	55,758
2011	6.4	0.3 %	356	55,370
2010	6.8	0.4 %	380	55,784
2009	6.8	0.4 %	393	57,551

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.9	0.3 %	219	55,686
2012	4.7	0.3 %	263	55,758
2011	4.0	0.3 %	219	55,370
2010	3.4	0.3 %	187	55,784
2009	3.7	0.3 %	215	57,551

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.5	0.2 %	137	55,686
2012	2.5	0.2 %	138	55,758
2011	2.5	0.2 %	137	55,370
2010	3.5	0.3 %	193	55,784
2009	3.1	0.2 %	178	57,551

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	150.9	16.5 %	84	55,686
2012	247.5	21.1 %	138	55,758

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	175.2	17.8 %	97	55,370
2010	166.7	17.3 %	93	55,784
2009	196.4	18.5 %	113	57,551

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	147.3	16.3 %	82	55,686
2012	123.8	14.9 %	69	55,758
2011	139.1	15.9 %	77	55,370
2010	164.9	17.2 %	92	55,784
2009	144.2	15.8 %	83	57,551

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	21.4	0.7 %	1,095	51,214
2011	18.2	0.6 %	927	51,020
2010	13.0	0.5 %	663	51,212
2009	10.9	0.5 %	575	52,873
2008	7.7	0.4 %	406	52,973

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.6 %	1.3 %	178,985	961,280

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	18.4	1.9 %	93	505,102
2012	22.0	2.1 %	112	508,169
2011	23.7	2.2 %	120	507,072
2010	23.7	2.2 %	121	510,066
2009	23.3	2.1 %	118	507,081

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	31.2	2.3 %	177	567,768
2012	39.4	2.6 %	224	568,657
2011	33.5	2.4 %	193	575,565
2010	40.1	2.6 %	233	580,949
2009	39.8	2.6 %	231	581,176

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	17.1	1.4 %	146	855,059
2010_2012	18.5	15.7 %	161	869,224
2009_2011	18.9	16.0 %	167	883,934
2008_2010	21.8	18.8 %	195	892,781
2007_2009	25.5	22.2 %	227	891,367

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	9.9	7.9 %	85	855,059

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2012	8.9	7.0 %	77	869,224
2009_2011	8.4	6.6 %	74	883,934
2008_2010	8.5	6.7 %	76	892,781
2007_2009	9.7	7.7 %	86	891,367

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.4 %	1.4 %	268,795	1,019,825
2007	24.4 %	1.3 %	247,147	1,013,459
2003	22.2 %	1.1 %	219,593	990,015

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	19.9 %	2.0 %	36,405	182,758

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.1 %	0.5 %	17,689	855,121
2007	1.4 %	0.4 %	11,503	837,602

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.8 %	1.4 %	117,527	849,462
2007	9.6 %	0.9 %	79,671	834,651

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	66.1 %	4.7 %	82,571	124,998
2007	65.2 %	5.4 %	46,279	71,031
2003	63.2 %	4.9 %	49,325	78,005

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	85.5 %	1.2 %	871,888	1,019,825
2007	86.3 %	1.0 %	874,230	1,012,905
2003	86.9 %	1.0 %	860,029	989,559

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.7 %	2.4 %	154,594	433,001
2007	37.1 %	2.1 %	166,241	447,719
2003	38.2 %	2.0 %	175,014	457,614

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	27.2 %	0.2 %	11,832	43,488

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	33.4 %	1.6 %	60,080	180,047
2011	31.9 %	1.4 %	54,556	170,998
2009	32.7 %	1.5 %	61,817	188,798
2007	31.7 %	1.2 %	53,790	169,772
2005	32.3 %	1.0 %	52,439	162,510

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.9 %	0.4 %	59,952	1,011,219
2012	5.9 %	0.5 %	60,230	1,015,554
2011	5.9 %	0.5 %	59,790	1,021,874
2010	5.8 %	0.4 %	59,114	1,017,772
2009	5.9 %	0.4 %	59,762	1,017,979

