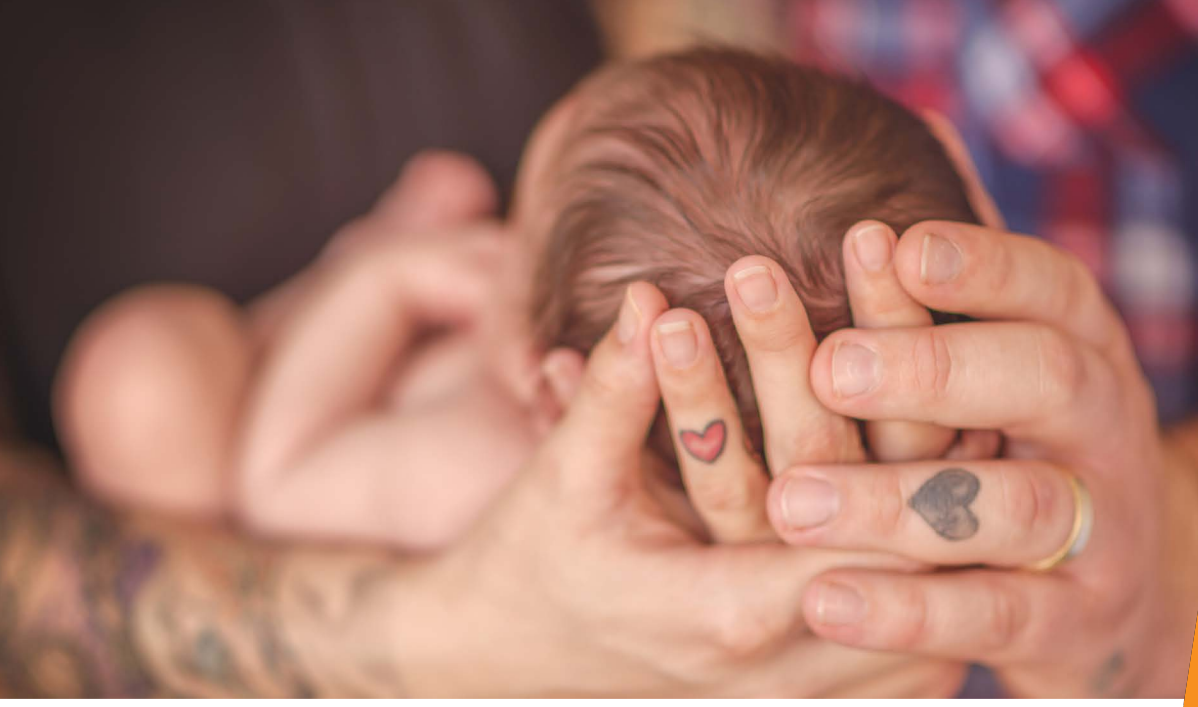

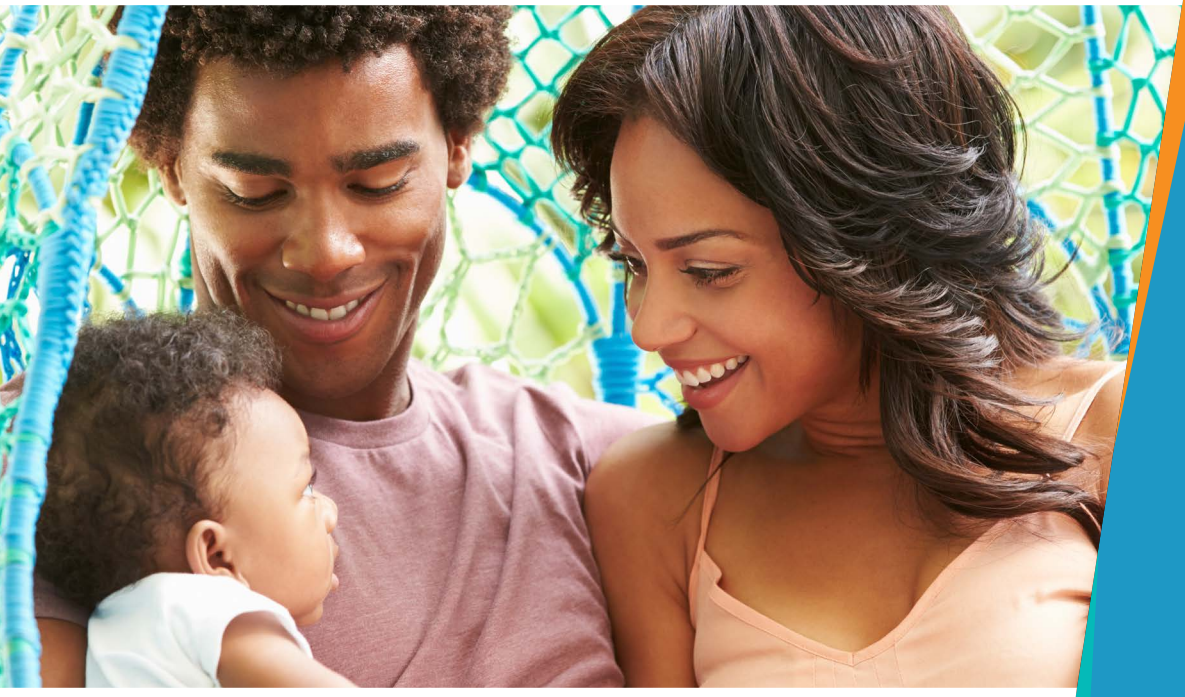

MCH 2025
TITLE V NEEDS ASSESSMENT

PRIORITIES AND ACTION PLAN **2021-2025**

KANSAS MATERNAL & CHILD HEALTH

KU THE UNIVERSITY OF KANSAS

Kansas Department of Health and Environment

Bureau of Family Health

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Kansas celebrates people of all races, ethnicities, gender identities, ages, sexual orientations, and abilities. Deliberate efforts have been made to showcase the broad diversity of our state (represented both within the narrative and through visual depictions) with dignity, honor, and cultural competency.

We are committed to representing the data herein responsibly and equitably and we therefore make every effort to be transparent in that process. The complete data collection process is documented thoroughly in Appendix A.

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Graphic Design: Eliza Bullock

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EXECUTIVE SUMMARY

Introduction

Enacted by Congress in 1935, Title V of the Social Security Act committed federal support to states to ensure adequate health services for maternal and child health populations, including an emphasis on Children with Special Health Care Needs (CSHCN) and their families. The Maternal and Child Health (MCH) Services Block Grant is predicated on life course theory and the knowledge of the importance of critical stages, beginning before a child is born and continuing throughout life, which can influence lifelong health and well-being. Title V MCH continues to be the only federal grant program solely focused on improving the health of all mothers and children. Title V legislation and the MCH Services Block Grant Program enables states to:

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

In Kansas, the Kansas Department of Health and Environment (KDHE) Bureau of Family Health (BFH) administers the Title V (MCH) Program.

MCH 2025: Title V Needs Assessment

Ongoing federal funding for the MCH program requires that each state complete a comprehensive needs assessment every five years. The needs assessment involves reporting on the health status of women and children in the state, identifying priority health needs of the target populations, and working collaboratively with stakeholders to adopt measures that will be used to monitor progress and guide programmatic decision-making.

The primary goals of the needs assessment were to identify the greatest needs of MCH populations in the state and to create a framework to guide and measure progress to improve the health status of these populations. This was done through meaningful engagement of key stakeholders including KDHE staff, representatives of other state agencies, statewide organizations engaged in efforts to enhance the well-being of MCH populations, local MCH lead agencies, other organizations who serve women and children across the state, MCH program clients, and other stakeholders including members of the public. For over a year, BFH staff and partners engaged in structured discussions, collected surveys in multiple formats, and collected feedback through Open House events. Unique approaches were also used to collect insights, including analysis of narrative stories collected by the Our Tomorrows project using Sensemaker®, collecting responses to questions on touch-pad kiosks placed in public locations like libraries, community centers, and MCH clinic waiting areas across the state, and asking adolescents to share their perceptions of factors influencing their health not only through focus groups but by capturing and narrating photos in their communities of important factors contributing to, or detracting from, their health.

Key Findings

Across all methodologies, Kansans shared a clear and consistent message: the health of all maternal and child health populations and their families is important. Kansans value health and well-being and believe it should be a top policy priority. However, they also witness -- and experience -- barriers to optimal health. Kansans recognized that there were unacceptable health disparities among women and children based on race, education, income, abilities, and other factors, and acknowledged that there were structural inequities in systems of care that resulted in these disparities.

Overarching Themes Heard Through the Needs Assessment Process

- Significant disparities exist that negatively impact the health status of women and children and their ability to access care.
- High-quality health care services are often out of reach for many, and far too often families report the affordability of health insurance, and out of pocket costs for health and related services, as a barrier to accessing them.
- There is a need for the development of policies and systems that focus on addressing the social determinants of health in a meaningful way, addressing widespread root causes and structural problems, as opposed to the existing approach to service delivery which focuses primarily on the physical and social needs of the individual.
- Mental health was cited as a major public health priority by more public health agencies in the state than any other issue. Every stakeholder group participating in the needs assessment identified behavioral health and access to high-quality behavioral health services as one of their most significant concerns.

Developing the MCH State Action Plan

Informed by needs assessment findings, MCH priority needs and goals were identified through a highly collaborative process, as were strategies and action steps to address them. Progress will be continuously monitored and evaluated by the MCH Program and its key partners, utilizing performance measures also identified as part of the needs assessment process.

MCH Priority Needs and Performance Measures

State Priorities

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

1. Women have access to and utilize integrated, holistic, patient-centered care before, during and after pregnancy.
2. All infants and families have the support of strong community systems to optimize infant health and well-being.
3. Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.
4. Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health.
5. Communities, families, and providers have the knowledge, skills, and comfort to partner with and support transitions and empowerment opportunities.
6. Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.
7. Strengths-based supports and services are available to promote healthy families and relationships.

National Performance Measures (NPM)

States select appropriate measures from 15 federally-designated measures (at least one per population domain) for 2021-2025 Kansas selected:

NPM 1: Well-woman visit
Percent of women, ages 18-44, with a preventive medical visit in the past year

NPM 5: Safe Sleep
Percent of infants placed to sleep; (A) on their backs; (B)on separate sleep surface; and (C) without soft objects and loose bedding

NPM 6: Developmental screening
Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

NPM 10: Adolescent well-visit
Percent of adolescents, 12 through 17, with a preventive medical visit in the past year

NPM 12: Transition
Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care

Title V Key Concepts and Definitions

Vision

Title V envisions a nation where all mothers, children and youth, including Children with Special Health Care Needs (CSHCN), and their families are healthy and thriving.

Mission

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

MCH Population Health Domains

- Women's/Maternal Health (women of reproductive age — 15 through 44 years — and pregnant women)
- Perinatal/Infant Health (infants less than 1 year)
- Child Health (1 through 11 years of age)
- Children with Special Health Care Needs birth through 21 years)
- Adolescent Health (12 through 21 years)
- Cross-Cutting/Systems Building (all populations and the MCH workforce)

Legislatively-defined state MCH population groups

- Pregnant women, mothers, and infants up to age 1
- Children
- Children with special health care needs

Priority Needs

Title V legislation directs states to conduct a state-wide MCH Needs Assessment every 5 years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and CSHCN. From this assessment, states select seven to ten priorities for focused programmatic efforts over the five-year reporting cycle.

Objectives

A statement of intention with which actual achievement and results can be measured and compared. SMART objectives are specific, measurable, achievable, relevant and time-phased.

Key Strategies

Strategies are the general approaches taken to achieve the objectives; activities are specific actions to implement the strategies. Strategies are defined as part of the interim Five-year State Action Plan Table and further refined in the second Application/Annual Report year. Program activities for implementing the identified program strategies will be discussed and updated annually as part of the State Action Plan narrative.

Performance Measures

The National Performance Measures, or NPMs (Kansas must select a minimum of 5 from 15 federally-defined measures) and State Performance Measures (SPMs) that are selected to align with strategies developed by the state, as well as with National Outcome Measures.

ACKNOWLEDGEMENTS

Thanks to all Kansans who participated in the MCH Needs Assessment. Thousands of individuals engaged in this process through surveys, focus groups, storytelling, photography, public open houses, meetings, and other forms of communication and input.

The individuals represented in this Assessment represent a broad range of expertise and experience in maternal and child health. We are appreciative of the diverse voices represented in these pages and are committed to ensuring Kansas' MCH Program is informed and guided by the needs and perspectives of all Kansans committed to the health and well-being of the women, infants, children, and adolescents of the state.

INTRODUCTION

Title V Maternal and Child Health Program

The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children, and youth, including children and youth with special health care needs, and their families.

Title V of the Social Security Act is the longest-standing public health legislation in the United States and represents one of the largest federal block grant programs supporting public health. With the passing of the Social Security Act of 1935, the federal government, working through Title V, committed its support to states in an effort to extend and sustain health services for maternal and child health populations.

For over 85 years, the Title V Maternal Child Health (MCH) Block Grant has been the only federal program with a singular focus on improving the health of all mothers and children.

What does Title V Do?

- Provides and assures mothers and children have access to quality MCH services
- Reduces infant mortality and the incidence of preventable diseases
- Provides rehabilitation services for blind and disabled individuals
- Provides and promotes family-centered, community-based, coordinated care
- Facilitates the development of community-based systems of services

Which populations does Title V impact?

Title V is responsible for promoting the health of all mothers and children across the life course, with a particular emphasis on Children with Special Health Care Needs (CSHCN) and their families. The federal program recognizes six domains including five MCH population domains as well as a cross-cutting/systems building domain:

- Women/Maternal Health
- Perinatal/Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs
- Cross-cutting/Systems Building

MCH Framework and Services

Vision, Mission, and Purpose

Specified in legislation, Title V's Vision and Mission statements serve a useful role in helping to guide priority setting within the federal and state MCH programs. The following Vision/Mission statements were developed as part of the MCH Block Grant transformation process.

Vision of Title V

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

Mission of Title V

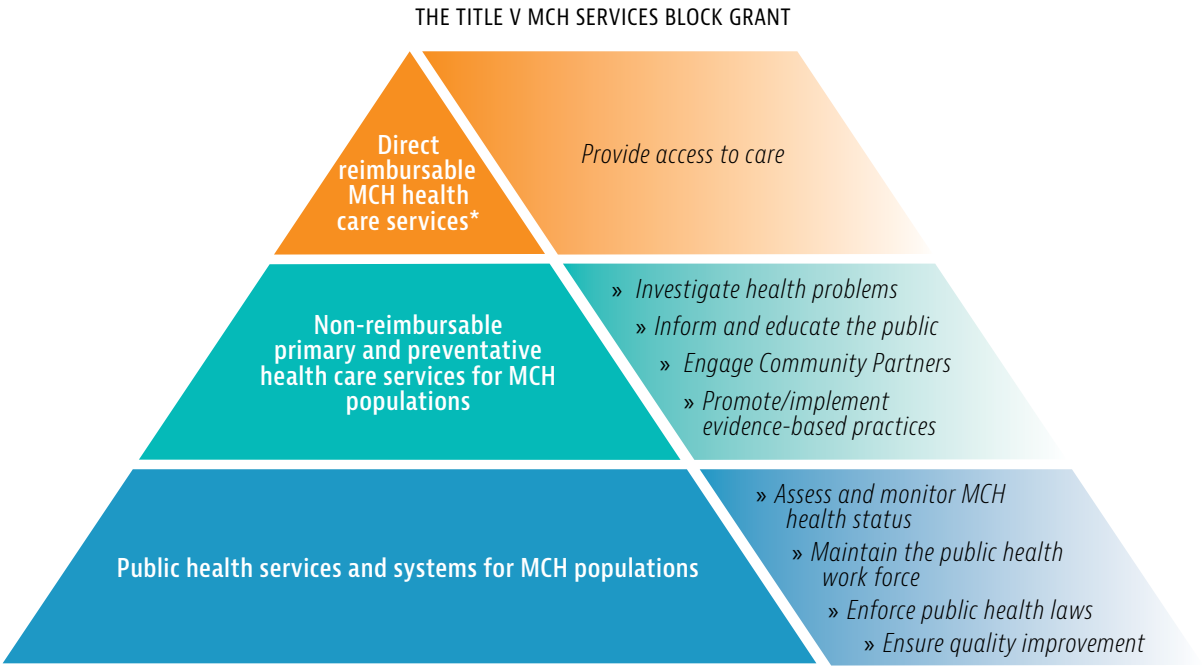
To improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

Purpose of the MCH Services Block Grant Program

As defined in section 501(a)(1) of the Title V legislation, the purpose of the MCH Services Block Grant Program is to enable each state to:

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

The title V systems level approach is captured in the framework for MCH services which is depicted as a pyramid of services. The framework aligns with the 10 MCH Essential Services and consists of three levels defined below.



** Payment for direct services not covered by public or private insurance*

Public Health Services and Systems

At the base of the pyramid are public health services and systems. This level includes activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services.

Enabling Services

At the middle of the pyramid are non-reimbursable primary and preventive enabling services. This level includes non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health-care and improve health outcomes where MCH Services Block Grant funds are used to finance these services.

Direct Services

At the top of the pyramid, which is the smallest section, are direct services. This level includes preventive, primary, or specialty clinical services to pregnant women and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts.

MCH Essential Services

In considering potential strategies for implementing Title V vision and mission statements, the 10 Essential Public Health Services were cross-walked with the purpose of the MCH Block Grant to States Program, as defined in Section 501(a)(1) of Title V of the Social Security Act. The following strategies were developed as a result of this effort:

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

Core Values & Guiding Principles

In addition to the MCH conceptual framework and public health essential services, the Kansas MCH program depends on core values and guiding principles when approaching all phases of the work: planning, design, implementation, and ongoing assessment/monitoring/evaluation. This commitment drives development of integrated systems of care, assessment for community level MCH initiatives, family and consumer engagement, and service coordination through innovative approaches to ensure families receive the right support and services they need to thrive. Kansas Title V recognizes and understands the connections between priorities across MCH population domains. Therefore, it is important to note that these core values and guiding principles do not stand alone, yet build upon and complement each other, further exemplifying the collaborative approach.

Kansas MCH Core Values

Prevention and wellness

Organized activities and system interventions that are directed at improving general well-being, protection from disease, identifying modifiable health risks, and influencing health behavior changes.

Life Course Perspective

The awareness of the long-term impact of events throughout life (e.g., fetal development, childhood, adolescence, adulthood) have on one's health in later stages of life.

Social Determinants of Health

The conditions in which people are born, grow, live, work and age. These circumstances are influenced by policy, shaped by distribution of money and power, and are often the root cause for health inequities.

Health Equity

The differences in population health that can be traced to unequal conditions and are systemic and unavoidable - and thus inherently unjust and unfair. When societal resources are distributed unequally by class, race, or disability, population health will be distributed unequally along those lines as well.

Kansas MCH Guiding Principles

Collaboration

Creating systems change that reduces barriers to women, infants, children, children with special health care needs, and adolescents getting the services that they need – both within and across agencies.

Consumer Engagement

Obtaining buy-in from those directly affected by systemic changes and assuring the consumer and family voice is central to programming, initiatives, and special projects.

Relationships

Collective partners at the individual and organizational level that provide a foundation for service delivery, continuous quality improvement, and positive community change.

Community Norms

Recognizing community values, beliefs, attitudes and behaviors and promoting positive community norms by addressing barriers to accessing services.

Program Organization and Capacity

KDHE and BFH Organization

The Kansas Department of Health and Environment (KDHE) is led by the Secretary, who is appointed by the Governor and serves on the Governor's Cabinet. As the State's public health agency, the KDHE mission is to protect and improve the health and environment of all Kansans. The agency is composed of three divisions: Public Health, Health Care Finance, and Environment. The Title V MCH Services Block Grant program is administered through the Bureau of Family Health (BFH), one of six bureaus in the KDHE's Division of Public Health.

BFH Mission

To provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.

BFH Goals

Improve Access to Services

Improve access to comprehensive health, developmental and nutritional services for women and children including children with special health care needs.

Improve Women and Children's Health

Improve the health of women and children in the State through prevention/wellness activities, a focus on social determinants of health, adopting a life-course perspective and addressing health equity.

Eliminate Barriers to Care

Strengthen Kansas' MCH infrastructure and systems to eliminate barriers to care and to reduce health disparities.

The BFH is comprised of an administration team which includes the Bureau Director, who also serves as the Title V MCH Director, and four Sections: Children & Families (core Title V staff including the MCH and SHCN program staff), System of Supports (core Title V staff including the Title V CSHCN Director), Nutrition & WIC Services, and Early Care and Youth Programs/Child Care Licensing). The Title V MCH Needs Assessment and State Action Plan reflect work and programs across the bureau; alignment and collaboration focus on ensuring a coordinated system of care for women, infants, children, and families across the life course.

The Children and Families Section is comprised of program staff and a team of Title V population domain consultants who serve as content experts to guide and inform development and implementation of cross-cutting Bureau education, tools, and resources for all population domains and behavioral health. State staff provide technical assistance to communities and agencies on identifying local health issues, developing policies and plans, identifying effective models, professional development opportunities, and monitoring progress. Programs include Maternal and Child Health (MCH), Reproductive Health and Family Planning (Title X), Pregnancy Maintenance Initiative (PMI), Teen Pregnancy Targeted Case Management (TPTCM), Special Health Care Needs (SHCN), Infant-Toddler Services tiny-k (Part C), Kansas Connecting Communities (perinatal behavioral health), and KSKidsMAP to Mental Wellness (pediatric mental health). The section also administers programming related to several other federal projects, including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Early Comprehensive Childhood Systems (ECCS) Impact grants.

The Section focuses on promoting optimal health for infants, children, adolescents, and women through systems development activities and grants to local communities. MCH grant funding is provided to approximately 80 local health agencies and community-based organizations to support programs and services for women, pregnant women, infants, children, adolescents, and their families. Strengths-based supports and services are available to promote healthy individuals, families, and relationships in alignment with the Title V State Action Plan. More than 50 local MCH agencies offer Universal Home Visiting services such as education, referrals, and community outreach to pregnant women and families with infants less than one year of age. MCH Home Visitors provide outreach calls and visits to pregnant women and families with infants.

MCH funding also supports SHCN satellite offices, clinics, and care coordinators in a number of locations across the state. The Kansas SHCN program promotes the functional skills of persons in Kansas who have or are at risk for a disability or chronic disease by providing or supporting a system of specialty health care. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care for individuals with eligible disabilities in accordance with state and federal funding and direction. SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions.

The System of Supports (SoS) Section (formerly Special Health Services) strives to cultivate partnerships to build and maintain a strong foundation of supports for Kansas families. The Section is comprised of core programming related to public health screening and surveillance programs (Newborn Screening, Birth Defects), family and consumer partnership initiatives (Family Advisory Council, Title V Family Delegate Program, Supporting You Peer to Peer Network), and activities related to improving systems of care for the Children with Special Health Care Needs (CSHCN) population, specifically advancement of the Kansas State Plan for Systems of Care for CSHCN. SoS works in collaboration with the Children and Families Section to align the state-mandated program and federal requirements/goals for the CSHCN population.

In addition to staffing within the Bureau and MCH program, two other KDHE Bureaus receive regular MCH support, including the Bureau of Community Health Systems (BCHS) for local public health workforce development, training, capacity building, and systems development, and the Bureau of Epidemiology and Public Health Informatics (BEPHI) for vital records data sharing, analysis, and reporting. MCH and State Systems Development Initiative (SSDI) funding supports two full-time MCH epidemiologists within BEPHI who interface with epidemiological work conducted in other bureaus inside the agency and with other organizations in the state. Both epidemiologists coordinate all data analyses for the MCH Needs Assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiological needs of the Bureau and MCH program.

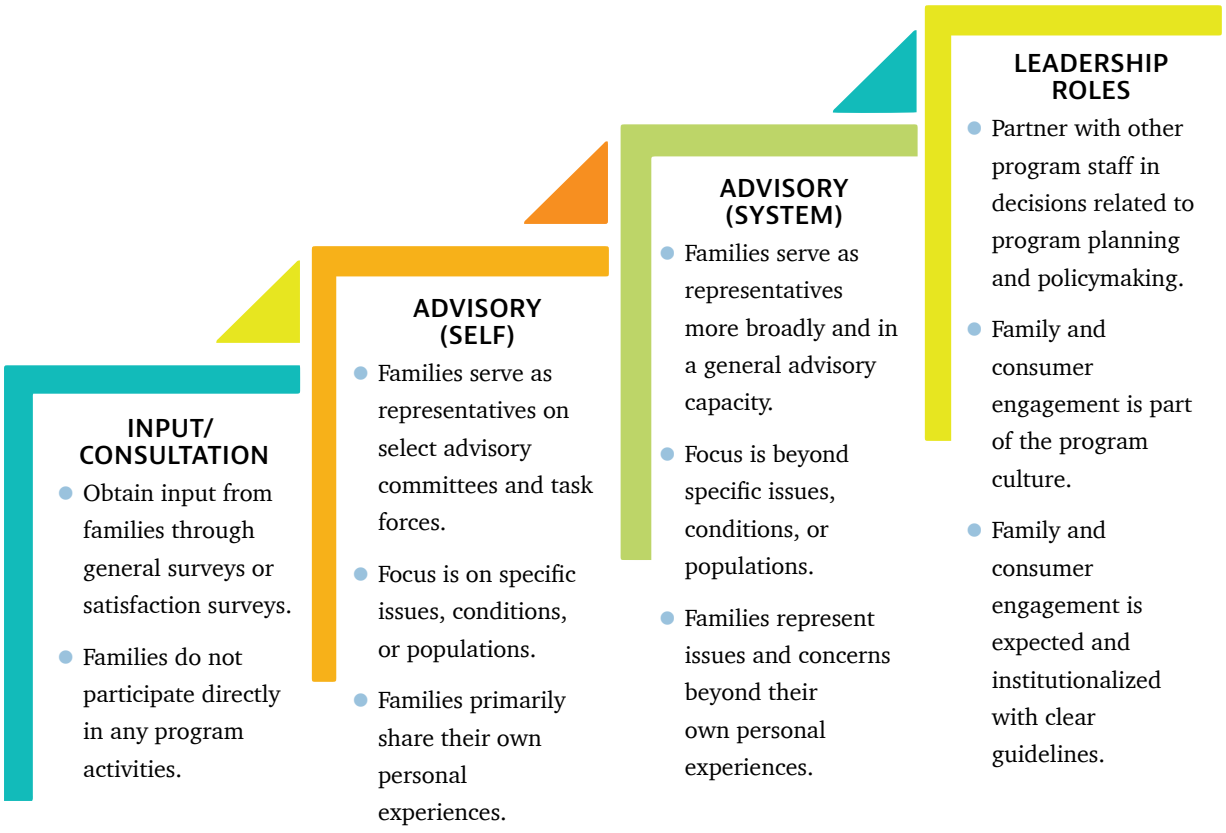
Family and Consumer Partnership

"Kansas invests in family/consumer engagement and partnership to affirm that the family and consumer voice is a critical component to moving services in the right direction."

Building the capacity of women and children, including CSHCN, and their families to partner in decision-making with Title V programs at federal, state and community levels is a critical strategy in helping states to achieve the identified MCH priorities. The MCH program's commitment to these partnerships is strong, and Kansas is continuously working to expand and strengthen family engagement and partnership activities in all MCH population domains.

For purposes of the MCH Block Grant, family partnership is defined as, "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making—to improve health and health care." This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course.

Families and consumers provide firsthand knowledge and insight to areas that state program staff may not have considered, as well as suggestions on how to make positive changes for the MCH populations, especially CSHCN. The Kansas Title V Program provides opportunities for meaningful engagement and leadership at varying levels of involvement and intensity to fit the needs of consumers and families. Title V strives to support family and consumer engagement at all levels. This includes engaging families through programmatic and community input surveys, offering opportunities to represent their individual families and communities in advisory capacities, and engaging with families as staff, leaders, and key partners in the Title V work.



The level and intensity of family engagement in MCH activities is tracked through the MCH Community Check Box, a web-based tool that supports evaluation of the implementation of the action plan and monitors progress towards MCH goals and outcomes.

State Program Coordination and Collaboration

Collaboration, relationships, and family/consumer engagement are guiding principles of the Title V program. As such, the BFH has fostered collaborative relationships, both formal and informal, at the state and local levels to ensure optimal coordination of the MCH system in the state. Two Title V stakeholder councils provide opportunities to foster statewide coordination: the Family Advisory Council (mentioned above) and the Kansas Maternal and Child Health (MCH) Council, whose members are appointed by the Title V MCH Director and represent a broad range of professionals, family members, and other stakeholders. The MCH program also routinely partners with local and state partners including local health departments, hospitals, Federally-Qualified Health Centers, other medical providers, other state agencies and programs, universities and other educational institutions, foundations, tribes (four in the state), community-based organizations including the faith community, and both local and state-wide membership organizations. The MCH program provides expertise, gathers feedback, and makes connections with all of these partners to efficiently align efforts, effectively utilize resources, and maximize collective impact.

Assessing MCH Needs

Kansas MCH is dedicated to ongoing and continuous assessment of the needs of women, infants, children and families. Every five years, Kansas MCH engages with communities, families, and key stakeholders to conduct a formal needs assessment that drives the development of a 5-Year State Action Plan. Development of the needs assessment and State Action Plan is part of the MCH Block Grant Application that is submitted to the Maternal and Child Health Bureau in the U.S. Department of Health and Human Services Health Resources and Services Administration. Kansas' complete MCH Block Grant Application and Report can be found online at **https://www.kdheks.gov/c-f/mch.htm**.

The MCH Needs Assessment is guided by the state's MCH program within the KDHE Bureau of Family Health (BFH), led by the state's MCH Director and a team of content experts in maternal and child health, special health care needs leaders, epidemiologists, and a variety of other experienced professionals.

The BFH already has an existing strong infrastructure that prioritizes ongoing evaluation and programmatic support. As such, even before the needs assessment process began, the MCH Director, BFH Section Directors, epidemiologists and key partners had a solid foundation to build upon. A framework based on five guiding questions served as the foundation for the needs assessment process. These questions were recognized to align both with the BFH vision and the MCH guidance:

Five Guiding Questions for the Needs Assessment

- *How will priorities be determined?*
- *How will gaps be filled?*
- *How will expectations for the MCH team be raised?*
- *How will planned efforts align with what is already offered by the BFH and KDHE?*
- *How will needs be continuously reassessed at the state and community level?*

Needs Assessment Process

The needs assessment included a comprehensive review of MCH population needs, program capacity, and partnerships/collaborations that are critical components of a state's system of care for addressing the needs of its MCH population. Based on the findings of the needs assessment, KDHE then identified seven Title V MCH priority needs, followed by development of strategies and overarching five year objectives to address the identified priority needs. KDHE then examined areas of potential alignment between its MCH priority needs and the Title V National Performance Measures (NPMs) and National Outcome Measures (NOMs), and selected one NPM in each of the five population health domains. For priority needs not addressed by selected NPMs, targeted State Performance Measures (SPM) were developed.

MCH priority needs, strategies and objectives, and performance measures are the principal components of the 5-Year MCH State Action Plan. The MCH Needs Assessment and Action Plan guide the work of the MCH program and is used to support policy and program decision-making. Through program evaluation and a comprehensive measurement framework, the needs of Kansas' MCH populations drive updates during the interim years.

An MCH Logic Model depicts the needs assessment process, which involved continuously analyzing performance and reassessing strategies over time.

TITLE V MCH BLOCK GRANT NEEDS ASSESSMENT FRAMEWORK LOGIC MODEL

More detailed information about the needs assessment process and methods are detailed in the following section.

Stakeholder Involvement

A principal focus of the Kansas MCH Maternal and Child Health Program is collaborative partnerships, and the program was committed to engaging state and local partners including local public health agencies and program representatives, healthy start and other home visiting programs, health care providers, educators, families, consumers, other government agencies, managed care organizations, Medicaid, representatives of health and wellness advocacy organizations, and associations in the areas of hospital/health systems, dental care, safe sleep, injury prevention, mental and behavioral health, among others.

The MCH Director and staff also worked directly with a core group of key partners (listed in the following table) in conducting the comprehensive MCH Needs Assessment for 2021-2025.

TABLE 2. CORE MCH NEEDS ASSESSMENT COLLABORATORS

KEY NEEDS ASSESSMENT PARTNERS	ROLE	DOMAIN(S)
University of Kansas Center for Public Partnerships and Research (Rebecca Gillam, Chris Tilden, Eliza Bullock)	Contractor, MCH Needs Assessment coordination and report development	All
American Academy of Pediatrics, Kansas Chapter (Mel Hudelson)	Coordination of Kansas Maternal and Child Health Council	All
EnVisage Consulting (Connie Satzler)	MCH Council meeting planning and facilitation	All
DCCCA (Chrissy Mayer, Lydia Fuqua)	Focus groups with students in middle schools, high school and colleges around the state	Adolescents

During the Spring and Summer of 2019 the needs assessment team shared information about assessment methods and outreach/engagement strategies with key partners including the MCH Council and the Family Advisory Council. Guidance from these advisory bodies helped finalize strategies, particularly in relation to stakeholder engagement.

Beginning in September 2019, the needs assessment team visited all regions of the state, facilitating discussions at regional MCH meetings, attending various meetings of key MCH stakeholders, and participating in other data collection efforts (described in more detail below and throughout the document) and strategic planning discussions with MCH staff and key stakeholders. The needs assessment team also engaged internal and external programs closely aligned with MCH (immunizations, chronic disease, oral health, injury prevention, preparedness, etc.) as well as those targeting high-need populations and addressing inequities in health.

Input from other program stakeholders

The BFH worked with CPPR to identify representations of key health and social service organizations in the state. Many of these stakeholders participated as key informant interviews; however one focus group was held with multiple stakeholders. These discussions took place in December 2019 and January 2020 via an online platform. These discussions served as a mechanism to gain additional perspective on needs and emerging issues. Themes from these discussions are included as Appendix L.

Review of Pertinent Documentation

A comprehensive and thorough review of recent evaluations, needs assessments, and strategic plans of these related programs was also an integral aspect of this needs assessment. Reviewed documents are listed below.

- **Healthy Kansans 2020**
- **Kansas Early Childhood Systems Building Needs Assessment, Kansas State Department of Education and the Kansas Children's Cabinet and Trust Fund (January 2020)**
- **Kansas Early Childhood Strategic Plan 2020-2025 "All in For Kansas Kids"**
- **Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs, Kansas Department of Health and Environment (November 2018)**
- **Kansas Infant-Toddler Services (Part C) Needs Assessment (2019)**

- **Kansas Maternal, Infant, and Early Childhood Home Visiting Program Statewide Needs Assessment** (in development).
- Kansas Oral Health Plan (2015)
- Kansas Injury Prevention Plan (March 2016)
- Kansas Tobacco Control Strategic Plan 2016-2020, **Tobacco Free Kansas Coalition**
- Kansas Action Plan for Heart Disease and Stroke Prevention 2012-2017, **Heart and Stroke Alliance of Kansas (April 2013)**
- Kansas Cancer Prevention and Control Plan 2017-2021, **Kansas Cancer Partnership**
- Governor's Substance Use Disorders Task Force Report (September 2018)
- Kansas Blue Ribbon Task Force on Bullying Final Report (December 2019)
- Domestic Violence, Stalking, and Sexual Assault in Kansas, **Kansas Bureau of Investigation (2017)**

Methods

A broad array of quantitative and qualitative methods were used to assess the strengths and needs of the MCH population, MCH program capacity, and the existence of partnerships/collaborations that support MCH program efforts across the state of Kansas. Qualitative data were often presented alongside the quantitative data and were used to help assign meaning to the quantitative data that were reviewed. A rich and varied array of data (sources are described in the next section) were used to ensure a data-driven decision-making process was at the heart of this needs assessment.

Data Sources

Both primary and secondary data were utilized in developing the findings presented in this needs assessment. These data are important in informing the Kansas MCH Program's strategic planning, decision-making, and resource allocation efforts.

Population-level data. Demographic data are presented for the state and the six MCH regions. This data was obtained from the U.S. Census and compiled by staff at the Institute for Policy and Social Research at the University of Kansas. Data tables can be found later in this report and in Appendix A.

Client-level data. The demographic profile for Kansas MCH clients was derived from data residing in DAISEY (Data Application and Integration Solutions for the Early Years), the data platform utilized to capture information on services provided by MCH-funded agencies to clients across the state. Demographic data are found later in this report and in Appendix A. Extensive aggregate data on health indicators among MCH populations were also compiled, analyzed, and aggregated by KDHE MCH epidemiologists to evaluate the population of health status of MCH populations in the state. Some key health status data are highlighted in the section on MCH population health status, and additional detailed data tables are located in Appendix B. These population health statistics were compiled from multiple sources including:

- Health Resources and Services Administration (HRSA). National Survey of Children's Health (NSCH), 2016, 2016-2017 combined
- Centers for Disease Control and Prevention (CDC): Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBS), National Immunization Survey (NIS), EHDI Hearing Screening & Follow-up Survey, WONDER

- Centers for Medicare & Medicaid Services (CMS) Hospital Compare
- U.S. Census Bureau: Population Estimate, Bridged-Race Vintage data set, Small Area Health Insurance Estimates (SAHIE), Small Area Income and Poverty Estimates (SAIPE)
- Agency for Healthcare Research and Quality (AHRQ). Healthcare Cost and Utilization Project (HCUP) - State Inpatient Database (SID)
- Feeding America. **Map the Meal Gap**.
- Kids Count. **Kids Count Data Center**.
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics: Kansas birth data (resident), Kansas death data (resident), Kansas fetal death data (resident), Kansas linked birth and infant death data (resident), Kansas abortion data (resident), Kansas hospital discharge data (resident)
- Kansas Department of Health and Environment (KDHE), Bureau of Family Health. Nutrition and WIC Services. Kansas WIC (KWIC) database
- Kansas Department of Health and Environment (KDHE), Form CMS-416: Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Participation Report
- Kansas Pregnancy Risk Assessment Monitoring System (PRAMS)
- Baby-Friendly USA and National Center for Health Statistics

Information from Local MCH Programs

Local MCH Program Aid to Local applications. As noted earlier, Kansas utilizes an Aid to Local (ATL) granting mechanism that solicits community agencies/organizations to apply for MCH funding. These agencies often include local health departments but may also include other non-profit organizations qualified to provide services, such as FQHCs. These ATL applications provide detailed information about local programs, so State Fiscal Year (SFY) 2019 and 2020 applications were reviewed to gather information on broad local public health priorities in the areas served by the applicant organizations, identified disparities and gaps in services for specific local MCH populations, and current and proposed MCH program priorities and activities. Information was also collected on organizational capacity, including details from program staffing plans and budgets. Some staffing information is included in a later section on workforce capacity and in Appendix D, and a comprehensive summary of key information gathered from the ATL applications is also included in Appendix C.

Semi-structured focus groups with MCH-funded programs. In the fall of 2019 KDHE sponsored five regional meetings across the state that all local programs funded by the KDHE BFH were encouraged to attend. These regional meetings were attended by 108 local program staff representing 59 local MCH programs, and CPPR staff asked a series of questions in a focus group format to all participants. Information gathered at these meetings is noted later and is summarized in a comprehensive fashion in Appendix C.

Program Self-Assessment. Local MCH programs were encouraged to complete, as a staff team, the Program Self-Assessment Summary Tool developed by the California Network of Family Strengthening Networks and adopted by the National Family Support Network. The tool is designed as a self-reflection exercise to assess the degree to which programs are working with families to help them build the five protective factors (parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children) that are shown to increase family stability, enhance child development, and reduce child abuse and neglect. The Center for Public Partnerships and Research (with permission of the national network) developed an online version of the tool in Qualtrics so that aggregate program

results across the state could be summarized and analyzed. These data are included in the Family Strengthening and Support Section on page 39.

Workforce data. Extensive information was gathered from programs for all positions, including information on roles/titles, full-time equivalents (FTEs), and demographics. Much of the information was gathered through ATL grant applications (described above). Programs were then asked to provide supplemental information where gaps existed. These data are summarized later in the MCH Workforce Profile 1 on page 35 of this document and are documented in greater detail in Appendix D. In addition to creating a comprehensive MCH staff profile for the state, CPPR asked all Kansas MCH personnel to complete the Self-Reflection Checklist based on the National Quality Standards of the National Family Strengthening Network. With permission of the national network, CPPR placed a Qualtrics version of the self-assessment online and sent the link to all MCH staff statewide. Much like the Program Self Assessment, this tool is designed for MCH staff to assess their day-to-day efforts to help build strong, healthy families. The Family Strengthening and Support Section on page 39 summarizes these results. Information from the 2017 Public Health Workforce Interests and Needs Survey (PH WINS), administered nationwide by the Association of State and Territorial Health Officials and several other partner organizations, with support from the de Beaumont Foundation, was also included in this needs assessment. PH WINS identifies respondents by program area, so findings could be specifically examined for the MCH workforce population (the definition used included staff who identified as MCH, family planning, WIC, and/or immunization program, a broader definition than employed in the other workforce analyses conducted here). All state health agencies and a random national sample of local health departments (excluding departments with less than 25 FTEs or serving a population of less than 25,000) were included. As such, many MCH-funded programs in Kansas were not selected as part of the national random sample. Participating health departments provided de Beaumont with a contact list of employees to receive the survey, and the survey was fielded between September 2017 and January 2018. The de Beaumont Foundation provided aggregate data for staff identified as part of the Kansas MCH workforce, which included 335 professionals (12% from the state health agency and 88% from local health departments). Finally, CPPR worked with staff at the National Center for Education in Maternal and Child Health at Georgetown University to assess the knowledge and skills of MCH staff in Kansas based on the MCH competencies developed by the HRSA Maternal and Child Health Bureau (MCHB). Kansas MCH personnel were encouraged to participate in the online self-assessment available through the MCH Navigator at **mchnavigator.org/assessment**. The National Center for Education in Maternal and Child Health then generated a competency report that was included as part of the needs assessment. A copy of that report is included in Appendix E.

Information from MCH clients and the general public

Gathering input from clients and their families who receive services and from interested members of the public is a vital aspect of the needs assessment. Considerable information was obtained from these stakeholders through the following methods.

- **Public kiosks.** Over a dozen wireless touch-screen terminals were deployed in public locations around the state. Kiosks were placed in public health department and FQHC waiting rooms, libraries, and other community centers/gathering places to seek responses to questions about the health needs and available services for women, infants, and children. Kiosks were designed to ask one question on any given day, and

questions were changed frequently to enable the collection of responses to an array of questions. Changes could be made remotely to one or all kiosks through web technology. Kiosks were placed across the state in a variety of urban and rural communities resulting in broad representation. Responses are summarized in a report found in Appendix F.

- **The Standards Participant Survey (based on the Quality Standards of the National Family Strengthening Network).** The survey is comprised of 14 questions to indicate how well programs are strengthening and supporting families, from the families' perspective. With permission of the national network, CPPR developed both a hard copy and an online version (in Qualtrics) of the survey. Local MCH programs were provided postcards with a link to the online survey and a hard copy version of the survey to distribute to clients. Completed paper surveys were collected by local programs, sent to CPPR, and were manually entered for analysis along with surveys completed online. Results are summarized in the Family Strengthening and Support Section on page 39.

- **Regional Open Houses.** In January 2020 CPPR hosted six regional open houses across the state in Lawrence, Salina, Hays, Chanute, Hutchinson, and Garden City. Open houses were held in public spaces like libraries to encourage participation by members of the public. Flyers were created for each open house, and each open house also had its own Facebook event. Local MCH programs were encouraged to share information about the open houses with clients and other stakeholders. Libraries and other partners also promoted the events through social media and other means. The events themselves were two hours in length. Each open house had stations that provided opportunities for input into issues impacting the health of women, infants and children. Specifically, there were stations about workforce adequacy/availability, home visiting programs, knowledge about MCH health status, and an exercise where participants were asked to create and allocate a "MCH budget" across different topics (mental health, nutrition, physical activity, tobacco and substance abuse, breastfeeding, women's health, and children's health) identified by MCH programs in the state. There was also a station where participants were provided the opportunity to provide open-ended comments about bright spots, challenges, and ideas to enhance the health of women, infants, and children in the state. In addition to members of the public, MCH staff from many programs around the state participated in the open houses. A total of 135 individuals (including 95 community members and 40 MCH professionals) participated. A summary of findings from the open houses is included in Appendix G.

- **Adolescent Focus Groups.** The BFH contracted with DCCCA to complete focus groups with adolescents around the state. DCCCA is an organization operating in Kansas, Oklahoma, and Missouri providing social and community services that improve the safety, health and well-being of the people it serves. In order to incorporate adolescent and young adult voices into the MCH Needs Assessment, DCCCA completed 19 focus groups with 180 middle, high school, and college students across the state. Groups from schools, tribal organizations, Boys and Girls Clubs, community organizations (such as the Total Equality Alliance and the Kansas Youth Empowerment Academy) and the juvenile justice system participated. Schools and community organizations were asked to select a variety of students from different backgrounds and social groups to ensure multiple perspectives were heard. A summary of focus group findings is included in Appendix H.

- **Adolescent photo project.** Youth groups around the state were invited to participate in a photo documentation project to capture images of community factors that contribute to or create barriers to good health. Three student groups were recruited to participate. The student photographers gathered photos and then shared them with their peers to collectively develop key "themes" using all their photographs. The students then assembled PowerPoint presentations with each photograph, its theme, and a quotation from the student photographer about how their image captured some aspect of health. Photos collected from the project are used throughout this needs assessment, and are also included in Appendix i.