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	72.7 %	4.1 %	56,137	77,268
2012	68.2 %	3.4 %	53,833	78,887
2011	77.6 %	3.5 %	62,510	80,570
2010	51.8 %	3.4 %	42,330	81,740
2009	43.4 %	3.1 %	36,497	84,127

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	54.0 %	2.1 %	514,249	951,632
2012_2013	59.0 %	2.7 %	571,430	969,106
2011_2012	48.9 %	2.4 %	464,496	950,390
2010_2011	51.3 %	3.2 %	492,630	960,293
2009_2010	42.6 %	2.4 %	387,505	909,635

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	47.6 %	5.0 %	65,891	138,551
2012	51.3 %	5.4 %	71,030	138,600
2011	46.0 %	5.0 %	63,681	138,443
2010	40.1 %	4.7 %	55,571	138,500
2009	31.0 %	3.9 %	42,925	138,660

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	19.0 %	3.8 %	27,681	145,976
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	84.4 %	2.6 %	240,214	284,527
2012	80.0 %	2.9 %	227,714	284,736
2011	70.0 %	3.1 %	199,606	285,351
2010	53.1 %	3.2 %	151,024	284,473
2009	37.5 %	2.8 %	106,384	284,013

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	71.2 %	3.2 %	202,449	284,527
2012	62.9 %	3.5 %	179,159	284,736
2011	55.0 %	3.4 %	156,902	285,351
2010	44.8 %	3.2 %	127,534	284,473

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	36.3 %	2.7 %	103,104	284,013

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Kentucky

NPM-2 Percent of cesarean deliveries among low-risk first births

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.2	30.2	30.0	30.0	29.5

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.0	62.0	63.5	63.5	64.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.5	14.5	15.0	15.0	15.2

NPM-5 Percent of infants placed to sleep on their backs

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.0	72.0	73.0	73.0	73.5

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	100.0	100.0	100.0	98.5	98.5

NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	38.5	38.5	38.5

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	40.0	40.0	40.0	40.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.0	30.0	32.0	32.0	32.5

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	76.0	76.0	76.5	76.5	77.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	21.0	21.0	20.0	20.0	19.5

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	38.5	38.5	38.0

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Kentucky

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Kentucky

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Kentucky

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	99.8	99.9	99.9	99.9	100.0
Annual Indicator	99.9	99.8	98.5	100.0	
Numerator	960	813	876	814	
Denominator	961	815	889	814	
Data Source	KY Newborn Screening database	KY Newborn Screening Database	KY Newborn Screening Database	KY Newborn Screening database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: 2013 data is preliminary and numbers could change.	
2.	**Field Name:**	**2012**
	Field Note: 2012 data is preliminary and numbers could change.	
3.	**Field Name:**	**2011**
	Field Note: 2011 data is prelminary and numbers could change.	

Data Alerts:

None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	97.0	97.0	97.0	97.0	98.0
Annual Indicator	97.0	96.9	96.8	97.9	
Numerator	3,695	5,156	5,329	2,210	
Denominator	3,810	5,321	5,505	2,257	
Data Source	CCSHCN Clinic Comment Cards	CCSHCN Clinic Comment Cards	CCSHCN Clinic Comment Cards	CCSHCN Clinic Comment Cards	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Information derived from averaging responses to two (2) questions on CCSHCN clinic comment cards: 1. Those responding "yes" to the question "Do you feel that CCSHCN staff listen to you regarding your care (or your child's care)?" (96.9%); and 2. Those responding "very satisfied" or "satisfied" to the question "How satisfied are you with the care you (or your child) received today at CCSHCN?" (98.9%)

2. **Field Name:** **2013**

Field Note:
Information derived from averaging responses to two (2) questions on CCSHCN clinic comment cards:
1. Those responding "yes" to the question "Do you feel that CCSHCN staff listen to you regarding your care (or your child's care)?" (94.2%); and
2. Those responding "very satisfied" or "satisfied" to the question "How satisfied are you with the care you (or your child) received today at CCSHCN?" (99.4%)