- **"Our Tomorrows" story collection project.** During 2019 CPPR led an initiative to support the Kansas Early Childhood Systems Building initiative, resulting in the collection of over 2,600 stories from Kansans about a time when their families were thriving or just surviving. These stories were collected through the innovative Sensemaker® software that collects stories but adds layers of meaning with unique question forms that help make sense of the complex, ambiguous, and nuanced experience of Kansas families. Using Our Tomorrow stories that were identified as specifically relevant to MCH domains, the Kansas MCH Council participated in a "sensemaking" session designed to provide context to the discussion that was instrumental in finalizing Kansas' MCH priorities and State Action Plan for 2021-2025. The stories used in the sensemaking session are included as Appendix J.

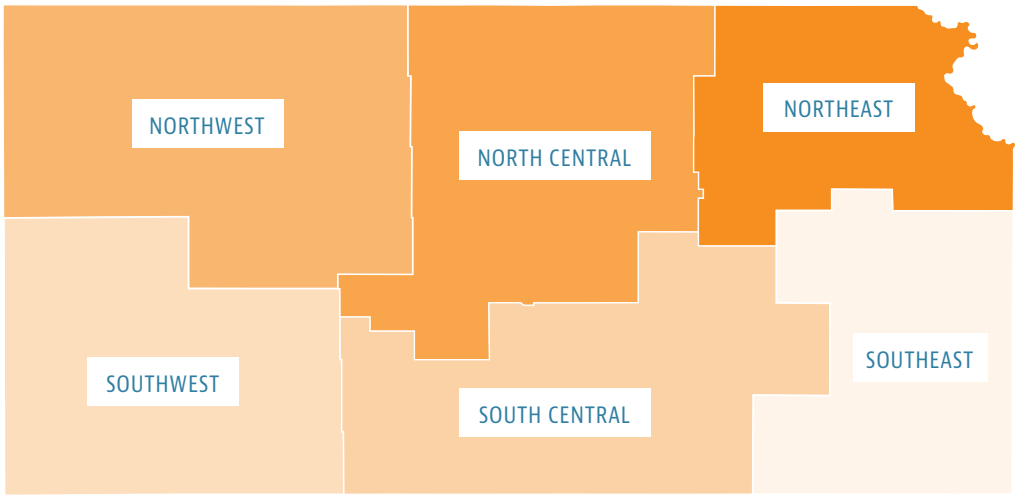
- **"Community Norms" survey.** As part of the needs assessment process, KDHE distributed an online survey to stakeholders, professionals, parents, and community members in February 2020 to get responses to questions addressing the emergent domain priorities in order for KDHE to begin finalizing priorities and objectives. Additionally, this survey also captured individual beliefs on MCH topics as well as their perception of community beliefs as part of a community norms assessment. A total of 532 responses were collected. These results are summarized in Appendix K.

Levels of Analysis

As part of this MCH Needs Assessment, a number of analyses examined differences by MCH region and by rural and urban areas. The Kansas MCH program utilizes a system of regions to manage communications and technical assistance to local programs. The KDHE regions are represented on the map below. These regions differ in many regards – demographics, population density, MCH services, and more – which will be explored in this needs assessment.

FIGURE 1

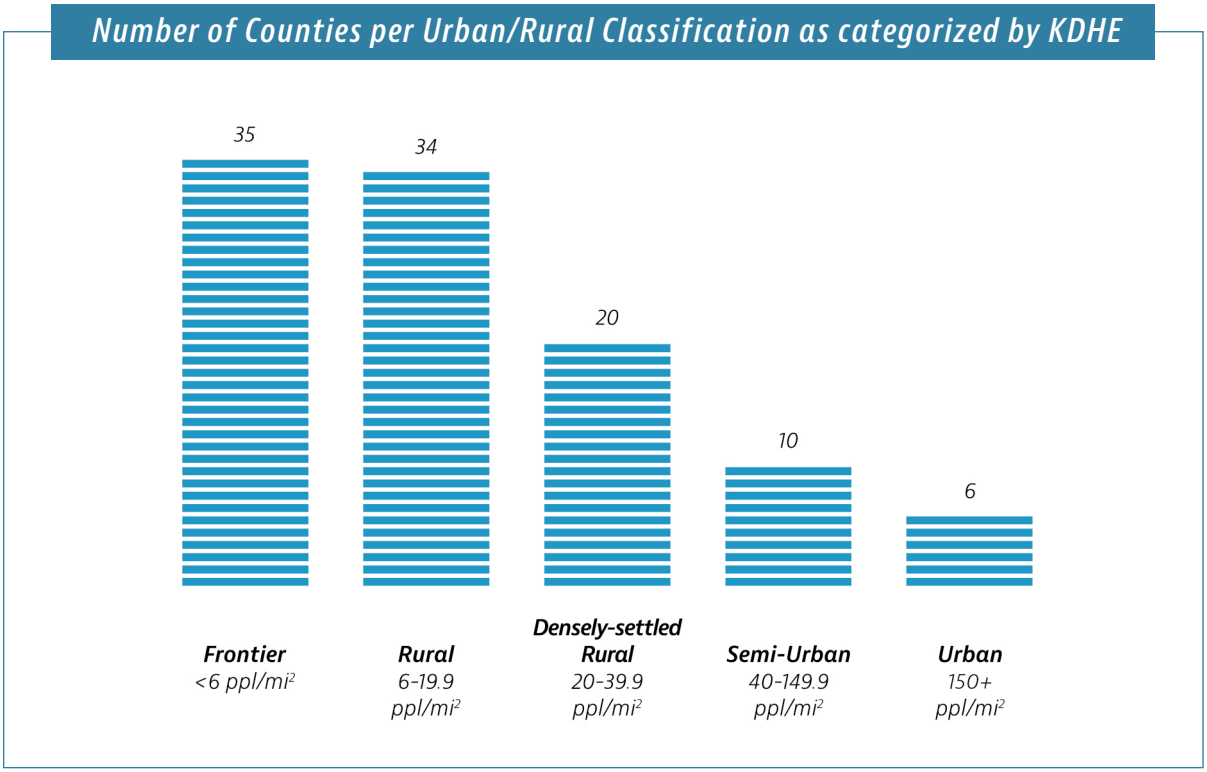
Recognized Regions of the Kansas MCH Program



NORTHWEST	NORTH CENTRAL	NORTHEAST	SOUTHEAST	SOUTH CENTRAL	SOUTHWEST
Ellis	Clay	Atchison	Allen	Barber	Clark
Gove	Cloud	Brown	Anderson	Barton	Finney
Graham	Dickinson	Chase	Bourbon	Butler	Ford
Logan	Ellsworth	Doniphan	Chautauqua	Comanche	Grant
Norton	Jewell	Douglas	Cherokee	Cowley	Gray
Phillips	Lincoln	Franklin	Coffey	Edwards	Greeley
Rawlins	Mitchell	Geary	Crawford	Harper	Hamilton
Rooks	Osborne	Jackson	Elk	Harvey	Haskell
Sheridan	Ottawa	Jefferson	Greenwood	Kingman	Hodgeman
Sherman	Republic	Johnson	Labette	Kiowa	Kearny
Thomas	Russell	Leavenworth	Linn	Marion	Lane
Trego	Saline	Lyon	Montgomery	McPherson	Meade
Wallace	Smith	Marshall	Neosho	Pawnee	Morton
	Washington	Miami	Wilson	Pratt	Ness
		Morris	Woodson	Reno	Scott
		Nemaha		Rice	Seward
		Osage		Rush	Stanton
		Pottawatomie		Sedgwick	Stevens
		Riley		Stafford	Wichita
		Shawnee		Sumner	
		Wabaunsee			
		Wyandotte			

KDHE also uses an urban/rural classification system that is based on population density. Many comparisons based on this classification will also be presented in this Need Assessment.

FIGURE 2



MCH POPULATION IN KANSAS

Demographics of the MCH Target Population

Kansas' estimated population of 2,911,505 (July 1, 2018 estimate) is comprised of 705,961 individuals (24.2%) under the age of 18, and 502,396 (17.3%) women between the ages of 18-44. As such, more than 4 of every 10 Kansans can be considered a part of the state's target MCH population.

The percentage of total population found in the different age groups served by Kansas MCH programs is fairly similar among the MCH regions. However, the percent of the population under 18 is lowest in the North Central and Northwest regions, while the percentage of the population under 18 is higher in the Southwest. The percentage of the population comprised of females 18-44 is somewhat higher in the Northeast region.

TABLE 3. DIFFERENT AGE POPULATION GROUPS BY MCH REGION

REGION	JULY 1, 2018 POPULATION ESTIMATE	PERCENT UNDER AGE 1	PERCENT AGE 1-5	PERCENT AGE 6-11	PERCENT AGE 12-17	PERCENT UNDER 18	PERCENT FEMALES AGE 18-44
North Central	137,925	1.1%	6.0%	7.7%	7.7%	22.5%	14.4%
Northeast	1,483,052	1.2%	6.5%	8.0%	8.0%	23.8%	18.3%
Northwest	80,896	1.2%	6.1%	7.4%	7.1%	21.9%	16.2%
South Central	858,879	1.2%	6.6%	8.5%	8.4%	24.8%	16.7%
Southeast	203,747	1.2%	6.2%	7.8%	8.0%	23.2%	15.3%
Southwest	147,006	1.6%	8.2%	10.1%	9.5%	29.3%	16.3%
Kansas	2,911,505	1.3%	6.6%	8.2%	8.2%	24.2%	17.3%

Source: U.S. Census Bureau, Vintage 2018 Bridged-Race Postcensal Population Estimates, https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2018%20 (accessed April 7, 2020).

The age distribution for youth is relatively consistent across urban and rural areas, but the percentage of the population comprised of women age 18-44 is higher in areas with higher population density; the lowest percentage of women age 18-44 are in rural and frontier areas of the state.

TABLE 4. DIFFERENT AGE POPULATION GROUPS BY AGE

URBAN/RURAL DESIGNATION	PERCENT UNDER AGE 1	PERCENT AGE 1-5	PERCENT AGE 6-11	PERCENT AGE 12-17	PERCENT UNDER 18	PERCENT FEMALES AGE 18-44
Urban	1.3%	6.7%	8.3%	8.3%	24.6%	18.0%
Semi-Urban	1.2%	6.4%	7.7%	7.7%	23.0%	18.0%
Densely-Settled Rural	1.3%	6.8%	8.5%	8.5%	25.1%	16.4%
Rural	1.1%	6.2%	8.0%	8.1%	23.5%	14.1%
Frontier	1.2%	6.2%	7.8%	7.6%	22.8%	13.3%
Kansas	1.3%	6.6%	8.2%	8.2%	24.2%	17.3%

Source: U.S. Census Bureau, Vintage 2018 Bridged-Race Postcensal Population Estimates, https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2018%20 (accessed April 7, 2020).

Demographics of the MCH Client Population in Kansas

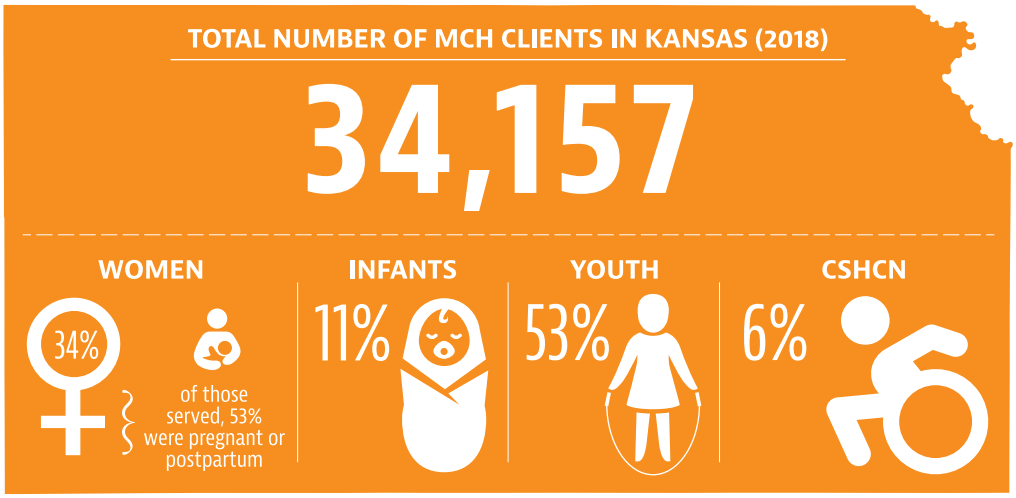
The number of clients in Kansas served by the MCH population was 34,157 in calendar year 2018. Of these clients, 12,369 (34.4%) were women, of which 6,616 were pregnant/postpartum women served by the program. Infants comprised 11.1% of clients, and children and adolescents over half (52.7%). Of children served by MCH, 2,102 (6.2%) were CSHCN.

Several factors are notable about the MCH client demographics. As a payor of last resort, one would expect the program to serve a large number of women and children who face barriers to access to care. This is confirmed by the data, as 42.0% of clients have public insurance coverage and 25.1% are uninsured, numbers that are far higher than for the general population. Only 24.5% of clients served through the program had private insurance coverage.

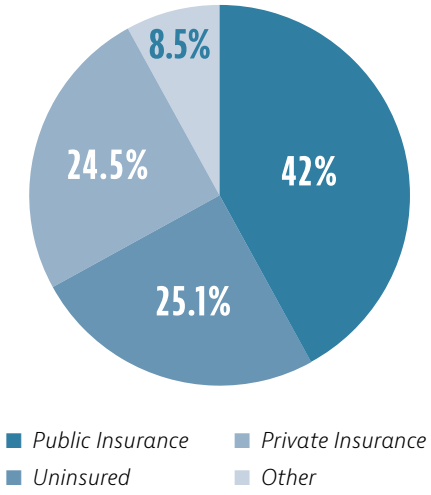
The MCH client population also has a very different, and much more diverse, racial/ethnic distribution than the general population. Only 54.8% of clients identify as white non-Hispanic (compared to 76.1% of the total Kansas population). Hispanic and Latino women and children make up 30.9% of the MCH program clients, while only 11.7% of the general population is Hispanic. The Hispanic population comprises nearly two of every three MCH clients (63.6%) in Southwest Kansas, and about three of every ten MCH clients in two other regions (31.0% in the Northeast region and 29.9% in South Central). In two regions over 10% of MCH clients are Non-Hispanic blacks (11.5% of clients in the Northeast and 10.4% of clients in the South Central region).

FIGURE 3

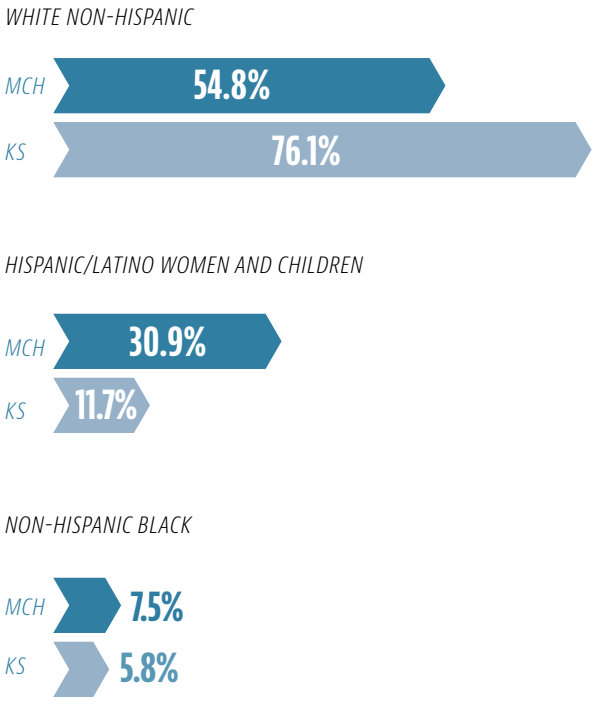
Kansas MCH Client Population Demographics

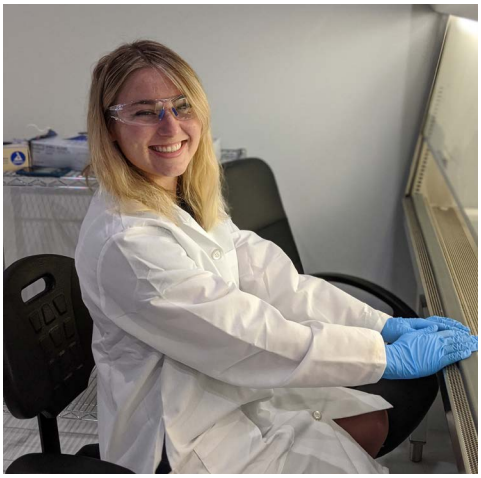


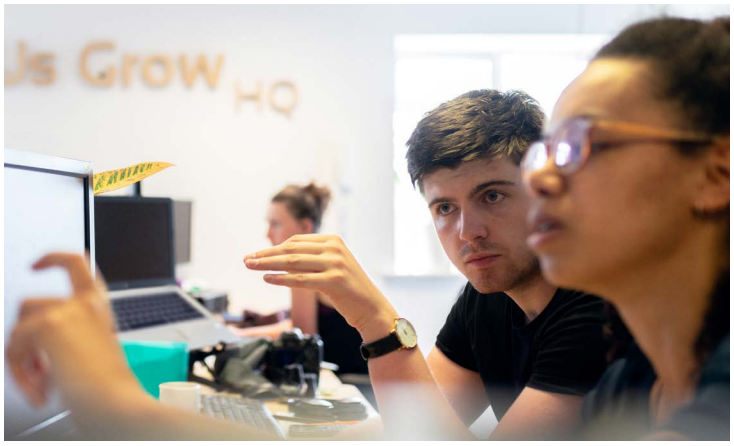
MCH CLIENT INSURANCE COVERAGE



MCH CLIENT VS. KANSAS RACIAL/ETHNIC DISTRIBUTION



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MCH WORKFORCE PROFILE

The MCH program can only implement core MCH public health functions by having an adequately sized and skilled workforce, and as such the program strongly believes in investing in its people. Recently the program recognized a specific need for greater capacity to ensure a coordinated, integrated statewide approach to MCH, including greater investment in monitoring and tracking changing MCH needs across the state, evaluating progress in relation to the state action plan, and enhancing state-local partnerships necessary to advance MCH goals and objectives. During the past several years, the BFH has been realigned/reorganized and four new positions have been added (Data Analyst, Women/Maternal Health Consultant, Behavioral Health Consultant, Health Planning Consultant). The growth has helped address the recognized need to build a strong multidisciplinary team focusing on upstream, preventive approaches, actively engaging in behavioral health work, and addressing disparities—all essential to make change happen.

Number, Location, and Full-time Equivalents of the Kansas MCH Workforce

The MCH program in Kansas funds an estimated 658 positions (see Table 5) and an estimated 192 total FTEs. Through the MCH Needs Assessment process, FTE information was collected for 550 of these 658 positions, or approximately 84% of the MCH staff positions in Kansas. Table 6 shows a breakdown of staff in MCH and related programs in the state (all funded by MCH except PMI, TPTCM, and LYFTE).

TABLE 5. TOTAL NUMBERS OF POSITIONS AND FTES BY MCH PROGRAM TYPES

PROGRAM	TOTAL POSITIONS	TOTAL FTEs*
State Program Staff	12	12
State CSHCN Program Staff	7	6.5
Local MCH Programs	450	103.8
CSHCN Satellite Offices	15	2.3
CSHCN	34	5.8
PMI	67	13.6
TPTCM	55	10.6
LYFTE	18	5.5
TOTAL	**658**	**160.2**

**FTE count based on information for 550 positions for which FTE data is available.*

The greatest number of staff (approximately 104 FTEs) are employed in local MCH programs. The state MCH program has 18.5 FTEs, with 6.5 of these focused on the CSHCN program.

The following table shows how positions are distributed across the state by primary position type. The highest numbers of FTEs in MCH programs are found in clinical nursing (25.3 FTEs), home visiting (18.5 FTEs), and administration (13.2 FTEs). The "administrative" category includes administrative support positions, but does not include leadership roles such as public health agency administrators/directors, department managers, and MCH directors/coordinators; these positions collectively comprise another 21.3 FTEs.

TABLE 6. NUMBER OF POSITIONS AND FTES BY POSITION TYPE

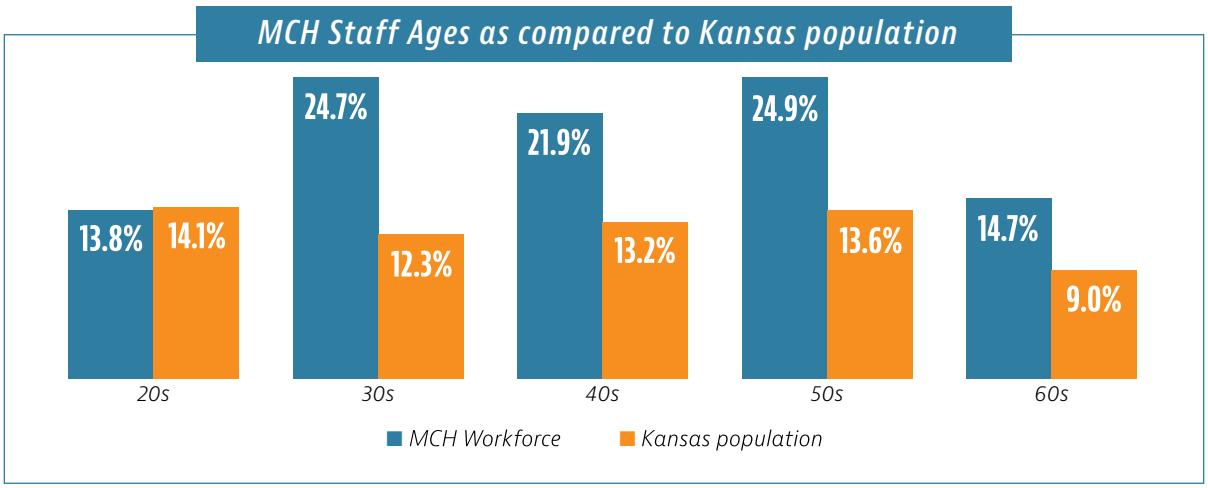
POSITION TYPE	NO HOURS/ MISSING DATA	TOTAL POSITIONS	TOTAL FTEs
Administrative	29	124	15.2
Agency Administrator/Director	7	68	8.3
Agency Manager/Supervisor	5	33	4.5
Breastfeeding Peer Counselor/Educator	3	9	1.3
Case Manager/Care Coordinator/Navigator	2	45	25.2
Clinical Nurse	13	127	26.5
Dietitian/Nutritionist	6	11	1.3
Home Visitor	0	59	18.8
Interpreter/Translator	6	15	1.9
MCH Program Director/Coordinator/ Supervisor	4	42	15.4
Physician/Medical Director	8	14	2.2
Social Work/Counselor	7	29	8.7
State MCH Program Staff	0	19	18.5
Other	18	63	12.4
Total	**108**	**658**	**160.2**

MCH Workforce Demographics

Females make up nearly all of the Kansas MCH workforce (95.8%). The median age of the MCH workforce in Kansas is higher than the overall state median age (45 years compared to a statewide median age of 36).

Compared to the state population as a whole, in the Kansas MCH workforce there is a much higher percentage of individuals in their 30's and 40's (24.7% in the 30's, compared to 12.3% of the population as a whole; and 21.9% in the 40's, compared to 13.2% of the population as a whole).

FIGURE 4



Sources: MCH based on information collected from KS MCH programs (as of 7/1/2019).
Kansas population based on U.S. Census, 2010 Profile of General Population and Housing Characteristics (DP-1).

The percentage of the MCH workforce over the age of 50 is almost one out of every four (24.9%). This high percentage means that the growth of the Kansas MCH workforce, like the total U.S. workforce, is aging towards retirement. While an in-depth projection of labor force growth by age was beyond the scope of this needs assessment, Kansas MCH recognizes its workforce is aging, and that the retention of older staff, and workers in general, will be important system priorities. However, according to the 2017 Public Health Workforce Interests and Needs Survey (PH WINS), the Kansas MCH system may be in a better position than the U.S. public health system as a whole. For this needs assessment, Kansas requested and was able to secure PH WINS data from the de Beaumont Foundation specifically for Kansas MCH professionals to compare against national survey results. Kansas MCH staff considering leaving in the next year (24%) is slightly lower than the U.S. public health workforce as a whole (25%), but the 10% of Kansas MCH professionals intending to retire by 2023 is far less than the 22% of the U.S. public health workforce who intend to retire by then, according to the 2017 PH WINS.

The racial composition of the Kansas MCH workforce closely mirrors the Kansas population. An estimated 86.7% of the MCH workforce in the state is non-Hispanic white, nearly identical to the state average of 86.4%. 4.0% of the workforce is black (compared to 5.8% of the total state population), 1.1% of the workforce is Asian (state 2.9%), and 0.4% of the workforce is American Indian/Alaska Native (state 0.1%). The percent of MCH staff in Kansas identifying as Hispanic (12.6%) is also just slightly higher than the overall state average of 11.7%.

The MCH Workforce is far less diverse than the clients it serves, however. Given the strong programmatic focus on health equity, continuing to promote the development of a diverse MCH workforce should be a strategic goal of Kansas MCH statewide.

More detailed information on MCH workforce demographics can be found in Appendix D.

MCH Workforce Competencies

As part of this needs assessment, Kansas MCH received support from the MCH Navigator project team at the National Center for Education in Maternal and Child Health (NCEMCH) at Georgetown University to assess the knowledge and skills of the Kansas MCH workforce. Using the results from MCH Navigator online self-assessment, NCEMCH developed a 2017-2019 "Kansas Workforce Snapshot." This snapshot included 296 responses from MCH professionals in Kansas. Detailed results from the "snapshot" are included in Appendix E.

Mean knowledge and skills scores were generally high in the areas of self-reflection, ethics, and communication. Areas that had lower knowledge and skills scores were MCH knowledge base/context, critical thinking, communities/systems work, and policy (policy was the lowest score for both knowledge and skills). Kansas' MCH workforce had a relatively high knowledge score in the area of cultural competency, but a much lower score for skills around cultural competency. This suggests there are still opportunities for improvement in addressing cultural issues and needs as part of MCH service delivery.

As noted earlier, Kansas was also able to acquire data from the 2017 Public Health Workforce Interests and Needs (PH WINS) Survey from the de Beaumont Foundation. The survey included several questions related to training needs. Similar to MCH Navigator results, an area seen as a significant training need among Kansas MCH professionals was systems and strategic thinking. However, the area of greatest training needs from PH WINS (among all respondents and also non-supervisors only) was budgeting and financial management. Responses to training needs for cultural competency were lower than found in MCH Navigator. Responses to the full question set in PH WINS is located in Appendix D.

TABLE 7. TRAINING NEEDS*

TYPES OF TRAINING NEEDS	ESTIMATE	95% CONFIDENCE INTERVAL (CI)
Effective Communication	10%	[3%-27%]
Data for Decision-Making	33%	[19%-27%]
Cultural Competency	35%	[21%-27%]
Budget and Financial Management	65%	[46%-27%]
Change Management	36%	[20%-27%]
Systems and Strategic Thinking	55%	[38%-27%]
Develop a Vision for a Healthy Community	47%	[30%-27%]
Cross-Sectoral Partnerships	43%	[27%-60%]

**Source: PH WINS 2017 (335 MCH responses for Kansas)*

TABLE 8. TRAINING NEEDS (NON-SUPERVISORS)*

TYPES OF TRAINING NEEDS (NON-SUPERVISORS)	ESTIMATE	95% CI
Effective Communication	13%	[4%-33%]
Data for Decision-Making	33%	[17%-54%]
Cultural Competency	32%	[17%-51%]
Budget and Financial Management	67%	[46%-84%]
Change Management	36%	[19%-57%]
Systems and Strategic Thinking	59%	[40%-76%]
Develop a Vision for a Healthy Community	42%	[25%-61%]
Cross-Sectoral Partnerships	39%	[23%-59%]

**A training need is defined as a skill that has high importance and low skill*

FAMILY STRENGTHENING AND SUPPORT

Consumer engagement is one of four guiding principles for the Kansas MCH program. This means that MCH professionals in Kansas involve and learn from clients and families directly affected by systemic changes. MCH programs work to assure consumer and family voice is central to programming, initiatives, and special projects. The MCH Program also promotes service approaches that strengthen families and communities so that they can foster the optimal development of children, youth, and adult family members.

The 5 Protective Factors

The Kansas MCH family strengthening approach focuses on building these protective factors to increase family stability, enhance child development, and reduce child abuse and neglect.

1. *Parental resilience*
2. *Social connections*
3. *Knowledge of parenting and child development*
4. *Social and emotional competence of children*
5. *Concrete support in times of need*

The family strengthening approach of Kansas MCH mirrors that promoted by the National Family Strengthening Network, and focuses on building protective factors within families: parental resilience, social connections, knowledge of parenting and child development, social and emotional competence of children, and concrete support in times of need. Research has shown that these five protective factors increase family stability, enhance child development, and reduce child abuse and neglect. The Standards of Quality for Family Strengthening and Support is one tool that promotes a strengthening families approach based on the five protective factors. The Standards are designed to be used by family strengthening and support stakeholders as a tool for planning, providing, and assessing quality services.

National Family Support Network's Support Materials Suite

The National Family Support Network offers of a suite of materials designed to support programs to implement the Standards effectively. The Kansas MCH program, with input and support from the Family Advisory Council, integrated this full suite of tools into the needs assessment as a way to understand -- from multiple perspectives -- how well the MCH system is strengthening families in Kansas, and where opportunities for improvement exist.

1. **Program Self-Assessment Tool**
   Designed to be used as a critical thinking exercise by program teams of managers, direct service staff, parent leaders, and other stakeholders as appropriate. Teams rate themselves on each indicator under the Standards, which fall under five categories: Family Centeredness, Family Strengthening, Embracing Diversity, Community Building, and Evaluation.

2. **Staff Self-Reflection Checklist**
   A set of 15 self-reflection questions for staff members to use as a reminder to implement the Standards.

3. **Standards Participant Survey**
   A set of 14 questions for program participants/clients to indicate how well the Program is meeting the Standards from their perspective. The tool is available in English, Spanish, and Chinese.

With permission of the National Family Support Network (NFSN), CPPR adapted the Standards tools listed above to online versions in Qualtrics. In October 2019, CPPR distributed a request to all local MCH-funded programs to participate in the NFSN Program Self-Assessment and the Staff Self-Reflection. Program coordinators/managers were asked to assemble as many staff as possible to participate in a collective discussion to complete the Program Self-Assessment and were asked to distribute the link for the Staff Self-Reflection Checklist to all MCH staff.

In November 2019, CPPR staff provided hard copies of the NFSN Participant Survey to Kansas MCH programs in addition to postcards containing the URL for the Qualtrics webpage. They requested that each MCH program distribute the information to their clients and collect at least 20 completed surveys. MCH programs mailed hard copies of completed surveys to CPPR, where staff entered them into the Qualtrics tool and stored them securely along with data from responses completed online in Qualtrics.

Program Self-Assessment

Twenty MCH-funded programs completed the Program Self-Assessment. Their responses for each standard indicated their own perception of the degree to which they meet the standard on a continuum from "minimum quality not yet addressed" to "meets minimum and high quality." The Standards provide detailed definitions for both "minimum" and "high" quality for each standard and indicator.

Family Centeredness (FC) Standards and Indicators

Standard FC. 1 Program encourages families to participate in program development and implementation (Indicator FC1.1).

Standard FC. 2 Program is accessible and welcoming to families.

- Indicator FC 2.1 – formal structure (convenience)
- Indicator FC 2.2 – family partnership (welcoming environment)

Standard FC. 3 Program conducts outreach to families and sustains ongoing relationships with them.

- Indicator FC 3.1 – formal structure (outreach)
- Indicator FC 3.2 – formal structure (constructive relationships)

Standard FC. 4 Program models family-centeredness approach with staff and in its related administrative practices (Indicator FC 4.1).

Most Kansas MCH programs believe they at least meet minimum quality on most Family Centeredness indicators. The highest scores are for Indicators FC 2.1 and 3.1, which are about having a formal structure in place to ensure programs are accessible to families and a formal structure to conduct outreach to families. The lowest score is for Indicator FC 1.1 which is related to family participation in program development and implementation. About one-third (35%) of programs indicated they had not yet addressed minimum quality or were approaching minimum quality for FC I.I.

TABLE 9. RELATIVE SCORES FOR FAMILY CENTEREDNESS INDICATORS

FC INDICATORS	MINIMUM QUALITY NOT YET ADDRESSED	APPROACHING MINIMUM QUALITY	MEETS MINIMUM QUALITY	MEETS MINIMUM & APPROACHING HIGH QUALITY	MEETS MINIMUM & HIGH QUALITY
Indicator FC 1.1	15%	20%	40%	15%	10%
Indicator FC 2.1	0%	0%	20%	35%	45%
Indicator FC 2.2	0%	0%	45%	25%	30%
Indicator FC 3.1	0%	0%	25%	35%	40%
Indicator FC 3.2	0%	5%	40%	30%	25%
Indicator FC 4.1	15%	0%	25%	30%	30%

Family Strengthening (FS) Standards and Indicators

Standard FS. 1 Program recognizes and affirms families' strengths and resilience and is responsive to their concerns and priorities.

- Indicator FS 1.1 (identify strengths, resilience, resources)
- Indicator FS 1.1 (access to services and supports)

Standard FS. 2 Program enhances families' capacity to support the healthy development (cognitive, social, emotional, and physical) of their family members.

- Indicator FS 2.1 (knowledge/skills of healthy family development)
- Indicator FS 2.2 (support healthy family development)

Standard FS. 3 Program recognizes families as significant resources for their own family members and each other.

- Indicator FS 3.1 (family engagement)
- Indicator FS 3.2 (building social connections)

Most Kansas MCH programs indicate they at least meet minimum quality for the Family Strengthening standards. The exception is Indicator FS 3.2, where 35% of programs indicated they did not feel they yet meet minimum quality. This indicator is around helping facilitate opportunities for families to build social connections with each other for resource sharing and mutual support.

TABLE 10. RELATIVE SCORES FOR FAMILY STRENGTHENING INDICATORS

FS INDICATORS	MINIMUM QUALITY NOT YET ADDRESSED	APPROACHING MINIMUM QUALITY	MEETS MINIMUM QUALITY	MEETS MINIMUM & APPROACHING HIGH QUALITY	MEETS MINIMUM & HIGH QUALITY
Indicator FS. 1.1	5%	0%	35%	25%	35%
Indicator FS. 1.2	0%	5%	35%	25%	35%
Indicator FS. 2.1	0%	0%	30%	50%	20%
Indicator FS. 2.2	0%	0%	40%	40%	20%
Indicator FS. 3.1	0%	5%	40%	30%	25%
Indicator FS. 3.2	25%	10%	25%	30%	10%

Embracing Diversity (ED) Standards and Indicators

Standard ED. 1 Program acknowledges and respects the diversity of the families they serve, including their cultural traditions, languages, values, socio-economic status, family structures, sexual orientation, religion, individual abilities and other aspects.

- Indicator ED 1.1 (family engagement)
- Indicator ED 1.2 (building social connections)

Standard ED. 2

Program enhances the abilities of families and staff to participate in a diverse society and navigate dynamics of difference.

- Indicator ED 2.1 (support families' navigation of diversity)
- Indicator ED 2.2 (support staff's navigation of dynamics of differences)

Standard ED. 3 Program engages in ongoing learning and adaptation of its practices to address diversity.

Scores were highest for Standard ED.1, which indicates programs believe they acknowledge and respect the diversity of families, including cultural traditions, languages, socioeconomic status, and other characteristics. Scores were generally high for Standard ED.3 about participating in ongoing learning and adapting practices to address diversity. Scores are somewhat lower for Standard ED.2 related to programs enhancing the ability of staff and families to participate in a diverse society and navigate the dynamics of difference.

TABLE 11. RELATIVE SCORES FOR EMBRACING DIVERSITY INDICATORS

ED INDICATORS	MINIMUM QUALITY NOT YET ADDRESSED	APPROACHING MINIMUM QUALITY	MEETS MINIMUM QUALITY	MEETS MINIMUM & APPROACHING HIGH QUALITY	MEETS MINIMUM & HIGH QUALITY
Indicator ED. 1.1	0%	10%	15%	40%	35%
Indicator ED. 1.2	0%	10%	15%	35%	40%
Indicator ED. 2.1	20%	5%	35%	35%	5%
Indicator ED. 2.2	15%	5%	20%	45%	10%
Indicator ED. 3.1	5%	0%	40%	50%	5%

Community Building (CB) Standards and Indicators

Standard CB. 1 Program is involved in and engages families in the larger community building process

- Indicator 1.1 (addressing community needs and priorities)
- Indicator 1.2 (lift up family voices for community impact)

Standard CB. 2 Program supports the development of community-based leadership (Indicator CB 2.1).

Standard CB. 3 Program builds collaborative relationships with other organizations and leverages resources that strengthen families and communities (Indicator CB 3.1).

All Kansas programs indicate they meet at least minimum quality for Standard CB.3, which assesses programs work building collaborative relationships with other organizations to strengthen families and communities. Scores are somewhat lower for Indicator CB 1.1 to create awareness of and involvement in community needs and priorities, and for CB 2.1 about facilitating leadership skills among the families that they serve. The lowest distribution of scores is for Indicator CB 1.2. One out of four programs indicated they have not met minimum quality for this standard, which is connecting families to community events to help raise awareness of community needs and assets.

TABLE 12. RELATIVE SCORES FOR COMMUNITY BUILDING INDICATORS

CB INDICATORS	MINIMUM QUALITY NOT YET ADDRESSED	APPROACHING MINIMUM QUALITY	MEETS MINIMUM QUALITY	MEETS MINIMUM & APPROACHING HIGH QUALITY	MEETS MINIMUM & HIGH QUALITY
Indicator CB. 1.1	5%	10%	20%	35%	30%
Indicator CB. 1.2	25%	10%	30%	15%	20%
Indicator CB. 2.1	10%	15%	40%	20%	15%
Indicator CB. 3.1	0%	0%	15%	30%	55%

Evaluation (E) Standards and Indicators

Standard E. 1 Program collects and analyzes information related to program participation (Indicator E 1.1).

Standard E. 2 Program collects and analyzes information related to program quality.

- Indicator E 2.1 (use assessment result to inform planning/programming)
- Indicator E 2.2 (analyzing and sharing feedback with stakeholders)

Standard E. 3 Program collects and analyzes information related to program outcomes (Indicator E 3.1).

Standard E. 4 Program demonstrates that it incorporates evaluation as a critical part of programming (Indicator E 4.1).

In the area of evaluation, the highest distribution of scores was in the area of intentional analysis of program activities and utilization and modifying programs based on results. For Indicator E2.2, which focuses on analyzing outcomes, about half of programs (45%) indicate they track participant and program outcomes, and another 40% track data and analyze it in partnership with stakeholders to inform program modification. Two indicators have lower score distributions, where 30% of programs indicate they have not yet met minimum quality. One of these indicators (E 2.1) is about annual use of these standards for program assessment. The other (Indicator E 4.1) is about programs identifying the key issues to be answered through evaluation and having an evaluation plan. This suggests program should put more energy into formal planning to ensure having robust program evaluation.

TABLE 13. RELATIVE SCORES FOR EVALUATION INDICATORS

E INDICATORS	MINIMUM QUALITY NOT YET ADDRESSED	APPROACHING MINIMUM QUALITY	MEETS MINIMUM QUALITY	MEETS MINIMUM & APPROACHING HIGH QUALITY	MEETS MINIMUM & HIGH QUALITY
Indicator E. 1.1	0%	5%	0%	50%	30%
Indicator E. 2.1	15%	15%	20%	30%	20%
Indicator E. 2.2	0%	20%	35%	25%	20%
Indicator E. 3.1	0%	5%	45%	35%	15%
Indicator E. 4.1	15%	15%	20%	35%	15%

Staff Self-Reflection Checklist

In total 186 respondents completed the checklist for this needs assessment. As noted earlier, the purpose of this checklist is for ongoing use by Program staff to promote behaviors that help strengthen families. Respondents answered each question voluntarily and were not required to rate every statement, which resulted in statement completion ranging from 178 to 186 responses per question.

Respondents from across the state participated in the self-reflection assessment: 18 respondents were from North Central Kansas, 58 from Northeast, 9 from Northwest, 37 from South Central, 37 from Southeast, 9 from Southwest; another 10 are employed in the state MCH program. The remaining respondents did not share their location.

Of local (non-state program) respondents, 34 (20%) were from urban counties, 49 (29%) from semi-urban counties, 40 (24%) from densely-settled rural counties, 28 (17%) from rural counties, and 17 (10%) from frontier counties.

Respondents were asked to describe their position type within their MCH programs. In Table 14 below, the roles of the respondents who answered this question is depicted.

TABLE 14. POSITION TYPE OF RESPONDENTS

POSITION TYPE	NUMBER OF RESPONDENTS	PERCENTAGE OF TOTAL RESPONDENTS
Administrative	22	12%
Agency Administrator/Director	23	13%
Agency Manager/Supervisor	9	5%
Case Manager/Care Coordinator/Navigator	14	8%
Clinical Nurse	42	24%
Dietitian/Nutritionist	3	2%
Family Advisory Council Member	1	1%
Home Visitor	20	11%
Interpreter/Translator	1	1%
MCH Program Director/Coordinator/Supervisor	13	7%
Social Work/Counselor	15	8%
State MCH Program Staff	9	5%
Other	6	3%

Respondents shared how long they had been with their MCH program organization and working in the MCH field. Forty-two percent (42%) of 179 respondents had been with their organization for 3 years or less while 33% had been with their organization for 3 to 10 years. The remaining 25% had been with their organization for more than 10 years.

TABLE 15.
RESPONDENTS' NUMBER OF YEARS WITH ORGANIZATION

NUMBER OF YEARS	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS
< 1	13	7%
1 – 3	63	35%
3.1 – 5	32	18%
5.1 – 10	27	15%
10.1 – 15	16	9%
15.1 – 20	10	6%
20.1 – 30	17	9%
> 30	1	1%

TABLE 16.
RESPONDENTS' NUMBER OF YEARS IN THE MCH FIELD

NUMBER OF YEARS	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS
< 1	17	9%
1 – 3	53	30%
3.1 – 5	24	13%
5.1 – 10	28	16%
10.1 – 15	17	9%
15.1 – 20	10	6%
20.1 – 30	26	15%
> 30	3	2%

The number of years in the MCH field mirrored years spent with the current organization fairly closely, with more than half (52%) of respondents had been in the MCH field for five years or less. Two-thirds had been in the field 10 years or less.

Response Data

The list of 15 statements respondents were asked to rate on a five-point Likert scale between "Strongly Disagree" and "Strongly Agree" is below, in addition to the response data.

Staff Self-Reflection Checklist Statements

- Statement 1: I do my best to schedule with families at a time and place convenient to them.
- Statement 2: I interact with families in a welcoming and respectful way.
- Statement 3: I develop and maintain constructive relationships with families.
- Statement 4: I recognize and affirm families' strengths.
- Statement 5: I utilize my understanding of healthy family development in my work and share this information with families.
- Statement 6: I ask about and listen to what families say about their needs and interests and those of their family members.
- Statement 7: I connect families with resources to address their needs and interests.
- Statement 8: I invite other/multiple family members to participate in services and activities.
- Statement 9: I facilitate opportunities for families to build relationships with other families.
- Statement 10: I am sensitive to and affirm families' diversity, including cultural traditions, languages, values, socio-economic status, structures, sexual orientation, religion, and individual abilities.
- Statement 11: I connect families with information about community issues, activities, and events.
- Statement 12: I support families to advocate for themselves to address their needs and to develop their community leadership skills.
- Statement 13: I build relationships with service providers and/or community groups to share resources and information and to address community needs and priorities.
- Statement 14: I regularly collect data to inform program quality and evaluation.
- Statement 15: I ask and listen to families' feedback and ideas about the Program and share this information with other staff/managers.

TABLE 17. ANSWERS TO SELF-REFLECTION CHECKLIST

STATEMENT	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	TOTAL RESPONSES
S1. I do my best to schedule with families at a time and place convenient to them.	8	0	8	22	148	186
S2. I interact with families in a welcoming and respectful way.	9	0	2	3	172	186
S3. I develop and maintain constructive relationships with families.	9	0	6	21	150	186
S4. I recognize and affirm families' strengths.	9	0	7	41	129	186
S5. I utilize my understanding of healthy family development in my work and share this information with families.	9	0	9	34	134	186
S6. I ask about and listen to what families say about their needs and interests and those of their family members.	3	0	3	25	154	185
S7. I connect families with resources to address their needs and interests.	2	0	5	21	157	185
S8. I invite other/multiple family members to participate in services and activities.	2	2	25	61	94	184
S9. I facilitate opportunities for families to build relationships with other families.	5	11	49	61	59	185
S10. I am sensitive to and affirm families' diversity, including cultural traditions, languages, values, socio-economic status, structures, sexual orientation, religion, and individual abilities.	3	0	8	34	140	185
S11. I connect families with information about community issues, activities, and events.	1	0	7	38	139	185
S12. I support families to advocate for themselves to address their needs and to develop their community leadership skills.	1	1	13	60	109	184
S13. I build relationships with service providers and/or community groups to share resources and information and to address community needs and priorities.	1	0	12	46	125	184
S14. I regularly collect data to inform program quality and information.	6	8	26	57	87	184
S15. I ask and listen to families' feedback and ideas about the Program and share this information with other staff/managers.	1	2	19	49	112	183

Of all responses received, 69% of responses were 'Strongly Agree" with the self-assessment statements and 90% of responses were "Somewhat Agree" or "Strongly Agree". This suggests, based on self assessment, that MCH staff largely feel they employ a family-centered approach in the services they provide.