3. **Field Name:** **2012**

Field Note:
Information derived from averaging responses to two (2) questions on CCSHCN clinic comment cards:
1. Those responding "yes" to the question "Do you feel that CCSHCN staff listen to you regarding your care (or your child's care)?" (98.9%); and
2. Those responding "very satisfied" or "satisfied" to the question "How satisfied are you with the care you (or your child) received today at CCSHCN?" (94.9%)

4. **Field Name:** **2011**

Field Note:
NPM 2:
Information derived from averaging responses to two (2) questions on CCSHCN clinic comment cards:
1. Those responding "yes" to the question "Do you feel that CCSHCN staff listen to you regarding your care (or

your child's care)?" (96.4%); and
2. Those responding "very satisfied" or "satisfied" to the question "How satisfied are you with the care you (or your child) received today at CCSHCN?" (97.6%)
Average of 96.4% & 97.6% = 97%

Data Alerts:

None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	94.0	95.0	95.0	95.0	96.0
Annual Indicator	94.5	93.9	94.7	96.0	
Numerator	7,383	8,054	8,321	8,311	
Denominator	7,812	8,575	8,785	8,660	
Data Source	CCSHCN CUP Information System	CCSHCN CUP Information System	CCSHCN CUP Information System	CCSHCN CUP Information System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator (KY 0-18 with Primary Care Physician) Denominator (KY 0-18)	
2.	**Field Name:**	**2013**
	Field Note: Numerator (KY 0-18 with Primary Care Physician) Denominator (KY 0-18)	
3.	**Field Name:**	**2012**
	Field Note: Numerator (KY 0-18 with Primary Care Physician) Denominator (KY 0-18)	
4.	**Field Name:**	**2011**

Field Note:
NPM 3
Numerator (KY 0-18 with Primary Care Physician)
Denominator (KY 0-18)

Data Alerts:

None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	99.0	96.0	97.0	97.0	97.0
Annual Indicator	96.0	96.3	96.8	96.8	
Numerator	7,500	8,257	8,500	8,384	
Denominator	7,812	8,575	8,785	8,660	
Data Source	CUP Database	CUP Database	CUP Database	CUP Database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator: KY CCSHCN enrollees 0-18 w/private or public insurance Denominator: KY CCSHCN enrollees 0-18	
2.	**Field Name:**	**2013**
	Field Note: Numerator: KY CCSHCN enrollees 0-18 w/private or public insurance Denominator: KY CCSHCN enrollees 0-18	
3.	**Field Name:**	**2012**
	Field Note: Numerator: KY CCSHCN enrollees 0-18 w/private or public insurance Denominator: KY CCSHCN enrollees 0-18	
4.	**Field Name:**	**2011**
	Field Note:	

NPM 4:
Numerator: KY CCSHCN enrollees 0-18 w/private or public insurance
Denominator: KY CCSHCN enrollees 0-18

Data Alerts:

None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	98.0	97.0	97.0	97.0	97.0
Annual Indicator	97.1	96.0	96.3	96.2	
Numerator	7,587	8,234	8,464	8,328	
Denominator	7,812	8,575	8,785	8,660	
Data Source	CCSHCN CUP Information System	CCSHCN CUP Information System	CCSHCN CUP Information System	CCSHCN CUP Information System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator: KY CCSHCN enrollees 0-18 with specified note type Denominator KY CCSHCN enrollees 0-18	
2.	**Field Name:**	**2013**
	Field Note: Numerator: KY CCSHCN enrollees 0-18 with specified note type Denominator KY CCSHCN enrollees 0-18	
3.	**Field Name:**	**2012**
	Field Note: Numerator: KY CCSHCN enrollees 0-18 with specified note type Denominator KY CCSHCN enrollees 0-18	
4.	**Field Name:**	**2011**

Field Note:
NPM 5:
Numerator: KY CCSHCN enrollees 0-18 with specified note type
Denominator KY CCSHCN enrollees 0-18

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	67.0	65.0	60.0	60.0	70.0
Annual Indicator	57.0	55.2	74.3	68.8	
Numerator	1,269	1,158	1,295	1,206	
Denominator	2,227	2,098	1,743	1,752	
Data Source	CUP & Comment Cards	CUP & Comment Cards	CUP & Comment Cards	CUP & Comment Cards	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Information derived from averaging CUP (information system) data query with two (2) questions on CCSHCN comment cards: 1. (CUP) KY children ages 14-18 with plans for an adult health care provider; (59.2%) 2. Those responding "becoming as independent as possible" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (78.3%); and 3. Those responding "getting the education and skills needed for a job" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (70.1%) Average of sum of numerators divided by sum of denominators = 68.8%

2. **Field Name:** **2013**

Field Note:
Information derived from averaging CUP (information system) data query with two (2) questions on CCSHCN comment cards: 1. (CUP) KY children ages 14-18 with plans for an adult health care provider; (78.4%)** 2. Those responding "becoming as independent as possible" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (69.2%); and 3. Those responding "getting the education and skills needed for a job" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (74%) Average of sum of numerators divided by sum of denominators = 74.3% **Note: CUP transition checklist not available in information system during full reporting period and results may be underreported.

3.	**Field Name:**	**2012**

Field Note:
Information derived from averaging CUP (information system) data query with two (2) questions on CCSHCN comment cards:
1. (CUP) KY children ages 14-18 with plans for an adult health care provider; (44.2%)
2. Those responding "becoming as independent as possible" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (65.2%); and
3. Those responding "getting the education and skills needed for a job" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (81.4%)
Average of sum of numerators divided by sum of denominators = 55.2%

4.	**Field Name:**	**2011**

Field Note:
NPM 6:
Information derived from averaging CUP (information system) data query with two (2) questions on CCSHCN comment cards:
1. (CUP) KY children ages 14-18 with plans for an adult health care provider; (56.4%)
2. Those responding "becoming as independent as possible" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (73.1%); and
3. Those responding "getting the education and skills needed for a job" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (65.1%)
Average of sum of numerators divided by sum of denominators = 61.7%

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	78.0	74.0	80.0	70.0	75.0
Annual Indicator	79.1	68.2	68.2	72.7	
Numerator					
Denominator					
Data Source	CDC's NIP Survey	CDC's NIP Survey for states	CDC's NIP Survey for States	CDC's NIP Survey for States	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator and denominator data are not available. Data is from the CDC NIP survey. The 4:3:1:3:3 series coverage is based on the original definition for this series.	
2.	**Field Name:**	**2013**
	Field Note: Numerator and denominator data are not available. Data is from the CDC NIP survey. Data is from 2012. The 4:3:1:3:3 series coverage is based on the original definition for this series.	
3.	**Field Name:**	**2012**
	Field Note: Numerator and denominator data are not available. Data is from the CDC NIP survey. Data is from 2011. The 4:3:1:3:3 series coverage is based on the original definition for this series.	
4.	**Field Name:**	**2011**
	Field Note: Numerator and denominator data are not available. Data is from the CDC NIP survey. Data is from 2010. The 4:3:1:3:3 series coverage is based on the original definition for this series. It is not recommended for comparison to years prior to 2009 because of the changes made in the way the HiB vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.	

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	21.0	18.0	17.0	16.0	14.0
Annual Indicator	19.2	17.6	16.3	14.4	
Numerator	1,594	1,440	1,345	1,187	
Denominator	83,089	81,902	82,494	82,494	
Data Source	KY live birth cert file	KY live birth cert file and population est from US	KY live birth cert file and population est from US	KY live birth cert file and population estimate from US Census Bureau	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 data is preliminary and numbers could change. The 2014 Census population estimates are not currently available therefore the denominator reflects 2013 census population estimates	
2.	**Field Name:**	**2013**
	Field Note: 2013 data is preliminary and numbers could change.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data is preliminary and numbers could change.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data is preliminary and numbers could change.	