TABLE 18. DISTRIBUTIONS OF RESPONSES TO ALL QUESTIONS IN THE SELF-REFLECTION CHECKLIST ACROSS CATEGORIES FROM "STRONGLY DISAGREE" TO "STRONGLY AGREE."

RESPONSE SELECTION	AGGREGATE RESPONSES	PERCENTAGE OF TOTAL RESPONSES
Strongly Disagree	69	2%
Somewhat Disagree	24	1%
Neither Agree Nor Disagree	199	7%
Somewhat Agree	573	21%
Strongly Agree	1909	69%

At the same time, however, there were five questions where 8 or 9 respondents answered "Strongly Disagree." While this response was in the minority, it does suggests there are opportunities for improvement and possible professional development opportunities. These questions were:

- I do my best to schedule with families at a time and place convenient to them.
- I interact with families in a welcoming and respectful way.
- I develop and maintain constructive relationships with families.
- I recognize and affirm families' strengths.
- I utilize my understanding of healthy family development in my work and share this information with families.

The two statements that received the highest total number of "Somewhat Disagree" and "Strongly Disagree" were:

- I facilitate opportunities for families to build relationships with other families (16 negative responses)
- I regularly collect data to inform program quality and information (14 negative responses)

Failing to build relationships among families is a missed opportunity to help people develop a network of resources, something that can be critical for families that lack resources, especially in a system like Kansas' where we recognize resource limitations, particularly in smaller, rural communities. There are clearly opportunities to continue staff development and other efforts to ensure capacity to use data to inform decision-making.

Participant Survey

In total, 362 respondents completed the NFSN Participant Survey. They answered each question voluntarily and were not required to rate every statement or provide their demographics. This resulted in statement completion ranging from 349 to 362 responses and demographic completion ranging from 294 to 354 responses per question.

Respondent Data

Regional and County Representation

Of the 362 respondents, some geographic information was available for 294 of them. Of these, 6 respondents were from North Central Kansas, 110 from Northeast, 1 from Northwest, 63 from South Central, 101 from Southeast, and 13 from Southwest.

Of the 294 respondents that shared their location, 92 were from urban counties (31%), 99 from semi-urban (34%), 60 from densely-settled rural (20%), 19 from rural (7%), and 24 from frontier counties (8%).

Sex

Of the 354 respondents who indicated their sex, 311 were female (88%), 35 were male (10%), and 8 indicated they preferred not to answer.

Ethnicity

Of the 350 respondents, 82 were Hispanic and/or Latino (23%), 256 were neither Hispanic nor Latino (73%), and 12 preferred not to answer.

Race

338 individual respondents indicated their race and were able to select all options that applied. Of the races selected, White was indicated 282 times, Black or African American 36 times, American Indian or Alaska Native 11 times, Asian 8 times, Native Hawaiian or Pacific Islander 3 times, Another Race 5 times, and Prefer Not to Answer 21 times. Of those respondents indicating Another Race applied to them, one wrote in Native American, one wrote Hispanic, and one wrote Islano.

TABLE 19. RACE OF MCH PROGRAM CLIENTS RESPONDING TO THE PARTICIPANT SURVEY

RACE	NUMBER OF RESPONDENTS	PERCENTAGE OF INDIVIDUAL RESPONDENTS (338)
White	282	83%
Black or African American	36	11%
American Indian or Alaska Native	11	3%
Asian	8	2%
Native Hawaiian or Pacific Islander	3	1%
Another Race	5	1%
Prefer Not to Answer	21	6%

Age

Of the 350 respondents who indicated their year of birth, their ages ranged from 0 to 85 years. The average age was 28 years and the median was 26 years, while the most frequently indicated age was 21 years. Age was calculated by subtracting the year of birth from the current year, 2020, and accuracy may vary slightly. To note, some clients may have indicated the year of birth for their child rather than themselves when they completed the NFSN Participant Survey.

TABLE 20. AGES OF MCH PROGRAM CLIENTS RESPONDING TO THE PARTICIPANT SURVEY

AGE RANGE (YEARS)	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS
0 – 14	14	4%
15 – 24	120	34%
25 – 34	116	33%
35 – 44	61	18%
45 – 54	10	3%
> 55	4	1%
Prefer Not to Answer	25	7%

Household Income

Of the 351 respondents who shared their household income, 103 lived in households that earned a yearly income of $14,999 or less while 46 earned $50,000 or more. 64 respondents indicated they preferred not to share their income.

TABLE 21. HOUSEHOLD INCOME OF PROGRAM CLIENTS RESPONDING TO THE PARTICIPANT SURVEY

INCOME RANGE	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS
Less than $10,000	67	19%
$10,000 - $14,999	36	10%
$15,000 - $19,999	18	5%
$20,000 - $24,999	43	12%
$25,000 - $34,999	47	14%
$35,000 - $50,000	30	9%
$50,000 - $79,999	31	9%
$80,000 or more	15	4%
Prefer Not to Answer	64	18%

Education

Of the 354 respondents who indicated their highest level of school completed or highest degree earned, 168 earned a high school diploma or less while 83 completed some college but did not earn a degree. 28 respondents preferred not to share their level of education.

TABLE 22. EDUCATIONAL ATTAINMENT OF PROGRAM CLIENTS RESPONDING TO THE PARTICIPANT SURVEY

LEVEL OF EDUCATION	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS
Less than high school degree	59	17%
High school graduate (high school diploma or equivalent including GED)	109	31%
Associate degree in college (2-year)	27	8%
Bachelor's degree in college (4-year)	34	9%
Master's degree	11	3%
Doctoral or Professional (JD, MD) degree	3	1%
Some college but no degree	83	23%
Prefer Not to Answer	28	8%

Response Data

The list of 13 statements respondents were asked to rate on a four-point Likert scale between "Strongly Disagree" and "Strongly Agree" is below, in addition to the response data.

Participant Survey Statements

- Statement 1: Services and activities are offered at a convenient location.
- Statement 2: Services and activities are offered at convenient times.
- Statement 3: Staff members are welcoming and respectful.
- Statement 4: Staff members have asked me about my family's strengths, needs, and interests.
- Statement 5: Staff members help me to understand healthy family development.
- Statement 6: Staff members have invited other people in my family to participate in services and activities.
- Statement 7: I have opportunities to meet and get to know other families through the Program.
- Statement 8: Staff members speak my language.
- Statement 9: Staff members understand my identity and culture (traditions, values, religion, sexual orientation, special needs, etc.).
- Statement 10 I have opportunities to learn about families that are different from mine.
- Statement 11: Staff members have helped me to learn about services, resources, and opportunities that are available in the community.
- Statement 12: I have opportunities to share my opinion and ideas about the program.
- Statement 13: Overall, this program has provided valuable support for me and my family

TABLE 23. RESPONSES TO THE PARTICIPANT SURVEY

STATEMENTS	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	TOTAL RESPONSES
S1. Services and activities are offered at a convenient location.	7	12	114	229	362
S2. Services and activities are offered at convenient times.	7	10	132	213	362
S3. Staff members are welcoming and respectful.	8	3	62	289	362
S4. Staff members have asked me about my family's strengths, needs, and interests.	9	10	131	208	358
S5. Staff members help me to understand healthy family dev't.	10	10	114	224	358
S6. Staff members have invited other people in my family to participate in services and activities.	11	27	132	188	358
S7. I have opportunities to meet and get to know other families through the Program.	14	53	153	139	359
S8. Staff members speak my language.	9	4	74	267	354
S9. Staff members understand my identity and culture (traditions, values, religion, sexual orientation, special needs, etc.).	8	2	94	251	355
S10. I have opportunities to learn about families that are different from mine.	10	48	151	140	349
S11. Staff members have helped me to learn about services, resources, and opportunities that are available in the community.	9	11	99	233	352
S12. I have opportunities to share my opinion and ideas about the program.	9	19	129	194	351
S13. Overall, this program has provided valuable support for me and my family.	8	6	93	248	355

Of the responses received, 61% of responses indicated strong agreement with the survey statements, indicating that clients across Kansas largely believe their families are being strengthened and supported by MCH programs.

Four questions that had higher percentages of "disagree" and "strongly disagree" were:

- Staff members have invited other people in my family to participate in services and activities.
- I have opportunities to meet and get to know other families through the Program.
- I have opportunities to learn about families that are different from mine.
- I have opportunities to share my opinion and ideas about the program.

While the majority of responses to these four questions were positive ("agree" or "strongly disagree"), a higher number of negative responses suggest opportunities for improvement. It is also worth noting that these responses are consistent with responses from the Program Self-Assessment and Self-Reflection Checklist. All three tools indicated opportunities for improvement in creating opportunities for families to get to know each other and learn from each other, in helping families learn about diversity, and in performing robust program evaluation, including integrating opinions and ideas of clients into program quality improvement.

TABLE 24. DISTRIBUTIONS OF RESPONSES TO ALL QUESTIONS IN THE PARTICIPANT SURVEY ACROSS CATEGORIES FROM "STRONGLY DISAGREE" TO "STRONGLY AGREE."

RESPONSE SELECTION	AGGREGATE RESPONSES	PERCENTAGE OF TOTAL RESPONSES
Strongly Disagree	119	2%
Disagree	215	5%
Agree	1478	32%
Strongly Agree	2823	61%

Strengths of Kansas MCH Populations

Given the known association between economic well-being and a lower likelihood of disease and premature death, lower levels of poverty in Kansas and higher levels of educational attainment compared to the United States as a whole can be considered a strength of our MCH population.

Compared to the U.S. population, a lower percentage of Kansans lived in households with incomes below the federal poverty level (8.2% in Kansas vs. 10.1% for the U.S.; 2013-2018 American Community Survey, Table DP03) and a lower percentage of children under 18 lived in households with incomes below the federal poverty level, with a figure of 17.7% in Kansas vs. 18.0% in the U.S. (2013-2018 American Community Survey, Table S1701). More than 9 in 10 (90.7%) Kansans have a high school education or higher (compared to 87.7% in the U.S.) and 32.9% have a bachelor's degree or higher, compared to 31.5% for the U.S. (American Community Survey 2014-2018 DP02). Kansas also saw a decrease in the percentage of children under 19 years old without health insurance from 6.2% in 2013 to 5.2% in 2017 (Census Bureau 2017 Small Area Health Insurance Estimates), a 16.1% decrease (this decrease happened despite the fact Kansas has not expanded Medicaid under the Affordable Care Act). Other noted strengths by population domain are outlined below. National Performance Measures (NPM) and National Outcome Measures (NOM) are documented in more detail in Appendix B.

Women/Maternal

- 87% of women aged 18-44 years say their general health is good, very good, or excellent[1].
- The percentage of non-Hispanic Black and non-Hispanic American Indian/Alaska Native women ages 18-44 with a preventive medical visit in the last year (NPM 1) trended up from 2013 to 2017[1].
- 81% of pregnant women in Kansas received prenatal care in the first trimester [2].
- The percent of women who smoke during pregnancy (NPM 14.1) decreased significantly from 12.5% in 2013 to 10.1% in 2017 and showed declines in most demographic groups[1].
- Rates of severe maternal morbidity per 10,000 delivery hospitalizations trended down among women over 35 years of age and among non-Hispanic white, non-Hispanic black, and Hispanic women from 2011 to 2015 (NOM 2)[3].
- The percent of cesarean deliveries among low-risk first births remained steady from 2013 to 2017 (23.8% in 2017), better than the Healthy People (HP) objective of 24.7% (NOM 7)[4].

Perinatal/Infant

- 98% of Kansas infants had a well-baby checkup[5]
- Nine in ten Kansas infants were ever breastfed[2], and 1 in 3 were breastfed exclusively for 6 months[6] (11th highest in the U.S.) (NPM 4)
- The percent of infants placed to sleep on their backs is 80.2%, higher than the Healthy People 2020 goal (NPM 5)[5]
- The sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births trended downward from 131.4 in 2013 to 107.0 in 2017 (NOM 9.5)[2]
- Infant mortality rates per 1,000 births (NOM 9.1) trended down from 6.4 in 2013 to 6.0 in 2017, meeting the HP 2020 objective[2]

Children

- 9 in 10 children are in excellent or very good health (NOM 19)[9]
- 7 in 10 Kansas children have completed the combined 7-vaccine series (NOM 22.1)[6]
- More than 3 in 4 Kansas children ages 0-17 years had a preventive dental visit in the past year (NPM 13.2)[9]
- 1 in 2 Kansas children have a medical home (NPM 11)[9]

Adolescents

- 78% of adolescents age 12-17 years had a preventive medical visit in the last year (NPM 10)[9]
- 9 in 10 adolescents ages 13-17 received at last one dose of the Tdap vaccine (NOM 22.4)[10]
- The birth rate per 1,000 teens age 15-17 years decreased significantly from 14.6 in 2013 to 9.5 in 2017 (NOM 23)[2]

Children with Special Health Care Needs (CSHCN)

- All Kansas children are screened for genetic conditions at birth[7]
- 93% of CSHCN have at least one preventive medical visit in a 12-month period[9]
- 4 in 5 CSHCN have a personal doctor or nurse[9]
- Almost 3 in 4 (73%) CSHCN in have teeth in good or excellent condition (compared to 66% in the U.S.)[9]

Needs of Kansas MCH Populations

Despite gains in health status of women, infants and children in Kansas on many fronts during the last five years, significant needs and issues remain. On many outcome measures, Kansas' performance is still well below where we would like to be, and disparities based on race, income, education, and many other important measures still exist.

Concerns facing Kansas' Women/Maternal population

- 12% of new mothers report symptoms of postpartum depression[7]
- Less than 2 in 3 women ages 18 to 44 years have had a preventive medical visit in the last year (NPM 1)[2]
- There are disparities in well-woman visits (NPM 1) based on educational attainment (2017 data): High school (56.8%) < High school graduation (63.5%) < Some college (63.8%) < College graduate (69.7%)[2]
- There are disparities in well-woman visits (NPM 1) based on household income (2017 data): Less than $15,000 (52.5%) < $15,000 to $24,999 (57.7%) < $25,000 to $49,999 (62.4%%) < $50,000 and higher (70.7%)
- 31% of women ages 18-44 years are obese[8]
- 18% of women ages 18-44 years smoke cigarettes[9]
- 19% of women drink excessively (8+ drinks per week or binge drank in last month)[10]
- There are disparities in severe maternal morbidity (NOM 2) based on race: Asian Pacific Islanders (178.8) > non-Hispanic black (161.61) > Hispanic (105.8) > non-Hispanic whites (88.2)[5]
- There are disparities in severe maternal morbidity (NOM 2) based on insurance status: uninsured women (156.1) and women on Medicaid (13.17) had much higher rates of morbidity than women on private insurance (73.8)[5]

Concerns facing Kansas' Perinatal/Infant population

- Only a little over one-third of infants (37.3%) are placed to sleep on a separate, approved sleep surface, and less than half (44.3%) are placed to sleep without soft objects or loose bedding (NPM 5)
- In 2017 7.4% of deliveries were to low birth weight babies (<2,500 grams) a percentage that has been increasing. Rates have trended negatively for non-Hispanic black, non-Hispanic other/multiple race, and Hispanic babies (NOM 4)
- An average of 230 infants deaths occur in the state each year. Kansas had the 17th highest infant mortality rate among non-Hispanic whites, the 14th highest among non-Hispanic blacks, and 7th highest among Hispanics (NOM 9.1)
- About 120 infants are diagnosed with neonatal abstinence syndrome (NAS) each year, and the rate has been increasing. Infants with NAS are more likely to be non-Hispanic white and insured by Medicaid. Rates of new mothers using marijuana or hashish during pregnancy have also been increasing (NOM11)
- Infants born to mothers with Medicaid coverage have a higher infant mortality rate per 1,000 live births (8.4) than those born to mothers with private insurance (4.7) (NOM 9.1)
- Black infants have higher rates of infant mortality per 1,000 live births (11.3) than non-Hispanic white infants (5.4) and infants of other races (NOM 9.1)

Concerns facing Kansas' Child population

- Just over one-third (37.8%) of children 9 through 35 months received a developmental screening using a parent-completed screening tool in the past year (NPM 6)
- Only about one-half (51.7%) of children ages 3 through 17 years of age with a mental or behavioral health condition are receiving counseling or treatment (NOM 18)
- 32% of children ages 10-17 years are overweight or obese (compared to U.S. 31%) (NOM 20)
- 3 of 4 children are not physically active at least 60 minutes per day (NPM 8)
- 15% of children live in a household were someone smokes and there are large disparities: 36.3% of children with parents who had a high school education lived in such a household, compared to 23.3% of children of parents with some college and 5.6% of children whose parents were college graduates (NPM 14.2)

Concerns facing Kansas' Adolescent population

- The adolescent suicide rate (per 100,000) has increased from 13.2 in 1013 to 14.5 in 2017, and is trending up among females (3 year rolling average) (NOM 16.3)
- The percentages of adolescents in Kansas who have received at least one dose of HPV vaccine (52.4%) and the meningococcal conjugate vaccine (72.1%) are well below national immunization rates (NOM 22.3)
- 28% of adolescents in grades 9 through 12 are overweight or obese (U.S. 30%) (NOM 20)
- 8 in 10 adolescents are not physical active 60 or more minutes a day (NPM 8.2)
- 25% of adolescents ages 12-17 years are bullied, and 16% of adolescent girls in grades 9 through 12 experienced sexual dating violence (both higher than national percentages) (NPM 9)

Concerns facing Kansas' Children with Special Health Care Needs population

- Less than one in five adolescents ages 12 through 17 receive the services necessary to make transitions to adult health care (CSHCN: 16.1%; non-CSHCN: 19.6%) (NPM 12)
- 61% of Kansas CSHCN received effective care coordination, compared to 81% of non-CSHCN
- 2 in 5 Kansas CSHCN had two or more adverse childhood experiences (compared to 19% of non-CSHCN)
- 49% of CSHCN were bullied or excluded (compared to 39% for the U.S.) (NPM 9)

[1] *Behavioral Risk Factor Surveillance System (BRFSS)*

[2] *KDHE Bureau of Epidemiology and Public Health Informatics*

[3] *Healthcare Cost and Utilization Project (HCUP)*

[4] *KDHE Vital Statistics*

[5] *Pregnancy Risk Assessment Monitoring System (PRAMS)*

[6] *CDC National Immunization Survey*

[7] *KDHE Newborn Screening Program*

[8] *Kansas Hospital Discharge Dataset*

[9] *National Survey of Children's Health (NSCH)*

[10] *NIS-Teen*

[11] *Youth Risk Behavior Surveillance System (YRBSS)*

Kansas' Gaps and Challenges Meeting MCH Needs

Throughout the MCH Needs Assessment process, findings suggested that there are gaps still remaining in the MCH system, and there is significant room for improvement in health outcomes for the women, infants, and children of Kansas. At the same time, data suggested improvements in many areas. Many stakeholders noted numerous positive changes (often referred to as "bright spots") in systems of care for MCH populations and in health outcomes of these populations. Some of the gaps and bright spots were highlighted in the health status indicators in the previous section (and are also highlighted in Appendix B). This section will focus on the top issues and themes highlighted again and again throughout the MCH Needs Assessment process by a broad array of stakeholders and through analysis of existing data.

MCH Top Issues & Themes

Generally speaking, the issues can be categorized into three themes. While we recognize these themes are not mutually exclusive, they will be addressed in discrete sections below.

Access and availability to care

Behavioral health

Social determinants of health and addressing disparities

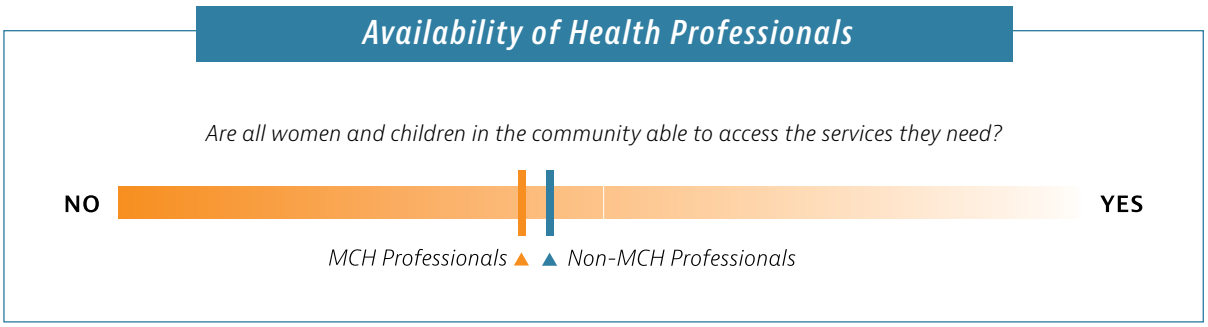
Access and availability to care

Gaps and Challenges

Many women, infants, and children face a variety of barriers accessing health care services. Availability of health insurance was a concern that was highlighted in every forum and by almost every stakeholder group that participated in the needs assessment process. A driving concern is that only 2 in 3 children (68.0% in 2017) in Kansas between the ages of 0 and 17 are continuously and adequately insured. Another "insurance gap" that garnered significant discussion at the Fall 2019 MCH regional meetings, in several key informant interviews, and among Kansas MCH Council members was the frequent loss of Medicaid coverage among women 60 days after delivery. Several comments were made that this narrow window of coverage is simply insufficient to adequately address issues such as postpartum depression. As one key informant interviewee noted, "We need life outcomes, not just birth outcomes." Key informants also spoke to the number of providers who do not accept Medicaid/KanCare (the gap is especially acute for dental care, since only about 1/3 of Kansas dentists accept Medicaid). Key informants also expressed concern about the "gap" between services needed by some MCH populations and what Medicaid sees as a reimbursable medical expense. For CSHCN who have mobility impairments, for example, wheelchairs and other mobility devices, and the fittings for these devices, are critical to mobility and health, but the costs associated with them are not traditionally covered by Medicaid.

Another gap that causes a barrier to services is the availability of health professionals. At a series of January open house events sponsored by CPPR, participants were asked if women and children were able to access the services they need in their community (the question was answered using a "slider" bar as in the figure below where respondents were asked to place an X on a horizontal bar with the left end of the bar representing "No" and the right end "Yes.") Responses of MCH professionals (the bar to the left shaded orange) and non-MCH professionals (the bar to the right shaded blue) are slightly to the left of the center of the slider bar. Since both bars are slightly left of center, both groups of respondents were more likely to select an answer closer to "No, not all women and children are able to access the services they need in the community."

FIGURE 5



When asked to explain their answers, many respondents mentioned shortages of health professionals to serve the needs of women, infants and children. Some of the specialties that were noted as having shortages were obstetrics and gynecology, pediatricians (both general and specialists), mental health and substance abuse treatment professionals, dental professionals, and complementary/alternative care providers.

MCH programs cite a lack of mental health services as the biggest challenge for women and children.

The availability of professionals was also cited in key informant interviews, that cited shortages of Ob/Gyn (especially in rural areas); therapists including Physical Therapy, Occupational Therapy, and Speech/Language Therapy; and mental health providers. The shortage of mental health providers was noted as a particular concern among MCH programs. Mental health was cited as a gap more than any other issue by MCH programs in their SFY 2020 MCH Aid to Local applications, and at each of the fall regional meetings of MCH programs a lack of mental health services was cited as the biggest challenge for women and children.

Perceptions about shortages in providers to serve MCH populations in Kansas are corroborated by other data sources. The 2017 supply of family and general practitioners per 100,000 population (23.3 providers) was significantly lower in Kansas than the national average (38.8), and 80 of Kansas' 105 counties are designated as Primary Medical Care Health Professional Shortage Areas (HPSAs). The number of obstetricians/gynecologists per 100,000 people (1.7) was also well below the national average of 5.8. The physician/population ratio for pediatrics is closer to the national average, but general pediatricians, and especially pediatric providers, are more clustered in the state's urban centers. As such, access for many residents of rural communities is a challenge, and in a state where 89 of 106 counties are designated as rural, this is problematic.

In 78 of Kansas' 105 counties there is a Dental Health Shortage Area designation, and only 4 counties in the entire state are not designated as a Mental Health Professional Shortage Area. Nearly statewide HPSA coverage for mental health is consistent with other concerns such as long wait times for appointments, and long travel distances to receive mental health care services. These issues were consistently cited as obstacles to optimal mental health care during the collection of input into the needs assessment.

Behavioral Health

Gaps and Challenges

In addition to the concerns cited above regarding access to mental health care services, there were a number of other major concerns cited around mental health throughout the needs assessment process. In fact, mental health was cited as a priority issue in more Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) than any other issue, being highlighted in 34 CHNA/CHIPs. Only two other issues (substance abuse in 29 and obesity in 28) were cited as a priority in Kansas in more than 25 CHNA/CHIPs. When asked to cite gaps/disparities in their SFY 2020 applications for funding, 24 local MCH agencies cited gaps and disparities in mental health, two times more often than substance abuse, which was the second-most cited (cited by 12 applicant agencies).

In a mock budgeting exercise conducted at the CPPR-sponsored Open Houses throughout the state, Mental health received far more "money" than any other issue.

During six regional Open Houses sponsored by CPPR in January 2020 to collect input for the needs assessment, a "budgeting" exercise was conducted where each participant was given fake money to budget among the eight priorities cited most frequently as MCH priorities by the local MCH agencies. Mental health received far more money than any other issue among both the MCH professionals who participated and by members of the general public. Out of $12,000 "budgeted" by Open House participants, $3,710 (or 29% of all available funds) was allocated to mental health. Children's health was a distant second being allocated 16% of available funds.

Also generating interest at the Open Houses were Kansas' numbers for three mental health-related National Outcomes Measures. These included (1) adolescent suicide (NOM 16), (2) mental health services for children ages 3-17, and (3) depression in women.

NOM 16.3: Adolescent Suicide. Kansas rate of suicide among youths age 15 through 19 years has been increasing and is considerably higher than the national average. Concerns about suicide voiced during the needs assessment ranged from concerns about lack of awareness of warning signs, lack of information about available services, and stigma associated with reaching out for help.

Some real-world examples of these concerns are found in the "Our Tomorrows" Project, a statewide effort to help shape policy and programming decisions in early childhood through the collection of stories from Kansans to help gain understanding about what Kansas families feel they need to thrive. These stories came from real Kansans during the 2019-2020 story collection process for Our Tomorrows.

> **A Personal Story**
>
> *"Last week a teenager in my building committed suicide… We feel bad for the family and it makes me feel different about life. I wish more people would reach out if life gets that bad."*

A Sister's Story

"My younger sister attempted suicide when she was a sophomore in high school. We were completely oblivious to the distress signs, the changes in her behavior, writing it off to teenage emotions and hormone changes, when it really was much more than that. She really needs our support and attention and instead we were just trying to get by and deal with our own life problems…it really was a wakeup call to the whole family about paying attention and following up with those closest to you."

NOM 18: Mental Health Services for Children. The percentage of children ages 3 through 17 with a mental/behavioral health condition who receive treatment or counseling, has also raised "red flags" among MCH stakeholders in Kansas. In 2017 the percentage of children who received treatment/counseling in Kansas was just over half (51.7%), well below the HP 2020 target of 75%.

Here is what the inability to receive care feels like to a Kansas family (from Our Tomorrows).

A Son's Mental Health Struggles

"I felt like our family was just surviving when my son was struggling with mental health issues. I felt like every day was a fight to ensure he had the services he needed. I wanted desperately for us to be safe, secure and happy but it felt like all the systems were stacked against us. He qualified for inpatient hospitalization but there were no beds available. He needed attendant care and case management but there weren't enough workers to provide the services. He still needed to go to school but the school would call the police on him. I felt so alone and just wanted my child to be safe."

NOM 24: Depression in women of reproductive age. The Kansas PRAMS 2017 Surveillance Report noted that in the year before pregnancy, 18.9% of mothers had been depressed, while a quarter of mothers (25.2%) had anxiety during this time. For NOM 24, the percent of women who experience postpartum depressive symptoms following a recent live birth, Kansas percentage of 12.4% was similar to the national average of 12.6%. How it impacts the lives of Kansas women is reflected in these stories shared as part of the Our Tomorrows project.

A New Mother's Challenges with Returning to Work

"I felt very little support from my employer and all of this contributed to the worsening of my postpartum anxiety. I'd been looking forward to returning to work and seeing purpose and progress in my days but instead I felt isolated and stressed… I do believe that having more time than the maximum 12 weeks of FMLA allowed by my employer would have helped me to deal with my anxiety before facing the added stress of returning to work. I also believe that more support and advocacy for my commitment to pump milk for my baby would have alleviated some anxiety. Families would greatly benefit from some type of paid maternity leave program also. I wish so badly I wouldn't have had to use all of my vacation time for maternity leave because when just returning to work, a sick day or a day with a child sick would mean no pay…"

A New Parent's Struggle with Depression

"After the baby I was depressed and I struggled with being a new mom and with my marriage and I just wanted things to go back to the way they were before. Looking back I realize I was probably suffering from postpartum depression but no one talked to me about this at the time."

A Parent Finds Solace in Community

"I suffered from postpartum depression with my second child. Living in southwest Kansas is really hard because there are no support groups to help with this issue. I tried online forums but it was not until I joined a Learn and Play group in my town that I felt the support I needed. It is easy to feel isolated and in the group I found other moms to talk with and a safe place for my baby to play and learn and we felt a part of a community. I told my Healthy Steps Specialist that Learn and Play has become my life-line! Since it is provided free of charge, my single income family could afford to attend."

Adolescent focus groups conducted by DCCCA shed interesting light on youth perceptions around behavioral health. High school and college participants indicated healthy choices they struggled to make were related to managing stress and avoiding vaping, drinking alcohol, and smoking marijuana (particularly in social settings like parties). While adolescents expressed a certain amount of awareness about health resources available in their community, they said they were less aware of behavioral health resources. Even in cases where adolescents were aware of those services, most indicated they did not personally utilize them for various reasons, most often stigma and cost.

Social determinants of health and addressing disparities

Gaps and Challenges

There is increasing recognition and concern among Kansas public health practitioners, and specifically within the MCH program, about health disparities among MCH populations. There is also a commitment to focus on disparities in health by looking "upstream" in order to influence the conditions and environments in which people live, work, and age that have a marked impact on health status.

This recognition of the role of "social determinants" is clear when examining statewide work to assess community health conditions. In the last five years issues such as affordability of housing, food insecurity, affordability of health insurance, and affordability of health care have been among the top issues cited in community health needs assessments conducted by Kansas health departments and their local partners. These issues of affordability were also cited frequently by MCH program staff during fall regional meetings as part of the MCH Needs Assessment. Staff cited example after example of families that were suffering economically, and as a result often went hungry, had inadequate transportation, were unable to afford quality child care (and often as a result were forced to give up employment, exacerbating economic hardship), and were forced to live in unhealthy and often unsafe housing situations. There is also recognition that these economic inequities are closely linked to racial inequities. In Kansas the percentage of young children living below the poverty level is significantly higher for black/African American, American Indian or Alaska Native, and Hispanic or Latino than for White/Non-Hispanic and overall.

The percentage of young children living below the poverty level is significantly higher for black/African American, American Indian or Alaska Native, and Hispanic or Latino Kansan children than it is for White/non-Hispanic children.

Not only public health practitioners, but others including economists and policy makers, have taken note of the connections between economic conditions and health. Nationwide many analysts have interpreted recent trends in life expectancy as a result of despair rising from economic stagnation, despair that has led to increases in suicide as well as drug- and alcohol-related deaths.

Kansas, in fact, is struggling with suicide as a public health problem. Kansas' suicide rate per 100,000 total population is 19.3, higher than the U.S. rate of 14.2 (2018 National Center for Health Statistics; wonder.cdc.gov), and this rate has increased every year from 2014 to 2018. When it comes to mental health more broadly, there are issues of racial disparity in the state. For example, the mental health hospital admissions rate per 100,000 population for Kansas blacks (106.1 for 2016-1018) is higher than that of the population as a whole by 31.0 (a 41.3% difference). According to the 2005 Kansas Health Institute Racial and Ethnic Minority Health Disparities Chartbook, American Indians in Kansas have the highest rate of mental disability (7.5%).

Alcohol and substance abuse are frequently mentioned as a concern by MCH programs, and with good reason. Rates of binge drinking are much higher among younger people (those more likely to be served by the MCH program). The percentage of persons aged 18 and older who reported binge drinking on one occasion in the last thirty days is much higher in younger age groups. The percentage is 25.0% for 18-24 year olds, and 25.9% for 25-34 year olds, compared to 19.4% (35-44 years), 14.8% (45-54 years), 9.7% (55-64 years), and 3.3% (65+ years). The overall incidence rate of infants born with neonatal abstinence syndrome (NAS) has been trending up in Kansas since 2000, and significant disparity has persisted over time between infants who were covered by Medicaid and private insurance. In 2018, the incidence of NAS was 11 times higher among infants who were covered by Medicaid (8.8 per 1,000 birth hospitalizations) compared with infants who were covered by private insurance (0.8 per 1,000 birth hospitalizations).

IDENTIFYING PRIORITY NEEDS AND LINKING TO PERFORMANCE MEASURES

Methods Used to Rank Identified Needs

Two half-day retreats were held in February 2020 with key stakeholders to review data collected through the MCH Needs Assessment and gather input into the development of MCH priorities. The first meeting primarily consisted of BFH staff; the second involved directors of other bureaus in the KDHE Division of Health, the medical director of Medicaid, and representatives from the Kansas African-American Affairs Commission and the Kansas Hispanic & Latino American Affairs Commission. All participants engaged in group exercises that resulted in each individual generating a ranking of the top five issues to be included in 2021-2025 MCH priorities. When individual rankings were consolidated, sixteen issues emerged as potential priorities.

Selecting/Finalizing Priorities

Staff epidemiologists in the BFH next compiled detailed information around these sixteen issues. That was reviewed at a March 2020 retreat of BFH staff and the MCH Needs Assessment Team. Six key issues emerged from this discussion:

1

Well-functioning/Holistic Systems of Care

Across all population domains and the state there is a need for access to high-quality, comprehensive, coordinated, and affordable services.

2

Mental Health

A priority in every community was access to screening, intervention, and referrals. There was significant focus and emphasis on "diseases of despair" (e.g., suicide, drug abuse/overdose, and excessive drinking).

3

Healthy Relationships

Interpersonal/domestic violence was identified as a contributor to stress, injury, death and other poor health outcomes.

4

Disparities & Social Determinants of Health

Chronic stress is increasingly recognized as a contributor to chronic disease. Taking an "upstream" approach will require intentionality to address the needs of the MCH population linked to stressors associated with social determinants of health.

5

Chronic disease

There are dramatic disparities in the chronic diseases that are leading causes of death and disability in the state and with the modifiable risk factors (tobacco use, physical inactivity, poor diets and food insecurity) associated with those conditions.

6

Family Strengthening & Supports

Services and supports for families are most beneficial when families are engaged and actively working with program and policy leaders to assure a strengths-based approach to service delivery.

Based on all of the information gathered and discussed during the needs assessment process, this group developed a set of seven draft priorities, one priority in each population domain and two additional Cross Cutting/Systems Building priorities. They also developed draft objectives and identified areas of alignment between the state priorities and the NPMs and NOMs. For each population domain, at least one NPM was chosen as the proposed area for programmatic focus. The group also established draft State Performance Measures (SPMs) for each priority.

This information was used to draft a Five-Year Action Plan Table that was the focus of an all-day meeting of the Kansas Maternal and Child Health Council (KMCHC), convened via videoconference on May 8, 2020. That day 58 participants reviewed the needs assessment process and findings, as well as the draft priorities, objectives, NPMs, and SPMs. The afternoon consisted of domain-specific discussions where subgroups examined the priorities, measures, and objectives proposed in each domain and provided additional input, including proposed strategies to address stated objectives. Each subgroup also provided feedback on the two cross-cutting/system building priorities. The core MCH team reviewed all of the discussion and recommendations from the KMCHC in developing a state action plan that was made available for public comment as part of the Kansas MCH Block Grant Application/Annual Report.

Comparison of 2021-2025 and 2016-2020 Priority Needs

Comparing 2021-2025 priorities to those from 2016-2020 reveals some similarities, and in some cases expansion, of themes identified during the MCH Needs Assessment five years ago. There are changes as well. The new needs assessment and Action Plan focuses even more pointedly on building strong systems of care and support, with emphasis on a system where transitions for families are more seamless than is true in the still-fragmented delivery system that exists today. Kansas envisions a fully-integrated system of care for MCH populations and the development of policies, systems and environments that reduce and/or eliminate persistent disparities. The tables below crosswalk the 2021-2025 priorities compared to those from 2016-2020, and some explanation of changes follows.

TABLE 25. CROSSWALK OF MCH PRIORITIES FOR KANSAS (2021-2025 COMPARED TO 2016-2020)

TABLE 25.1 P: WOMEN & INFANT

2021-2025	2016-2020
Women have access to and utilize integrated, holistic, patient-centered care before, during and after pregnancy.	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
All infants and families have support from strong community systems to optimize infant health and well-being.	Families are empowered to make educated choices about infant health and well-being.

TABLE 25.2: CHILD & ADOLESCENT

2021-2025	2016-2020
Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.	Developmentally appropriate care and services are provided across the lifespan.
Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health.	Communities and providers support physical, social and emotional health.

TABLE 25.3: CSHCN

2021-2025	2016-2020
Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	Services are comprehensive and coordinated across systems and providers.

TABLE 25.4: CROSS-CUTTING/SYSTEMS BUILDING

2021-2025	2016-2020
Professionals have the knowledge, skills and comfort to address the needs of maternal and child health populations.	Professionals have the knowledge and skills to address the needs of maternal and child health populations.
Strengths-based supports and services are available to promote healthy families and relationships.	Information is available to support informed, healthy decisions and choices.

Women/Infant

Priority #1 is closely aligned with the 2016-2020 women/maternal priority but expands on the concept. Two overarching concerns that surfaced consistently during discussions were the need to ensure a seamless system of care and to improve the quality and comprehensiveness of services provided. Stakeholders provided multiple examples of difficulties navigating the system and receiving inadequate care because of gaps/deficiencies in coordination of care. Kansans envision a system that goes beyond coordination and ensures that women receive all of the screening, diagnostic, preventive care and treatment needed (including mental health services) in the most efficient possible way.

Priority #2 focuses on reducing disparities in the health of newborn and young infants by supporting communities and young families. There is special emphasis on two issues: (1) safe sleep, because there is still improvement needed in Kansas' performance, and (2) breastfeeding, since there are marked racial and ethnic disparities in breastfeeding rates, and evidence that duration (not initiation) continues to be a challenge for Kansas women. This priority is similar to Priority 2 from 2016-2020 but focuses more on ensuring high-functioning community systems and not simply ensuring parents have information and support to make healthy choices. This reflects the growing focus within the Kansas MCH program on social determinants and the recognition that social and environmental determinants – and not simply "healthy choices" – are key drivers of health outcomes.

Children/Adolescents

Priority #3 is a broad priority that seeks to ensure appropriate screening, referral and treatment when needed to support healthy physical, social, and emotional development of children. It aligns closely with last year's priority 3. It does add additional emphasis on access, given an overarching concern highlighted throughout the needs assessment process was that there are barriers to services for many underserved and marginalized people across the state. This concern echoes that of other Kansas needs assessments, including the recently-completed needs assessment of Kansas Early Childhood Systems. That assessment also found that many families with children experience a gap between the services that are available and their actual needs, and these gaps disproportionately affect vulnerable and underserved populations.

Priority #4 remains largely unchanged. Mental health will continue to be a key focus around adolescent health, in addition to physical health. There is an increased emphasis on access in the new plan compared to the previous plan (similar to Priority 3).

Children with Special Health Care Needs

Priority #5 seeks to expand on the 2016-2020 priority around system coordination. The new priority focuses on empowering adolescents, with and without special health care needs, who are envisioned to be active participants in their own health and involved in transition planning with their primary care provider and others. It also focuses on broader youth leadership development, recognizing the important link between engagement and leadership, social connectedness, and positive health outcomes.

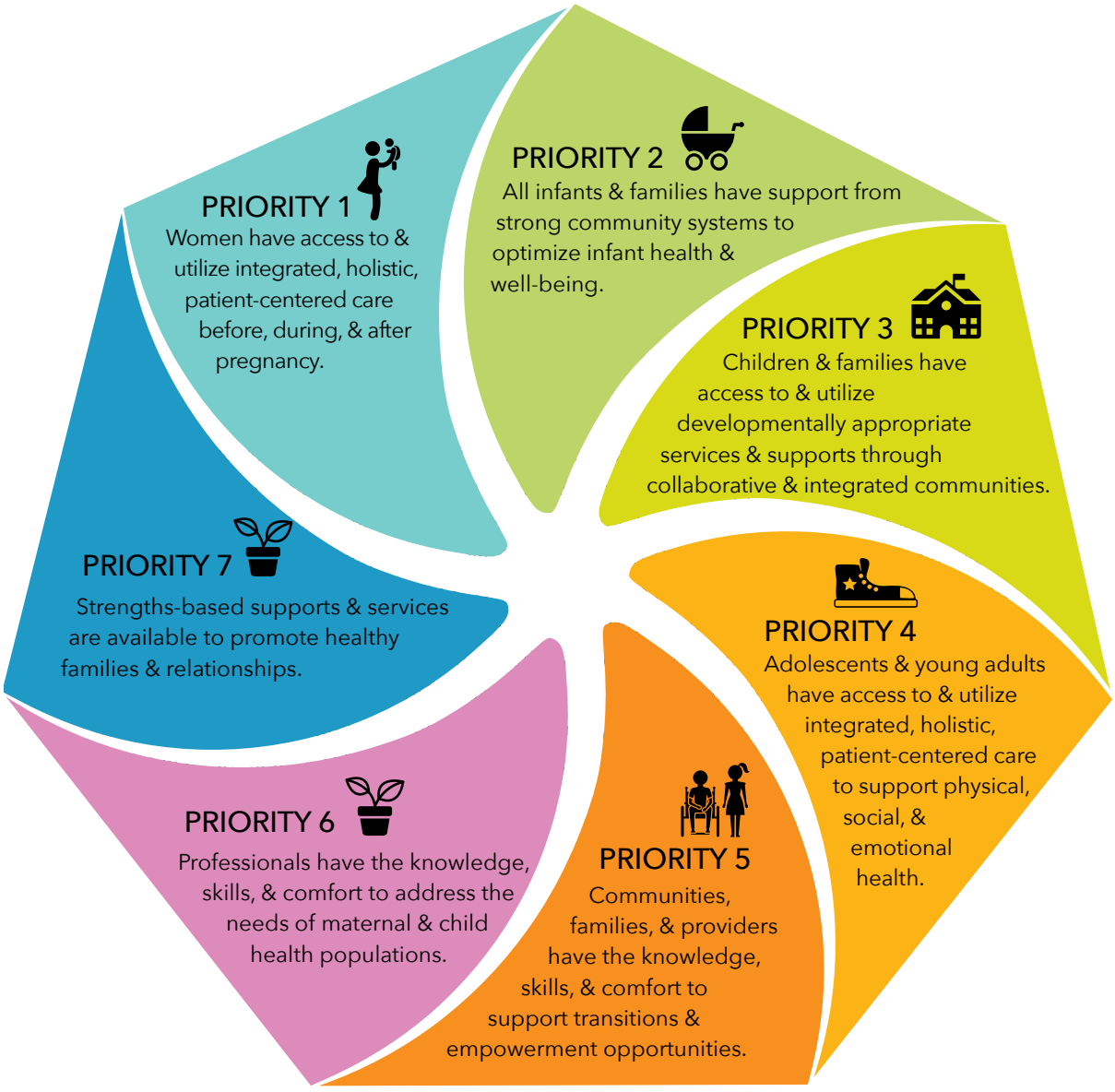
Cross-cutting/Systems Building

Priority #6 (workforce development) and **Priority #7** (promoting healthy families) have been expanded, but generally capture the intent of the 2016-2020 Action Plan to build comfort, knowledge, skills, and abilities among both MCH staff and families. In this priority 7, like Priority 2, focuses less on promoting good choices and instead focuses more on building strong support/services systems that promote healthy outcomes. In particular, it emphasizes the need for holistic care coordination. While it was frequently noted that there is a desire for collaboration and cooperation among providers and stakeholders, overall there is a shared recognition that efforts are still largely disconnected and uncoordinated, leading to unacceptable gaps in care.

2021-2025 Maternal and Child Health State Action Plan

The Kansas MCH Needs Assessment process focused on identifying and addressing issues at the state and local levels, and priorities were selected with the MCH mission, purpose, and legislation in mind. Within each of the five population domains, priorities align closely with at least one NPM. For the Cross-cutting/Systems Building domain a SPM was selected to track progress.

The following pages outline the selected priorities and corresponding performance measures that will drive the work of Title V through September 2025.



PRIORITY 1

Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.

WOMEN & MATERNAL

OBJECTIVE 1.1

Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit by 5% by 2025.

OBJECTIVE 1.2

Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period by 5% annually through 2025.

OBJECTIVE 1.3

Increase the proportion of high-risk pregnant and postpartum women receiving prenatal education and support services through perinatal community collaboratives by 10% annually by 2025.

OBJECTIVE 1.4

Increase the proportion of women receiving pregnancy intention screening as part of preconception and inter-conception services by 10% by 2025.

NPM 1: *Well-woman visit (Percent of women, ages 18-44, with a preventive medical visit in the past year)*

SPM 1: *Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)*

PRIORITY 2

All infants and families have support from strong community systems to optimize infant health and well-being.

PERINATAL & INFANT

OBJECTIVE 2.1
Promote and support cross-sector breastfeeding policies, practices, and environments to increase exclusive breastfeeding rates at 6 months by 2.5% annually through 2025.

OBJECTIVE 2.2
Promote and support safe sleep practices and cross-sector initiatives to reduce the SUID rate by 10% by 2025.

OBJECTIVE 2.3
Implement at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC) by 2025.

OBJECTIVE 2.4
Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services by 15% by 2025.

NPM 5: *Safe Sleep (Percent of infants placed to sleep (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)*

SPM 2: *Breastfeeding (Percent of infants breastfed exclusively through 6 months)*

PRIORITY 3

Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

CHILD

OBJECTIVE 3.1

Increase the proportion of children age 1 month to kindergarten entry who receive a parent-completed developmental screening by 5% annually through 2025.

OBJECTIVE 3.2

Increase the proportion of children, 6 through 11 years, with access to activities and programs that support their interests, healthy development, and learning by 10% by 2025.

OBJECTIVE 3.3

Increase the proportion of MCH program participants, 1 through 11 years, receiving quality, comprehensive annual preventive services by 10% annually through 2025.

NPM 6: *Developmental screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening toolin the past year)*

PRIORITY 4

Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.

ADOLESCENT

OBJECTIVE 4.1

Increase the proportion MCH program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services by 5% annually through 2025.

OBJECTIVE 4.2

Increase the proportion of adolescents and young adults that have knowledge of and access to quality health and positive lifestyle information, prevention resources, intervention services, and supports from peers and caring adults by 10% by 2025.

OBJECTIVE 4.3

Increase the number of local health agencies and providers serving adolescents and young adults that screen, provide brief intervention and refer to treatment for those at risk for behavioral health conditions by 5% by 2025.

NPM 10: *Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)*

PRIORITY 5

Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

OBJECTIVE 5.1

Increase the proportion of adolescents and young adults who actively participate with their medical home provider to assess needs and develop a plan to transition into the adult health care system by 5% by 2025.

OBJECTIVE 5.2

Increase the proportion of families of children with special health care needs who report their child received care in a well-functioning system by 5% by 2025.

OBJECTIVE 5.3

Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2025.

NPM 12: *Transition: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care*

PRIORITY 6

Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.

CROSS-CUTTING AND SYSTEMS BUILDING

OBJECTIVE 6.1

Increase the proportion of providers with increased comfort to address the behavioral health needs of MCH populations by 5% by 2025.

OBJECTIVE 6.2

Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction and healthier work environments by 5% annually through 2025.

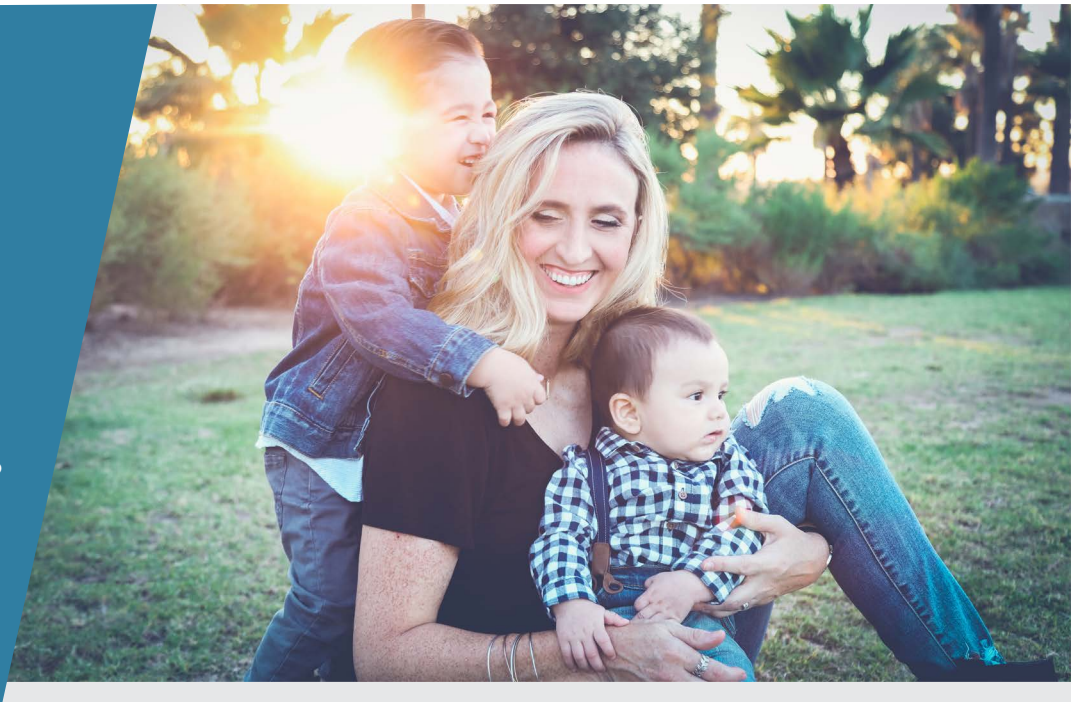
OBJECTIVE 6.3

Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations by 15% annually through 2025.

SPM 3: *Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event.*

PRIORITY 7

Strengths-based supports and services are available to promote healthy families and relationships.



CROSS-CUTTING AND SYSTEMS BUILDING

OBJECTIVE 7.1
Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP) to 75% by 2025.

OBJECTIVE 7.2
Increase the number of individuals receiving peer supports through Title V-sponsored programs by 5% annually through 2025.

OBJECTIVE 7.3
Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program by 5% annually through 2025.

OBJECTIVE 7.4
Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration by three through 2025.

SPM 4: *Percent of children whose family members know all/most of the time they have strengths to draw on when the family faces problems*

APPENDICES

APPENDIX A: DEMOGRAPHICS

General Demographics

Of Kansas' 2,911,505 residents (July 1, 2018 estimate), 705,961 (24.2%) are young people under the age of 18. Another 502,396 are females 18-44 years of age, or another 17.3% of the population. In total, then, if these subpopulations are considered the target population of the MCH program, there are over 1.2 million Kansas residents in this population (Figure A1).

Table A1 shows the percent of different population group by MCH region. The percent of total population under 18 is lowest in the North Central and Northwest regions, while the percentage of the population under 18 is higher in the Southwest. The percentage of the population comprised of females 18-44 is somewhat higher in the Northeast region.

FIGURE A1

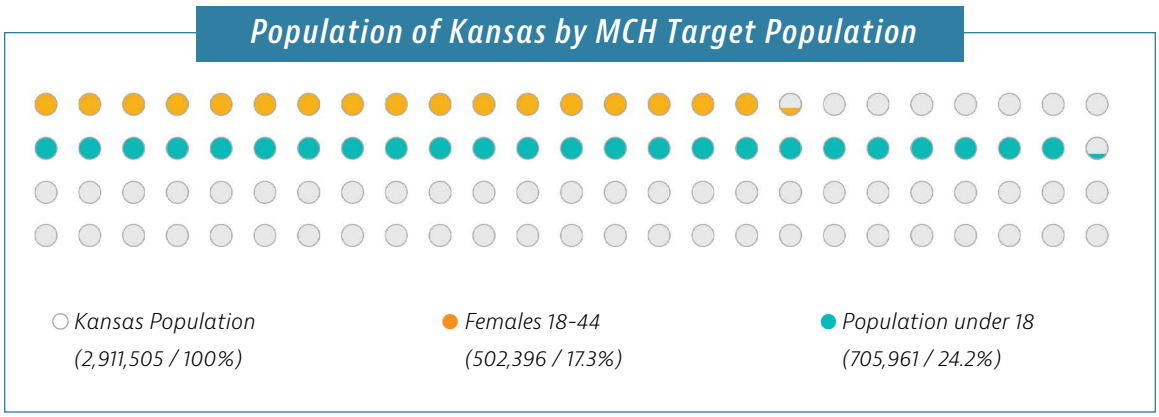


TABLE A1: AGE DEMOGRAPHICS BY REGION

REGION	JULY 1, 2018 POPULATION ESTIMATE	POP. UNDER AGE 1	PERCENT UNDER AGE 1	POP. AGE 1-5	PERCENT AGE 1-5	POP. AGE 6-11	PERCENT AGE 6-11	POP. AGE 12-17	PERCENT AGE 12-17	TOTAL POP. UNDER 18	PERCENT UNDER 18	POP. FEMALES AGE 18-44	PERCENT FEMALES AGE 18-44
North Central	137,925	1,539	1.1%	8,342	6.0%	10,638	7.7%	10,561	7.7%	31,080	22.5%	19,829	14.4%
Northeast	1,483,052	18,486	1.2%	97,050	6.5%	119,188	8.0%	118,878	8.0%	353,602	23.8%	270,860	18.3%
Northwest	80,896	990	1.2%	4,972	6.1%	5,991	7.4%	5,767	7.1%	17,720	21.9%	13,065	16.2%
South Central	858,879	10,710	1.2%	56,947	6.6%	73,100	8.5%	72,469	8.4%	213,226	24.8%	143,446	16.7%
Southeast	203,747	2,398	1.2%	12,629	6.2%	15,853	7.8%	16,390	8.0%	47,270	23.2%	31,242	15.3%
Southwest	147,006	2,316	1.6%	12,021	8.2%	14,826	10.1%	13,900	9.5%	43,063	29.3%	23,954	16.3%
Kansas	2,911,505	36,439	1.3%	191,961	6.6%	239,596	8.2%	237,965	8.2%	705,961	24.2%	502,396	17.3%

Source: U.S. Census Bureau, Vintage 2018 Bridged-Race Postcensal Population Estimates, https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2018%20 (accessed April 7, 2020).

The age profile of counties based on their urban/rural classification is fairly uniform (Table A2), although there is a higher percentage of women 18-44 years of age in more urbanized areas, and a lower percentage in more rural counties.

TABLE A2: AGE DEMOGRAPHICS BY URBAN/RURAL DESIGNATION

URBAN/RURAL DESIGNATION	JULY 1, 2018 POP. ESTIMATE	POP. UNDER AGE 1	PERCENT UNDER AGE 1	POP. AGE 1-5	PERCENT AGE 1-5	POP. AGE 6-11	PERCENT AGE 6-11	POP. AGE 12-17	PERCENT AGE 12-17	TOTAL POP. UNDER 18	PERCENT UNDER 18	POP. FEMALES AGE 18-44	PERCENT FEMALES AGE 18-44
Urban	1,656,773	21,023	1.3%	110,763	6.7%	138,207	8.3%	136,943	8.3%	406,936	24.6%	298,259	18.0%
Semi-Urban	454,465	5,548	1.2%	28,988	6.4%	35,126	7.7%	34,916	7.7%	104,578	23.0%	82,008	18.0%
Densely-Settled Rural	439,143	5,762	1.3%	29,788	6.8%	37,415	8.5%	37,458	8.5%	110,423	25.1%	71,951	16.4%
Rural	258,664	2,924	1.1%	16,110	6.2%	20,814	8.0%	20,865	8.1%	60,713	23.5%	36,523	14.1%
Frontier	102,460	1,182	1.2%	6,312	6.2%	8,034	7.8%	7,783	7.6%	23,311	22.8%	13,655	13.3%
Kansas	2,911,505	36,439	1.3%	191,961	6.6%	239,596	8.2%	237,965	8.2%	705,961	24.2%	502,396	17.3%

Source: U.S. Census Bureau, Vintage 2018 Bridged-Race Postcensal Population Estimates, https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2018%20 (accessed April 7, 2020).

For other demographic variables, there is substantial variation across MCH region. The prevalence of racial/ethnic minorities, educational attainment, rates of insurance (total and for children), and poverty (total and for children) differ substantially by region (Table A3). There are only small differences in these same variables between urban and rural counties (Table A4), although rates of college graduation are somewhat higher in more urban counties.

TABLE A3. ADDITIONAL DEMOGRAPHICS BY MCH REGION

REGION	NORTH CENTRAL	NORTHEAST	NORTHWEST	SOUTH CENTRAL	SOUTHEAST	SOUTHWEST	KANSAS
Percent Minority[1]	12.0%	24.5%	9.3%	24.4%	12.1%	49.3%	23.9%
Percent High School or Higher (pop. Over 25y)[1]	91.7%	92.8%	92.5%	89.8%	89.9%	74.6%	90.7%
Percent College Graduate (pop. Over 25y)[1]	33.7%	48.0%	36.9%	37.2%	30.5%	26.2%	41.4%
Percent children under 18y with Disability[2]	4.6%	4.0%	4.3%	4.7%	5.4%	3.5%	4.3%
Percent uninsured[2]	8.0%	7.9%	7.3%	10.0%	10.5%	13.9%	9.0%
Percent children under 19y uninsured[2]	3.7%	4.3%	4.0%	5.7%	7.5%	8.0%	5.2%
Percent families in Poverty (below 100% FPL)[3]	7.3%	6.9%	8.2%	9.2%	12.0%	10.0%	8.2%
Percent children under 5 in Poverty[4]	15.3%	13.0%	12.7%	17.8%	22.9%	18.5%	15.6%
Percent children under 18 in Poverty[4]	15.3%	15.6%	14.1%	19.0%	27.1%	21.6%	17.7%

[1] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table DP05, https://data.census.gov/cedsci/ (accessed April 6, 2020).*

[2] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table DP02, https://data.census.gov/cedsci/ (accessed April 6, 2020).*

[2] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table B17026, https://data.census.gov/cedsci/ (accessed April 7, 2020).*

[4] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table S1701, https://data.census.gov/cedsci/ (accessed April 7, 2020).*

TABLE A4: ADDITIONAL DEMOGRAPHICS BY URBAN/RURAL DESIGNATION

DEMOGRAPHIC	URBAN	SEMI-URBAN	DENSELY-SETTLED RURAL	RURAL	FRONTIER	KANSAS
Minority[1]	28.2%	18.0%	23.7%	11.2%	13.4%	23.9%
High School or Higher (pop. Over 25y) [1]	91.7%	92.8%	92.5%	89.8%	89.9%	90.7%
College Graduate (pop. Over 25y)[1]	47.5%	37.6%	31.4%	31.0%	31.3%	41.4%
Children under 18y with Disability[2]	4.1%	4.3%	4.7%	4.5%	5.1%	4.3%
Uninsured[2]	9.0%	8.1%	9.9%	8.6%	9.4%	9.0%
Children under 19y uninsured[2]	5.0%	4.8%	5.7%	5.2%	7.5%	5.2%
Families in Poverty (below 100% FPL)[3]	7.7%	8.5%	9.9%	7.5%	8.3%	8.2%
Children under 5 in Poverty [4]	14.6%	16.5%	18.7%	14.9%	15.1%	15.6%
Children under 18 in Poverty [4]	16.9%	17.7%	21.7%	16.6%	16.2%	17.7%

[1] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table DP05, https://data.census.gov/cedsci/ (accessed April 6, 2020).*

[2] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table DP02, https://data.census.gov/cedsci/ (accessed April 6, 2020).*

[3] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table B17026, https://data.census.gov/cedsci/ (accessed April 7, 2020).*

[4] *Source: U.S. Census Bureau, 2013-2018 American Community Survey, Table S1701, https://data.census.gov/cedsci/ (accessed April 7, 2020).*

MCH Client Demographics

A total of 34,157 women, infants, children and youth were served by the MCH program (calendar year 2018). Table A5 shows the number of clients in different client groups by number and percentage of all MCH clients. Roughly half of MCH clients are children 1-21 years of age, of whom 2,102 (6.2%) are CSHCN. Pregnant and postpartum women make up 19.4% of clients and infants less than a year of age another 11.1%. The "other" category is primarily women who are not pregnant or postpartum, but also some males.

TABLE A5. UNDUPLICATED MCH CLIENTS FOR CALENDAR YEAR 2018

MCH CLIENTS	CY 2018 UNDUPLICATED CLIENTS	CLIENTS AS A PERCENT OF TOTAL CY 2018 MCH CLIENTS
Pregnant and postpartum women (≤60 days after delivery)	6,616	19.4%
Infants <1 year	3,779	11.1%
Children 1-21 years without SHCN	15,907	46.6.%
Children 1-21 years with SHCN	2,102	6.2%
Other	5,753	16.8%
TOTAL	34,157	100.0%

Race

Table A6 below shows the numbers of clients by race/ethnicity. Non-Hispanic whites represent the greatest number of clients in each category, followed by Hispanics. Table A7 shows the same breakdown by percentages.

TABLE A6. MCH CLIENTS BY RACE AND ETHNICITY (TOTAL NUMBER).

RACE AND ETHNICITY	PREGNANT/ POSTPARTUM WOMEN	INFANTS <1 YEAR	CHILDREN 1-21 (W/O SHCN)	CSHCN	OTHERS	TOTAL
Non-Hispanic White	3,804	2,032	8,098	1,249	3,310	18,493
Non-Hispanic Black	488	288	1,276	132	482	2,666
Non-Hispanic Native American/Alaska Native	32	20	52	21	39	164
Non-Hispanic Asian	136	83	362	18	160	759
Non-Hispanic Native Hawaiian/Other Pacific Islander	21	8	32	8	20	89
Multiple Race	145	81	305	19	86	636
Unknown/Other	113	135	399	340	101	1,088
Hispanic	1,877	1,132	5,383	315	1.555	10,262
Total	6,616	3,779	15,907	2,102	5,753	34,157

TABLE A7. MCH CLIENTS BY RACE AND ETHNICITY (BY PERCENTAGE)

RACE AND ETHNICITY	PREGNANT AND POSTPARTUM WOMEN (≤60 DAYS AFTER DELIVERY)	INFANTS <1 YEAR	CHILDREN 1-21 YEARS WITH-OUT SHCN	CHILDREN 1-21 YEARS WITH SHCN	OTHERS	TOTAL
Non-Hispanic White	57.5%	53.8%	50.9%	59.4%	57.5%	54.1%
Non-Hispanic Black	7.4%	7.6%	8.0%	6.3%	8.4%	7.8%
Non-Hispanic Native American/Alaska Native	0.5%	0.5%	0.3%	1.0%	0.7%	0.5%
Non-Hispanic Asian	2.1%	2.2%	2.3%	0.9%	2.8%	2.2%
Non-Hispanic Native Hawaiian/Other Pacific Islander	0.3%	0.2%	0.2%	0.4%	0.4%	0.3%
Multiple Race	2.2%	2.1%	1.9%	0.9%	1.5%	1.9%
Unknown/Other	1.7%	3.6%	2.5%	16.2%	1.8%	3.2%
Hispanic	28.4%	30.0%	33.8%	15.0%	27.0%	30.0%
Total	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A8 provides a breakdown of race by MCH region, with the numbers of clients, by race, in each of the 6 MCH regions. It should be noted that the total number of clients in the following tables differ from the totals discussed above. This is because some demographic data for program/service clients were submitted to the state through aggregate reporting, and it was not technically feasible to determine race/ethnicity by region for 1,815 of these children. Those children are excluded from these calculations.

TABLE A8. MCH CLIENTS SERVED (BY RACE AND ETHNICITY) IN EACH MCH REGION

MCH REGION	WHITE NON-HISPANIC	BLACK NON-HISPANIC	NATIVE AMERICAN/ ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	MULTIPLE RACES	UNKNOWN/ OTHER	HISPANIC	TOTAL
North Central	2,942	66	17	25	3	52	201	272	3,578
Northeast	5,895	1,387	76	398	39	321	176	3,728	12,020
Northwest	1,933	29	0	18	5	32	9	171	2,197
South Central	3,742	728	28	115	17	129	130	2,083	6,972
Southeast	1,550	50	20	6	18	74	48	333	2,099
Southwest	1,522	146	1	140	1	26	89	3,361	5,286
Out of State/ Unknown	126	12	2	0	1	2	12	35	190
Total	17,710	2,418	144	702	84	636	665	9,983	32,342

Table A9 below provides a breakdown with the percentages of clients, by region, for each race/ethnicity category. It is worth noting that the percentage of non-Hispanic whites in every region is higher in the general population than in the MCH client population, although those differences are much greater in some regions than others. Notably, non-Hispanic whites comprise 75.5% of the general population but only 49.0% of MCH clients. The percentage of non-Hispanic whites is much higher in the general population in South Central (75.6% in the general population compared to 53.7% among MCH Clients), Southeast (87.9% general; 73.8% MCH clients), and Southwest (49.3% general; 28.8% MCH clients).

TABLE A9. PERCENT OF MCH CLIENTS BY RACE AND ETHNICITY SERVED IN EACH MCH REGION

RACE	NORTH CENTRAL	NORTHEAST	NORTHWEST	SOUTH CENTRAL	SOUTHEAST	SOUTH-WEST	OUT OF STATE/ UNKNOWN	TOTAL
Non-Hispanic White	82.2%	49.0%	88.0%	53.7%	73.8%	28.8%	66.3%	54.8%
Non-Hispanic Black	1.8%	11.5%	1.3%	10.4%	2.4%	2.8%	6.3%	7.5%
Non-Hispanic Native American/Alaska Native	0.5%	0.6%	0.0%	0.4%	1.0%	0.0%	1.1%	0.4%
Non-Hispanic Asian	0.7%	3.3%	0.8%	1.6%	0.3%	2.6%	0.0%	2.2%
Non-Hispanic Native Hawaiian/Other Pacific Islander	0.1%	0.3%	0.2%	0.2%	0.9%	0.0%	1.1%	0.3%
Multiple Race	0.1%	0.3%	0.2%	0.2%	0.9%	0.0%	0.5%	0.3%
Unknown/Other	1.5%	2.7%	1.5%	1.9%	3.5%	0.5%	1.1%	2.0%
Hispanic	5.6%	1.5%	0.4%	1.9%	2.3%	1.7%	6.3%	2.1%
Total	7.6%	31.0%	7.8%	29.9%	15.9%	63.6%	18.4%	30.9%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The two tables below (Tables A10 and A11) show race/ethnicity of MCH clients by urban/rural classifications. The first table provides actual numbers and the second table provides percentages.

TABLE A10. THE NUMBER OF MCH CLIENTS BY RACE/ETHNICITY AMONG URBAN/RURAL CLASSIFICATIONS

RACE	URBAN	SEMI-URBAN	DENSELY-SETTLED RURAL	RURAL	FRONTIER	OUT OF STATE/ UNKNOWN	TOTAL
Non-Hispanic White	3,523	3,092	4,784	3,915	2,270	126	17,710
Non-Hispanic Black	1,662	376	301	54	13	12	2,418
Non-Hispanic Native American/ Alaska Native	24	25	56	31	6	2	144
Non-Hispanic Asian	360	151	157	33	1	0	702
Non-Hispanic Native Hawaiian/ Other Pacific Islander	24	44	7	1	7	1	84
Multiple Race	192	123	167	114	38	2	636
Unknown/Other	173	115	186	167	12	12	665
Hispanic	4,555	930	2,709	1,242	512	35	9,983
Total	10,513	4,856	8,367	5,557	2,859	190	32,342

TABLE A11. THE PERCENTAGE OF MCH CLIENTS BY RACE/ETHNICITY AMONG URBAN/RURAL CLASSIFICATIONS

RACE	URBAN	SEMI-URBAN	DENSELY-SETTLED RURAL	RURAL	FRONTIER	OUT OF STATE/ UNKNOWN	TOTAL
Non-Hispanic White	33.5%	63.7%	57.2%	70.5%	79.4%	66.3%	54.8%
Non-Hispanic Black	15.8%	7.7%	3.6%	1.0%	0.5%	6.3%	7.5%
Non-Hispanic Native American/ Alaska Native	0.2%	0.5%	0.7%	0.6%	0.2%	1.1%	0.4%
Non-Hispanic Asian	3.4%	3.1%	1.9%	0.6%	0.0%	0.0%	2.2%
Non-Hispanic Native Hawaiian/ Other Pacific Islander	0.2%	0.9%	0.1%	0.0%	0.2%	0.5%	0.3%
Multiple Race	1.8%	2.5%	2.0%	2.1%	1.3%	1.1%	2.0%
Unknown/Other	1.6%	2.4%	2.2%	3.0%	0.4%	6.3%	2.1%
Hispanic	43.3%	19.2%	32.4%	22.4%	17.9%	18.4%	30.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Insurance Status

Another demographic characteristic where the MCH population varies considerably from the general population (particularly in some regions) is insurance coverage (Tables A12 and A13). The MCH programs in South Central, Southeast, and Southwest all serve a considerably higher percentage of uninsured clients than compared to percent of uninsured in the general population of the region (SC: general 10.0% and MCH 17.3%; SE: general 10.5% and MCH 17.5%; SW: general 13.9% and MCH 23.5%). It is of significant to note that the Northeast region has an uninsured rate of 7.9% in the general population but uninsured women, infants, children and youth comprise 39.9% of clients. All regions serve a very high percentage of Medicaid/CHIP (public insurance). Individuals insured by Medicaid/CHIP ranges from 37.8% in South Central Kansas to 63.5% in the Southeast. These percentages are far higher than those for the general population, which are 9.0% among all Kansans, 7% among adults 19-64 years, and about 28% among children 0-18 years.

TABLE A12. HEALTH INSURANCE COVERAGE OF MCH CLIENTS BY REGION

MCH REGION	MEDICAID/PUBLIC	PRIVATE/OTHER	UNINSURED	UNKNOWN	TOTAL
North Central	1644	1441	269	308	3662
Northeast	4863	2158	4784	182	11987
Northwest	854	1063	203	29	2149
South Central	2638	1107	1208	2019	6972
Southeast	1333	273	368	125	2099
Southwest	2277	1757	1241	58	5283
Out of State/ Unknown	35	113	29	13	190
Total	13594	7912	8102	2734	32342

TABLE A13. HEALTH INSURANCE COVERAGE OF MCH CLIENTS BY REGION (SHOWN IN PERCENTAGES)

MCH REGION	MEDICAID/CHIP	PRIVATE/OTHER	UNINSURED	UNKNOWN	TOTAL
North Central	44.9%	39.4%	7.3%	8.4%	100.0%
Northeast	40.6%	18.0%	39.9%	1.5%	100.0%
Northwest	39.7%	49.5%	9.4%	1.3%	100.0%
South Central	37.8%	15.9%	17.3%	29.0%	100.0%
Southeast	63.5%	13.0%	17.5%	6.0%	100.0%
Southwest	42.2%	33.3%	23.5%	1.1%	100.9%
Out of State/Unknown	18.4%	59.5%	15.3%	6.8%	100.0%
Total	42.0%	24.5%	25.1%	8.5%	100.0%

Tables A14 and A15 below present insurance status by urban/rural status. The percent of MCH clients covered by private insurance is markedly lower in urban counties, while the percent of clients who are uninsured is very high in urban counties. Private insurance coverage is highest in the frontier counties.

TABLE A14. TYPE OF HEALTH INSURANCE COVERAGE BY URBAN/RURAL CLASSIFICATION

URBAN/RURAL CLASSIFICATION	MEDICAID/CHIP	PRIVATE/OTHER	UNINSURED	UNKNOWN	TOTAL
Urban	3272	820	4718	1668	10478
Semi-Urban	2117	1606	736	399	4858
Densely-Settled Rural	4253	2208	1638	311	8410
Rural	2750	1971	656	218	5595
Frontier	1167	1194	325	125	2811
Out of State/ Unknown	35	113	29	13	190
Total	13594	7912	8102	2734	32342

TABLE A15. TYPE OF HEALTH INSURANCE COVERAGE BY URBAN/RURAL CLASSIFICATION (BREAKDOWN BY PERCENTAGE)

MCH REGION	MEDICAID/CHIP	PRIVATE/OTHER	UNINSURED	UNKNOWN	TOTAL
Urban	31.2%	7.8%	45.0%	15.9%	100.0%
Semi-Urban	43.6%	33.1%	15.2%	8.2%	100.0%
Densely-Settled Rural	50.6%	26.3%	19.5%	3.7%	100.0%
Rural	49.2%	35.2%	11.7%	3.9%	100.0%
Frontier	41.5%	42.5%	11.6%	4.4%	100.0%
Out of State/ Unknown	18.4%	59.5%	15.3%	6.8%	100.0%
Total	42.0%	24.5%	25.1%	8.5%	100.0%

Data Sources

Pregnant women: In July 2016, Kansas implemented a new data system called DAISEY (Data Application and Integration Solution for the Early Years), a web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data. The data set includes data from MCH DAISEY entered directly into the system by grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) and from aggregate data reports from those MCH grantees that do not enter client-level data into DAISEY, but upload aggregate information on MCH clients and services.

Infants: Clients included in the report were identified through MCH programs including MCH DAISEY direct-entry grantees (MCH, Universal Home Visiting), MCH DAISEY non-direct entry grantees' aggregate reports, newborn metabolic screening follow-ups, critical congenital heart defects follow-ups, and newborn hearing follow-ups.

Children 1 through 21 years of age: Programs included MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management), MCH DAISEY non-direct entry grantees' aggregate reports, and children and youth with special health care needs in the Kansas Special Health Care Needs (SHCN) Program.

Children with special health care needs: CSHCN data reflects all numbers served through the Direct Assistance Programs, Care Coordination, Special Bequest, and Clinical services provided by grantees. Note: The current data system for the program is unable to break this down by age, therefore this is reflective of both children and adults served by the Kansas MCH CSHCN program. Due to the development of a new data system, program specific information will be able to be used beginning in 2020. Programs included: CSHCN in the Kansas Special Health Care Needs (SHCN) Program, MCH DAISEY direct entry grantees (MCH, Universal Home Visiting, Kansas Perinatal Community Collaborative/Becoming a Mom, Pregnancy Maintenance Initiative, Teen Pregnancy Targeted Case Management) and MCH DAISEY non-direct entry grantees' aggregate reports.

APPENDIX B: KANSAS MCH PERFORMANCE MEASURES

Introduction

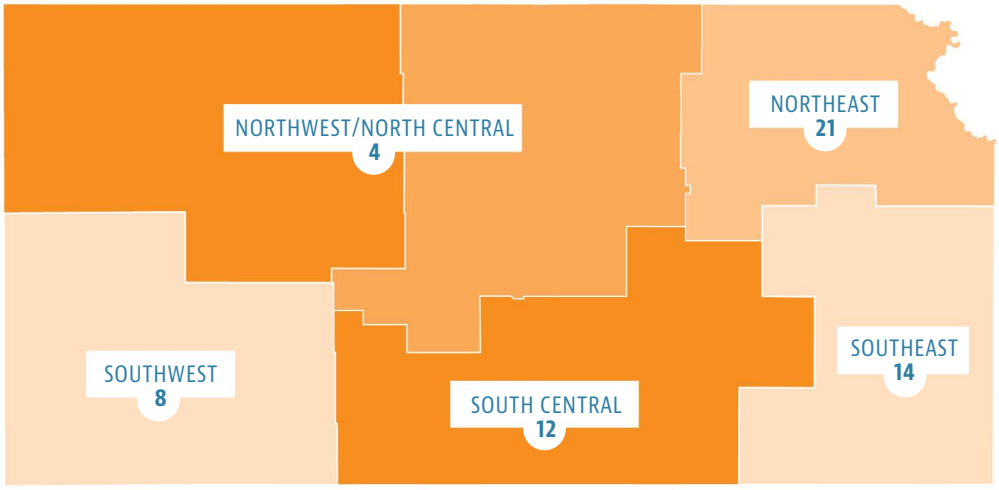
To evaluate trends in performance measure data, the Joinpoint regression program, Version 4.6.0.0 (Statistical Research and Applications Branch, National Cancer Institute) was used. By using performance measure rates/percentages as inputs, this method identifies the year(s) when a trend change is produced, it calculates the annual percent change (APC) in rates/percentages between trend-change points, and it also estimates the average annual percentage change (AAPC). If a trend in a measure changed less than or equal to 0.5% per year (-0.5% < APC < 0.5%) and the APC was not statistically significant, it was classified as "no change." If it was changing with a statistically significant APC>0, it was classified as "negative" or "positive" depending upon whether the change was in a desired direction or not and the change was significant is noted. Changes are also noted as "negative" or "positive" when there was a change either up or down of more than 0.5% per year, although this change was not statistically significant.

APPENDIX C: AID TO LOCAL APPLICATIONS AND REGIONAL MEETING SUMMARY

Introduction

As part of the Kansas 2025 MCH Needs Assessment, staff of CPPR facilitated discussions with staff from local MCH-funded programs at a series of regional Children and Families Aid to Local (ATL) meetings convened by KDHE between October 3, 2019 and November 5, 2019. Local programs funded through both MCH and Title X participated in these regional meetings (Figure C1).

FIGURE C1. NUMBER OF MCH-FUNDED PROGRAMS THAT ATTENDED REGIONAL MEETINGS



A total of 123 staff participated in the discussions.

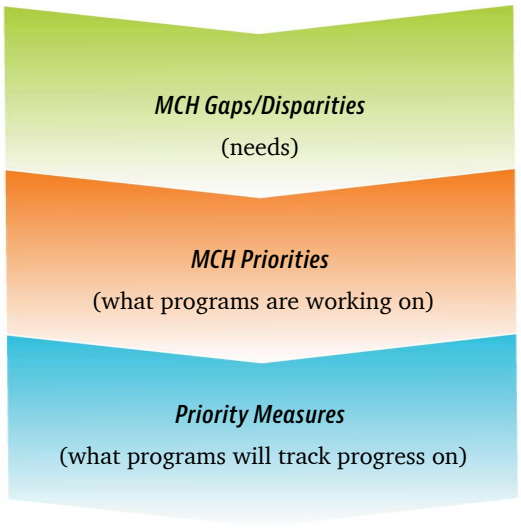
In preparation for these meetings, CPPR synthesized information from State Fiscal Year (SFY) 2020 grant applications submitted by local MCH programs to KDHE for funding through KDHE's ATL grant-making process. This report includes information gathered from these applications and from the regional meeting discussions, and is organized into three sections:

Section One describes information about issues faced by MCH programs from the programs' point of view. Information gleaned from ATL applications as well from discussion among MCH programs at the regional meetings about issues their programs are facing is summarized in this section. Specifically, four types of information were extracted from the ATL applications for this analysis.

TABLE C1.

SUBJECT	DESCRIPTION
Community Health Priorities	MCH programs were asked to list the top health priorities/needs in their community based on the most recent Community Health Needs Assessment (CHNA)
MCH Gaps/Disparities	Programs were asked to describe gaps and/or disparities related to specific MCH needs that had been identified in their communities
MCH Priorities	Programs were asked to describe the MCH priorities that their programs would work to address in SFY 2020
Priority Measures	Programs were asked to select the MCH performance measures that their programs would work on – and track -- in 2020 (programs were required to select at least one measure from each domain)

Information was summarized by region for discussion at each of the six regional meetings, which are described in more detail later in this report. These discussions were essentially centered around the degree to which information in the application "matched" what programs feel are current priorities and what they currently are doing, as well as the degree to which there are appropriate connections between needs and services. Ideally, there would be a "logic model" relationship among these various elements:



In reality, however, perfect alignment of these factors does not always happen. There are legitimate reasons for lack of alignment, but when there is a lack of alignment it does create an opportunity to explore "why" and evaluate the opportunity for improvement.

Section Two: information gathered from local MCH programs about the support provided to them by the state MCH program in the Bureau of Family Health at KDHE.

Section Three: some of the "bright spots" in MCH services provided across the state, based on discussions of the MCH programs at the regional meetings.

Note: Some of the data in this report are reported at the regional level. See ***Figure 1 on page 27*** to view the MCH region map.

TABLE C2.

REGION	GRANTEES	COUNTIES
North Central	11	15
Northeast	18	23
Northwest	3	3
South Central	11	11
Southeast	13	15
Southwest	12	18
Total	**68**	**85**

Section One: Community Health and MCH Needs

Community Health Priorities

Applicants for MCH funding through the Aid to Local process were asked to list the public health priorities for their community/region that were identified in their most recent Community Health Needs Assessment (CHNA). CHNA refers to a local, tribal, or statewide health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. The goal of a CHNA is to utilize community engagement and a collaborative process among broad community stakeholders to inform the development of strategies that address the community's health needs and identified issues. These strategies are generally included in a Community Health Improvement Plan that is informed by the CHNA. CHNAs are required of public health agencies seeking accreditation by the Public Health Accreditation Board (PHAB).

There were 68 ATL applications for MCH funding reviewed as part of this report. While there were many common issues identified among those 68 applications, there were only three issues that were cited in CHNAs in every region of the state:

- Mental Health by 50% (34/68) of programs
- Substance Abuse by 43% (29/68) of Programs
- Obesity by 41% (28/68) of programs

There were another five topics that were noted in at least one CHNA in 5 of 6 regions:

- Access to Health Care by 31% (21/68) of programs
- Chronic Disease by 28% (19/68) of programs
- Tobacco Use by 18% (12/68) of programs
- Prevention and Health Education by 13% (9/68) of programs
- Children's Health by 10% (7/68) of programs

In addition to those topics consistently cited statewide, there were several issues that were particularly prevalent in one region or another. Issues frequently cited in one region (defined as being cited in 25% or more of a region's CHNAs) were:

TABLE C3.

REGION	ISSUE FREQUENTLY CITED	PREVALENCE IN REGION BY NUMBER OF COUNTIES	PREVALENCE IN REGION BY PERCENTAGE OF COUNTIES
North Central	Communication/collaboration among health providers	3/11	27%
Northeast	Access to healthy food	7/18	39%
Northwest	Assisted living/housing for elderly	1/3	33%
Southwest	Affordable health insurance	3/12	25%
South Central	N/A (no other "high prevalence" issues)	N/A	N/A
Southeast	N/A (no other "high prevalence" issues)	N/A	N/A

TABLE C4: HEALTH PRIORITIES IDENTIFIED IN CHNAS BY KDHE MCH REGION

PRIORITY ISSUES	STATEWIDE	NORTH CENTRAL	NORTH EAST	NORTH WEST	SOUTH CENTRAL	SOUTH EAST	SOUTH WEST
Mental Health	34	6	12	1	6	6	3
Substance Abuse	29	5	10	1	4	4	5
Obesity	28	4	8	1	4	7	4
Access to Health Care	21	5	6	0	3	2	5
Chronic Disease	19	6	1	0	3	7	2
Tobacco Use	12	1	6	0	2	2	1
Access to Healthy Food	11	1	7	0	0	1	2
Prevention and Health Education	9	2	1	0	1	3	2
Access to Dental Care	8	2	3	0	0	1	2
Affordable Housing	8	1	4	0	0	2	1
Children's Health	7	1	2	1	1	2	0
Access to Specialists	6	1	0	0	2	1	2
Affordable Health Insurance	6	1	0	0	3	0	2
Promoting Healthy Lifestyles	6	1	0	0	2	1	2
Violence Prevention	5	1	2	0	2	0	0
Communication/Collaboration among Health Care Providers	4	3	0	0	0	1	0
Education/Awareness about Resources and Services	4	0	3	0	1	0	0
Aging Population	3	2	0	0	1	0	0
Access to Physical Activity	3	0	3	0	0	0	0
Access to Women's Healthcare	3	1	1	0	1	0	0
Assisted Living/Housing for Elderly	3	1	1	1	0	0	0
Child Care	3	1	2	0	0	0	0
Teen Pregnancy	3	0	1	0	0	1	1
Infant Death	3	0	1	0	2	0	0
Transportation	3	0	3	0	0	0	0
Elder Care	2	1	0	0	0	0	1
Sexually Transmitted Infection	2	1	0	0	1	0	0
Trauma/Falls	1	1	0	0	0	0	0
Creating Strong Families	1	0	0	0	0	0	1
Breastfeeding	1	0	1	0	0	0	0
Health Care Coordination	1	0	0	0	1	0	0
Premature Birth	1	0	1	0	0	0	0
Low Birthweight	1	0	0	0	1	0	0
Language barriers	1	0	1	0	0	0	0

Gaps and Disparities Experienced by MCH Populations

In addition to asking about the broad context of community health needs, MCH applicants were asked to describe gaps and/or disparities related to specific MCH needs that had been identified in their communities. A summary of responses is presented in Table C5.

It is worthwhile noting that some issues cited as gaps and/or disparities are not issues prominent in CHNAs of Kansas communities. A number of MCH programs see disparities in access to women's health care, access to dental care, and language barriers even though these issues are not frequently noted as issues of greatest global public health concern in CHNAs around the state.

Importantly, however, there are notable consistencies. Mental health and substance abuse were the most frequently cited issues both as MCH disparities and community health needs, demonstrating clearly the recognition of Kansas communities regarding of the importance of behavioral health in overall health, and the need to systemically address barriers to quality behavioral health services. Access to health care and tobacco use were two other issues that were frequently cited both as broad community health priorities as well as observed gaps specifically for MCH populations across the state.

There were several issues cited as gaps/disparities that were not frequently included in CHNAs across the state but that appeared frequently (>25%) in one of more regions. Access to healthy food was cited as a gap/disparity in Southwest Kansas by 25% (3/12) of programs. Breastfeeding was cited as another area where there was a gap in Southwest Kansas by 25% (3/12) of programs and in Northwest Kansas by 33% (1/3) of programs. Northwest Kansas also cited affordable housing, language services, and child care as gaps/disparities in 33% (1/3) of their programs.

TABLE C5: MCH GAPS/DISPARITIES BY KDHE MCH REGION

PRIORITY ISSUES	STATEWIDE	NORTH CENTRAL	NORTH EAST	NORTH WEST	SOUTH CENTRAL	SOUTH EAST	SOUTH WEST
Mental Health	24	4	11	1	4	4	2
Substance Abuse	12	3	3	0	1	5	1
Access to Women's Healthcare	9	1	4	0	1	3	5
Tobacco Use	9	3	4	0	0	2	2
Access to Health Care	8	1	5	0	1	1	4
Access to Dental Care	5	1	2	0	2	0	2
Affordable Housing	5	1	2	1	0	1	0
Obesity	5	1	1	0	1	2	1
Promoting Healthy Lifestyles	5	0	2	0	1	2	0
Violence Prevention	4	2	1	0	1	0	0
Creating Strong Families	4	0	2	0	0	2	1
Language Barrier	4	0	0	1	2	1	2
Access to Healthy Food	3	1	1	0	0	1	3
Access to Specialists	3	2	0	0	0	1	0
Affordable Health Insurance	3	0	2	0	1	0	2
Child Care	3	1	1	1	0	0	0
Children's Health	3	2	0	0	1	0	0
Breastfeeding	3	0	0	1	0	2	3
Premature Birth	3	1	1	0	1	0	0
Infant Death	3	0	2	0	1	0	0
Education/Awareness About Resources and Services	2	1	0	0	1	0	0
Low Birthweight	2	0	1	0	1	0	0
Physical Activity	1	0	1	0	0	0	2
Chronic Disease	1	0	0	0	0	1	1
Prevention and Health Education	1	1	0	0	0	0	1
Teen Pregnancy	1	0	1	0	0	0	1
Adolescent Services	1	0	1	0	0	0	0

Maternal and Child Health -- Identified Priorities

In their ATL applications, MCH applicants also were asked to describe the MCH priorities that their programs would seek to address in SFY 2020. Table C6 provides information on how many programs identified specific issues. The number in each cell indicates the number of programs citing the priority in their SFY 2020 Aid-to-Local grant application for MCH funding.

Access to women's health care was cited by 50% (34/68) MCH programs in their SFY 2020 applications, more than any other issue. It was also the only issue cited by at least 25% of programs in each of the six MCH regions of the state.

Mental health was the next most frequently cited issue, included as an MCH priority issue by 38% (26/68) MCH programs. It was a priority issue in every region except the Northwest region.

Children's health and tobacco use were both cited by 35% (24/68) MCH programs as an MCH priority.

Other MCH priorities cited by more than 10 programs were breastfeeding, substance abuse, access to healthy food, and physical activity.

Other issues appeared to be important to specific regions, although not cited by high percentages of programs statewide. Issues cited by at least 25% of programs in a region (in addition to those already mentioned) included:

- Creating Strong Families by 33% (1/3) of programs in Northwest Kansas
- Health Care Coordination by 36% (4/11) of programs in North Central Kansas, and by 67% (2/3) of programs in Northwest Kansas
- Affordable Health Insurance by 36% (4/11) of programs in South Central Kansas
- Infant Death by 27% (3/11) of programs in South Central Kansas

Alignment of Public Health and MCH Priorities

In general, MCH applications seem to suggest that public health and MCH priorities are conceptually well-aligned in communities across the state. Mental health is clearly front-of-mind when it comes to improving the health of Kansans. Mental health is cited in more CHNAs than any other issue. Gaps in mental health services are of concern to MCH programs statewide, and MCH programs cited mental health as a priority for their program more than any other issue except access to women's health services.

Substance abuse is also a broad public health concern as well as priority topic for MCH programs. The concern manifests itself somewhat differently in communities across the state, but abuse of alcohol, drugs (including methamphetamines and opioids), and tobacco are all public health -- and MCH -- concerns in Kansas.