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	25.0	26.0	26.0	26.0	27.0
Annual Indicator	23.9	23.9	23.9	23.9	
Numerator	18,790	18,790	18,790	18,790	
Denominator	78,505	78,505	78,505	78,505	
Data Source	UK dental sealant program data	UK dental sealant program data	UK dental sealant program data	UK dental sealant program data	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2014 data is currently not available data for this indicator actually reflects year 2008.

2. **Field Name:** **2013**

Field Note:
2013 data is currently not available data for this indicator actually reflects year 2008.

3. **Field Name:** **2012**

Field Note:
2012 data is currently not available data for this indicator actually reflects year 2008.

4. **Field Name:** **2011**

Field Note:
2011 data is currently not available data for this indicator actually reflects year 2008.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	2.0	1.1	2.9	1.5	2.0
Annual Indicator	2.6	3.2	1.7	2.5	
Numerator	22	27	14	21	
Denominator	849,107	849,272	844,643	844,643	
Data Source	KY vital stats death cert files	KY vital stats death cert files and population est	KY vital stats death cert files and population est	KY vital stats death cert files and population estimates from US Census Bureau	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
2014 data is preliminary and numbers could change. 2014 census population estimates are not currently

available therefore, 2013 population estimates were used for the denominator.

2.	**Field Name:**	**2013**
	Field Note: 2013 data is preliminary and numbers could change.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data is preliminary and numbers could change.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data is preliminary and numbers could change.	

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	30.0	30.0	31.0	32.8	32.8
Annual Indicator	29.6	29.6	32.5	31.5	
Numerator					
Denominator					
Data Source	CDC National Immunization survey state specific da	CDC National Immunization survey state specific da	CDC's National Immunization Survey state specific	CDC's National Immunization Survey State specific data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.	
2.	**Field Name:**	**2013**

Field Note:
Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.

3. **Field Name:** **2012**

Field Note:
Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey. This survey has not been updated and data actually reflect year 2010; there is currently no other data source for this indicator.

4. **Field Name:** **2011**

Field Note:
Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.0	99.0	99.0	99.0	99.0
Annual Indicator	98.1	98.5	96.7	96.8	
Numerator	51,155	52,482	51,625	51,781	
Denominator	52,132	53,295	53,376	53,514	
Data Source	EHDI program/Vital Statistics	EHDI program/Vital Statistics	EHDI program/Vital Statistics	EHDI program/Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Numerator = # screened within 30 days (not including NICU, demise, home births)

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	8.0	6.5	6.5	5.2	6.0
Annual Indicator	6.8	6.7	6.5	6.5	
Numerator					
Denominator					
Data Source	U.S. Census Bureau Current Population Survey for 2	U.S. Census Bureau Current Population Survey for 2	US Census Bureau Small Area Health Insurance Estimates	US Census Bureau Small Area Health Insurance Estimates	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 data is currently not available so 2013 data is used for preliminary reporting. Data for this indicator was obtained from the Small Area Health Insurance Estimates from the US Census Bureau. Numerator and denominator were not available. Age group is for those <19 years of age.	
2.	**Field Name:**	**2013**
	Field Note: Data for this indicator was obtained from the Small Area Health Insurance Estimates from the US Census Bureau. Numerator and denominator were not available. Age group is for those <19 years of age.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data not available yet, so 2011 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.	

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	30.0	29.0	29.0	22.5	26.0
Annual Indicator	31.6	31.6	22.8	29.6	
Numerator	23,759	23,759	17,356	22,062	
Denominator	75,189	75,189	76,273	74,600	
Data Source	Pediatric Nutrition Surveillance system state spec	Pediatric Nutrition Surveillance System state spec	WIC clinic data from all WIC sites in KY	WIC clinic data from all WIC sites in KY	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
PedNSS data has been the data source for this indicator for several years. Since the CDC no longer provides PedNSS data to the states, previous years PedNSS data was used for this indicator for years 2011 and 2012. However, in 2013, data was pulled and analyzed from all of the WIC clinics across the state of KY to provide updated data for this indicator. Methodology on how the data was pulled was based off of what was reported for PedNSS. 2014 data is preliminary and numbers may change.