Access to health care is another broad concern in the Kansas public health community. Among MCH programs this concern manifests itself as the most frequently-cited MCH priority among local programs. Child health is also cited by many MCH programs.

Another group of top MCH priorities (breastfeeding, access to healthy food, physical activity) are not as frequently cited in CHNAs, but they are topics that impact obesity, which is an overarching issue of public health concern statewide.

TABLE C6: MCH PRIORITIES BY KDHE MCH REGION

PRIORITY ISSUES	STATEWIDE	NORTH CENTRAL	NORTH EAST	NORTH WEST	SOUTH CENTRAL	SOUTH EAST	SOUTH WEST
Access to Women's Healthcare	34	8	7	2	4	8	5
Mental Health	26	3	10	0	5	4	4
Children's Health	24	3	8	1	2	5	5
Tobacco Use	24	4	8	1	5	4	2
Breastfeeding	16	2	5	0	2	3	4
Substance Abuse	13	4	5	0	3	1	0
Access to Healthy Nutrition	11	2	3	0	2	2	2
Physical Activity	11	1	4	0	0	2	4
Creating Strong Families	10	0	2	1	2	3	2
Prevention/Health Education	8	0	2	0	0	2	4
Health Care Coordination	7	4	1	2	0	0	0
Developmentally appropriate care/ Services across Lifespan	6	1	0	0	1	2	2
Adolescent Services	6	2	2	0	1	0	1
Access to HealthCare	5	0	2	0	1	1	1
Affordable Health Insurance	5	0	1	0	4	0	0
Promoting Healthy Lifestyles	5	1	1	0	1	0	2
Premature birth	5	1	2	0	2	0	0
Teen Pregnancy	4	0	1	0	2	0	1
Infant Death	4	1	0	0	3	0	0
Low Birthweight	3	1	1	0	0	1	0
Affordable Housing	2	0	0	0	2	0	0
Violence Prevention	2	0	0	0	2	0	0
Access to Dental Care	1	0	1	0	0	0	0
Child Care	1	1	0	0	0	0	0
Obesity	1	0	1	0	0	0	0

MCH Program Work in 2020

In their ATL applications, MCH applicants also were asked to select MCH priority measures that their programs would work on – and track -- in 2020. Table C7 provides information on how many programs indicated they would track a given performance measure in the 2020 grant year. There were 8 areas that were chosen by more than 50% of local MCH programs which mapped to the following MCH domains:

Woman/Maternal	*Perinatal/Infant*	*Child*	*Adolescent*
Well-woman visit	Breastfeeding	Developmental screening	Adolescent well visit
Smoking during pregnancy/ Household smoking	Safe sleep	Child injury	
Preterm birth			

TABLE C7: MCH PRIORITY MEASURES BY KDHE MCH REGION

PROGRAM	STATEWIDE	NORTH CENTRAL	NORTH EAST	NORTH WEST	SOUTH CENTRAL	SOUTH EAST	SOUTH WEST
Smoking Pregnancy	52	8	11	3	9	12	9
Breastfeeding	51	8	12	3	8	10	10
Developmental Screening	37	6	11	1	7	7	5
Preterm Birth	30	4	9	3	6	6	2
Safe Sleep	29	4	8	1	7	5	4
Well Woman Services	28	5	7	2	5	4	5
Adolescent Well Visits	26	4	6	2	6	3	5
Child Injury	25	5	6	2	5	2	5
Other Adolescent	22	3	7	0	3	4	5
Child Physical Activity	18	4	5	1	3	2	3
Other Perinatal Infant	18	6	6	0	1	3	2
Other Woman	17	1	6	0	4	3	3
Medical Home	9	1	4	1	1	1	1
Other Child	8	1	5	0	0	1	1
Other CSHCN	6	0	2	1	0	2	1

MCH Priorities and Local MCH Program Work Alignment

Comparing MCH priorities (Table C6) and priority measures MCH programs reported they would work on in SFY 2020 (Table C7), there are some areas of close alignment. The most frequently cited activity by MCH programs is tobacco cessation during pregnancy, which aligns with the also-frequently cited MCH priority of tobacco use. Breastfeeding is another top MCH priority where many MCH programs also are carrying out programmatic work. There are several categories of activity that align with the MCH priority of access to women's health care, including programmatic efforts to reduce pre-term birth, provide well-woman services, and provide other maternal health services. The highly-cited priority of children's health appears to be addressed by many MCH programs through activities including developmental screening, safe sleep initiatives, efforts to reduce child injury, and efforts to promote physical activity among youth.

It is less clear how MCH programs are seeking to address other MCH priorities, however. This may not be because these programs are not addressing them, because the section in the ATL application is a "checkbox" section based on MCH performance measures, and three top MCH priority areas (mental health, substance abuse, healthy food) are not included in the HRSA performance measure set. However, while there was much discussion among MCH programs at the regional meetings (discussed next) regarding concerns about these issues, it is still not entirely clear how these concerns are being addressed broadly by MCH programs across the state.

Public Health and MCH Needs -- Regional Meeting Discussion

During facilitated discussions at the five regional meetings, the data pulled from MCH applications were shared with all participants, who were then asked to discuss a series of questions in small groups (generally 3-4 people) followed by larger group discussion. The questions were:

- What, if anything, resonates with you in this information? What is consistent with your experience?
- What surprises you among the priorities and identified disparities/gaps cited by MCH programs around the state?
- Is anything missing? Participants were asked to reflect on changes they have witnessed in the recent years, including emerging issues, and to highlight issues not noted in the tables.
- What challenges make your work difficult?
- What needs in your community required immediate attention moving forward?

Discussion at all regional meetings reinforced many of the MCH priorities highlighted in ATL applications, specifically the issues of:

An increase in mental health needs and the lack of mental health services. Participants cited long waits to receive mental health services. Community Mental Health Centers were mentioned as a community resource, but in general there was recognition that these centers do not have sufficient resources to meet all community needs. People lacking health insurance have particular difficulty gaining access to affordable mental health care. Several participants mentioned the high Adverse Childhood Experience (ACE) scores seen in their communities, and how ACEs contributes to mental and behavioral issues and the need for more trauma informed services in their communities to combat this.

Use/abuse of tobacco products and controlled substances. One specific concern cited on multiple occasions was increased vaping among adolescents. Another was high rates of tobacco use by pregnant and postpartum mothers, and parents. Easy access to controlled substances is another problem that appears ubiquitous across regions.

Access to health care. Barriers to health care are many, but themes universal across regions were:

- Transportation. Many MCH clients throughout the state have limited access to health care due to the lack of public transportation in their region. In addition to being a barrier to services, lack of transportation leads to social isolation and limited social connections.
- A lack of continuity of care, which is often the results of a lack of collaboration among health care, public health and social service agencies. A couple of specific examples came up multiple times during the regional meetings. One concern was decreasing referrals from hospital to home visiting services, particularly in communities that have lost a hospital or where the hospital was no longer providing birthing services. This issue also was brought up by programs in communities where the hospital management has shifted to a larger hospital system, sometimes resulting in policy changes that were seen as barriers to referrals. Another issue that was discussed in several regions was the need to coordinate home visiting (HV) services between the various agencies offering HV. Several programs indicated that clients were confused about various home visiting models. One participant explained that when they showed up at a home, the family had recently had a Parents as Teachers (PAT) representative at the home, and the family didn't understand that this home visitor provides different services than PAT. Several participants commented on how essential it was for there to be cooperation between agencies offering preventive, primary, and mental and health care to ensure coordinated "wraparound" services for clients. Unfortunately many participants report this level of collaboration is not happening in their communities.
- Fear among immigrant families to seek services due to concerns about immigration and customs enforcement. MCH providers note many young immigrant mothers are not seeking prenatal services, WIC or other health services for themselves or their children.
- Shortages of translation services and foreign-language educational information in communities with large immigrant populations. Many providers expressed interest in Becoming a Mom (BaM) materials being offered in Spanish. While availability of Spanish translators and materials was a concern nearly "across the board," many participants also expressed difficulty providing translation services given the growing diversity of languages seen among their client populations.
- Shortages of nurses, primary care physicians, mental health providers and dentists. Many rural areas have clients that need to travel out of their county to receive OB/GYN services and to deliver their babies. This leads to lack of communication between delivering hospitals and local Health Departments. Because of this, many clients are said to not receive HV services they are entitled to.
- Multiple barriers to utilization of home visiting services, including:
    - Difficulty in following up with families because of changing contact information;
    - Reticence on the part of families to allow home visitors into home; several programs said they had overcome this through various means, however, principally using licensed nurses (the perceived professionalism of nurses apparently gave a sense of comfort and confidence to families) and using individuals who were "from the community" and were therefore trusted;
    - Decreasing referrals from hospitals (as described above under Coordination of Care).

- Affordability. Many mothers and fathers do not have the necessary financial means to access preventive care or other basic healthcare needs. Parents in poverty often forgo taking care of their own health issues in order to afford housing and food for their children (and even then, the only affordable housing for some is in unsafe neighborhoods and/or in poor condition, and the most affordable foods are often those with poor nutritional value). Affordable health insurance is often not available, even if one or more parents are working.

Child care availability was also brought up as a concern at all regional meetings. Specifically mentioned by many was the lack of infant care. A number of participants shared stories about licensed child care providers shuttering their doors in recent months, and in several regions there were discussions about months-long waiting times for people to get their young children into a daycare provider. These discussions happened before the COVID pandemic, which has exacerbated challenges associated with child care for many families.

Many regions also expressed the need for more adolescent services. A number of participants expressed interest in providing more sex education and relationship building skills classes in local schools. In several regions participants did indicate that there is a lack of interest to outright opposition among many community stakeholders to reproductive health education.

Conclusions – Public Health and MCH Issues

The needs of those who seek Maternal and Child Health services in the state of Kansas is consistent with the growing recognition in public health and other health disciplines about the impact social determinants (where people work, live, and play) have on the health of the families served by the MCH system and the broader public health system. It is important that MCH programs not only strive to provide access to quality MCH services, but that they are integrally involved in community-based discussions and efforts to impact policies and systems to improve community conditions to enhance health. Specifically, issues highlighted consistently across Kansas were:

- Growing concern about mental health and the lack of services to treat mental health conditions
- Substance abuse, including;
    - Controlled substances such as opioids
    - Methamphetamines
    - Tobacco (where issues of greatest concern are tobacco use among pregnant women and increased prevalence of vaping among adolescents)
- Obesity, and related areas (breastfeeding, access to healthy food, physical activity)
- Affordability of services, and in general the concern of the impact of poverty on quality of life due to challenges associated with the ability to secure safe housing, quality child care, good food, as well as health insurance and health care

Section Two: State Support of Local MCH Programs

After discussion of broad MCH priorities, discussion at regional meetings turned to a series of questions about support provided to local MCH programs by the state MCH program in the Bureau of Family Health (BFH) at the Kansas Department of Health and Environment. Questions were in three general categories:

- The Aid-to-Local (grant application) process
- Data collection
- General program support from the BFH

Aid-to-Local (ATL)

MCH funding is distributed to local agencies through a competitive grant process. KDHE distributes MCH funding to local programs through two different Aid-to-Local applications:

- Maternal and Child Health (MCH). MCH grants promote the development of local systems of health care to improve the health and well-being of mothers, infants, children and youth, including those with children with special health care needs (CSHCN), and their families.
- Special Health Care Needs (SHCN). SHCN grants fund programs that ensure cross-system care coordination, support family caregiver health, promote behavioral health integration, provide training and education, and that address a specific community or CSHCN-population need or provide gap-filling services to CSHCN.

MCH programs were asked to discuss what was working well in the ATL process as well as ideas for improving the process. Aspects of ATL that were highlighted as working well included:

- A shortened, streamlined application process (there was universal belief the application has improved substantially)
- The revised program reporting requirement (now twice a year as opposed to quarterly)
- One-on-one support through the application process from state staff
- A new grants management system (Kansas Grants Management System) that is a major improvement over the previous system (Catalyst)

Areas for the improvement of ATL that came up in the majority of the regional discussions:

- Continue to make the application process and reporting less resource-intensive
- More direct assistance is needed to assist applicants with budget information (this is still a complicated process)
- Kansas Grants Management System could still be made easier to navigate for applicants

Data Systems

MCH grantees use Data Application and Integration Solutions for the Early Years (DAISEY), a shared measurement system designed to help communities see the difference they are making in the lives of at-risk children, youth and families. Implementation of a shared measurement system allows the Kansas Department of Health and Environment (KDHE) Bureau of Family Health and their grantees to improve data quality, track progress toward shared goals, and enhance communication and collaboration.

What was shared as working well with DAISEY was:

- DAISEY provides good reporting that allows programs to quickly run reports on:
    - Number of clients served
    - Number and type of services provided
- Reports can help analyze program trends, to see areas of high performance and areas for improvement;
- DAISEY reports are easy to run on a monthly or quarterly basis, and some grantees share reports with stakeholders and key community decision- and policy-makers

Areas for improvement that were suggested included:

- Improved support by both phone and email; one common theme was confusion about "who has answers," as some organizations felt like they were caught between KDHE and CPPR when trying to get answers about use of the system
- Combining multiple forms into one (or at least less) forms; there was frustration expressed about the need to enter the same information on multiple forms during one client visit and an overall sense that reporting burden is too great

Program Support from KDHE

Positive themes that were cited frequently across the regional meetings were:

- The webinars/ trainings/zoom calls offered by KDHE are helpful
- KDHE staff are very responsive to grantee inquiries and needs, and in general MCH staff have good rapport with sites
- KDHE willingness to hold conference calls with individual programs is greatly appreciated

Areas for improvement suggested consistently at the regional meetings:

- Programs would like to see more webinars for general training, and they would like webinars to be recorded so that they do not have to be watched the one time they are provided
- Programs would like more face-to-face time with BFH staff and would like onsite visits
- While programs felt BFH staff were very helpful, there were some reported delays in answering emails that respondents felt are problematic
- Some concern was expressed about the amount of turnover at KDHE, although there was nearly universal appraisal that "current staff are great."

Conclusions – State Support

Local MCH programs around the state were appreciative of the support provided by the state, and also feel that efforts are being made to continuously improve support and the broad state MCH system. On-going changes to streamline MCH grant application and reporting were applauded. Increased general training provided in a flexible format were requested across regions. Data collection could be expedited by changes in DAISEY by combining or streamlining forms.

Section Three: Bright Spots in MCH Services in Kansas

During the regional meetings, programs were able to discuss how they overcame some of the challenges they are facing, and offered some "bright spots" they have experienced in service to their communities. Some successes that were shared addressed some of the broad public health and MCH priorities highlighted in this report.

Mental Health

People who have experienced abuse, neglect and other adverse childhood experiences (ACEs) such as living with domestic violence during their childhood are at much greater risk of mental illness throughout life. Therefore, efforts to address ACEs are an effective public health strategy to improve prevention of mental illness. Several MCH programs mentioned that they have provided ACEs training to staff as well as community partners as a first step in combating a perceived increase in clients who exhibit high ACE scores.

Screening for mental health conditions is also an important evidence-based practices, and MCH programs in several regions noted that postpartum depression and intimate partner violence screening rates are increasing in their areas.

Obesity Prevention

There are many benefits to breastfeeding, including a lower risk of obesity among breastfed babies. It was positive to hear during several regional discussions that many programs are seeing increase in breastfeeding initiation rates. Some programs also indicated they had seen increases in duration of breastfeeding, while other programs indicated this was still an area for improvement.

Prevention and Health Education

Since 2010 Kansas has promoted a perinatal community collaborative education model utilizing the Becoming a Mom/Comenzando bien® (BaM/Cb) curriculum to address birth disparities primarily among low-income, minority women who are eligible for Medicaid. This program covers a variety of topics in order to promote healthy pregnancy including nutrition, tobacco and substance use, and others. It also integrates early care including breastfeeding, safe sleep, etc. A number of programs indicated they have integrated BaM/Cb into their MCH programs, and some of these programs indicated they have been seeing substantial increases in enrollment.

A number of programs highlighted partnership with community-based agencies and area businesses to hold community baby showers for expectant mothers. Baby showers provide an opportunity to create awareness of available services, and to open doors to educational offerings.

Access to Health Care

One success highlighted by several programs was improved access to prenatal care for undocumented, expectant mothers secured by collaboration between health departments and local Ob/Gyn physicians.

Overall Conclusions

Examination of public health and MCH priorities through guided discussion at Children and Families ATL meetings (sponsored by the Kansas Department of Health and Environment, the home of the Kansas MCH program) provided valuable insight into needs of MCH programs, and their clients, in the State of Kansas. Findings from these discussions suggests a high degree of common need around the state in important areas of mental health, substance abuse, obesity and chronic disease, and access to care.

It was also clear from these discussions that there are barriers shared by many MCH clients when it comes to achieving good health. Cultural and language barriers, transportation, access to health care, and affordability of services were all discussed across all regions. The inability of many clients to afford care, and to afford basic human needs (food, housing, child care) was also discussed in every region. In rural communities particularly, access to care was a great concern, with concern shared about the loss of primary care and other providers (and growing difficulty accessing obstetrical services highlighted as a specific concern).

There are many positive things happening around the state, and notable "bright spots" in the state's MCH system. There are also areas with the potential to receive more focused attention. Three areas of potential concern are:

- **Mental health.** It is not clear how universally MCH programs are working with partners to address concerns about increasingly mental health needs of the populations served by MCH programs.
- **Substance abuse.** While substance abuse was a frequently noted local public health priority, and substance abuse services were also cited as gaps by many MCH programs, there was little discussion in MCH applications nor at the regional meetings as to how MCH programs would seek to address these issues.
- **Obesity.** While obesity is noted as a significant public health and MCH concern in the state, there was also limited mention of MCH involvement in strategies to address healthy eating outside of efforts to promote breastfeeding. It is also not clear the role MCH programs are playing in promoting physical activity in their target populations.

Although many programs indicated they would work on -- and track -- developmental screening, preterm birth, adolescent well visits, and child injury, there was also limited discussion about how programs would seek to address these issues. Finding solutions to "social determinants" that are contributing to poor health outcomes is not the purview of MCH providers alone, as the root causes of many of these community concerns are disparities in social determinants of health such as housing, child care, employment, and other factors that require broad-based policy, system and environmental solutions. However, these discussions highlight the utility of a broad examination of the MCH system – at the state and local levels – to understand how the system can help address, in the most effective way possible, barriers to optimal health including community-based social determinants of health.

APPENDIX D: KANSAS MCH WORKFORCE DATA

Introduction

MCH program efforts to implement core public health functions are highly dependent on a appropriately-sized and skilled workforce, so as part of the MCH Needs Assessment efforts were undertaken to develop a detailed profile of Kansas' MCH workforce. The assessment including gathering information on the number, location and full-time equivalents of state and local MCH staff; and detailed demographic information such as age, gender, ethnicity, race, and language. Information on MCH competencies from two secondary data sources was also examined. Some of information comes from the Public Health Workforce Interests and Needs Survey (PH WINS) managed by the Association of State and Territorial Health Officials, which also has additional information on staff satisfaction and motivation. Information from PH WINS is included later in this Appendix. Additional information on MCH Staff competencies came from MCH Navigator, a self-assessment coordinated by the National Center for Education in Maternal and Child Health. The MCH Navigator report is included separately in Appendix E.

Methodology

Each MCH-funded program in Kansas was asked to provide a completed workforce demographic table for staff employed as of July 1, 2019. Tables were initially developed for each program by CPPR staff using information provided in SFY 2020 Aid to Local Applications. Each table was then distributed to the appropriate MCH program director/coordinator to validate the information for their program and to collect additional demographic information. There were a total of 658 staff identified through this analysis. The goal of the effort was to develop a comprehensive and complete data set, but incomplete information was collected for many demographic variables. FTE data were collected for 550 staff. In some cases programs reported based on FTEs, while in other cases hours were provided. In those cases where hours were provided an FTE was calculated based on a standard work year of 2080 hours. Many findings are presented based on the following categorizations:

- Geographical regions as defined by KDHE: Northwest, North Central, Northeast, Southwest, South Central, Southeast. There is also a category for employees who provide services to regions across the state or are employed at the state MCH program (statewide positions).
- Population peer groups as defined by KDHE urban/rural classifications: urban, semi-urban, densely-settled rural, rural, frontier. This also includes a category for employees who provide services to regions across the state (statewide positions).
- MCH program type: KDHE staff, CSHCN, MCH, PMI, TPTCM, and LYFTE. Some breakdowns also include Family Advisory Council members, who are considered key contributors to the state MCH program.
- Key position types: administrative, agency administrator/director, agency manager/director, breast-feeding peer counselor/educator, case manager/care coordinator/navigator, clinical nurse, dietitian/nutritionist, home visitor, interpreter/translator, MCH program director/coordinator/supervisor, physician/medical director, social work/counselor, state MCH program staff, FAC member, and other.
- Home visiting classification: employee does or does not provide home visitation.
- Interpretation classification: employee does or does not provide interpretation services.

The PH WINS data were provided in the form of data tables (all presented here) provided to Kansas by the de Beaumont Foundation from the 2017 PH WINS. The data tables were received on November 11, 2019. All state health agencies and member agencies of the Big City Health Coalition are invited to participate in PH WINS. Additionally, a random national sample of local health departments (excluding small local health departments with fewer than 25 staff or serving a population of fewer than 25,000 people) were invited to participate. Participating agencies provided ASTHO with a contact list of employees to receive the survey, and the survey was fielded between September 2017 and January 2018. PH WINS identifies respondents by the type of public health program area, so findings could be specifically examined for the MCH workforce population. The definition used in the PH WINS survey for Maternal and Child Health included staff who identified as MCH, family planning, WIC, and/or immunization program (this is a broader definition than employed in the other workforce analyses that are part of this needs assessment). The de Beaumont Foundation provided aggregate data for staff identified as part of the Kansas MCH workforce, which included 335 respondents (12% from the state health agency and 88% from local health departments).

Results

Numbers of Positions and FTEs

As noted above, FTE information is available for 550 of the 658 MCH position in Kansas, which represents 84% of the MCH staff positions in the state and comprises approximately 160 FTEs. If the average FTE of these 550 positions (average FTE = 0.29) is extrapolated across all 658 positions, there would be an estimated 192 FTEs in funded MCH programs serving the women, infants, children, and youth in the state of Kansas.

Of the total 658 MCH positions statewide, 450 positions (approximately 104 FTEs) were employed in local MCH programs (see table below). The state MCH program has 18.5 FTEs, with 6.5 of these focused on the CSHCN program. Other types of programs funded through MCH have far fewer full-time equivalent staff positions.

TABLE D1. TOTAL NUMBERS OF POSITIONS AND FTES BY MCH PROGRAM TYPE

PROGRAM	TOTAL POSITIONS	TOTAL FTES*
State Program Staff	12	12
State CSHCN Program Staff	7	6.5
Local MCH Programs	450	103.8
CSHCN Satellite Offices	15	2.3
CSHCN	34	5.8
PMI	67	13.6
TPTCM	55	10.6
LYFTE	18	5.5
TOTAL	**658**	**160.3**

The following table shows how these positions are distributed by primary position type. The most FTEs are found in clinical nursing (25.3 FTEs), home visiting (18.5 FTEs), and administration (15.2 FTEs). The "administrative" category includes administrative support positions (clerical staff, billing/fiscal staff, etc.) but does not include leadership roles such as public health agency administrators/directors, department managers, and MCH directors/coordinators; these leadership positions collectively comprise another 21.3 FTEs.

TABLE D2. NUMBER OF POSITIONS AND FTES BY POSITION TYPE (MCH PROGRAM ONLY)

POSITION TYPE	NO HOURS/ MISSING DATA	TOTAL POSITIONS	TOTAL FTES
Administrative	29	124	15.2
Agency Administrator/Director	7	68	8.3
Agency Manager/Supervisor	5	33	4.5
Breastfeeding Peer Counselor/Educator	3	9	1.3
Case Manager/Care Coordinator/Navigator	2	45	25.2
Clinical Nurse	13	127	26.5
Dietitian/Nutritionist	6	11	1.3
Home Visitor	0	59	18.8
Interpreter/Translator	6	15	1.9
MCH Program Director/Coordinator/ Supervisor	4	42	15.4
Physician/Medical Director	8	14	2.2
Social Work/Counselor	7	29	8.7
State MCH Program Staff	0	19	18.5
Other	18	63	12.4
Total	**108**	**658**	**160.3**

Examining the distribution of the MCH workforce geographically across the state, (see tables below), these professionals are unequally distributed across regions and urban/rural communities. For example, both of the more heavily-populated regions (Northeast and South Central) have a lower percentage of funded MCH staff compared to the total MCH population in those regions. This is also reflected in the table that shows a lower percentage of FTEs in urban counties compared to those counties' MCH populations.

TABLE D3. MCH WORKFORCE DISTRIBUTION BY REGION

REGION	NO. OF POSITIONS	% OF POSITIONS	NO. OF FTES	% OF FTES	% OF MCH POPULATION
Northwest	35	5.3%	4.7	2.9%	2.5%
North Central	53	8.1%	10.1	6.3%	4.2%
Northeast	189	28.7%	54.3	33.9%	51.7%
Southwest	68	10.3%	14.4	9.0%	5.5%
South Central	165	25.1%	29.9	18.7%	29.5%
Southeast	95	14.4%	22.6	14.1%	6.5%
Statewide	53	8.1%	24.3	15.2%	N/A
TOTAL	**658**	**100.0%**	**160.3**	**100.0%**	**100.0%**

TABLE D4. MCH WORKFORCE DISTRIBUTION BY URBAN/RURAL COMMUNITIES

REGION	NO. OF POSITIONS	% OF POSITIONS	NO. OF FTES	% OF FTES	% OF MCH POPULATION
Urban	147	22.3%	51.8	32.3%	58.4%
Semi-urban	116	17.6%	36.0	22.5%	15.4%
Densely-Settled Rural	174	26.4%	24.8	15.5%	15.1%
Rural	115	17.5%	16.0	10.0%	8.0%
Frontier	53	8.1%	7.3	4.6%	3.1%
Statewide	53	8.1%	24.3	15.2%	N/A
TOTAL	**658**	**100.0%**	**160.3**	**100.0%**	**N/A**

MCH Workforce Demographics

The following tables and descriptions provide details regarding the age, gender, ethnicity, race, and language of the MCH workforce from the data available. Tables reflect the percentages of employees in each sub-group. Select tables reflecting the actual numbers of employees are included for additional context.

Age

The table below indicates the percentage of MCH employees across five age ranges (for 429 employees). Statewide, employees in the youngest age range (20s) make up 13.8% of the workforce, employees between the ages of 30 and 59 are 71.6% of the workforce, and 39.6% of employees are over the age of 50. The mean age of the MCH workforce in Kansas is 44.4 years.

TABLE D5. STATEWIDE PERCENTAGE OF MCH EMPLOYEES BY AGE

AGE AS OF JULY 1, 2019	FREQUENCIES (FOR ALL PROGRAMS STATEWIDE)	PERCENTAGES
20s	59	13.8%
30s	106	24.7%
40s	94	21.9%
50s	107	24.9%
60+	63	14.7%
Valid Total	**429**	**100.0%**

Information not available for 229 positions.

TABLE D6. STATEWIDE AGE STATISTICS

AGE AS OF JULY 1, 2019	AGE STATISTICS (FOR ALL PROGRAMS STATEWIDE)
Mean	44.4
Median	45
Mode	50
Std. Deviation	13.15
Range	63
Minimum	20
Maximum	83

The mean age of the MCH workforce in Kansas is 44.4 years.

By geographical region, age distribution varies, as does the population count. Employees in some regions are heavily concentrated in the 50 and over age range and other regions have a greater percentage of employees in the younger age ranges.

Northwest: 62.5% of the workforce is age 50 and; no employees are in the 20s age range.

North Central: age distribution resembles statewide distribution, with 72.9% of the workforce in the 30 to 59 age range.

Northeast: the workforce is younger, with 50% of employees in their 20s and 30s.

Southwest: the workforce is younger, with over 50% of employees in their 20s and 30s.

South Central: employees in the 50 and over age group make up nearly one-half (49.1%) of the workforce.

Southeast: employees in the 50 and over age ranges make up 50% of the workforce.

Statewide positions: most of the workforce is in 30 to 59 age range (84.9%).

TABLE D7. REGIONAL AGE DISTRIBUTION OF FTES BY PERCENTAGE

REGION	20s	30s	40s	50s	60+	TOTAL
Northwest	0%	12.5%	25.0%	34.4%	28.1%	100.0%
North Central	13.5%	32.4%	13.5%	27.0%	13.5%	100.0%
Northeast	14.0%	36.0%	27.0%	14.0%	9.0%	100.0%
Southwest	19.5%	34.1%	19.5%	14.6%	12.2%	100.0%
South Central	20.0%	19.1%	11.8%	33.6%	15.5%	100.0%
Southeast	9.2%	13.2%	27.6%	28.9%	21.1%	100.0%
Statewide Positions	9.1%	27.3%	36.4%	21.2%	6.1%	100.0%
Total	**13.8%**	**24.7%**	**21.9%**	**24.9%**	**14.7%**	**100.0%**

TABLE D8. REGIONAL AGE DISTRIBUTION OF FTES BY NUMBER

REGION	20S	30S	40S	50S	60+	MISSING	TOTAL
Northwest	0	4	8	11	9	0	32
North Central	5	12	5	10	5	15	52
Northeast	14	36	27	14	9	82	182
Southwest	8	14	8	6	5	26	67
South Central	22	21	13	37	17	55	165
Southeast	7	10	21	22	16	19	95
Statewide Positions	3	9	12	7	2	32	65
Total	**59**	**106**	**94**	**107**	**63**	**229**	**658**

Across rural and urban population peer groups, age distribution of the workforce varies when compared to statewide percentages. Like geographical regions, some population peer groups have employees heavily concentrated in the 50 and over age ranges and others have a greater percentage of employees in the younger age ranges.

Urban: employees are primarily in the 30s to 59 age range (75%); over half (58.3%) are in the youngest two age groups.

Semi-Urban: employees are primarily in the 30s to 59 age range (74%).

Densely-Settled Rural: a greater percentage of employees are in their 20s and approximately half (50.5%) of the workforce is age 50 and over.

Rural: less than 10% of employees are in their 20s and nearly half (47.9%) are 50 and over.

Frontier: less than 5% of employees are in their 20s and most employees are in the 30s to 59 age range (84.9%).

TABLE D9. PERCENTAGE OF EMPLOYEES BY POPULATION PEER GROUP

URBAN/RURAL	20s	30s	40s	50s	60+	TOTAL
Urban	18.3%	40.0%	18.3%	16.7%	6.7%	100.0%
Semi-Urban	10.4%	19.8%	31.3%	22.9%	15.6%	100.0%
Densely-Settled Rural	21.5%	14.0%	14.0%	33.1%	17.4%	100.0%
Rural	9.6%	23.3%	19.2%	26.0%	21.9%	100.0%
Frontier	4.3%	43.5%	21.7%	19.6%	10.9%	100.0%
Statewide Positions	9.1%	27.3%	36.4%	21.2%	6.1%	100.0%
Total	**13.8%**	**24.7%**	**21.9%**	**24.9%**	**14.7%**	**100.0%**

TABLE D10. COUNT OF EMPLOYEES BY POPULATION PEER GROUP

URBAN/RURAL	20s	30s	40s	50s	60+	MISSING	TOTAL
Urban	11	24	11	10	4	85	145
Semi-Urban	10	19	30	22	15	17	113
Densely-Settled Rural	26	17	17	40	21	50	171
Rural	7	17	14	19	16	39	112
Frontier	2	20	10	9	5	6	52
Statewide Positions	3	9	12	7	2	32	65
Total	**59**	**106**	**94**	**107**	**63**	**229**	**658**

By MCH program type, age distribution varies from statewide percentages for some program types. Two programs employ a greater percentage of workers in their 20s (PMI and TPTCM) and employ a greater percentage of employees age 50 and over. Three program types (Family Advisory Council, KDHE Staff, and LYFTE) employ over 80% of employees in the 30s to 59 age range.

TABLE D11. MCH AGE DISTRIBUTION BY PROGRAM TYPE

PROGRAM TYPE	20S	30S	40S	50S	60+	TOTAL
Family Advisory Council	11.1%	11.1%	44.4%	33.3%	N/A	100.0%
KDHE Staff	6.3%	37.5%	37.5%	12.5%	6.3%	100.0%
CSHCN	12.5%	25.0%	25.0%	25.0%	12.5%	100.0%
LYFTE	7.7%	38.5%	30.8%	15.4%	7.7%	100.0%
MCH	12.0%	24.6%	22.6%	24.9%	15.9%	100.0%
PMI	28.2%	23.1%	5.1%	30.8%	12.8%	100.0%
TPTCM	18.6%	20.9%	18.6%	25.6%	16.3%	100.0%
Total	**13.8%**	**24.7%**	**21.9%**	**24.9%**	**14.7%**	**100.0%**

Age distribution across key position types varies greatly. Several positions include no or very few employees in their 20s (agency administrator/director, agency manager/supervisor, breastfeeding peer counselor/educator, home visitor, physician/medical director, and state MCH program staff) while other positions include a greater percentage of workers in this age range (administrative, case manager/care coordinator/navigator, dietitian/nutritionist, and social worker/counselor). Employees ages 50 and up fill approximately half of three position types (administrative, agency administrator/director, social worker/counselor, and other). Two positions (agency manager/supervisors and breastfeeding peer counselor/educators) are filled by a greater percentage of employees in their 30s. Age is unknown for physicians/medical directors.

TABLE D12. AGE DISTRIBUTION PERCENTAGE ACROSS KEY POSITION TYPES

PRIMARY POSITION TYPE	20s	30s	40s	50s	60+	TOTAL
Administrative	19.8%	20.9%	8.8%	30.8%	19.8%	100.0%
Agency Administrator/Director	2.4%	21.4%	28.6%	35.7%	11.9%	100.0%
Agency Manager/Supervisor	0%	54.5%	22.7%	4.5%	18.2%	100.0%
Breastfeeding Peer Counselor/Educator	0%	66.7%	22.2%	11.1%	0%	100.0%
Case Manager/Care Coordinator/Navigator	21.4%	39.3%	14.3%	21.4%	3.6%	100.0%
Clinical Nurse	12.5%	23.9%	21.6%	25.0%	17.0%	100.0%
Dietitian/Nutritionist	25.0%	**0.0%**	25.0%	12.5%	37.5%	100.0%
Home Visitor	5.0%	17.5%	35.0%	20.0%	22.5%	100.0%
Interpreter/Translator	12.5%	12.5%	37.5%	25.0%	12.5%	100.0%
MCH Program Director/Coordinator/Supervisor	14.3%	25.0%	28.6%	21.4%	10.7%	100.0%
Social Work/Counselor	27.8%	11.1%	11.1%	44.4%	5.6%	100.0%
State MCH Program Staff	6.3%	37.5%	37.5%	12.5%	6.3%	100.0%
FAC Member	11.1%	11.1%	44.4%	33.3%	0%	100.0%
Other	31.8%	18.2%	22.7%	18.2%	9.1%	100.0%
Total	**13.8%**	**24.7%**	**21.9%**	**24.9%**	**14.7%**	**100.0%**

TABLE D13. AGE DISTRIBUTION COUNT ACROSS KEY POSITION TYPES

PRIMARY POSITION TYPE	20s	30s	40s	50s	60+	MISSING	TOTAL
Administrative	18	19	8	28	18	31	122
Agency Administrator/Director	1	9	12	15	5	23	65
Agency Manager/Supervisor	0	12	5	1	4	11	33
Breastfeeding Peer Counselor/Educator	0	6	2	1	0	0	9
Case Manager/Care Coordinator/Navigator	6	11	4	6	1	14	42
Clinical Nurse	11	21	19	22	15	38	126
Dietitian/Nutritionist	2	0	2	1	3	3	11
Home Visitor	2	7	14	8	9	18	58
Interpreter/Translator	1	1	3	2	1	7	15
MCH Program Director/Coordinator/ Supervisor	4	7	8	6	3	12	40
Physician/Medical Director	0	0	0	0	0	14	14
Social Work/Counselor	5	2	2	8	1	11	29
State MCH Program Staff	1	6	6	2	1	3	19
FAC Member	1	1	4	3	0	0	9
Other	7	4	5	4	2	44	67
Total	**59**	**106**	**94**	**107**	**63**	**229**	**658**

Of employees who provide home visitation services, age distribution follows similar trends as the state. For employees who do not provide these services, a greater percentage are in the 50 and up age range. Of positions that provide interpretation services, over one-third are in their 20s and nearly two-thirds are in their 20s and 30s.

TABLE D14. STATEWIDE AGE DISTRIBUTION OF HOME VISITORS

HOME VISITOR	20s	30s	40s	50s	60+	TOTAL
Yes	13.7%	26.5%	26.5%	23.5%	9.8%	100.0%
No	9.9%	26.7%	21.5%	23.8%	18.0%	100.0%
Total	**13.8%**	**24.7%**	**21.9%**	**24.9%**	**14.7%**	**100.0%**

TABLE D15. STATEWIDE AGE DISTRIBUTION OF INTERPRETATION SERVICES BY PERCENTAGE

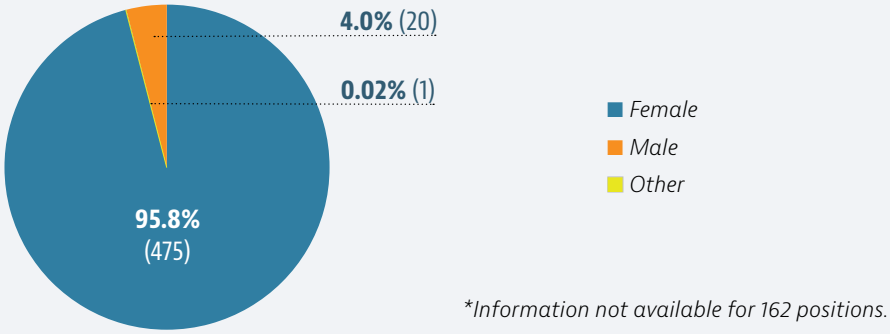
DOES THIS PERSON PROVIDE INTERPRETATION SERVICES?	20s	30s	40s	50s	60+	TOTAL
Yes	37.2%	27.9%	16.3%	9.3%	9.3%	100.0%
No	9.1%	26.3%	23.2%	24.9%	16.5%	100.0%
Total	**13.8%**	**24.7%**	**21.9%**	**24.9%**	**14.7%**	**100.0%**

Gender

Of 496 MCH employees in the state's MCH workforce, the vast majority are female (95.8%). In the Northwest region, all positions are filled by females. Positions that serve statewide, including state MCH program staff, include a greater percentage of males (20.6% compared to 4% for the state). Across MCH program types, CSHCN varies with 62.5% female employees. While some key positions types are entirely filled by female employees, physician/medical director employees are only 40% female. Tables below provide additional details regarding gender across the various sub-groups.

FIGURE D1. MCH EMPLOYS WOMEN AT A MUCH HIGHER RATE THAN ANY OTHER GENDER*

Valid Total: 100.0% (496)



**Information not available for 162 positions.*

TABLE D16. MCH EMPLOYMENT BY GENDER

REGION	FEMALE	MALE	OTHER	TOTAL
Northwest	96.9%	3.1%	0%	100.0%
North Central	100.0%	0%	0%	100.0%
Northeast	94.7%	4.5%	0.8%	100.0%
Southwest	97.7%	2.3%	0%	100.0%
South Central	98.4%	1.6%	0%	100.0%
Southeast	96.5%	3.5%	0%	100.0%
Statewide Positions	79.4%	20.6%	0%	100.0%
Total	**95.8%**	**4.0%**	**0.2%**	**100.0%**

TABLE D17. MCH URBAN/RURAL DESIGNATION EMPLOYMENT BY GENDER

URBAN/RURAL	FEMALE	MALE	OTHER	TOTAL
01 Urban	94.6%	4.3%	1.1%	100.0%
02 Semi-Urban	94.4%	5.6%	0%	100.0%
03 Densely-Settled Rural	99.2%	0.8%	0%	100.0%
04 Rural	98.8%	1.2%	0%	100.0%
05 Frontier	98.0%	2.0%	0%	100.0%
Statewide Positions	79.4%	20.6%	0%	100.0%
Total	**95.8%**	**4.0%**	**0.2%**	**100.0%**

TABLE D18. MCH PROGRAM EMPLOYMENT BY GENDER

PROGRAM TYPE	FEMALE	MALE	OTHER	TOTAL
Family Advisory Council	88.9%	11.1%	0%	100.0%
KDHE Staff	82.4%	17.6%	0%	100.0%
CSHCN	62.5%	37.5%	0%	100.0%
LYFTE	84.6%	15.4%	0%	100.0%
MCH	97.0%	2.8%	0.3%	100.0%
PMI	97.7%	2.3%	0%	100.0%
TPTCM	100.0%	0%	0%	100.0%
Total	**95.8%**	**4.0%**	**0.2%**	**100.0%**

While some key positions types are entirely filled by female employees, physician/medical director employees are only 40% female.

TABLE D19. MCH PRIMARY POSITION TYPE BY GENDER

PRIMARY POSITION TYPE	FEMALE	MALE	OTHER	TOTAL
Administrative	98.0%	2.0%	0%	100.0%
Agency Administrator/Director	91.8%	8.2%	0%	100.0%
Agency Manager/Supervisor	92.3%	7.7%	0%	100.0%
Breastfeeding Peer Counselor/Educator	100.0%	0%	0%	100.0%
Case Manager/Care Coordinator/Navigator	96.7%	3.3%	0%	100.0%
Clinical Nurse	100.0%	0%	0%	100.0%
Dietitian/Nutritionist	100.0%	0%	0%	100.0%
Home Visitor	95.6%	4.4%	0%	100.0%
Interpreter/Translator	100.0%	0%	0%	100.0%
MCH Program Director/Coordinator/ Supervisor	100.0%	0%	0%	100.0%
Physician/Medical Director	40.0%	40.0%	20.0%	100.0%
Social Work/Counselor	100.0%	0%	0%	100.0%
State MCH Program Staff	82.4%	17.6%	0%	100.0%
FAC Member	88.9%	11.1%	0%	100.0%
Other	91.2%	8.8%	0%	100.0%
Total	**95.8%**	**4.0%**	**0.2%**	**100.0%**

TABLE D20. MCH HOME VISITORS BY GENDER

HOME VISITOR	FEMALE	MALE	OTHER	TOTAL
Yes	98.1%	1.9%	0%	100.0%
No	94.6%	5.4%	0%	100.0%
Total	**95.8%**	**4.0%**	**0.2%**	**100.0%**

TABLE D21. MCH INTERPRETATION SERVICES BY GENDER

DOES THIS PERSON PROVIDE INTERPRETATION SERVICES?	FEMALE	MALE	OTHER	TOTAL
Yes	98.1%	1.9%	0%	100.0%
No	95.8%	4.2%	0.2%	100.0%
Total	**95.8%**	**4.0%**	**0.2%**	**100.0%**

Ethnicity

Across the MCH workforce statewide, 12.6% of employees are Hispanic (of 470 employees). Variations exist by geographical region and population peer groups. Employees in three regions (Northwest, North Central, and Southeast) and one peer group (Semi-Urban) are primarily or 100% non-Hispanic. One region (Southwest) has a greater percentage of Hispanic employees (40.9%) as does one peer group (Urban) at 22.7%.

FIGURE D2. MCH WORKFORCE BY ETHNICITY FOR ALL PROGRAMS STATEWIDE

Valid total: 470 (100%)

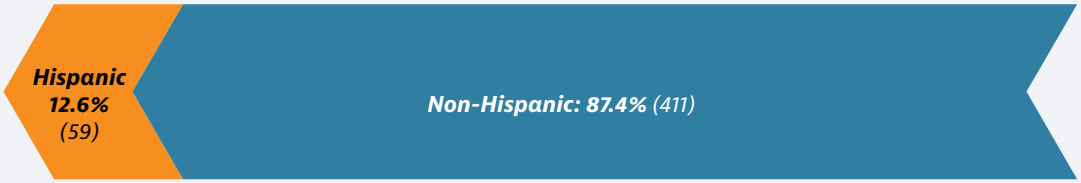


TABLE D22. ETHNICITY OF MCH WORKFORCE STATEWIDE BY REGION

REGION	HISPANIC	NON-HISPANIC	TOTAL
Northwest	0%	100.0%	100.0%
North Central	2.6%	97.4%	100.0%
Northeast	12.0%	88.0%	100.0%
Southwest	40.9%	59.1%	100.0%
South Central	16.7%	83.3%	100.0%
Southeast	2.4%	97.6%	100.0%
Statewide Positions	11.8%	88.2%	100.0%
Total	**12.6%**	**87.4%**	**100.0%**

TABLE D23. ETHNICITY OF MCH WORKFORCE STATEWIDE BY URBAN/RURAL DESIGNATION

URBAN/RURAL	HISPANIC	NON-HISPANIC	TOTAL
Urban	22.7%	77.3%	100.0%
Semi-Urban	4.7%	95.3%	100.0%
Densely-Settled Rural	15.1%	84.9%	100.0%
Rural	8.9%	91.1%	100.0%
Frontier	14.3%	85.7%	100.0%
Statewide Positions	11.8%	88.2%	100.0%
Total	**12.6%**	**87.4%**	**100.0%**

By MCH program type, most programs have a similar percentage of Hispanic and non-Hispanic employees except for the Family Advisory Council and LYFTE (100% non-Hispanic) and KDHE staff (17.6% Hispanic). By position type, a greater percentage of employees in the following positions are Hispanic, compared to statewide percentages: administrative (23.4%), interpreter/translator (83.3%), social work/counselor (26.3%), state MCH program staff (17.6%), and other (19.2%). Several positions are filled primarily by non-Hispanic employees (agency administrator/director, agency manager/supervisor, Case Manager/Care Coordinator/Navigator, Clinical Nurse, Home Visitor, MCH Program Director/Coordinator/Supervisor) or completely filled by non-Hispanic employees (Dietitian/Nutritionist, Physician/Medical Director, FAC Member).