2. **Field Name:** **2013**

Field Note:
PedNSS data has been the data source for this indicator for several years. Since the CDC no longer provides PedNSS data to the states, previous years PedNSS data was used for this indicator for years 2011 and 2012. However, in 2013, data was pulled and analyzed from all of the WIC clinics across the state of KY to provide updated data for this indicator. Methodology on how the data was pulled was based off of what was reported for PedNSS.

2013 data is preliminary and numbers may change.

3. **Field Name:** **2012**

Field Note:
2012 PedNSS data is not currently available therefor, 2010 data was used.

PedNSS data has been the data source for this indicator for several years. Since the CDC no longer provides PedNSS data to the states, previous years PedNSS data was used for this indicator.

4. **Field Name:** **2011**

Field Note:
2011 PedNSS data is not currently available therefor, 2010 data was used.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	19.0	19.0	19.0	18.0	18.0
Annual Indicator	20.4	20.1	19.3	19.0	
Numerator	10,749	10,610	10,369	9,899	
Denominator	52,798	52,867	53,625	52,210	
Data Source	KY Vital statistics live birth cert files year 201	KY vital stats live birth cert files for year 2012	KY vital stats live birth cert files for year 2013	KY vital stats live birth cert files for year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   2014 data is preliminary and numbers could change.

2. **Field Name:** **2013**

   Field Note:
   2013 data is preliminary and numbers could change.

3. **Field Name:** **2012**

   Field Note:
   2012 data is preliminary and numbers could change.

4. **Field Name:** **2011**

   Field Note:
   2011 data is preliminary and numbers could change.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.0	6.5	9.8	9.5	6.0
Annual Indicator	8.3	10.3	9.9	6.4	
Numerator	24	29	28	18	
Denominator	289,595	282,834	282,630	282,630	
Data Source	KY vital stats death cert files year 2011	KY vital stats death cert files and current popula	KY vital stats death cert files and US Census bure	KY vital stats death cert files and population estimates from US Census Bureau	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 data is preliminary and numbers could change. 2014 population estimates are currently not available therefore, 2013 population estimates were used for the denominator.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data is preliminary and numbers could change.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data is preliminary and numbers could change.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data is preliminary and numbers could change.	

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	59.0	59.0	62.0	56.0	67.0
Annual Indicator	58.4	59.7	65.6	64.2	
Numerator	426	436	469	453	
Denominator	730	730	715	706	
Data Source	KY vital stats live birth cert files year 2011	KY vital stats live birth cert files year 2012	KY vital stats live birth cert files year 2013	KY vital stats live birth cert files year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
2014 data is preliminary and numbers could change. KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center. Data for 2014 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

2. **Field Name:** **2013**

Field Note:
2013 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2013 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

3. **Field Name:** **2012**

Field Note:
2012 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2012 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

4.	**Field Name:**	**2011**

Field Note:
2011 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2011 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	74.0	75.5	76.0	76.0	75.0
Annual Indicator	72.5	74.8	75.4	73.9	
Numerator	38,292	38,505	39,303	37,413	
Denominator	52,798	51,498	52,125	50,643	
Data Source	KY vital stats live birth cert files year 2011	KY vital stats live birth cert files year 2012	KY vital stats live birth cert files year 2013	KY vital stats live birth cert files year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2013 data is preliminary and numbers could change.

2.	**Field Name:**	**2013**

Field Note:
2013 data is preliminary and numbers could change.

3.	**Field Name:**	**2012**

Field Note:
2012 data is preliminary and numbers could change.

4.	**Field Name:**	**2011**

Field Note:
2011 data is preliminary and numbers could change.

Data Alerts:

None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Kentucky

SPM 1 - Percentage of first time births to Kentucky resident women aged 18 and older who had a pre-pregnancy BMI in either the overweight or obese category.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	50.0
Annual Indicator	50.8	51.8	51.4	53.4	
Numerator	10,840	11,086	11,058	10,726	
Denominator	21,342	21,419	21,508	20,096	
Data Source	KY Vital statistics files, live birth cert files	KY vital stats live birth cert files year 2012	KY vital stats live birth cert files year 2013	KY vital stats live birth cert files year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 data is preliminary and numbers could change.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data is preliminary and numbers could change.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data is preliminary and numbers could change.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data is preliminary and numbers could change.	