TABLE D24. ETHNICITY OF MCH WORKFORCE STATEWIDE BY PROGRAM TYPE

PROGRAM TYPE	HISPANIC	NON-HISPANIC	TOTAL
Family Advisory Council	0%	100.0%	100.0%
KDHE Staff	17.6%	82.4%	100.0%
CSHCN	12.5%	87.5%	100.0%
LYFTE	0%	100.0%	100.0%
MCH	13.2%	86.8%	100.0%
PMI	11.1%	88.9%	100.0%
TPTCM	13.6%	86.4%	100.0%
Total	**12.6%**	**87.4%**	**100.0%**

TABLE D25. ETHNICITY OF MCH WORKFORCE STATEWIDE BY PRIMARY POSITION TYPE

PRIMARY POSITION TYPE	HISPANIC	NON-HISPANIC	TOTAL
Administrative	23.4%	76.6%	100.0%
Agency Administrator/Director	4.3%	95.7%	100.0%
Agency Manager/Supervisor	8.0%	92.0%	100.0%
Breastfeeding Peer Counselor/ Educator	11.1%	88.9%	100.0%
Case Manager/Care Coordinator/ Navigator	3.4%	96.6%	100.0%
Clinical Nurse	3.0%	97.0%	100.0%
Dietitian/Nutritionist	0%	100.0%	100.0%
Home Visitor	7.0%	93.0%	100.0%
Interpreter/Translator	83.3%	16.7%	100.0%
MCH Program Director/ Coordinator/Supervisor	7.4%	92.6%	100.0%
Physician/Medical Director	0%	100.0%	100.0%
Social Work/Counselor	26.3%	73.7%	100.0%
State MCH Program Staff	17.6%	82.4%	100.0%
FAC Member	0%	100.0%	100.0%
Other	19.2%	80.8%	100.0%
Total	**12.6%**	**87.4%**	**100.0%**

Of positions that are considered home visitors, little variation exists from statewide percentages. Of positions that provide interpretation services, the majority are Hispanic.

TABLE D26. MCH HOME VISITOR ETHNICITY STATEWIDE

HOME VISITOR	HISPANIC	NON-HISPANIC	TOTAL
Yes	9.5%	90.5%	100.0%
No	8.5%	91.5%	100.0%
Total	**12.6%**	**87.4%**	**100.0%**

TABLE D27. ETHNICITY OF MCH WORKFORCE STAFF (BY INTERPRETER STATUS)

DOES THIS PERSON PROVIDE INTERPRETATION SERVICES?	HISPANIC	NON-HISPANIC	TOTAL
Yes	79.2%	20.8%	100.0%
No	2.6%	97.4%	100.0%
Total	**12.6%**	**87.4%**	**100.0%**

Race

Of 474 MCH employees across the state for whom race is known, 86.7% are white, 1.1% are Asian, 4.0% are black, 0.4% are Native American/Alaskan Native, 5.9% are another race, and 1.9% are two or more races. By geographical regions and population peer groups, variations exist. Four geographical regions employ no or fewer than 10% non-white employees: Northwest, North Central, Southwest, Southeast. Three population groups also employ no or fewer than 10% non-white employees: Semi-Urban, Rural, Frontier. Overall, positions that serve statewide have greater racial diversity (23.4% non-white employees compared to 13.3% statewide).

TABLE D28. STATEWIDE MCH EMPLOYEES BY RACE*

RACE	FREQUENCIES (FOR ALL PROGRAMS STATEWIDE)	PERCENTAGES
Asian	5	1.1%
Black	19	4.0%
Native American or Alaska Native	2	0.4%
Native Hawaiian or Other Pacific Islander	0	0.0%
Other	28	5.9%
Two or more races	9	1.9%
White	411	86.7%
Valid Total	**474**	**100.0%**

**Information not available for 184 positions.*

TABLE D29. RACE OF STATEWIDE MCH EMPLOYEES BY REGION

REGION	NORTHWEST	NORTH CENTRAL	NORTHEAST	SOUTHWEST	SOUTH CENTRAL	SOUTHEAST	STATEWIDE POSITIONS	TOTAL
Not White	0.0%	0.0%	21.4%	6.8%	18.3%	4.8%	23.4%	13.3%
White	100.0%	100.0%	78.5%	93.2%	81.7%	95.3%	76.5%	86.7%

TABLE D30. RACE OF STATEWIDE MCH EMPLOYEES BY URBAN/RURAL DESIGNATION

URBAN/ RURAL	URBAN	SEMI- URBAN	DENSELY-SETTLED RURAL	RURAL	FRONTIER	STATEWIDE POSITIONS	TOTAL
Not White	35.5%	5.5%	14.3%	0%	6.1%	23.4%	13.3%
White	64.5.0%	94.4%	85.7%	100.0%	93.9%	76.5%	86.7%

Across MCH program categories, the racial make-up of KDHE staff and CSHCN employees differs from the statewide make-up, with a greater percentage of non-white employees. By key position type, the following positions have a greater percentage of non-white employees than statewide: case manager/care coordinator/navigator, interpreter/translator, social work/counselor, state MCH program staff, and other. Physician/medical doctor is the only position type filled by greater than half non-white employees (60%).

TABLE D31. RACIAL MAKEUP OF MCH PROGRAM STAFF AND EMPLOYEES BY PROGRAM TYPE

PROGRAM TYPE	ASIAN	BLACK	NATIVE AMERICAN OR ALASKA NATIVE	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	OTHER	TWO OR MORE RACES	WHITE	TOTAL
Family Advisory Council	0%	0%	0%	0%	0%	11.1%	88.9%	100.0%
KDHE Staff	5.9%	0%	5.9%	0%	17.6%	0%	70.6%	100.0%
CSHCN	0%	12.5%	0%	0%	12.5%	0%	75.0%	100.0%
LYFTE	0%	7.7%	0%	0%	0%	0%	92.3%	100.0%
MCH	1.2%	3.3%	0.3%	0%	5.4%	0.9%	88.9%	100.0%
PMI	0%	4.4%	0%	0%	6.7%	6.7%	82.2%	100.0%
TPTCM	0%	8.3%	0%	0%	6.3%	4.2%	81.3%	100.0%
Total	**1.1%**	**4.0%**	**0.4%**	**0%**	**5.9%**	**1.9%**	**86.7%**	**100.0%**

TABLE D32. RACIAL MAKEUP OF MCH PROGRAM STAFF AND EMPLOYEES BY PRIMARY POSITION TYPE

PRIMARY POSITION TYPE	ASIAN	BLACK	NATIVE AMERICAN OR ALASKA NATIVE	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	OTHER	TWO OR MORE RACES	WHITE	TOTAL
Administrative	0%	3.2%	0%	0%	14.9%	0%	81.9%	100.0%
Agency Administrator/ Director	0%	2.1%	2.1%	0%	0%	0%	95.7%	100.0%
Agency Manager/ Supervisor	0%	3.8%	0%	0%	3.8%	0%	92.3%	100.0%
Breastfeeding Peer Counselor/Educator	0%	0%	0%	0%	11.1%	0%	88.9%	100.0%
Case Manager/Care Coordinator/ Navigator	0%	22.6%	0%	0%	0%	0%	77.4%	100.0%
Clinical Nurse	1.0%	3.0%	0%	0%	1.0%	0%	94.9%	100.0%
Dietitian/ Nutritionist	11.1%	0%	0%	0%	0%	0%	88.9%	100.0%
Home Visitor	0%	0%	0%	0%	0%	0%	100.0%	100.0%
Interpreter/ Translator	0%	0%	0%	0%	25.0%	0%	75.0%	100.0%
MCH Program Director/ Coordinator/ Supervisor	0%	0%	0%	0%	0%	3.4%	96.6%	100.0%
Physician/Medical Director	20.0%	20.0%	0%	0%	20.0%		40.0%	100.0%
Social Work/Counselor	0%	5.3%	0%	0%	0%	21.1%	73.7%	100.0%
State MCH Program Staff	5.9%	0%	5.9%	0%	17.6%		70.6%	100.0%
FAC Member	0%	0%	0%	0%	0%	11.1%	88.9%	100.0%
Other	4.0%	8.0%	0%	0%	16.0%	12.0%	60.0%	100.0%
Total	**1.1%**	**4.0%**	**0.4%**	**0.0%**	**5.9%**	**1.9%**	**86.7%**	**100.0%**

Of employees who are considered home visitors, a greater percentage are white. Of employees who provide interpretation services, a greater percentage are non-white (nearly 50%).

TABLE D33. RACIAL MAKEUP OF MCH PROGRAM HOME VISITORS

HOME VISITOR	ASIAN	BLACK	NATIVE AMERICAN OR ALASKA NATIVE	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	OTHER	TWO OR MORE RACES	WHITE	TOTAL
Yes	0.9%	1.9%	0%	0%	0.9%	0%	96.3%	100.0%
No	1.5%	4.5%	0%	0%	3.5%	0.5%	90.0%	100.0%
Total	**1.1%**	**4.0%**	**0.4%**	**0.0%**	**5.9%**	**1.9%**	**86.7%**	**100.0%**

TABLE D34. RACIAL MAKEUP OF MCH PROGRAM INTERPRETATION SERVICE PROVIDERS

DOES THIS PERSON PROVIDE INTERPRETATION SERVICES?	ASIAN	BLACK	NATIVE AMERICAN OR ALASKA NATIVE	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	OTHER	TWO OR MORE RACES	WHITE	TOTAL
Yes	5.7%	3.8%	0%	0%	37.7%	1.9%	50.9%	100.0%
No	0.3%	3.9%	0.3%	0%	0.6%	0.0%	94.9%	100.0%
Total	**1.1%**	**4.0%**	**0.4%**	**0.0%**	**5.9%**	**1.9%**	**86.7%**	**100.0%**

Language

Across the state, just over one-tenth (12.3%) of the workforce speaks Spanish (based on 495 employees). Other reported languages included: French, Italian and Portuguese, Korean, Swahili, Maasai, and Vietnamese. By geographical region, variations exist for the Northwest region (100% non-Spanish Speaking), North Central (97.4% non-Spanish speaking), Southwest (36.4% Spanish speaking), and Southeast (97.6% non-Spanish speaking). By population peer groups, variations occur for Urban (20.4% Spanish speaking), Semi-Urban (92.4% non-Spanish speaking), and Rural (93% non-Spanish speaking).

TABLE D35. MCH WORKFORCE WHO ARE SPANISH SPEAKING

DOES THIS PERSON SPEAK SPANISH?	FREQUENCIES FOR ALL (PROGRAMS STATEWIDE)	PERCENTAGES
Yes	61	12.3%
No	434	87.7%
Valid Total	**495**	**100.0%**

Information not available for 163 positions.

TABLE D36. MCH WORKFORCE WHO ARE SPANISH SPEAKING BY REGION

REGION	SPEAK SPANISH	DO NOT SPEAK SPANISH	TOTAL
Northwest	0%	100.0%	100.0%
North Central	2.6%	97.4%	100.0%
Northeast	13.5%	86.5%	100.0%
Southwest	36.4%	63.6%	100.0%
South Central	15.5%	84.5%	100.0%
Southeast	2.4%	97.6%	100.0%
Statewide Positions	11.8%	88.2%	100.0%
Total	**12.3%**	**87.7%**	**100.0%**

TABLE D37. MCH WORKFORCE WHO ARE SPANISH SPEAKING BY URBAN/RURAL DESIGNATION

URBAN/RURAL	SPEAK SPANISH	DO NOT SPEAK SPANISH	TOTAL
01 Urban	20.4%	79.6%	100.0%
02 Semi-Urban	7.5%	92.5%	100.0%
03 Densely-Settled Rural	13.5%	86.5%	100.0%
04 Rural	7.0%	93.0%	100.0%
05 Frontier	14.3%	85.7%	100.0%
Statewide Positions	11.8%	88.2%	100.0%
Total	**12.3%**	**87.7%**	**100.0%**

By MCH program type, the most notable difference is in the Family Advisory Council (100% non-Spanish speaking). By key position type, variations occur for several positions. Some positions are filled mostly by employees who are non-Spanish speaking (agency administrator/director, agency manager/supervisor, clinical nurse, dietitian/nutritionist, physician/medical director, FAC member) and others include greater percentages of Spanish speaking staff (primarily administrative, interpreter/translator, state MCH program staff, and other positions).

TABLE D38. MCH WORKFORCE WHO ARE SPANISH SPEAKING BY POSITION TYPE

PROGRAM TYPE	SPEAK SPANISH	DO NOT SPEAK SPANISH	TOTAL
Family Advisory Council	0%	100.0%	100.0%
KDHE Staff	17.6%	82.4%	100.0%
CSHCN	12.5%	87.5%	100.0%
LYFTE	7.7%	92.3%	100.0%
MCH	13.2%	86.8%	100.0%
PMI	11.1%	88.9%	100.0%
TPTCM	8.3%	91.7%	100.0%
Total	**12.3%**	**87.7%**	**100.0%**

TABLE D39. MCH WORKFORCE WHO ARE SPANISH SPEAKING BY PRIMARY POSITION TYPE

PRIMARY POSITION TYPE	SPEAK SPANISH	DO NOT SPEAK SPANISH	TOTAL
Administrative	22.2%	77.8%	100.0%
Agency Administrator/Director	2.1%	97.9%	100.0%
Agency Manager/Supervisor	0%	100.0%	100.0%
Breastfeeding Peer Counselor/ Educator	11.1%	88.9%	100.0%
Case Manager/Care Coordinator/ Navigator	10.0%	90.0%	100.0%
Clinical Nurse	4.0%	96.0%	100.0%
Dietitian/Nutritionist	0%	100.0%	100.0%
Home Visitor	6.8%	93.2%	100.0%
Interpreter/Translator	100.0%		100.0%
MCH Program Director/Coordinator/ Supervisor	9.7%	90.3%	100.0%
Physician/Medical Director	0%	100.0%	100.0%
Social Work/Counselor	8.7%	91.3%	100.0%
State MCH Program Staff	17.6%	82.4%	100.0%
FAC Member	0%	100.0%	100.0%
Other	18.2%	81.8%	100.0%
Total	**12.3%**	**87.7%**	**100.0%**

Of employees who are considered home visitors, little variation exists. Of employees who provide interpretation services, the vast majority are Spanish speaking.

TABLE D40. MCH HOME VISITORS WHO ARE SPANISH SPEAKING

HOME VISITOR	SPEAK SPANISH	DO NOT SPEAK SPANISH	TOTAL
Yes	12.0%	88.0%	100.0%
No	8.7%	91.3%	100.0%
Total	**12.3%**	**87.7%**	**100.0%**

TABLE D41. MCH STAFF WHO PROVIDE INTERPRETATION SERVICES

DOES THIS PERSON PROVIDE INTERPRETATION SERVICES?	SPEAK SPANISH	DO NOT SPEAK SPANISH	TOTAL
Yes	92.5%	7.5%	100.0%
No	1.8%	98.2%	100.0%
Total	**12.3%**	**87.7%**	**100.0%**

Summary of Demographics

The available data for the Kansas MCH workforce indicate variations across the various sub-groups. While these results must be considered in the context of general population demographics, a few key trends emerge from the available data around geographic region and population peer group. First, the Kansas MCH workforce is primarily female, regardless of region or population peer group. When considering age, older employees make up much of the workforce in the Northwest and South Central regions as well as rural groups. The Northwest, rural, and frontier groups have almost no younger employees. The Northeast and Southwest regions as well as urban groups have a younger workforce. When considering diversity across ethnicity, race, and language, the Northwest, Southeast, semi-urban, rural, and frontier groups have less diversity across these demographics. The Southwest, Northeast, and urban groups have more ethnic and racial diversity.

By program and position type, fewer trends exist related to age. The most notable is position types that have fewer younger workers or a higher concentration of older workers. These include administrator and manager positions, social workers/counselors, and physician/medical director positions. When considering diversity across ethnicity, race, and language, a few programs and position types are less diverse across more than one demographic: the FAC (and FAC members), administrator and manager positions, and clinical nurses.

By region, variations to statewide percentages include the following:

- **Northwest:** the workforce in primarily white, non-Hispanic, non-Spanish speaking, and older, with few young employees.
- **North Central:** the workforce is primarily white, non-Hispanic, non-Spanish speaking.
- **Northeast:** the workforce is younger and includes a greater percentage of black employees.
- **Southwest:** the workforce is primarily white and includes a greater percentage of younger employees, Spanish speaking employees, and Hispanic employees.
- **South Central:** the workforce is older.
- **South East:** the workforce is primarily white, non-Hispanic, non-Spanish speaking, and older.
- **Statewide positions:** the workforce serving residents statewide includes a greater percentage of non-white and male employees.

By peer group, variations to statewide percentages include the following:

- **Urban:** the workforce is younger and includes a greater percentage of Hispanic and black employees and Spanish speaking employees
- **Semi-Urban:** the workforce is primarily white, non-Hispanic, non-Spanish speaking.
- **Densely Settled Rural:** the workforce is more heavily concentrated in the younger and older age ranges.
- **Rural:** the population is primarily white, non-Spanish speaking, with fewer younger employees and a greater percentage of older employees.
- **Frontier:** the workforce is primarily white with fewer younger employees.

The results also indicate variation across MCH program types, key position types, home visitor classification, and interpretation classification.

By MCH program type, variations to statewide percentages include the following:

- **Family Advisory Council:** primarily non-Hispanic and completely non-Spanish speaking.
- **KDHE staff:** greater percentage of non-white and Hispanic employees.
- **CSHCN:** greater percentage of non-white and male employees.
- **LYFTE:** primarily non-Hispanic.
- **MCH:** little variation.
- **PMI:** greater percentage of younger employees as well as older employees.
- **TPTCM:** greater percentage of younger employees as well as older employees.

By key position type, variations to statewide percentages include the following:

- **Administrative:** greater percentage of employees who are younger, in the older age ranges, Hispanic, and Spanish speaking.
- **Agency administrator/director:** fewer younger employees and primarily non-Hispanic, non-Spanish speaking.
- **Agency manager/director:** fewer younger employees and primarily non-Hispanic, non-Spanish speaking.
- **Breastfeeding peer counselor/educator:** fewer younger employees.
- **Case manager/care coordinator/navigator:** more younger employees and a greater percentage of non-Hispanic employees and non-white employees.
- **Clinical nurse:** greater percentage of non-Hispanic, non-Spanish speaking employees.
- **Dietitian/nutritionist:** younger employees and a greater percentage of non-Hispanic and non-Spanish speaking employees.
- **Home visitor:** fewer younger employees and a greater percentage of non-Hispanic employees.
- **Interpreter/translator:** greater percentage of Hispanic, non-white, and Spanish speaking employees.
- **MCH program director/coordinator/supervisor:** greater percentage of non-Hispanic employees.
- **Physician/medical director:** fewer younger employees with less than half female employees, over half non-white employees, and greater percentage of non-Spanish speaking employees.
- **Social work/counselor:** greater percentage of older employees with greater percentages of Hispanic and non-white employees.
- **State MCH program staff:** fewer younger employees, more male employees, and greater percentage of Hispanic, non-white, and Spanish speaking employees.
- **FAC member:** primarily non-Hispanic, non-Spanish speaking employees.
- **Other:** greater percentage of Hispanic and Spanish speaking employees.

For employees providing home visiting and employees providing interpretation services, variations to statewide percentages include the following:

- **Home visitation services:** little variation.
- **Interpretation services:** primarily younger employees and primarily Hispanic, non-white, Spanish speaking employees.

PH WINS Survey Results

The first several tables provide a characterization of Kansas respondents to PH WINS Survey. These descriptive demographic tables are followed by information to questions about employee engagement, staff satisfaction, training needs, and perceptions of health department activities and priorities.

TABLE D42. WORKFORCE BREAKDOWN

WORKFORCE PARTICIPANTS	WEIGHTED COUNT	95% CI
Kansas non-MCH	1015	[802-1227]
Kansas MCH	335	[240-430]
Total	**1349**	**N/A**

TABLE D43. PRIMARY PROGRAM AREA

MCH AREA	ESTIMATE	95% CI
Clinical Services - Immunization	6%	[2%-20%]
MCH	30%	[17%-47%]
MCH-Family Planning	13%	[5%-27%]
MCH-WIC	51%	[35%-67%]

TABLE D44. JOB CLASSIFICATION

JOB TYPE	ESTIMATE	95% CI
Administrative	20%	[10%-36%]
Clinical and Lab	50%	[34%-65%]
Public Health Sciences	18%	[9%-32%]
Social Services and All Other	12%	[5%-28%]

TABLE D45. SETTING

ORGANIZATION TYPE	ESTIMATE	95% CI
State Health Agency	12%	[7%-21%]
Local/Regional Health Department	88%	[79%-93%]

Demographics of Respondents

TABLE D46. TENURE

TENURE IN CURRENT AGENCY (CATEGORIES)	ESTIMATE	95% CI
0-5 years	55%	[39%-71%]
6-10 years	21%	[10%-37%]
11-15 years	10%	[3%-26%]
16-20 years	6%	[2%-19%]
21 or above	9%	[3%-23%]

TABLE D47. EDUCATIONAL ATTAINMENT

HIGHEST DEGREE ATTAINED	ESTIMATE	95% CI
No college degree	14%	[6%-29%]
Associates	6%	[1%-19%]
Bachelors	61%	[45%-74%]
Masters	19%	[10%-34%]
Doctoral	1%	[0%-7%]

TABLE D48. AGE

AGE IN YEARS (CATEGORIES)	ESTIMATE	95% CI
<21	3%	[0%-17%]
21-30	11%	[4%-26%]
31-40	36%	[22%-52%]
41-50	16%	[8%-30%]
51-60	24%	[13%-39%]
61+	11%	[4%-25%]

TABLE D49. SUPPORT AND ENGAGEMENT

STATEMENTS	ESTIMATE	95% CI
I know how my work relates to the agency's goals and priorities	96%	[85%-99%]
The work I do is important	100%	N/A
Creativity and innovation are rewarded	57%	[41%-71%]
Communication between senior leadership and employees is good	56%	[41%-71%]
Supervisors work well with employees of different backgrounds	74%	[58%-85%]
Supervisors in my work unit support employee development	79%	[63%-90%]
My training needs are assessed	80%	[66%-90%]
Employees have sufficient training to fully utilize technology	78%	[63%-88%]
Employees learn from one another as they do their work	94%	[81%-98%]
My supervisor provides me with opportunities to demonstrate my leadership skills	88%	[73%-95%]
I have had opportunities to learn and grow in my position over the past year	87%	[73%-95%]
I feel completely involved in my work	91%	[77%-97%]
I am determined to give my best effort at work every day	99%	[93%-100%]
I am satisfied that I have the opportunities to apply my talents and expertise	90%	[76%-96%]
My supervisor and I have a good working relationship	85%	[70%-93%]
My supervisor treats me with respect	83%	[66%-92%]
I recommend my organization as a good place to work	86%	[72%-94%]

**Respondents who stated that they "agreed" or "strongly agreed" with the statement*

TABLE D50. SATISFACTION

DEGREE OF SATISFACTION	ESTIMATE	95% CI
Job Satisfaction	92%	[79%-97%]
Organizational Satisfaction	86%	[72%-94%]
Pay Satisfaction	67%	[52%-80%]

**Respondents who stated that they were "very satisfied" or "somewhat satisfied."*

TABLE D51. INTENT TO LEAVE

INTENT TO LEAVE	ESTIMATE	95% CI
Considering leaving in the next year (excl retirement)*	24%	[13%-40%]
Retire by 2023**	10%	[4%-24%]
Considering leaving for more than 6 months***	43%	[17%-73%]

**Excludes retirements **Percentage among respondents who said they intended to leave within the next year*

TABLE D52. REASONS FOR LEAVING

REASONS TO CONSIDER LEAVING	ESTIMATE	95% CI
Lack of acknowledgment/recognition	25%	[7%-57%]
Job satisfaction	7%	[2%-26%]
Lack of opportunities for advancement	14%	[3%-46%]
Lack of training	10%	[1%-47%]
Leadership changeover	14%	[3%-48%]
Other opportunities outside agency	14%	[3%-48%]
Pay	27%	[9%-58%]
Retirement	0%	N/A
Satisfaction with your supervisor	36%	[13%-67%]
Stress	38%	[15%-68%]
Lack of flexibility (flex hours/telework)	21%	[5%-56%]
Weakening of benefits (e.g., retirement contributions/pensions, health insurance	14%	[3%-48%]
Work overload / burnout	28%	[9%-60%]

TABLE D53. TRAINING NEEDS*

TYPES OF TRAINING NEEDS	ESTIMATE	95% CI
Effective Communication	10%	[3%-27%]
Data for Decision-Making	33%	[19%-27%]
Cultural Competency	35%	[21%-27%]
Budget and Financial Management	65%	[46%-27%]
Change Management	36%	[20%-27%]
Systems and Strategic Thinking	55%	[38%-27%]
Develop a Vision for a Healthy Community	47%	[30%-27%]
Cross-Sectoral Partnerships	43%	[27%-60%]

TABLE D54. TRAINING NEEDS (NON-SUPERVISORS)*

TYPES OF TRAINING NEEDS (NON-SUPERVISORS)	ESTIMATE	95% CI
Effective Communication	13%	[4%-33%]
Data for Decision-Making	33%	[17%-54%]
Cultural Competency	32%	[17%-51%]
Budget and Financial Management	67%	[46%-84%]
Change Management	36%	[19%-57%]
Systems and Strategic Thinking	59%	[40%-76%]
Develop a Vision for a Healthy Community	42%	[25%-61%]
Cross-Sectoral Partnerships	39%	[23%-59%]

**A training need is defined as a skill that has high importance and low skill*

TABLE D55. MOTIVATION FOR ADDITIONAL TRAINING

REASONS TO SEEK TRAINING	ESTIMATE	95% CI
Maintenance of licensure	54%	[39%-69%]
Taken into account during performance reviews	34%	[22%-50%]
Requirement for promotion	32%	[20%-48%]
Peers were taking it	19%	[10%-34%]
Expectation from my supervisor	49%	[34%-64%]
Mandated by agency supervisor/management/leadership	48%	[33%-64%]
Covered time for training	55%	[39%-69%]
Paid travel for training	44%	[30%-60%]
Availability of applicable in-person training opportunities	38%	[24%-54%]
Availability of applicable online training opportunities	44%	[30%-60%]
Personal growth/interest	86%	[72%-94%]
None of the above	3%	[0%-18%]
Other	0%	N/A

TABLE D56. AWARENESS OF EMERGING CONCEPTS IN PUBLIC HEALTH

SELF-REPORTED AWARENESS OF EMERGING PUBLIC HEALTH CONCEPTS	ESTIMATE	95% CI
Cross-jurisdictional sharing of public health services	37%	[24%-53%]
Fostering a culture of quality improvement (QI)	95%	[81%-99%]
Public health and primary care integration	64%	[48%-77%]
Evidence-based public health practice (EBPH)	84%	[69%-93%]
Health in All Policies (HiAP)	52%	[37%-67%]
Multi-sectoral collaboration	48%	[33%-63%]

**Respondents stated that they had heard about the concept "a little" or "a lot"*

TABLE D57. AGENCY INVOLVEMENT IN SOCIAL DETERMINANTS OF HEALTH

AREAS OF MCH PROGRAM INVOLVEMENT (SOCIAL DETERMINANTS)	ESTIMATE	95% CI
The K-12 Education System	71%	[55%-83%]
The Economy	64%	[48%-77%]
The Built Environment	66%	[49%-79%]
The Quality of Housing	59%	[43%-73%]
The Quality of Transportation	56%	[41%-71%]
The Quality of Social Support Systems	84%	[69%-93%]
Health Equity	83%	[66%-92%]

**Respondents stated that their agency should be "somewhat involved" or "very involved"*

APPENDIX E: MCH NAVIGATOR, KANSAS WORKFORCE SNAPSHOT

Introduction

An important aspect of the 5-year needs assessment process was developing an understanding of the MCH workforce composition and learning needs in order to gauge strengths and areas of growth. The MCH Navigator assisted in preparing this report of professionals in Kansas who have taken the online self-assessment from 2017 – 2019 to serve as a snapshot of workforce knowledge/skills across the MCH Leadership Competencies.

Demographics and Learning Needs Based on Self-Assessment Data 2017-2109

Demographic data was analyzed across seven measures with an overall sample size of n=296. The majority of participants were:

- White (89%)
- Not of Hispanic or Latino origin (86%)
- Female (92%)
- 1-5 years of service (36%)
- 41-50 years of age (24%)
- Health Provider/Professionals (33%)

FIGURE E1. MCH PROFESSIONALS IN KANSAS BY RACE

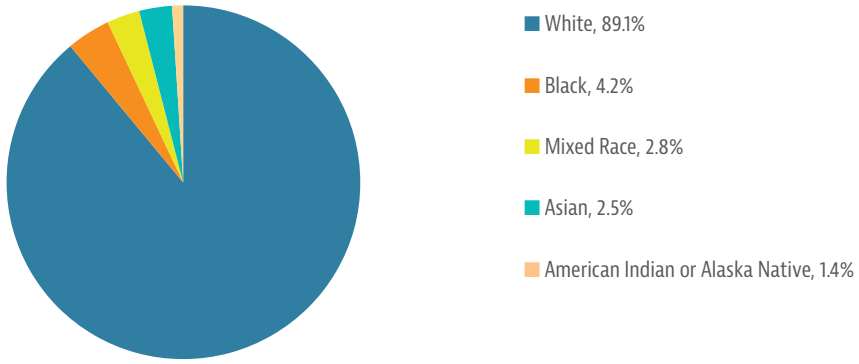


FIGURE E2. MCH PROFESSIONALS IN KANSAS BY GENDER

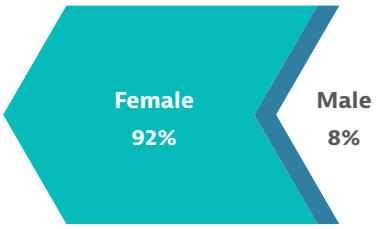


FIGURE E3. MCH PROFESSIONALS IN KANSAS BY ETHNICITY

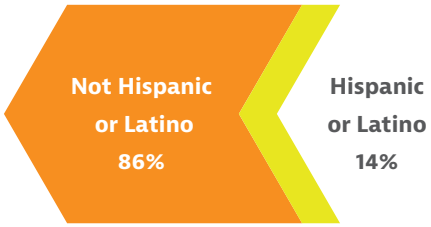


FIGURE E4. MCH PROFESSIONALS IN KANSAS BY YEARS OF SERVICE

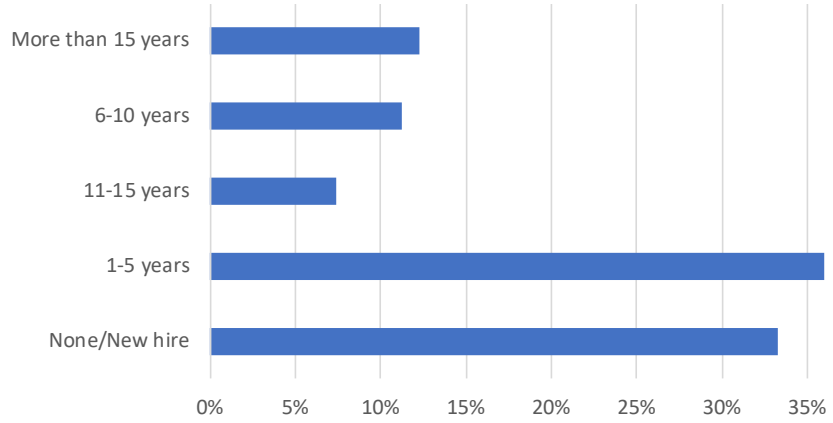


FIGURE E5. MCH PROFESSIONALS IN KANSAS BY AGE

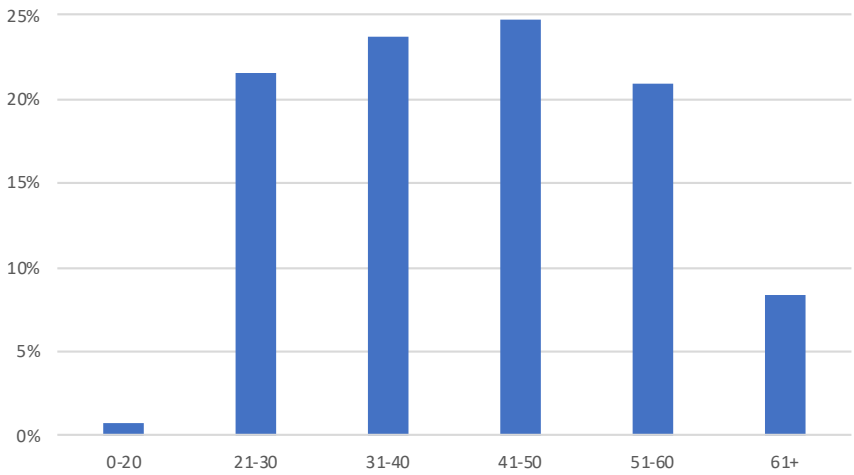
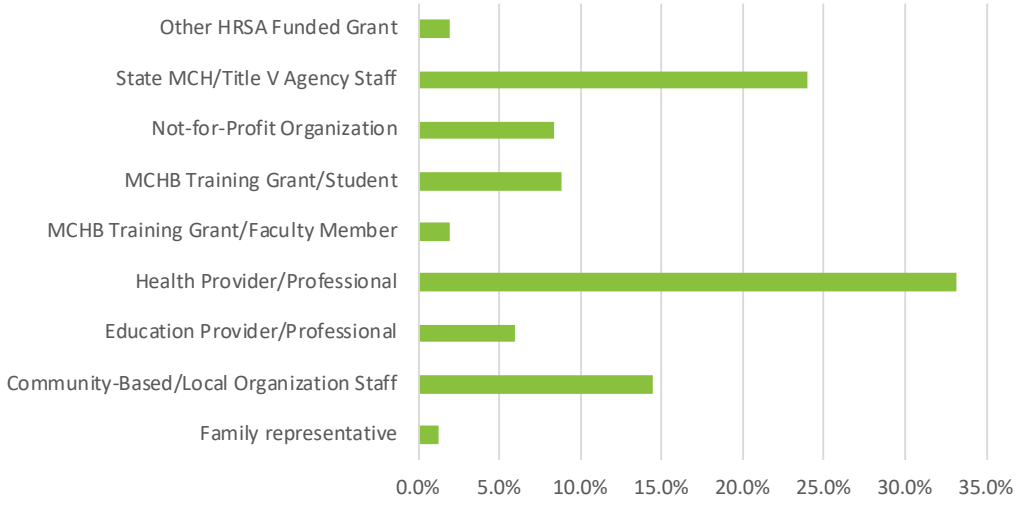


FIGURE E6. MCH PROFESSIONALS IN KANSAS BY DISCIPLINE/PROFESSION



Understanding Knowledge and Skills of the Workforce

Self-assessment provides an opportunity for professionals to reflect on competency-based strengths and areas to grow in order to identify learning needs and reinforce new skills in order to improve performance. The MCH Navigator has been collecting data from the online **Self-Assessment** since 2014 (with nearly 3,000 completed assessments) and during that time have identified a number of data trends:

Trend #1: Learners consistently report high levels of knowledge but low levels of skills across a number of competencies including cultural competency and family-professional practice. This translates into MCH professionals understanding the concepts of a competency but not as much self-efficacy in translating this knowledge into practice. In response to this need, the MCH Navigator has developed a series of **implementation briefs** that provides specific learning opportunities that focus on how to implement and execute skills associated with the leadership competencies.

Trend #2: Learners consistently report low knowledge and skills scores for policy. In response to this finding, the Navigator has developed a **Policy 101 Portal** to aid the workforce in this area.

The chart below analyzes mean knowledge and skill scores for each of the 12 MCH Leadership Competencies for Kansas. In line with national data trends, cultural competency had the largest gap in knowledge and skills followed by ethics. Also in line with national data trends, policy has the lowest knowledge and skills scores across competencies.

TABLE E1. MCH NAVIGATOR SELF-ASSESSMENT (KANSAS)

Mean Knowledge and Skills Competency

COMPETENCY	MEAN KNOWLEDGE SCORE	MEAN SKILL SCORE
Comp 1: MCH Knowledge Base/Context	1.8	1.7
Comp 2: Self-reflection	2.1	2.1
Comp 3: Ethics	2.2	2
Comp 4: Critical Thinking	1.7	1.6
Comp 5: Communication	2.2	2.2
Comp 6: Negotiation and Conflict Resolution	1.7	2
Comp 7: Cultural Competency	2.2	1.8
Comp 8: Family Professional Partnerships	1.9	1.8
Comp 9: Developing Others Through Teaching, Coaching and Mentoring	1.9	1.8
Comp 10: Interdisciplinary/Interprofessional Team Building	1.8	1.8
Comp 11: Working with Communities and Systems	1.6	1.7
Comp 12: Policy	1.4	1.3

APPENDIX F: COMMUNITY PERCEPTIONS (KIOSK QUESTIONS) AND EDUCATOR RESPONSES (CHILD AND ADOLESCENT SURVEY)

Introduction

An important aspect of the MCH Needs Assessment is gathering perceptions from members of the general public about issues affecting the health and well-being of women, children, and families. Here we describe the use of free-standing electronic kiosks to gather input from members of the public who might not otherwise have participated through other, more traditional methods. HappyOrNot® Smiley Touch™ terminals were disseminated to locations statewide to gather insights on a wide range of maternal and child health issues. The terminals provided 3-tiered insight, including a multiple choice question, a second multiple choice selection (based on the first response), and an optional open-ended response.

Another important group of stakeholders in the MCH space are educators. While several stakeholders representing education were involved in this project, the MCH Needs Assessment team felt like important perspectives could be garnered through a survey of educators. Working with the Kansas State Department of Education (KSDE) and other partners (including the Kansas School Nurses Organization) a "Child & Adolescent Health Survey" (mirroring many of the questions used on the Smiley Touch™ kiosks) was distributed to school nurses and school counselors around the state in January and February 2020.

This Appendix provides a description of results from both of these efforts.

Methodology

Smiley Touch™ Kiosks

Figure F1. HappyOrNot® Smiley Touch™ terminal at KU Edwards Campus (Johnson County).

Kiosks were placed in a variety of locations across the state, including frontier (Rooks, Hodgeman), rural (Pawnee, Ottawa), densely-settled rural (Ellis), semi-urban (Saline, Riley, Crawford), and urban (Johnson, Wyandotte) counties. Most kiosks were placed in a public setting like a library, clinic, or public health department. In addition to these locations, two kiosks were taken to various statewide events and locations.

The questions used on the kiosks were created by the MCH Needs Assessment team based on information gleaned in early stages of the needs assessment process. Questions had to be constructed based on limited character space on the kiosks. Kiosks were controlled remotely using a web-based application. One question was asked at a time, and approximately every week new questions were loaded to the kiosks.

Kiosk Questions

Kiosks responses were primarily collected in January and February 2020.

- Do pregnant women and/or new parents have access to the help they need?
- Can young people get help in our community when they are feeling down?
- Do you think kids and teens in your community have access to comprehensive, stable, and continuous sources of health care?
- In our community, is injury prevention a priority for child care providers?
- Is there help for women with anxiety and depression in our community?
- Do children you know regularly ride in a car seat, booster seat, or wear their seatbelts?
- Do families of children with special health care needs or disabilities know where to find resources and services for their children?
- Do you think moms who want to breastfeed feel supported by doctors, employers, and others in the community?
- Are women able to get yearly check-ups in your community?
- Do people have access to family planning and birth control in our community?

HappyOrNot® Smiley Touch™ Terminals Key

Kiosk response options were presented in the following four option format:

very positive

positive

negative

very negative

Child & Adolescent Survey

Survey questions were loaded to an online survey site (Qualtrics), and a link to the survey was sent to school nurses and counselors statewide through several list-servs and electronic distribution lists maintained by the Kansas Department of Health and Environment, the Kansas State Department of Education, and partner organizations. Responses were collected between January 18, 2020 and February 18, 2020. Surveys were collected from 179 individuals.

Results

Kiosks

Responses from the Smiley Touch™ kiosks are summarized first and are grouped by the following categories and topics.

- Maternal: resources and supports.
- Children: intervention services and safety.
- Youth: resources and supports.
- Health Care: health care accessibility.

Results for the KSDE Survey (completed by 179 individuals) are grouped by the following categories and topics:

- Children: developmental screenings and intervention services, safety, and physical activity.
- Youth: resources and supports, choices and decision-making, and safety.
- Health Care: health care accessibility, dental care availability, dental care accessibility.

A comparison of results from these two different tools follows the individual results. A summary of overarching themes and key is also included.

FIGURE F2. DO PREGNANT WOMEN AND/OR NEW PARENTS HAVE ACCESS TO THE HELP THEY NEED? (35 RESPONDENTS)

63% 22 resp. | 17% resp. | 11% 4 resp. | 9% 3 resp.

Most respondents answered this question positively (63% happy and 17% mostly happy), indicating that pregnant women and/or new parents have access to the help they need. The responses varied by geographical area, with one urban community indicating a 100% happy response.

FIGURE F3. IS THERE HELP FOR WOMEN WITH ANXIETY AND DEPRESSION IN OUR COMMUNITY? (398 RESPONDENTS)

34% 137 resp. | 20% 78 resp. | 23% 91 resp. | 23% 92 resp.

There was a fairly even distribution of responses between more negative and more positive responses.

FIGURE F4. DO YOU THINK MOMS WHO WANT TO BREASTFEED FEEL SUPPORTED BY DOCTORS, EMPLOYERS, AND OTHERS IN THE COMMUNITY? (501 RESPONDENTS)

33% 164 resp. | 24% 121 resp. | 20% 101 resp. | 23% 115 resp.

Just over half of respondents indicated a positive answer to this question (33% happy and 24% partially happy). Responses by geographic area varied greatly.

FIGURE F5. DO PEOPLE HAVE ACCESS TO FAMILY PLANNING AND BIRTH CONTROL IN THIS COMMUNITY? (185 RESPONSES)

54%
100

23%
42 resp.

9%
16 resp.

15%
27 resp.

Nearly three-fourths of respondents provided a positive answer to this question, with over half (54%) answering with a happy face response. Responses ranged by community.

MCH Kiosk: Children: intervention Services

FIGURE F6. DO FAMILIES OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS OR DISABILITIES KNOW WHERE TO FIND RESOURCES AND SERVICES FOR THEIR CHILDREN? (421 RESPONDENTS)

37%
155

17%
72 resp.

27%
114 resp.

19%
80 resp.

Just over half of respondents (54%) responded positively to this question, with 37% happy and 17% partially happy responses. Across communities, five had more than 50% unhappy responses to this question.

MCH Kiosk: Children: Safety

FIGURE F7. IN OUR COMMUNITY, IS INJURY PREVENTION A PRIORITY FOR CHILD CARE PROVIDERS? (681 RESPONDENTS)

43%	22%	14%	21%
293 resp.	150 resp.	96 resp.	142 resp.

The majority of individuals responded positively, indicating that they felt injury prevention is a priority for child care providers (43% happy, 22% mostly happy). Approximately one in five provided an unhappy response. Responses ranged by geographic area.

FIGURE F8. DO CHILDREN YOU KNOW REGULARLY RIDE IN A CAR SEAT, BOOSTER SEAT, OR WEAR THEIR SEATBELTS? (658 RESPONDENTS)

65%	11%	7%	17%
425 resp.	75 resp.	44 resp.	114 resp.

More than three of four respondents indicated a positive response to this question. In some communities, the response was almost entirely happy, while in others, there were more unhappy responses.

Youth: Resources and Supports

FIGURE F9. CAN YOUNG PEOPLE GET HELP IN OUR COMMUNITY WHEN THEY ARE FEELING DOWN? (1,161 RESPONDENTS)

37%	21%	20%	22%
355 resp.	203 resp.	188 resp.	215 resp.

The responses to this question varied greatly by geography, with some communities responding almost entirely unhappy and some over 80% happy.

Health Care: Accessibility

FIGURE F10. DO YOU THINK KIDS AND TEENS IN YOUR COMMUNITY HAVE ACCESS TO COMPREHENSIVE, STABLE, AND CONTINUOUS SOURCES OF HEALTH CARE? (470 RESPONDENTS)

35%
165 resp.

18%
86 resp.

19%
88 resp.

28%
131 resp.

Approximately half of all respondents provided a happy response to this question (35% happy and 18% mostly happy), but about a quarter responded unhappy (28%). This varied greatly by location.

FIGURE F11. ARE WOMEN ABLE TO GET YEARLY CHECK-UPS IN YOUR COMMUNITY? (421 RESPONDENTS)

54%
227 resp.

17%
71 resp.

13%
54 resp.