Data Alerts:

None

SPM 2 - Percent of Kentucky high school students who smoked cigarettes on one or more of the past thirty days.

	2011	2012	2013	2014	2015
Annual Objective	26.0	25.0	24.0	17.5	17.5
Annual Indicator	24.1	24.1	17.9	17.9	
Numerator					
Denominator					
Data Source	KY Youth Risk Behavior Surveillance System 2011 su	KY Youth Risk Behavior Surveillance System year 20	KY Youth Risk Behavior Surveillance System Year 20	KY Youth Risk Behavior Surveillance System Survey Year 2013	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator and denominator data are not available. This survey is only conducted every other year in KY and is currently administered during the odd numbered years. Therefore, data actually reflects 2013 weighted survey results.	
2.	**Field Name:**	**2013**
	Field Note: Numerator and denominator data are not available.	
3.	**Field Name:**	**2012**
	Field Note: Numerator and denominator data are not available. The YRBS survey is only conducted in the odd years, therefore, data for 2012 is actually from the 2011 survey.	
4.	**Field Name:**	**2011**
	Field Note: Numerator and denominator data are not available.	

Data Alerts:

None

SPM 3 - Percent of singleton live births to Kentucky residents that are 34-36 weeks (late preterm) at delivery.

	2011	2012	2013	2014	2015
Annual Objective	8.8	8.6	7.8	8.2	7.5
Annual Indicator	8.7	7.9	8.5	7.9	
Numerator	4,445	4,067	4,433	3,974	
Denominator	51,109	51,230	51,913	50,524	
Data Source	KY Vital statistics files, live birth cert files	KY vital stats live birth cert files year 2012	KY vital stats live birth cert files year 2013	KY vital stats live birth cert files year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 data is preliminary and numbers could change.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data is preliminary and numbers could change.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data is preliminary and numbers could change.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data is preliminary and numbers could change.	

Data Alerts:

None

SPM 4 - Proportion of Kentucky children birth to 5 years of age who die from child abuse.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	8.5	9.5	7.2	4.9	5.0
Annual Indicator	9.6	7.5	5.1	6.5	
Numerator	27	21	14	18	
Denominator	282,367	279,535	274,874	274,874	
Data Source	DCBS case files plus death certificate files	DCBS case files plus death certificate files for y	DCBS case files for year 2013	DCBS case files for year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   2014 data is preliminary and numbers could change. Five cases are still pending due to incomplete reviews. 2014 census data is currently not available and will not be until sometime late summer. Therefore, the denominator reflects 2013 population estimates.

2. **Field Name:** **2013**

   Field Note:
   2013 data is preliminary and numbers could change. Five cases are still pending due to incomplete reviews.

3. **Field Name:** **2012**

   Field Note:
   2012 data is preliminary and numbers could change.

   2012 census data is currently not available and will not be until sometime late summer. Therefore, the denominator reflects 2011 population estimates.

4. **Field Name:** **2011**

   Field Note:
   2011 data is preliminary and numbers could change.

   2011 census data is currently not available and will not be until sometime late summer. Therefore, the denominator reflects population estimates from the 2010 census.

Data Alerts:

None

SPM 5 - Percent of 12-17 year old Kentucky residents reporting illicit drug use in the past month.

	2011	2012	2013	2014	2015
Annual Objective	12.0	8.0	8.0	7.8	7.5
Annual Indicator	8.1	8.5	7.9	7.9	
Numerator					
Denominator					
Data Source	SAMHSA state specific data on illicit drug use	SAMHSA state specific data on illicit drug use	SAMHSA state specific data on illicit drug use	SAMHSA state specific data on illicit drug use by age groups	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator and denominator data are not available. Survey data is currently not available for 2014 so indicator reflects 2013 survey data.	
2.	**Field Name:**	**2013**
	Field Note: Numerator and denominator data are not available.	
3.	**Field Name:**	**2012**
	Field Note: Numerator and denominator data are not available.	
4.	**Field Name:**	**2011**
	Field Note: Numerator and denominator data are not available.	