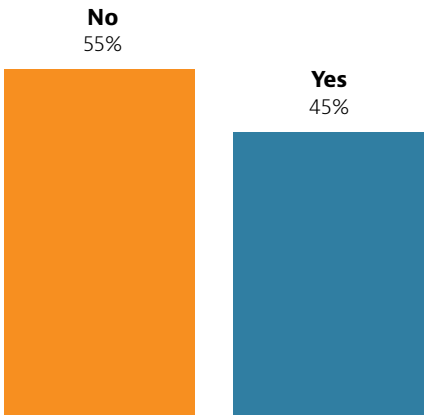
16%
69 resp.

Most respondents indicated a positive response to this question (69% overall). The responses were mostly positive across communities.

Children: Developmental Screenings and Intervention Services

FIGURE F12. DO PARENTS KNOW WHERE TO GO WHEN THEY ARE CONCERNED ABOUT THEIR CHILD'S DEVELOPMENT?

RESPONSES	PERCENT RESPONSES
No, parents need more information about developmental milestones	30.3%
No, there aren't enough resources like this in our community	24.7%
Yes, they mostly get this at the doctor	34.8%
Yes, the mostly get this at an early intervention program	7.9%
Yes, they mostly get this at home	1.1%
Yes, they mostly get this from child care	0.6%
Yes, the mostly get this from online screening	0.6%



Over half (55%) of survey respondents indicated that parents need more information or resources in this area. Another 35% indicated that parents get this information from a doctor, and 8% indicated they get this information from an early intervention program.

FIGURE F13. DO CHILDREN GET SCREENED REGULARLY TO TRACK THEIR DEVELOPMENT?

RESPONSES	PERCENT RESPONSES
Yes, all these things	21.3%
Yes, some of these things	57.3%
No, this is a need in our community	13.5%
No, parents don't know where to go for this	7.9%
TOTAL	100.0%

Over half of survey respondents indicated that most children are screened for some aspects of development, with 21% indicating yes for all aspects of development. Another 21% indicated that more screening resources are needed or that parents do not know where to go to access screenings.

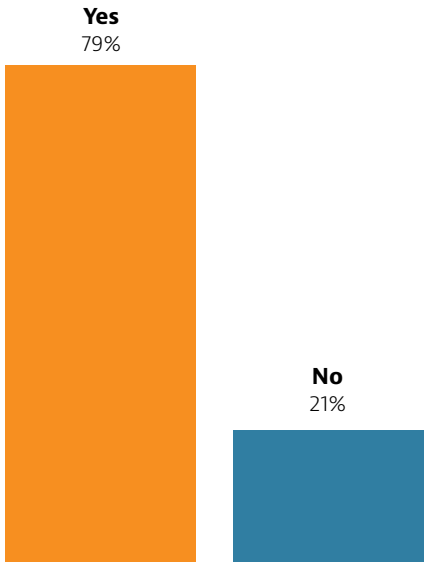


FIGURE F14. DO FAMILIES OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS OR DISABILITIES KNOW WHERE TO FIND RESOURCES AND SERVICES FOR THEIR CHILDREN?

RESPONSE	FREQ.	PERCENTAGE
Yes	130	73.9%
No	46	26.1%
TOTAL	**176**	**100.0%**

About three-fourths of respondents (74%) indicated that parents know where to access resources and services for their children with special health care needs. Of those that indicated parents do not know where to find these resources and services, most identified a lack of awareness about such resources or difficulties navigating the referral process.

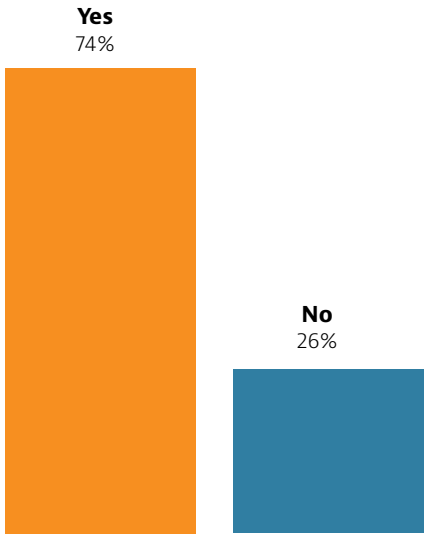


FIGURE F15. DO CHILDREN YOU KNOW REGULARLY RIDE IN A CAR SEAT, BOOSTER SEAT, OR WEAR THEIR SEATBELTS?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	147	82.6%
No	31	17.4%
TOTAL	**178**	**100.0%**

Overwhelmingly (83%), respondents indicated that children regularly follow these safety practices.

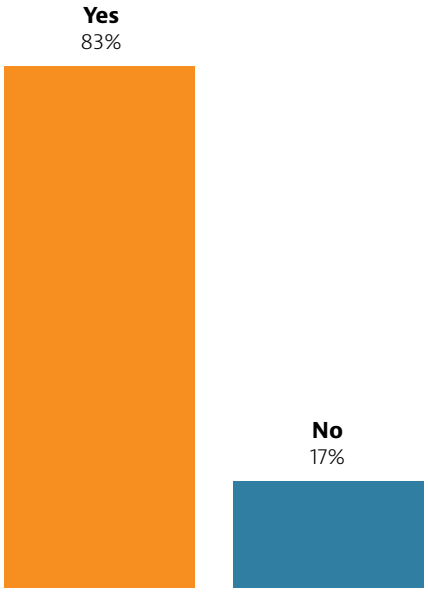


FIGURE F16. ARE THERE SAFE PLACES FOR CHILDREN TO PLAY AT HOME AND IN YOUR COMMUNITY?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	132	78.1%
No	37	21.9%
TOTAL	**169**	**100.0%**

Most respondents (78%) felt there are safe places for children to play at home and in their communities. Comments include positives about the availability of community locations, like parks and playgrounds, as well as children's own homes and neighborhoods. Concerns included lack of parental supervision and disparity in safety between and/or within communities.

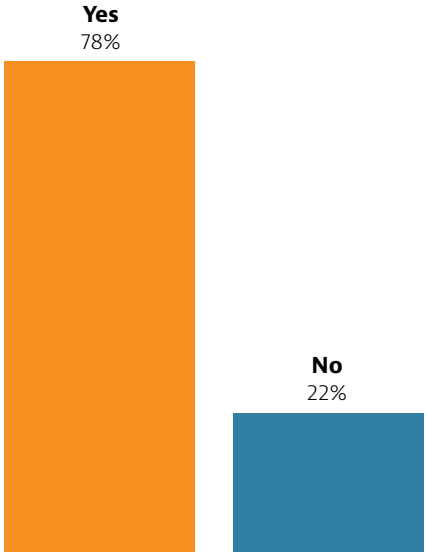


FIGURE F17. ARE CHILDREN RESPECTFUL TO EACH OTHER IN YOUR COMMUNITY?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, respectful in person and online	21	12.0%
Yes, respectful in person, but online bullying is a problem	55	31.4%
Yes, respectful online, but in person bullying is a problem	1	0.6%
No, bullying online is a problem	11	6.3%
No, bullying in person is a problem	7	4.0%
No, bullying in person and online is a problem	80	45.7%
TOTAL	**175**	**100.0%**

Most responses to this question indicate some level of concern about bullying, with 56% of respondents indicating that bullying is a problem in person, on-line, or both, and another 31% indicating that children are respectful in person but are participating in on-line bullying. Only 12% of respondents indicated that children are respectful in both settings.

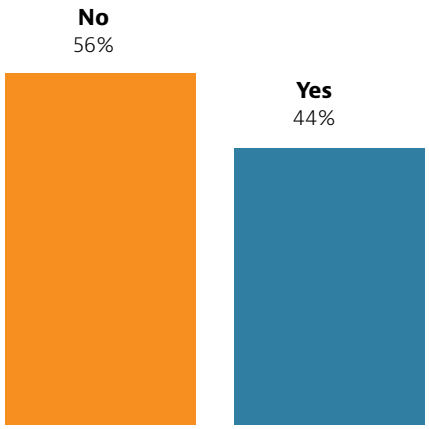


FIGURE F18. ARE CHILDREN AND FAMILIES PHYSICALLY ACTIVE IN YOUR COMMUNITY?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, mostly in youth sports	65	36.3%
Yes, mostly at recess	51	28.5%
Yes, mostly in outdoor activities	15	8.4%
No	48	26.8%
TOTAL	**169**	**100.0%**

Sixty-five percent of respondents indicated that children and families are physically active either through sports (36%) or at recess (29%). About 27% indicated that children and families are not active enough. Comments for "no" responses included lack of recess time, neighborhood safety, affordability of sports and athletic activities, parental engagement, as well as many concerns about the amount of time children spend online or on digital devices.

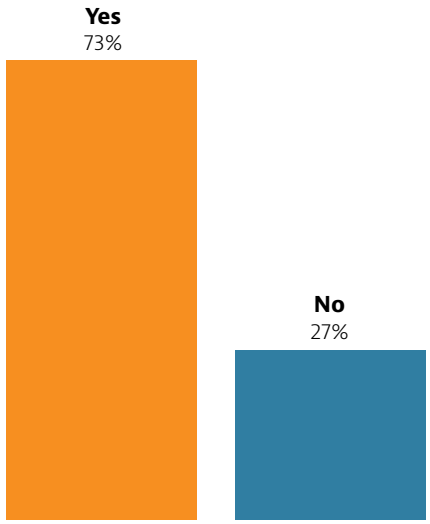


FIGURE F19. ARE CHILDREN IN YOUR COMMUNITY ENCOURAGED TO BE PHYSICALLY ACTIVE?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	134	75.3%
No	44	24.7%
TOTAL	**178**	**100.0%**

About three-fourths of respondents responded "yes" to this question, reflecting the positive responses regarding the level of physical activity by children and families in the community.

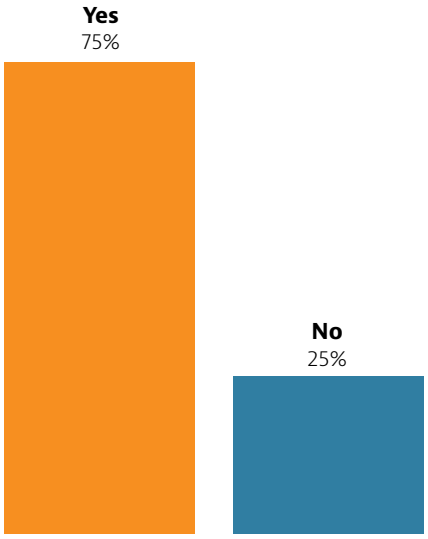
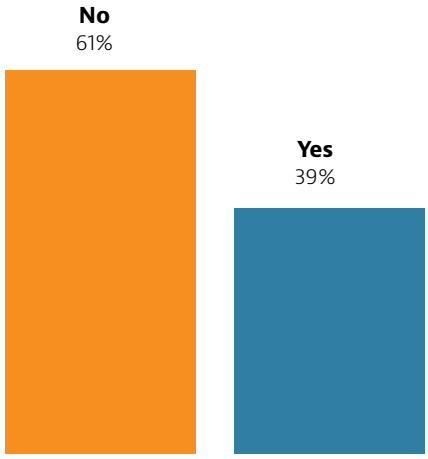


FIGURE F20. CAN YOUNG PEOPLE GET HELP IN YOUR COMMUNITY WHEN THEY ARE FEELING DOWN?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, mostly at mental health centers	18	10.1%
Yes, mostly at school	41	22.9%
Yes, mostly at the doctor	1	0.6%
Yes, mostly from friends and family	9	5.0%
No, we need more mental health services	69	38.5%
No, we need more school supports	37	20.7%
No, we need more health services	4	2.2%
TOTAL	**179**	**100.0%**



Over half of the survey respondents indicated that the community needs more services and resources in this area, with 41% indicating a need for more mental health or health services, and 21% indicating a need for more school supports. Of those who indicated that young people can access help, most indicated this help was available at school (23%). Less than 1% indicated this help is available from doctors.

FIGURE F21. DO YOUTH HAVE RESOURCES TO GO TO IF THEY ARE IN AN EMOTIONAL CRISIS?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, mostly from mental health centers	22	12.3%
Yes, mostly from doctors offices	0	0.0%
Yes, mostly from a school counselor	60	33.5%
Yes, mostly from friends and family	5	2.8%
No, we need more mental health services	59	33.0%
No, we need more school services	31	17.3%
No, we need more health services	2	1.1%
TOTAL	**179**	**100.0%**

More respondents indicated that youth have resources when they are having an emotional crisis, rather than feeling down (49% compared to 39%). Such resources are most readily available from a school counselor (34%) or a mental health center (13%). Of respondents who indicated a need for more resources in this area, most identified a need for more mental health services (33%) and school resources (17%).

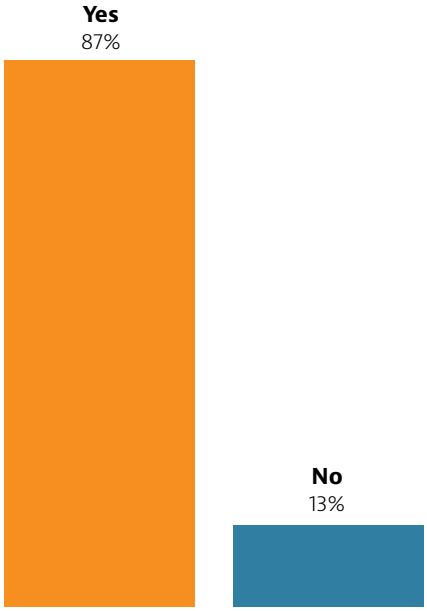


FIGURE F22. DO YOUTH HAVE SOMEONE TO TALK TO IF THEY NEED HELP WITH DRUG/ALCOHOL USE OR UNSAFE SEX?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, mostly from a community program	8	4.6%
Yes, mostly from school staff	102	58.3%
Yes, mostly from an adult friend or family member	25	14.3%
Yes, mostly from another professional	3	1.7%
No, no community programs offer this kind of support	34	19.4%
No, no adult is available to them	3	1.7%
TOTAL	**175**	**100.0%**

Almost 80% of respondents indicated that youth have someone to talk to for help regarding drug/alcohol abuse or unsafe sex, primarily school staff (58%), followed by an adult friend or family member (14%). Very few identified other professionals as a resource for youth to talk to regarding these matters. Just over 20% indicated that this is not a resource available to youth, either via a community program or other adult.

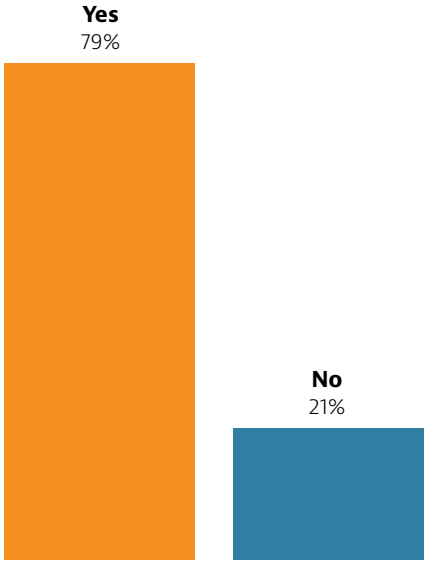


FIGURE F23. DO YOUNG PEOPLE IN YOUR COMMUNITY MAKE GOOD CHOICES ABOUT SAFE SEX?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Usually	17	9.8%
Sometimes	103	59.5%
Infrequently	50	28.9%
Never	3	1.7%
TOTAL	**173**	**100.0%**

Many respondents indicated that youth make good choices regarding safe sex sometimes (60%) or usually (10%). Nearly a third (30%) indicated that youth make good choices regarding safe sex infrequently (29%). Very few (2%) indicated that youth never make good choices in this area.

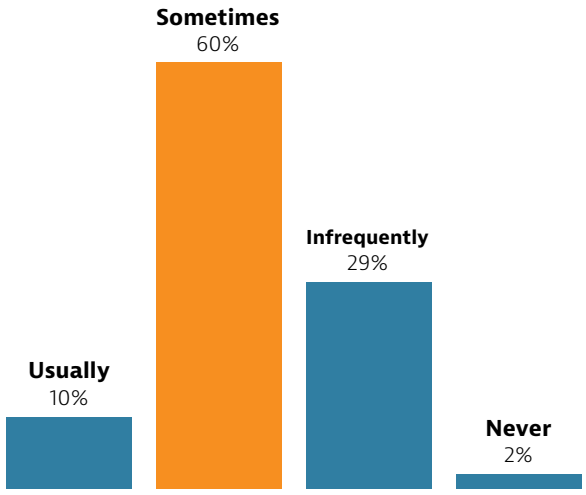


FIGURE F24. DO YOUNG PEOPLE IN YOUR COMMUNITY MAKE GOOD CHOICES ABOUT SUBSTANCE USE?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Usually	7	4.0%
Sometimes	107	61.5%
Infrequently	57	32.8%
Never	3	1.7%
TOTAL	**174**	**100.0%**

Almost two-third of respondents indicated that youth make good choices about substance abuse sometimes (62%) or usually (4%). The remainder mostly indicated that youth make these choices infrequently (33%), with only 2% indicating that youth never make good choices regarding substance abuse.

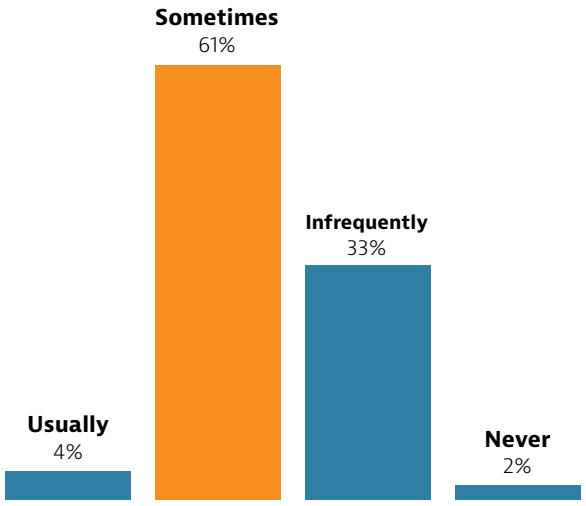


FIGURE F25. DO YOUNG PEOPLE IN YOUR COMMUNITY MAKE GOOD CHOICES ABOUT EATING HEALTHY FOOD?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Usually	1	0.6%
Sometimes	82	46.1%
Infrequently	90	50.6%
Never	5	2.8%
TOTAL	**178**	**100.0%**

Less than one percent of respondents indicated that youth usually make good choices about eating healthy food. The majority indicated that youth make good choices in this area only sometimes (46%) or infrequently (51%).

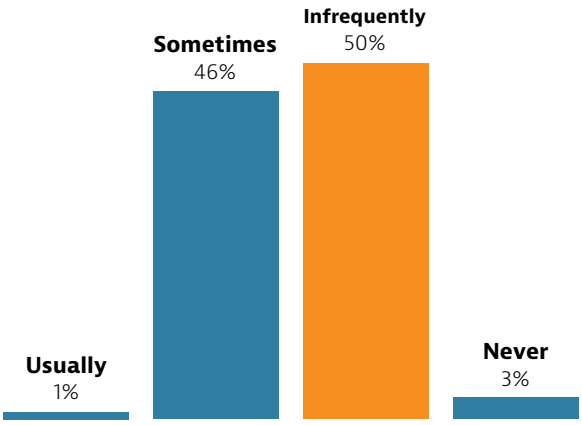


FIGURE F26. DO YOUNG PEOPLE IN YOUR COMMUNITY PRACTICE SAFE DRIVING BEHAVIOR?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Usually	22	12.7%
Sometimes	122	70.5%
Infrequently	28	16.2%
Never	1	0.6%
TOTAL	**173**	**100.0%**

Most respondents indicated that youth practice safe driving behavior sometimes (71%) or usually (13%).

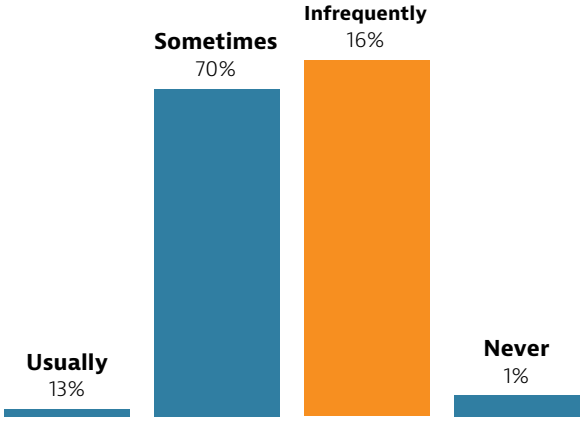
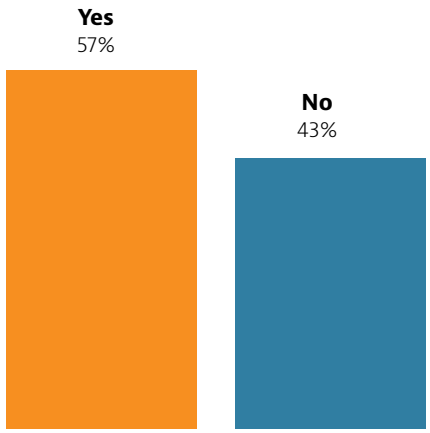


FIGURE F27. IS YOUR COMMUNITY SAFE FOR TEENAGERS?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, there are things for them to do	25	14.3%
Yes, they have positive role models	4	2.3%
Yes, they have opportunities to learn and work	39	22.3%
Yes, they are encouraged to be involved in the community	34	19.4%
No, not enough activities for them	58	33.1%
No, no jobs for them	5	2.9%
No, no role models	9	5.1%
No, no academic extracurriculars	1	0.6%
TOTAL	**175**	**100.0%**



Most respondents (58%) indicated that the community is safe for teenagers. Of those indicating it is not safe, most said there were not enough activities for teenagers (33%).

FIGURE F28. DO YOU THINK CHILDREN AND YOUTH IN YOUR COMMUNITY HAVE ACCESS TO COMPREHENSIVE, STABLE, AND CONTINUOUS SOURCES OF HEALTH SERVICES?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	97	54.2%
No	82	45.8%
TOTAL	179	100.0%

Just over half of respondents indicated that children and youth have access to health care that meets these criteria. The other indicated that they do not have access. For those respondents indicating "no", they identified primary barriers as transportation, money/cost, and parental responsibility.

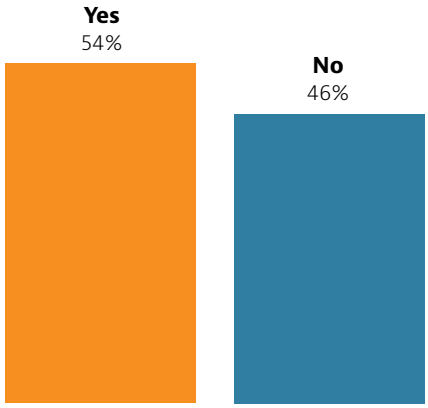


FIGURE F29. DO PEOPLE KNOW HOW TO ACCESS HEALTH INSURANCE FOR THEIR CHILDREN?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	107	61.5%
No	67	38.5%
TOTAL	174	100.0%

Nearly two-thirds (62%) indicated that people know how to access health insurance for their children. Of those indicating "no" to this question, primary reasons listed included cumbersome or confusing application processes, lack of parental follow-through, lack of awareness of insurance options like Medicaid, and concerns regarding immigration status.

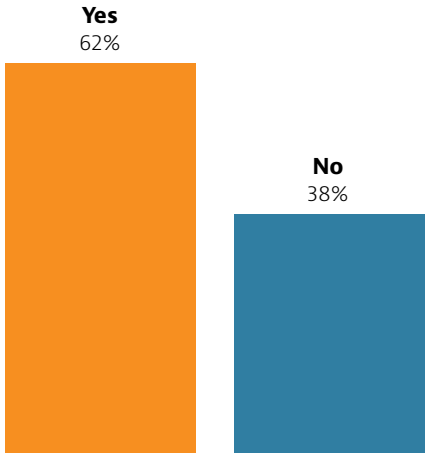


FIGURE F30. DO YOUNG PEOPLE GET REGULAR HEALTH CHECKUPS IN YOUR COMMUNITY?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	87	49.4%
No	89	50.6%
TOTAL	176	100.0%

The split between "yes" and "no" responses to this question was nearly fifty/fifty. Comments related to "no" responses indicated that youth are less likely to have regular check-ups than younger children because it is not required, unless they need a sports physical. Respondents also identified cost, accessibility and availability, and parent engagement as barriers.

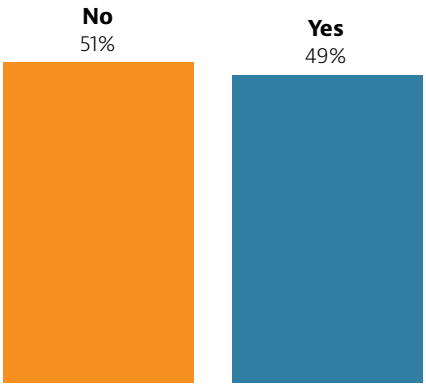


FIGURE F31. DOES YOUR COMMUNITY HAVE ENOUGH DENTAL PROVIDERS TO MEET THE NEEDS OF CHILDREN AND FAMILIES?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	130	73.9%
No	46	26.1%
TOTAL	**176**	**100.0%**

Two-thirds of respondents (66%) indicated that there are enough dental providers to meet the needs in the community.

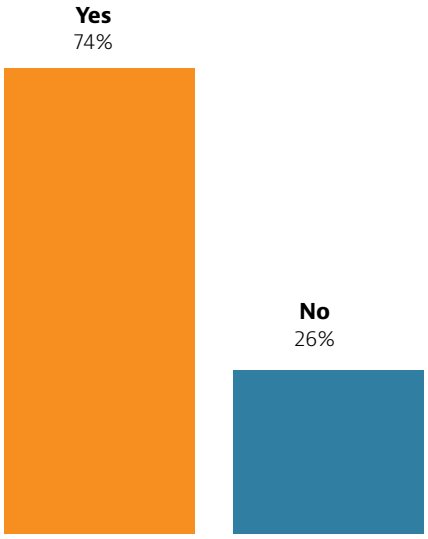
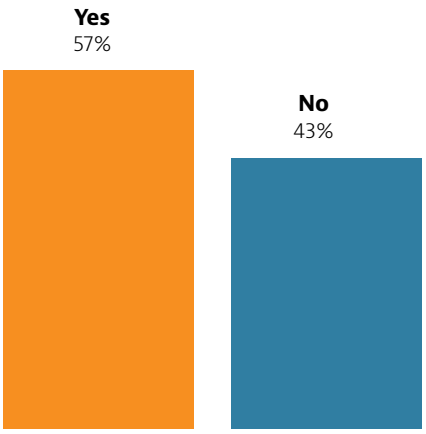


FIGURE F32. SO CHILDREN AND YOUTH HAVE THE RESOURCES THEY NEED TO GET ROUTINE DENTAL CHECK-UPS IN YOUR COMMUNITY?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes	100	56.8%
No, not enough dentists in the area	19	10.8%
No, not dentists that take Medicaid	39	22.2%
No, the hours are not convenient	15	8.5%
No, they don't need it	3	1.7%
TOTAL	**176**	**100.0%**

Over half (59%) indicate that children and youth can access resources for routine check-ups. Of those that indicate they cannot, most indicate dentists not accepting Medicaid as the primary reason (22%).

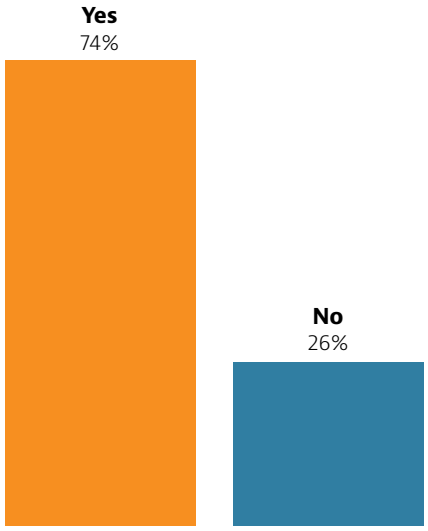


Other Observations

While the goal of this effort was to gather statewide perspective on MCH issues, responses to some Smiley Touch™ questions varied among communities. There were also interesting contrasts between responses to some Smiley Touch™ questions and similar questions on the educator survey.

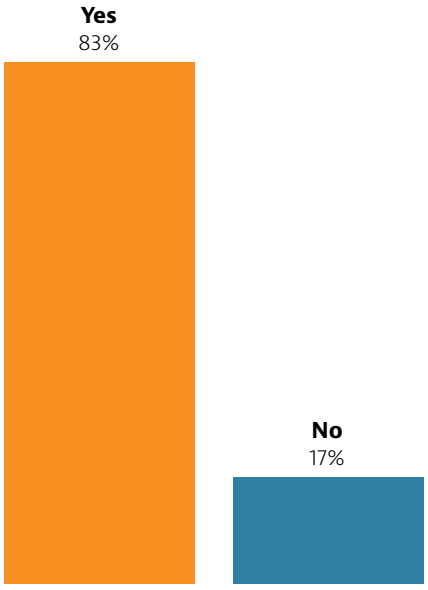
DO FAMILIES OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS OR DISABILITIES KNOW WHERE TO FIND RESOURCES AND SERVICES FOR THEIR CHILDREN?

In total, just over half of educator respondents answered this question positively (54%) a much lower score than among educators (74%). There was substantial variation by community, with positive responses varying from 12% in one community up to 76% positive in another community.



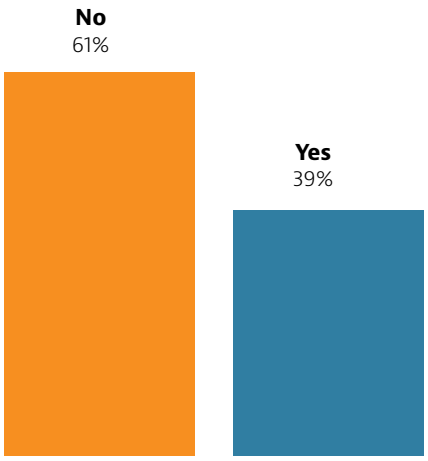
DO CHILDREN YOU KNOW REGULARLY RIDE IN A CAR SEAT, BOOSTER SEAT, OR WEAR THEIR SEATBELTS?

Nearly 3 out of every 4 educator respondents answered this question positively (74%), but responses ranged from 59% to 100% across communities. The general public responding to the kiosk question had a less positive perception than school personnel regarding the use of these safety practices.



CAN YOUNG PEOPLE GET HELP IN YOUR COMMUNITY WHEN THEY ARE FEELING DOWN?

RESPONSES	FREQUENCY	PERCENT RESPONSES
Yes, mostly at mental health centers	18	10.1%
Yes, mostly at school	41	22.9%
Yes, mostly at the doctor	1	0.6%
Yes, mostly from friends and family	9	5.0%
No, we need more mental health services	69	38.5%
No, we need more school supports	37	20.7%
No, we need more health services	4	2.2%
TOTAL	**179**	**100.0%**



Responses to kiosk questions were more positive than school survey responses to the question.

APPENDIX G: OPEN HOUSE EVENTS

Introduction and Methods

In January of 2020 the Centers for Public Partnerships and Research hosted six open house events around the state of Kansas, one in each of the six MCH-designated regions. The goal of these events was to gather public input into issues affecting the health of women, infants and children in Kansas in order to inform the development of the Kansas MCH Needs Assessment and State Action Plan.

KANSAS MCH REGIONAL OPEN HOUSE EVENTS 2020

NORTH CENTRAL REGION
SALINA | JANUARY 14

NORTHWEST REGION
HAYS | JANUARY 15

NORTH EAST REGION
LAWRENCE | JANUARY 21

SOUTH EAST REGION
CHANUTE | JANUARY 24

SOUTH CENTRAL REGION
HUTCHINSON | JANUARY 29

SOUTH WEST REGION
GARDEN CITY | JANUARY 30

In order to attract "foot traffic" the events were held in local public libraries, with the exception of Chanute, where the event was held in the municipal building. Events were promoted through local MCH programs, through CPPR communications including social media (Facebook events were created for each event), and by the host sites. MCH staff in each region were invited to attend, and MCH programs were encourage to promote local events to their clients and the general public.

THE NUMBERS

EVENTS	PARTICIPANTS	*PUBLIC ATTENDEES*	*MCH STAFF ATTENDEES*
6	135	*90*	*45*

Open House Stations

At each open house there were a series of "stations" to inform and educate participants, and to seek feedback/input.

Station 1	Station 2
Workforce and access to MCH services. This station included a poster which had information on the number and types of professionals working in the MCH-funded programs around the state. These questions were about access to services: • Are there enough health providers in the area to meet your family's needs? • Are all women and children in the community able to access the services they need?	**Information on Kansas' MCH performance and outcomes.** This station featured posters with statistics for a number of National Performance Measures and National Outcome Measures. Participants were given stickers where they could indicate which measure they felt was most surprising, most concerning, and most important.

Station 3	Station 4
Budgeting. This station had boxes for the eight issues identified as the topical areas of greatest importance by Kansas MCH programs (these eight issues were the top eight based on a simple count of how many MCH programs cited the issue as a priority in their SFY 2020 MCH Aid to Local application). Each participant was given ten bills (fake money) and asked to allocate their money to the issues of greatest importance to women, infants and children in Kansas. Participants were instructed that they could "budget" their money in any way they saw fit (all ten bills could be spent on one issue, or they could distribute them in any way across the eight issues).	**Open-ended Responses.** Participants were asked, in their own words, to share what they considered to be bright spots for the health of women and children in Kansas, what they saw as barriers to optimal health of Kansas women and children, and ideas they had to improve the health of women and children in the state.

Station 5
This station featured the MIECHV Needs Assessment (happening concurrently in the state). Participants were that asked about their awareness and use of MIECHV home visiting services.

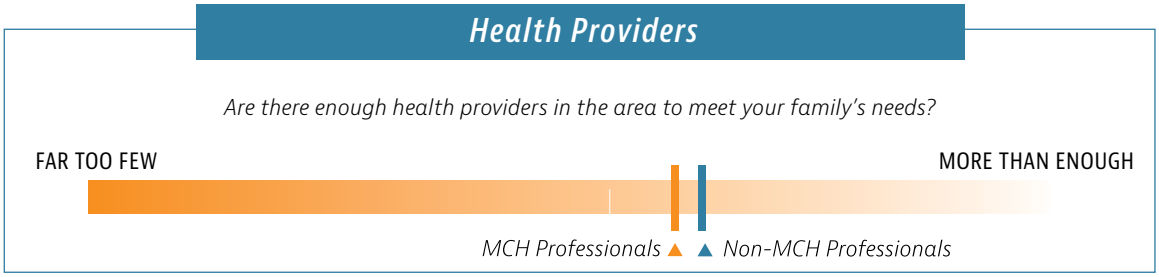
For the workforce, performance/outcome measure and budgeting stations data were collected separately for public and MCH professionals so that responses could be compared.

Findings

Workforce

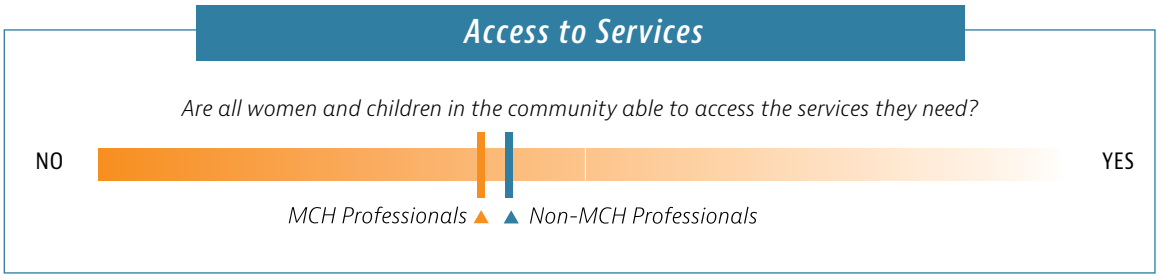
Responses to workforce questions were collected by asking respondents to place an X on a bar. The ends of the scale were opposite ends of the question, with the left end of the bar representing the answer, "Far too few providers" and the right end of the bar representing the answer, "More than enough providers." The bar to the left (orange) is the average response of MCH professionals who participated; the bar to the right (blue) is the average response of non-MCH professionals. The average responses fall to the right of the midpoint of the bar, suggesting that both MCH and non-MCH respondents answered more positively than negatively, indicating most respondents feel there are enough providers in their area to meet their and their families' health needs.

FIGURE G1



A second question was, "Are all women and children in the community able to access the services they need?" In this case, responses of both MCH professionals (the bar to the right shaded blue) and non-MCH professionals (the bar to the right shaded purple) are slightly to the left of the center of the bar. In this bar answers to the left indicate a "No" response while answers to the right hand side indicate "Yes." Since both bars are slightly left of center, both groups of respondents were more likely to select an answer closer to "No, not all women and children are able to access the services they need in the community." MCH professionals were more likely to say that women and children are not able to access the services they need than were non-MCH professionals.

FIGURE G2



Respondents were also allowed to write comments, and most of the comments were about certain health and medical specialties respondents felt were in short supply. Some of the specialties noted as having shortages were obstetrics and gynecology, pediatricians (both general and specialists), mental health and substance abuse treatment professionals, dental professionals, and complementary/alternative care providers. Concerns about the quality of available providers was also mentioned by some respondents. Other barriers to access cited by respondents were affordability, lack of access to health insurance (and some providers' unwillingness to accept public insurance), limited transportation, and limited scheduling options.

Performance and Outcome Measures

At one station participants were presented with data on Kansas' latest statistics for 17 selected MCH National Performance Measures and National Outcome Measures. Participants were provided with sticky dots and were asked to indicate issues of greatest concern (one color dot) and which issues were most important to address to improve the health of women and children in the state (a different colored dot). The issues of greatest concern to MCH professionals were low rates of adequate/continuous health insurance among children, high rates to adolescent suicide, low adherence to recommendations for infant safe sleep, and high rates of Sudden Unexpected Infant Death (SUID) and pre-term births. Children's health insurance status, adolescent suicide, and SUID were among the greatest concerns of non-MCH professionals as well. Also of concern to non-MCH participants was the percentage of adolescents (with and without special health care needs) who receive services necessary to make transitions to adult health care. The factors cited as being most important for Kansas to address in order to improve the health of women, infants, and children were:

- Ensuring children have adequate and continuous health insurance coverage (MCH providers and general public)
- Ensuring pregnant women receive care in the first trimester (MCH providers and general public)
- Improving rates of vaccination (MCH providers and general public)
- Reducing teen suicide (MCH providers)
- Improving rates of developmental screening (MCH providers)
- Reducing the number of children born with low birth weight (MCH providers and general public)
- Increasing the duration of breastfeeding (general public)

Budgeting Among Key Priorities

At another station participants were provided with $100 of fake money (ten $10 bills) and asked to "budget" their money among eight priorities. The table below depicts the number of programs that cited the issue as a priority in their ATL application, the number of dollars "budgeted" to the eight issues by the MCH providers that participated in the Open Houses, and the dollars budgeted among the issues by members of the public (non-MCH professionals) who were at the Open Houses.

TABLE G1. PRIORITIZATION OF SELECTED MCH ISSUES BY SEVERAL METHODS AND AUDIENCES.

ISSUE AREA	NUMBER OF PROGRAMS CITING ISSUE IN ATL APPLICATION	FUNDS BUDGETED BY MCH PROFESSIONALS	FUNDS BUDGETED BY NON-MCH PROFESSIONALS
Physical Activity	11	$320	$620
Access to Women's Health	34	$560	$960
Access to Healthy Food	11	$600	$1,140
Tobacco Use	24	$190	$280
Breast Feeding	16	$380	$550
Children's Health	24	$630	$1,440
Mental Health	26	$1,500	$2,210
Substance Abuse	13	$710	$810

Mental health clearly stands out as the area cited as a priority by a relatively large number of programs and that was given the largest "budget" by both MCH professionals and members of the public at the open house. The broad categories of women's health and children's health were also cited as a priority and had high "budgets." Access to healthy food and physical activity received far greater recognition from the general public than from MCH professionals, especially in relation to food which received the third highest "budget" by members of the public.

Open-Ended Comments

All participants were given the opportunity to provide open-ended responses to three "prompts." Participants received cards to write down their answers and affix them to large posterboards for each of the three questions listed below. All responses, sorted by the six regions where open house events were hosted, are included below.

THE PROMPTS

"What are the greatest challenges to health for women and children in your area?"

"What are the bright spots for women's and children's health in your area?"

"What ideas do you have to improve the health and well-being of women and children in your area?"

What are the greatest challenges to health for women and children in your area?

Challenges to Health: North Central

- More mental health assistance
- Quality child care needs are limited by income potential.
- Lack of transportation (in small rural communities).
- Dental care for whole family.
- Not enough dentist and vision care for those with medical cards and children.
- No health insurance and low wages prevent families from looking for or receiving the help/service they need!
- Need affordable dental care needs for people with no insurance or high deductibles.
- Access to infant/ toddler childcare.
- Easy access to medical transportation with easy reimbursement process.
- Personal accountability for an individual health and for health of their children.
- Need more providers that help and diagnose autism.

Challenges to Health: Northwest

- Insurance gap, awareness that women qualify for their pregnancy.
- Stigma towards receiving mental health services.
- Day cares that have a two year waiting list.
- Access to options in health care (limited amounts of providers many utilizing urgent cares to have zero medical homes). Access to safe, affordable daycare. Access to safe/affordable lead free housing.
- Day care options. Lack of activity for some kids live in an area where it is not safe for outdoor play (or mom's perception of safe to be outside). Mental health. Dental for kids and low income in our area only one dentist who accepts Kancare.
- Limited dental care for children or state insurance. Access to mental health care.
- Cost of daycare and baby food.
- Holistic, whole spectrum care support/care that begins with families before conception and continues into the postpartum period. Women should not need to access services in five separate locations to get their needs met with their new babies. Kansas Needs more midwives, doulas, postpartum care providers and information about these services for women who wouldn't normally be exposed to this kind of care.
- Lack of mental health services and coverage for reasonable fees for lower socioeconomic groups.
- State agencies working together. Reduction of paperwork to provide services to families. Money at state agencies should go more directly to families not oversight of programs.
- Rise of respect and pay for individual services in childhood population.
- Lack of paid maternity leave. Transportation. Lack of wrap around and collaboration.
- Lack of childcare.
- Affordable housing.
- Number of master social workers to fill keyholes.
- I believe there are a lot of miscommunication or wrong perceptions for mental health and the impact on childcare.
- More supports for families that have children with autism specifically. ABA provides in western KS.
- Childcare affordability.
- Limited or not enough mental health care for children.

Challenges to Health: Northeast

- Miscarriage support
- Affordable childcare
- Lack of resources and providers
- Pregnant women and tobacco use
- Mental health / sub. Abuse resources
- Lack of awareness around resources available
- Lack of transportation
- Transportation, empowerment, home trauma, mental health uninsured.
- Transportation, child care
- Lack of accessible childcare
- Transportation
- Lack of reliable transportation available for clients and money for medical care, more affordable childcare.
- Empowerment options
- Literacy
- Lack of Medicaid offered medical care
- KS has expanded insurance coverage for reimbursable perinatal MH Screenings in pediatric settings.
- Mental health concerns
- Affordable, high quality childcare
- Shortage of qualified EMCH therapist and services
- Lack of trauma workers
- In Leavenworth Co. both hospitals have closed the maternity wards. Creating a HUGE shortage in maternal care.
- Not enough support for postpartum depression
- No standardized or protected maternity leave
- Need Medicaid expansion
- No healthcare for uninsured
- States failure to expand Medicaid
- Transportation
- Research vaccines - our kids get way too many
- Reliable transportation especially in rural areas
- Insurance access to healthcare, access to mental health care
- Work force for home visitors/home healthcare
- Failure of KS legislature to expand KANCARE
- Lack of affordable, quality childcare
- Programs for new mothers
- Misinformation and conspiracy theories undermining science
- Lack of affordable childcare
- Poor literacy and nutrition

Challenges to Health: Southeast

- Transportation needs
- Transportation needs
- Inadequate child care, poverty, domestic violence, drug and substance abuse
- Transportation
- Transportation, childcare, housing/we need temporary housing for families, physician knowledge of substance abuse, DV resources, so many barriers for families
- Transportation needs
- Physician knowledge and support for exclusively breastfeeding
- Mental health services, transportation, recognition of need by "public"

Challenges to Health: South Central

- Lack of OB doctors
- Lack of OB
- Language
- Transportation
- Transportation
- Invasive agencies
- Fear of losing children if help is asked for.
- Access to help with breastfeeding and other services outside of 8-5 M-F
- Insurance
- Lack of accessible mental health services for women, specifically perinatal services
- Lack of Spanish speaking staff on ACI levels of MCH services
- Access to qualified providers without having to travel
- Competition and lack of collaboration between programs
- Specialists that offer services in other languages other than English
- Lack of specialty providers

Challenges to Health: Southwest

- Money
- Transportation
- Time for working mothers/ parents
- Language
- No health insurance
- High costs
- Cultural barriers
- Language barriers
- Immigration status
- Lack of knowledge over health care
- Insurance gaps
- Cultural barriers
- Decreased funding
- No health insurance
- Gaps in plans for breastfeeding access in contradiction to the ACA
- Health insurance for children 6-17
- Not specialty doctors
- Insurance resources for help
- Transportation
- Mental Health Insurance
- No health insurance due to legal status
- Money
- Time
- Day-care providers for different educational programs
- 2 parents working - some multiple jobs
- Transportation
- Financial issues for clients and not having many providers
- Being able to access their services
- Transportation to doctors' office in other communities
- Decreased funding to local health departments equals less services
- Cost
- Language barriers
- Language barriers
- Translators are need in our area or a constant effective phone line

"What are the bright spots for women's and children's health in your area?"