Data Alerts:

None

SPM 6 - The number of Medicaid covered women who had at least one dental visit during their pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	35.0	36.0	28.0	25.0	13.5
Annual Indicator	32.5	25.6	22.7	12.9	
Numerator	12,140	11,108	9,821	6,412	
Denominator	37,392	43,386	43,334	49,587	
Data Source	KY Medicaid Claims database	KY Medicaid Claims data warehouse for year 2012	KY Medicaid Claims Files year 2013	KY Medicaid Claims Files year 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts:

None

SPM 7 - Decreased percentage of children, ages 0 to 18, receiving CCSHCN services, with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	32.0	35.0	34.0	33.0	34.0
Annual Indicator	36.7	34.8	35.8	36.5	
Numerator	1,584	1,583	1,522	1,464	
Denominator	4,320	4,543	4,249	4,007	
Data Source	CCSHCN CUP database	CCSHCN CUP database	CCSHCN CUP database	CCSHCN CUP database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator (0-18 CCSHCN-enrolled with BMI>=85% as of 6/30/14) Denominator (0-18 CCSHCN-enrolled with a	

BMI measurement as of 6/30/14)

2.	**Field Name:**	**2013**

Field Note:
Numerator (0-18 CCSHCN-enrolled with BMI>=85% as of 6/30/13)
Denominator (0-18 CCSHCN-enrolled with a BMI measurement as of 6/30/13)

3.	**Field Name:**	**2012**

Field Note:
Numerator (0-18 CCSHCN-enrolled with BMI>=85% as of 6/30/12)
Denominator (0-18 CCSHCN-enrolled with a BMI measurement as of 6/30/12)

4.	**Field Name:**	**2011**

Field Note:
SPM 7:
Numerator (0-18 CCSHCN-enrolled with BMI>=85% as of 6/30/11)
Denominator (0-18 CCSHCN-enrolled with a BMI measurement as of 6/30/11)

Data Alerts:

None

SPM 8 - Degree to which CCSHCN transition action plan is successfully completed and implemented.

	2011	2012	2013	2014	2015
Annual Objective	55.0	60.0	77.0	80.0	97.0
Annual Indicator	63.5	75.0	86.5	92.3	
Numerator	33	39	45	48	
Denominator	52	52	52	52	
Data Source	CCSHCN Transition Action Plan Ratings	CCSHCN Transition Action Plan Ratings	CCSHCN Transition Action Plan Ratings	CCSHCN Transition Action Plan Ratings	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator: Total annual score on transition action plan. Scoring based on a total score (maximum=52), and

measured yearly for increase or decrease from prior year. Scoring by consensus, led by agency Transition Administrator. Scoring: 0: activities have not yet begun; 1: activities have just begun; 2: activities are progressing; 3: activities are well-established; 4: activities are sustained. Denominator: Total possible score on transition action plan (=52)

2.	**Field Name:**	**2013**

Field Note:
Numerator: Total annual score on transition action plan.

Scoring based on a total score (maximum=52), and measured yearly for increase or decrease from prior year. Scoring by consensus, led by agency Transition Administrator.

Scoring:
0: activities have not yet begun;
1: activities have just begun;
2: activities are progressing;
3: activities are well-established;
4: activities are sustained.

Denominator:
Total possible score on transition action plan (=52)

3.	**Field Name:**	**2012**

Field Note:
Numerator: Total annual score on transition action plan.

Scoring based on a total score (maximum=52), and measured yearly for increase or decrease from prior year.

Scoring:
0: activities have not yet begun;
1: activities have just begun;
2: activities are progressing;
3: activities are well-established;
4: activities are sustained.

Denominator:
Total possible score on transition action plan (=52)

Data Alerts:

None

Form 11

Other State Data

State: Kentucky

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Kentucky

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table