Bright Spots: North Central

- Opportunities for MCH providers to meet/ discuss and share.
- Communities are focusing more on collaboration than in the past.
- Our county health dept. coordinates with multiple programs in dept. for one stop visits for multiple programs. Breastfeeding rates are very good. Community partnerships.
- Community advocate meetings (EX: PIECE).
- Community programs that are available are of high quality.
- Women are starting to dominate the workforce.
- Continuing to see more individuals learning and talking about mental health.
- Rise in local 'Becoming a Mom' participants.
- We have seen a decrease in teen pregnancies.
- A one stop place for people to access info in the community.
- Annual community baby shower. Goal: to bring awareness to pregnant women and families about resources available to them!

Bright Spots: Northwest

- Excellent infant/toddler services that work well together to support families' needs.
- Wonderful community of professionals support "all" programs.
- Ability to individualize services for each client. Able to come for one visit and receive access to many of their needs. Now including the importance of fathers through fatherhood incentive.
- Rise in community referral collaboration through IRIS. Rise referral followers.
- IRIS. Excellent pediatric clinic and doctors. Excellent public health dept.
- Four out of five receiving prenatal care is probably pretty good, decreases maternal death rate.

Bright Spots: Northeast

- Crawford Co. HD WIC Clinic Perinatal MH Screenings!
- Free transportation for non-emergent services
- Strong community partners - PAT Public Library Build your village etc.
- The HD programs, WIC, etc.
- Douglas Co. HD LMH work to address health equity.
- Offering PMI services to those in need - helpful and awesome for getting mothers what they need and being successful.
- Healthy families at HD.
- ELKAN Early Child access
- Recent focus on mental health in our community
- Positive budget start ECMH.
- Kansas health foundation access to healthy food.
- Attention / focus on important.
- Community baby shower in Lyon Co.
- Great new leadership at state of KS.
- Strong time at library.
- LMH care
- Teddy bear clinic in Emporia
- Tiny K HD healthy families WI positive stars.
- Children's programs at library, parent/child medication at library.
- LMH post natal programs, lactation support, and build your village.
- Well connected net of agencies collaborating (Lawrence).
- Prenatal birthing classes, cost waived for families in need.
- Prenatal classes at NRH.
- Dedicated providers of health and wellness of women and children.
- Do Co. PAT
- Providing PNC to immigrant woman with collaboration with public HD/ OB's and volunteer interpreter
- Breast feeding clinic at NRH
- Access to healthcare for women 10-29.
- Dedicated providers who care about children and families.
- Childrens Mercy Hospital in Jo. Co. serving entire KC metro.

Bright Spots: Southeast

- Breastfeeding afterhours line and weekend support
- Breastfeeding support
- Rockstar IBCLC in Chanute @ NCHD - rates up! :)
- Support for parents
- Lots of IRIS participation, building has a breastfeeding room, great partnerships between great partners (MIECHV)
- MIECHV
- Coordination of programs
- among agencies, mental health services/intake in schools
- PAT now in Chanute
- Fantastic community collaboration, strong social networks

Bright Spots: South Central

- Access to programs
- Kansas Breastfeeding coalition
- People are realizing the importance of breastfeeding
- Kansas perinatal quality collaborative
- Increasing awareness of mental health of caregiver and effect on the child
- Federal funding for home visiting programs
- Pediatric mental health workforce development (KSKidsMap)
- Statewide Safe Sleep Infrastructure
- MCH program at Reno County Health Dept, Hutchinson Clinic OB dept, and Hutchinson Regional Medical center

Bright Spots: Southwest

- Seward county has great participation in the Becoming a Mom classes
- Library - Free/Family programs from birth - senior
- Universal access like parents as teachers; Becoming a Mom in community
- Breastfeeding support
- Baby love group
- RCDC NBFU program
- Parents as teachers programs
- Preschools
- Library Finney County
- School programs for struggling families/ students
- Local health clubs
- Zoo
- Immunization Rates
- Relationships with Parents and student
- Russell - genesis, library, parents as teachers, head start
- Library program is great! - Greeley County
- Great turn out with BAM classes at Seward County
- Several options available
- BAM has really grown and become a great service in the community
- Communities libraries and other programs are in place learn and play
- Health Departments. RCDC Healthy steps program
- Health depts do a great job in providing services

What ideas do you have to improve the health and well-being of women and children in your area?"

Ideas: North Central

- Paid maternity leave
- Partner with other non-profit community service org. to spread word, share info, provide programs (like YMCA).
- I believe we should have more housing resources for families without homes, and quicker waiting process.
- We need legislative change to include mental health as part of medical care and tax. The brain is an organ!
- We need affordable health care for everyone!
- Employ different types of health providers for prenatal services such as midwives, family practice doctors. Birth centers. Employ IBCLC's in the community.
- Opportunities for physical activity for kids.

Ideas: Northwest

- Employ mental health service providers who can see clients during their visit if there is the need. Housing voucher program only have one in Bt. Co. that has a wait list of 6 months.
- Mental health service/therapy at health departments. Paid maternity and paternity leave.
- Mental health providers with expertise in Early Childhood Development. Mental health services checked under insurance.
- Form groups for SHCN to inform, share, and bounce ideas off one another.
- Use workforce sheet questions in health departments. Specify "health" as something that includes mental health.
- Birth centers, midwives, doulas - I know these providers/programs (breastfeeding/ lactation, postpartum care providers) exist in the community. They're not being supported/loud enough.

Ideas: Northeast

- Free Pre-K
- Coordinated system of multidisciplinary home visiting that includes physician, care worker and therapist to provide in-home therapy
- Co-op childcare options
- Comprehensive behavioral health services. Screen every mom, every visit
- Broader EAP for mental health
- Don't serve processed food at your events!! This is NOT promoting health
- Paid leave after birth and delivery, affordable infant/toddler care for working parents
- Stronger collaboration with other agencies to improve wrap around services
- More affordable childcare
- Include supports to your children experiencing trauma @ new crisis center
- Parenting skills classes
- Networks of providers who care for the family as a whole
- Weekend/overnight childcare options accessible and affordable
- Provide free transportation for appointments
- Centering health care. Community gathering transportation
- Free Pre-K child care program
- Investigate vaccine safety for the 1000's of vaccine injuries in Kansas
- Providing more support for prenatal/ medical/ and mental health
- Incentive opening childcare services.
- Classes on healthy relationships/developing boundaries
- State mandated maternity and paternity leave
- Providing school/home/community/faith based/ parenting classes.
- Same day access to contraceptive including LARC
- Medicaid
- Doctors should NOT ban unvaccinated children. Mothers should be tested for Hep. B - if she is neg. a newborn should NOT receive the vaccine on the first day of life. WIC food should be healthy, unprocessed, anti-biotic free WHOLE FOOD

Ideas: Southeast

- Prenatal breastfeeding education classes
- Workforce development programs tied to HV programs, ESL classes increased
- Public announcements to promote MCH in SEK
- More ability to help family with substance abuse in MCH

Ideas: South Central

- IT would be nice to bring back the pregnant list sharing that took place among Kancare and health depts at enrollment in Kancare to address HIPAA
- Better collaboration between organization and agencies
- More mental health options
- Designated women's treatment center
- Better and more mental health options
- More OBGYN providers available so we don't lose clients to surrounding communities
- More providers accepting Medicaid participants
- Offer services beyond 8-5 m-f
- Centralized OB Navigation to connect women to services and providers based on need
- Train CHW on basic services/care for women, infants, and children. Ex-breastfeeding, infant care, what's normal postpartum
- More opportunities for natural/alternative/ complimentary services

Ideas: Southwest

- Need mental health psychologist
- Need mental health counselors
- Need mental health case workers
- Need Legal Help
- Reimbursement for IBCCC support for all moms - serving the insurance GAP
- Becoming a Mom funding for program sustainability
- Better Doctors.
- Place for exercise and day care
- Encourage them to come to scheduled prenatal appointments by teaching about importance and offering incentives
- Funding/flexibility for becoming a mom program
- IF funding was available staff could expand in performing more home visits to our community! We could increase the number of prenatal BAM classes in Seward if a full time employee could do the job!
- More breast feeding support would be great.
- Funding for local programs is scarce and hard for communities to provide.
- Encourage mental health evaluations after birth
- More funding to expand early childhood home visiting programs reaching young children in family preservation or foster care.
- UBI & M4A option to opt in
- More direct dollars to support local players supporting children's health

APPENDIX H: ADOLESCENT FOCUS GROUPS

Introduction

The Kansas Department of Health and Environment, as part of the 2025 MCH Needs Assessment development, contracted with DCCCA to gather data specific to the adolescent population statewide, with an emphasis on reaching underserved youth (rural, LGBTQ, youth with disabilities and other special health care needs, youth in the juvenile justice system, youth in foster care, etc.) to understand health needs from the perspective of adolescents themselves. DCCCA is a 501©(3) organization headquartered in Kansas that provides social and community services to enhance the health and well-being of those it serves. The organization's primary focus is prevention and treatment of alcohol and drug abuse, but they partner with other health and social service agencies in the Midwest to more broadly address the health and safety of women, children, and other populations. They work closely with children-serving organizations in the state and thus were an ideal partner to conduct this work.

The objective of this project was to facilitate conversations and record youth voice and perspectives regarding five areas.

- Their views on health and the healthcare system
- What services they feel are available to them
- What are the barriers to receiving whole health services
- What tools do they need to help them navigate the healthcare system
- What are their health priorities and biggest needs

To that end, 19 focus groups with 180 students in middle schools, high schools, and colleges around the state of Kansas participated.

Participating Communities

Northeast

Prairie Band Potawatomi Nation Boys and Girls Club – High School Youth

Haskell University

Baker University

Total Equality Alliance at Lawrence High School

Kansas Youth Empowerment Academy – High School and College Youth

Holton High School

Southeast

DCCCA Elm Acres Recovery Services – High School Youth

Juvenile Services District 5 (Lyon County) – Middle and High School Youth

Yates Center High School (Two groups)

Northwest

Northwest Kansas Juvenile Services – Middle and High School Youth

Wallace County High School

Stockton High School

North Central

Smith Center High School

Clay Center High School

South Central

Butler Community College

Wellington High School

Southwest

Dodge City High School

Ness City Junior High School

The focus group format consisted of a variety of questions related to adolescent health and wellness needs, barriers, and priorities. Schools and community organizations were asked to select a variety of students from different backgrounds and social groups to ensure that multiple perspectives were heard. Each focus group lasted 45-60 minutes. At the beginning of each focus group, whole health was defined for the participants to lay the foundation for the discussion.

Less than five of the youth surveyed were slightly over 21, but those participants' responses did not vary significantly from the feedback received overall.

Questions Presented to the Students

- Keeping in mind what we said about "health" earlier, can you tell us what being healthy means to you?
- What kinds of things can you or your friends do (actions and decisions) that are healthy/good for you?
- What kinds of things do you or your friends do (actions and decisions) that are unhealthy/not good for you?
- Out of all of those things, what do you think is the thing you or your friends care about most that keeps you healthy? Unhealthy?
- Where do you or your friends go if they are sick or have questions about how to stay healthy?
- What foods do you or your friends think are healthy to eat? Where can you go to get healthy food?
- Where do you or your friends go to exercise, work out or just be physically active?
- Where do you or your friends go if they need someone to talk to?
- Do you or your friends have someplace to go in your community where you feel comfortable talking about your health and how you are feeling?
- What kinds of things make it hard for you or your friends to get help with your health and wellness needs?
- How well do you think you or your friends could explain their health needs to others?
- What do you do to take care of your health and health care needs?
- If you need help with meeting your health needs, who helps you? Are you comfortable with their help?
- Is there any place where you or your friends can learn about how to be healthy and how to take care of your health care needs?
- What kinds of things do you think you or your friends would need to know in order to take care of your health and health care needs?
- Is there anything about your health or health care that we haven't discussed that you'd like to share?

Question 1: What healthy means

The most common response from youth was that being healthy means having a good balance, both in every aspect of life and in mental and physical health. This did not vary between locations or ages.

Eating healthy and exercising was frequently mentioned as well as refraining from substance use. Youth reported that taking time for self-care, being happy and having a positive mindset, making smart decisions, and trying to be the best version of oneself are all components of what health means to them.

Question 2: Healthy actions and decisions

Youth reported many options for healthy actions they can take in their lives. Responses frequently focused on physical health and included actions such as eating healthy, drinking water, having good hygiene, exercising or working out, going on walks with friends, and participating in school sports. High school participants in particular focused on physical activity as a healthy action they can take.

Youth overwhelmingly reported that social connections were very important to health, including surrounding oneself with positive people and avoiding negative behaviors and toxic relationships.

Youth overwhelmingly reported that social connections were very important to health, including surrounding oneself with positive people and avoiding negative behaviors and toxic relationships. Relationships with peers and hanging out with friends were often reported as healthy decisions. Youth indicated that talking to friends about problems helped them and that it was also important to look out for friends and help others who might be struggling.

Three areas high school and college youth indicated were healthy choices they struggled to make were time management, sufficient sleep, and stress management. Youth reported that decision making was an important component of health but indicated that at times they do not always make positive decisions related to time management and sleep, which contributes to stress. Youth across the board reported that hobbies such as writing songs, creating art, playing video games, and participating in extracurricular activities were very important actions they can take to stay healthy.

Though refraining from substance use was sometimes mentioned, it was not a primary or initial response from the majority of participants. College youth and justice-involved youth were more likely to offer this action as a way to stay healthy than middle school or high school youth. With the exception of vaping/juuling, substance use was not mentioned frequently.

There was mixed reaction from youth regarding technology and screen time. Some groups indicated that limiting screen time was a healthy choice, others shared that phones and video games were healthy outlets in their lives.

Question 3: Unhealthy actions and decisions

Youth overwhelmingly reported that poor food choices including eating out, consuming junk food or fast food, and binge eating was an unhealthy decision that they frequently made. Youth often made the connection between eating unhealthy food and not being physically active or sitting around all day as another unhealthy behavior.

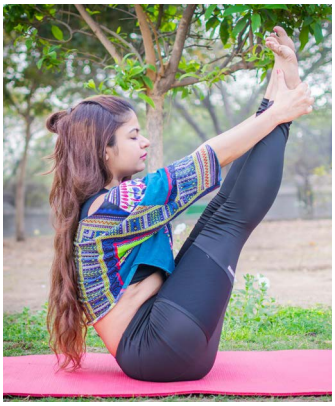
Procrastination, poor time management, and stress from school and life were commonalities across every age and location. Sleeping too much or too little was a common unhealthy behavior that high school and college youth engaged in due to stress, homework, or entertainment like video games or TV. Concerns over unhealthy screen time either through phone usage, gaming, social media, or streaming services were brought up often among youth.

Youth shared that engaging in toxic friendships and relationships is unhealthy behavior, including peers who bully and/or gossip about others. High school and college youth mentioned that caring about what other people think and comparing oneself to others is an unhealthy behavior. Youth also reported that arguing and physically fighting are unhealthy behaviors, though this was mentioned less frequently than other behaviors.

Another unhealthy action or decision reported by youth was keeping personal issues they are struggling with to themselves or isolating themselves. Fear of judgment, concern over confidentiality, or lacking the ability to express their emotions were three reasons often cited for this behavior.

Partying and substance use such as drinking alcohol, doing drugs, vaping or smoking, and smoking marijuana were also indicated as unhealthy behaviors. Drinking alcohol and/or drinking and driving was mentioned frequently by college youth and rural youth; vaping was mentioned among all ages and groups; drugs and smoking marijuana was mentioned most often by justice-involved youth and college youth.

Question 4: Most important healthy/unhealthy actions and decisions



Of all the potential healthy actions and decisions mentioned, youth overwhelmingly emphasized physical activity such as working out or playing sports as the thing they and their friends cared the most about. Additionally, they indicated that connections with others such as talking to friends about problems, being a positive influence, and staying away from toxic people were significant to them.

Eating healthy and drinking plenty of water was also recognized by many youth as a healthy decision. Self-care and doing things to regenerate was mentioned by some youth as a priority. Screen time and video games were indicated by a few youth as a healthy action, but they were not mentioned as frequently as the other decisions and actions above.

Unhealthy eating such as eating out or eating fast food/junk food was the thing youth and their friends indicated they care the most about. They shared that it is cheaper, quicker, and more available than healthy food options. They also stated that it is a way to socialize with others and in smaller communities, is sometimes the only social activity available. Eating too much, skipping meals, and consuming too much caffeine were also mentioned as behaviors they engaged in related to unhealthy eating.

High school and college youth also mentioned staying up too late and/or procrastination as another unhealthy decision made frequently amongst their peers. Due to busy schedules, homework, and extracurricular activities it can be hard to find time to practice self-care or get proper sleep. Youth shared that lack of time management and procrastination contributes to increased stress and lack of sleep sometimes. Screen time either through phone usage, gaming, social media, or streaming services was mentioned fairly frequently as an unhealthy action or decision made my youth. Another unhealthy behavior shared by youth was being too hard on oneself and caring about what others think.

Substance use such as smoking, vaping, drinking alcohol, and doing drugs was also mentioned somewhat frequently by high school and college youth, particularly justice-involved youth.

Question 5: Where to go when sick or have health questions

Overall, youth had a fairly strong awareness of health resources such as hospitals and clinics that were and were not available in their community. They had slightly less information about mental health resources available and if they were aware of those resources, many indicated that they did not personally utilize them for various reasons including stigma and cost.

Google, WebMD, or other online resources were frequently mentioned as places youth across all ages and regions go when they are sick or have questions about how to stay healthy. Youth indicated that when they are sick, they frequently self-diagnose and deal with it on their own or with their parent/guardian's help either with bedrest, over the counter medicines, or both.

Most youth responded with individual practitioners that they see as opposed to businesses or organizations. Friends, parents or other family members, therapists, teachers, professors, counselors, coaches, teammates, doctors, nurses or a trusted adult were mentioned as individuals to whom youth might go.

One group indicated that they would first visit with their family if they are sick or have questions about how to stay healthy. The same group indicated that they feel their counselors are available for any issue they may face, and they feel comfortable going to them.

One group of youth shared that when their friends struggle with mental health issues, they seek support from each other, and they try their best to help.

Youth reported urgent care facilities, community clinics, mental health centers, doctor's offices, churches, and hospitals as locations they could go to if they are sick or have questions about how to stay healthy.

One group of youth shared that when their friends struggle with mental health issues, they seek support from each other, and they try their best to help. They expressed uncertainty with providing that support for their friends because sometimes they do not have the answers they are looking for and it can take a toll on the supporter.

All three college groups indicated that college health centers were a resource they could utilize.

Question 6: Healthy foods and where to get them

Many high school and college youth indicated fast food options purchased from a restaurant were healthy food options including Subway, the Pizza Hut salad bar, Jimmy John's, McDonald's, Tropical Café, Qdoba, and Osaki. Some youth also shared that items purchased at a grocery store or convenience store such as chips, tacos, jerky, pizza rolls, hot pockets, burritos, pizza, and bagels were considered healthy food options. While this may be contrary to what some individuals believe, there is a perception among some youth that these items are healthy.

Water, fruits and vegetables, whole grains, healthy fats, protein, dairy, and leafy greens were often mentioned across all ages and locations. The plate diagram or the food pyramid was referenced occasionally, but this was not consistent across all groups. Some youth indicated a stronger awareness of the components of healthy food and discussed elements such as caloric or portion balance, foods made at home versus foods at a restaurant, foods that are not processed, and foods that are rich in the right nutrients. Others did not express a strong awareness of food as a resource for health.

Most youth reported that they had access to healthy foods through a local or regional grocery store such as Dillon's, a franchise store with produce such as Walmart or Target, or in the school cafeteria. Farmer's markets, gardens, churches, and Dollar Generals were also mentioned, but not as frequently.

Many youth from rural communities indicated that healthy food was more difficult or even impossible to get because families have to travel to another community to access these foods.

Several high school and college groups reported that some options offered by the school cafeteria are not healthy.

Question 7: Where to get physical activity

Youth across all ages and locations reported both an awareness and utilization of an abundance of resources for physical activity. Resources were dependent upon the community but included community centers or recreation centers, fitness centers, parks, backyards, community gyms, YMCAs, outdoor trails, community basketball courts, sports practice, school weight rooms, the pool, school gyms, dog parks, their own homes, skate parks, or the outdoors.

Two of the three college groups indicated that athletics were celebrated on campus and that youth bond over physical activity. One college group shared that dancing at a dance club is a way to get exercise. Middle school and high school youth overwhelmingly reported that physical activity plays a very important role in their schools, communities, and their own lives.

Many rural participants indicated that the quality or availability of resources were not as plentiful, and one group expressed concern over the future of those resources as their communities age.

Many youth shared that community gyms or fitness centers can be too expensive.

Question 8: Where to go for someone to talk to

Most youth across all ages and locations reported that they first approach their friends and peers when they need someone to talk to, either in person or virtually through texting and social media. Specific social media platforms that were mentioned included Snapchat, which was mentioned most often, and Instagram. Parents were the second most mentioned group that youth would go to when they need someone to talk to. However, many youth indicated that it can be awkward or embarrassing to go to adults. Youth feel that adults do not understand what they are going through and they fear judgment. They also indicated that they feel adults are too busy and they do not take the time to listen to their concerns.

High school and college youth frequently reported keeping the things they deal with to themselves or utilizing the internet to cope with issues due to lack of trust in others.

High school and college youth frequently reported keeping the things they deal with to themselves or utilizing the internet to cope with issues due to lack of trust in others.

Youth indicated that parents, foster parents, family members, teachers, and coaches play a particularly important role in their lives and they expressed that these are the adults they would go to if they needed someone to talk to. Some youth indicated that they already reach out to these adults and others indicated that they would need to build trust with them before they feel like they could reach out.

A few groups did report that they felt like their school counselor or social worker was a positive support, but the majority of high school and college youth reported that they would not visit with their school counselor or social worker if they needed someone to talk to. There is a perception that these individuals are not trained to deal with personal issues, do not have the time to support youth, or cannot be trusted to keep information shared confidential.

Mental Health Centers were mentioned somewhat frequently as a resource for support in the community, though most youth, particularly those in rural communities, reported that they would not feel comfortable visiting a mental health clinic due to confidentiality concerns and stigma.

Question 9: Where in the community can you talk about health/how you're feeling

Most often, youth across all ages and locations referenced hang out spots with their friends such as the cafeteria, driving around, or the lake in their community as the place they go to talk about health or how they are feeling.

Youth reported that they are sometimes able to approach certain teachers, coaches, or parents to discuss how they are feeling, but some youth mentioned that it can be uncomfortable. Many youth expressed distrust and discomfort at approaching the school counselor to meet these needs.

Community resources such as youth group, therapy, doctors, clinics, hospitals, health departments, student success centers, and other organizations were cited as places to go for support, though not as frequently or consistently as they mentioned support from their peers.

Question 10: Barriers to meeting health and wellness needs

Stigma was frequently mentioned as a barrier to getting health and wellness needs met. One group indicated that the environment a person grows up in can dictate how or even if they access services to get the help they need at all. Another group reported that being surrounded by others with unhealthy habits can prevent them from taking steps to have healthy habits as well. Pride, denial, shyness, and lack of motivation were also mentioned as feelings that keep youth from meeting their health needs. Youth across all ages and locations expressed a lack of trust in others as a barrier to getting their needs met, whether it be mistrust of professionals or the fear of judgment from those around them, particularly as it pertains to mental health needs.

Lack of resources was also frequently mentioned as a barrier to getting health and wellness needs met. Time was the most frequent resource youth expressed they did not have enough of; due to school, homework, and extracurricular commitments it can be tough for them to find the time to focus on their health and wellness. High school and college youth frequently mentioned the cost of services and navigating that cost as a roadblock to getting services. Transportation and lack of services were also two barriers, particularly for rural communities. Having to travel many miles to receive services because they are not available in their community can be difficult and expensive for families.

Some youth indicated a lack of awareness regarding what resources were available in their community, particularly around mental health. College youth seemed to be the most informed as to what was available to them, particularly on campus.

Question 11: Comfort level in explaining your health needs

Youth across all ages and locations expressed a clear distinction between explaining physical health needs and mental health needs. Youth indicated that it feels comfortable to approach an adult, be it a parent, teacher, or doctor about a physical issue. Youth overwhelmingly reported that they were far less comfortable explaining mental health needs to adults. They indicated that they feel adults do not necessarily understand their mental health issues or take them seriously. Youth also shared that it is difficult to discuss mental health issues because it can be vulnerable, making it hard to trust other people. Youth reported a strong fear of judgment from others. They expressed that it can be tough to find the right language to talk about mental health needs. One group in a rural community indicated that because it is a farming community, boys are told to have a beer and girls are told to calm down instead. Youth also reported that they did not want to feel like a burden by expressing their needs to others.

Youth overwhelmingly reported that they were far less comfortable explaining mental health needs to adults.

One group shared that they need a role model to follow in regard to talking about emotions to make it more normalized. Another group indicated that it is important that they are asked the right questions to be able to explain their health needs, particularly as it pertains to mental health. They did not provide specific examples of what those questions would be.

College youth indicated that applied health science majors are more equipped than other students to talk about health and it can be a struggle with health terminology to voice concerns. They expressed that because parents used to help, it can be more difficult now to do this themselves.

Youth reported confusion around accessing mental health services and parental involvement in that process and expressed the desire for confidentiality.

Youth across all ages and locations reported being very comfortable explaining their physical health needs with friends and some groups reported being comfortable explaining their mental health needs with friends.

Question 12: Taking care of your health needs

Youth demonstrated a wide range of things they do to take care of their health needs. Connection with others was the most frequently mentioned way that youth take care of their health needs. Some youth mentioned their relationship with their parents and family to demonstrate their point, while others reported hanging out with their friends and being around positive people were ways they take care of their health needs.

Various hobbies were also mentioned as a way to take care of needs. Students most often reported that participating in sports either through school or on their own informally is a way they take care of themselves. Watching movies, reading, listening to music, and going for walks were also frequently mentioned.

Youth reported that self-care is another way they take care of their health needs. They practice self-care through several different activities like relaxation, having fun, joking around, eliminating stressors, meditation, and self-reflection.

Many youth indicated that eating healthy, taking vitamins, drinking water, getting plenty of sleep and exercise, and going for regular check-ups were ways they take care of their overall health.

Youth also reported that sticking to a routine schedule, going to school and/or work consistently, and practicing good time management are things they do or can do to take care of their needs.

Another answer provided by one group of youth was utilizing prayer to help take care of their health needs.

Question 13: Who helps meet your health needs

Youth most widely reported that their friends or parents are who helps them meet their health needs. Several groups also referenced Google and WebMD as a resource they utilize. Many also indicated that other family members, friends' parents, coaches, and teachers also support them in meeting their needs. Therapists, school counselors, and doctors were also mentioned but not as frequently.

Youth indicated that it can be difficult to decide when to go to the doctor and when to stick it out. They shared that it is easier to help someone else than to help meet their own needs. One group mentioned that it can be difficult to get needs met if there is a lack of family stability.

Question 14: Where can you learn about how to be healthy

School was the main resource for many youth to learn about how to be healthy, but the resources varied greatly depending upon location. Resources included campus organizations, college health forums, nutritionists, school speakers, wellness meetings, coaches, and middle school or high school health class. There was a mixed opinion on whether school health classes are a good resource, many youth felt as though it lacked useful information particularly around mental health. The internet, including YouTube, was another main resource mentioned across ages and locations. Asking family members or visiting gyms, libraries, and hospitals were also mentioned as resources, though not as frequently as school and internet resources.

Question 15: What do you need to take care of health needs

Youth across all ages and locations had an abundance of ideas for what they need to take care of their health.

Physical & Food Health

- How to eat well and cooking tips
- More transparency from adults about information related to health
- Communication from adults about health
- How much exercise to get each day
- More comprehensive sex education

Area Resources

- Places for teens to go/positive activities (bowling alley, movie theatre, teen center, etc.)
- Easier access to services and how to find out about them
- Basic information about what's available nearby and how to access
- Convenient places to access care such as a school-based health center or places that are close by and easy to get to
- More local counseling services

Health Insurance

- Health insurance: how to get it, how to use it
- Cost of care, what is covered by insurance
- Personal health plans, not one size fits all
- Insurance coverage for those who don't have it

Communication

- How to talk about what you need
- Learning the skills to talk to a doctor - what to do and say to care providers
- What to do at the doctor's office
- Role models for how to talk about emotions

School

- More health sessions in school
- School-based health care
- Mental health days from school
- Rooms or spaces in school that students can visit when they need to calm down, relax, or de-stress

Habits & Personal Growth

- Information about how to form healthy habits and break unhealthy habits
- How to manage time
- How to know when you should go to the doctor physically or mentally

Mental and Emotional Health

- How to deal with your own emotional problems
- Coping skills
- Breathing and meditation skills
- Yoga, meditation
- Understanding self-care
- Understanding triggers
- Who can help you if you aren't feeling happy?
- Ways to stay mentally healthy
- Support for depression

Support

- More understanding and approachable adults
- Make time to have conversations with youth
- Listen first
- Build trust by taking an interest in what is going on in youths' lives
- Take the issues youth approach adults with seriously
- Support from adults and parents
- How to transition to college

Question 16: Suggestions

- Raise awareness about and normalize getting help with health needs, specifically mental health
- Make services more welcoming and positive
- Send out information about health and health resources often to youth-serving organizations such as school systems
- Provide classes about transitioning to adulthood
- Need to know about health insurance
- Rooms or spaces in schools where students can calm down
- Therapy dogs in schools
- More available and approachable counselors
- Treat youth like adults
- Keep youth issues confidential
- Need to know parents are available and have time to listen
- Need counselors to be more comfortable discussing certain topics
- Have open discussions in class and not forced conversations
- Need to know how to deal with certain emotions like depression, anger
- Free health insurance
- Offer more sweat lodges in communities with native populations
- Offer resources for smudging rituals in communities with native populations
- Start the discussion about healthy habits at a younger age
- More and better school food
- Share flyers that contain resources as well as making people available to talk to about the resources
- Improve food assistance programs
- Rework insurance to pay more for preventive measures, particularly in the population of youth with special health care needs
- Protect the environment
- Make therapy easier to access
- Make gender therapy easier to access
- Be more transparent with youth when making decisions on their behalf or in support of them – explain the "why" behind the "what"
- How not to fall victim to peer pressure
- Resources for youth on how to control attitude, body language, and how to better communicate with others
- More comprehensive sex education
- Youth want to be respected by teachers and other adults
- Make sure youth know what resources are available
- How do we trust health care as a whole?
- More access to mental health providers
- In-school therapist
- Health resources for transgender and LGBTQ+ youth
- Mental health days from school
- Low-income health resources – affordable health care
- More patience and understanding from adults when it comes to the stress teenagers face with school and life

Special Considerations

Eight of the focus groups contained youth from special populations offering perspectives specific to their experiences and communities.

Tribal Communities (2 groups)

Youth from tribal communities indicated that religious ceremonies and community gatherings were healthy events they can participate in. During these ceremonies, they eat traditional foods, practice songs, and participate in drum circles. They also indicated that food one can get from the earth is what is most healthy and that food that has prayer put into it contributes to its healthiness. They reported that Indian Health Services is a health and wellness resource for their community, but one group indicated confusion around navigating healthcare and understanding tribal clinic costs.

Another group addressed specific challenges with utilizing Medicaid insurance across state lines. College youth reported the desire to have access to a sweat lodge and resources for smudging rituals in the community where they are attending school.

Youth with Special Health Care Needs (1 group) Youth with special needs shared that a unique challenge they face is that some youth in their community do not have the ability to be physically active, which can also impact their mental health. They indicated they could go to the leadership group they are involved in for support around their health and wellness needs and that their support staff are crucial in meeting their health needs. Youth expressed that transportation, not knowing what resources are available, and fear of reaching out to people they are unfamiliar with are barriers to taking care of health and wellness needs. The group was unaware of a place in the community where they would feel comfortable talking about their health and how they are feeling. The youth reported that they would like the food assistance programs that are available to include more options specific to dietary restrictions. They also expressed frustration with insurance limiting preventative care such as paying for a wheel chair and joy stick but not the mount and shared a desire for insurance to pay more for preventive measures or doctor visits.

LGBTQ+ Or Allies (1 group) Youth reported that a healthy action and decision they make is to participate in their LGBTQ+ organization at school. They reported distrust for school social workers due to untrustworthiness and judgment and expressed the desire for confidentiality and stronger listening skills from adults at school. Judgment from others and labels were two barriers to getting help with health and wellness that were mentioned. They reported the need for gender therapy, a better interview/evaluation for consideration of gender therapy, and more transparency from adults related to decisions that impact youth.

Justice-Involved (2 groups) Youth indicated that staying clean from drugs is one element of what being healthy means to them and that drugs are one of the unhealthy things they care the most about. They shared that AA meetings are place they go to if they are sick, have questions about how to stay healthy, or to talk about their health or how they are feeling. Early curfew that prevents time to hang out with friends and de-stress, denial and lack of trust are barriers to getting help with health and wellness needs. They reported that they smoke and drink as a way to take care of their mental health needs.

They indicated that probation officers and therapists help meet their needs. Youth expressed a desire for learning healthy coping skills and how to deal with certain emotions as well as safe, fun, teen-specific places to go in their free time. They also reported the need for free health insurance so that more people can get help. They expressed feeling judgment towards youth who are involved in actions that are viewed as unfavorable and that they need a support system with someone who cares for them. They recommended programs in school to have more information related to health and wellness.

Spanish Speaking or Marginalized Households (1 group) Youth shared that their parents have a hard time dealing with the expression of mental health issues due to their culture. They reported that their parents' attitude is that their children do not have anything to be sad about because they had a different life and have lived in war zones. As a result, they downplay sadness and issues and make their children feel guilty for expressing mental health issues. They stated that they feel guilty asking parents for help particularly when there is a cost involved. They expressed the need for parents to communicate that they are available and have time to listen. Youth reported that they overwork themselves through school and jobs to cope. They indicated a sense of discomfort from counselors and teachers when discussing certain topics and they would like to be able to turn to those individuals for support. They recommended a room in the school where students could go to calm down, more open conversations amongst teachers and peers, therapy dogs, more available counselors, school-based health care, and someone who can be there to listen to them.

Youth Who Are Substance-Involved (1 group) Youth indicated that staying sober is one element of what being healthy means to them, and that drugs, alcohol, and criminal activity are three unhealthy actions they care about. They indicated that there are a lot of 18-and-over businesses in their community including vape shops and CBD shops. They indicated a desire for safe, fun, teen-specific places to go in their free time. They reported that they feel comfortable going to their caseworker to talk about their health and how they are feeling. Youth expressed a lack of good mental health resources in their community and a lack of trust in those resources. They reported that they distract themselves from doing drugs through other hobbies as a way of taking care of their health and health care needs. They expressed the desire to learn more about self-care.

Survey Results

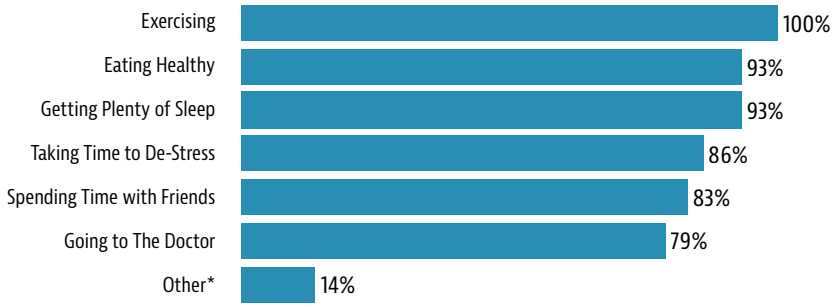
A survey containing the same questions related to health and wellness was shared with approximately 1,000 youth. 34 youth completed the survey, though it is worth noting that not all 34 youth answered every question. Overall, the survey results did not vary significantly from the perspectives provided by the focus groups. One variation indicated by participants in the survey was that they rely on their family and parents/guardians most frequently to guide them with their health and wellness needs, whereas the focus groups most often indicated that their friends are their initial support. It is worth noting that the pre-developed answers provided in the survey could have limited participants on how they considered their responses to the questions. The conversational nature of the focus groups created an atmosphere where youth were able to provide their unique perspective, while pre-determined answer options could have tethered survey respondents to specific ways of thinking about the question.

What Healthy Means

The individual answers from the survey did not vary greatly from the perspectives captured in the focus groups. Participants most often indicated that mental and physical fitness, making good choices, and maintaining a balance in life were components of what being healthy means to them.

FIGURE H1. HEALTHY ACTIONS AND DECISIONS

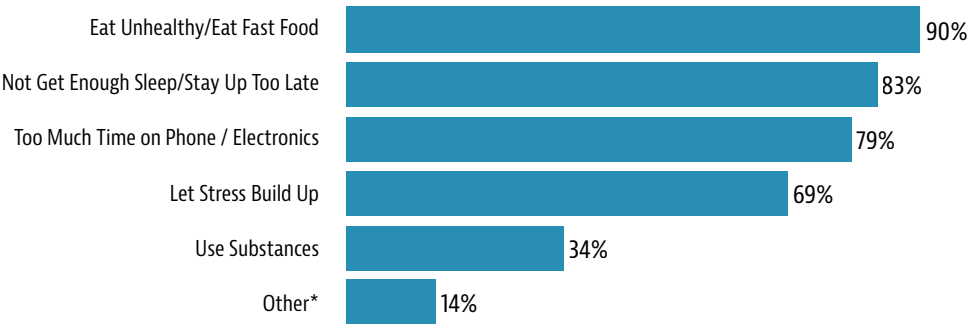
Survey participants were able to check all answers that applied to them.



Other: Personal hygiene, Not sitting on your butt all day, Go on runs, Do activities that you enjoy.

FIGURE H2. UNHEALTHY ACTIONS AND DECISIONS

Survey participants were able to check all answers that applied to them.



Other: Be lazy all day not doing anything, Focusing on the negative or surrounding yourself by bad people/drama, Putting things off, Put yourself around the wrong crowd

MOST IMPORTANT HEALTHY ACTION/DECISION

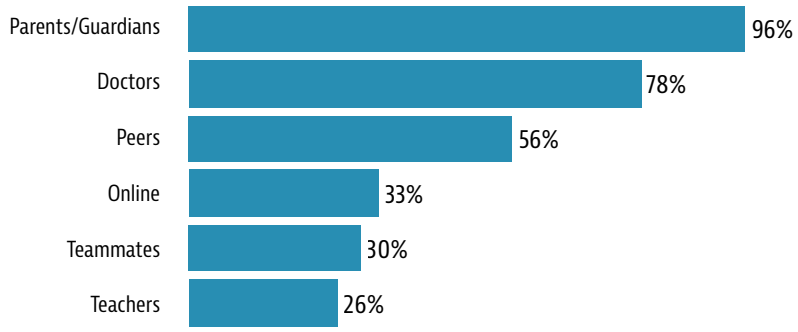
Participants' responses did not vary significantly from the perspective of focus groups. Hanging out with friends, exercising or playing sports, and taking time to relax were the most common responses.

MOST IMPORTANT UNHEALTHY ACTION/DECISION

Participants' responses did not vary significantly from the perspective of focus groups. Common responses included lack of sleep, unhealthy eating habits or eating fast food, letting stress build up, and use of electronics or phones. Illegal substances and vaping/Juuling were also mentioned by two out of the 26 participants who responded to this question.

FIGURE H3. WHERE TO GO WHEN SICK OR FOR HEALTH QUESTIONS

Survey participants were able to check all answers that applied to them.



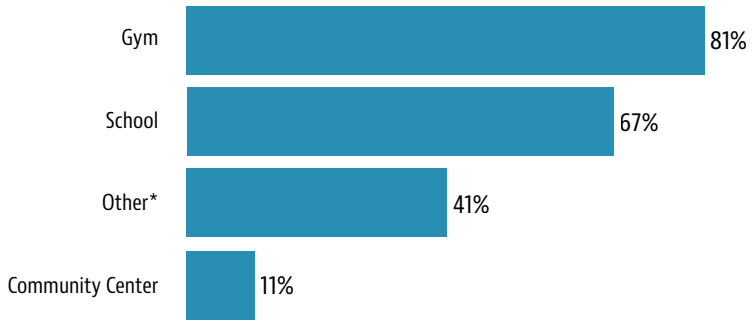
Other: Coaches, Just depends on what it is

HEALTHY FOODS

Survey participants seemed to be mildly more aware of healthy food choices than those in focus groups and answers included fruits, vegetables, proteins, salads, pasta, nuts, and beans. One participant indicated that a balanced meal is very important, while another stated that meals cooked at home are healthier. Many youth indicated a local or regional grocery store such as Dillon's or a franchise store with produce such as Walmart or Target as a place to access healthy foods. Subway, Olive Garden, Panera, and sit-down restaurants were also mentioned by participants as places to get healthy foods.

FIGURE H4. WHERE TO GET PHYSICAL ACTIVITY

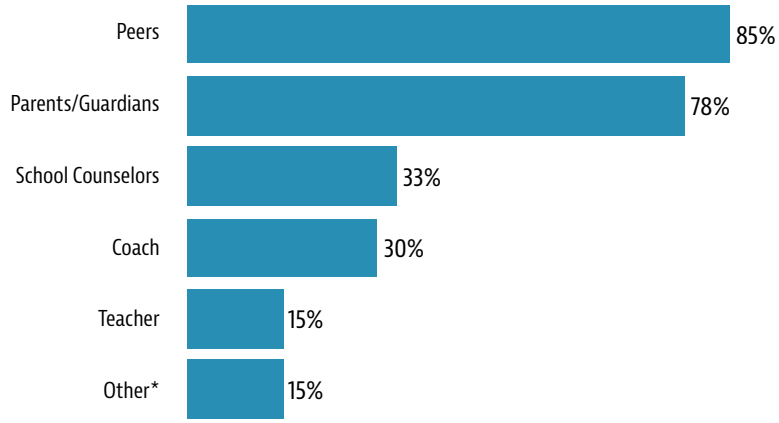
Survey participants were able to check all answers that applied to them.



**Other: Friend's house, Park, Backyard, Anywhere, Basketball court, Golf course, Home, The pool, Club sports*

FIGURE H5. WHERE TO GO FOR SOMEONE TO TALK TO

Survey participants were able to check all answers that applied to them.

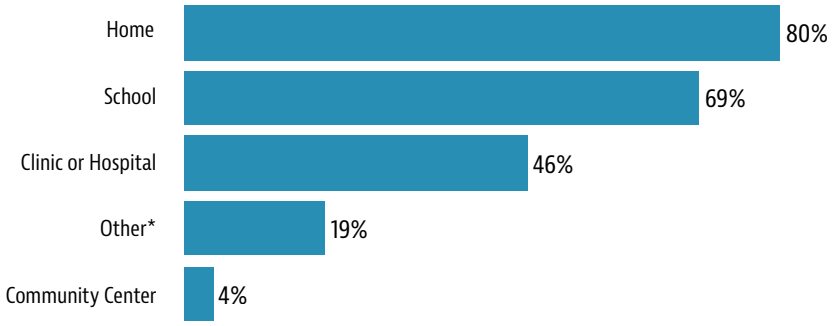


**Other: Therapist, Depends on what it is, Church leaders*

FIGURE H6. DO YOU OR YOUR FRIENDS HAVE SOME PLACE TO GO IN THE COMMUNITY TO TALK ABOUT HEALTH?

- Yes – 100%
- No – 0%

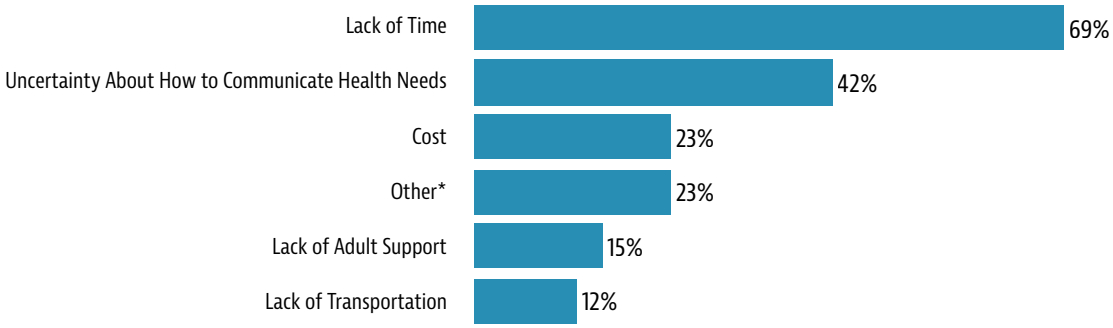
If yes, check all that apply:



*Other: Friend's House, Therapy/Therapist/Counseling

FIGURE H7. BARRIERS TO GETTING HELP WITH HEALTH NEEDS

Survey participants were able to check all answers that applied to them.



*Other: Teachers piling on homework, Being hesitant of what others think - It's hard to tell people about the things you feel and think, Lack of motivation, Lack of information, Fear of being judged

FIGURE H8. HOW WELL COULD YOU EXPLAIN YOUR HEALTH NEEDS TO OTHERS

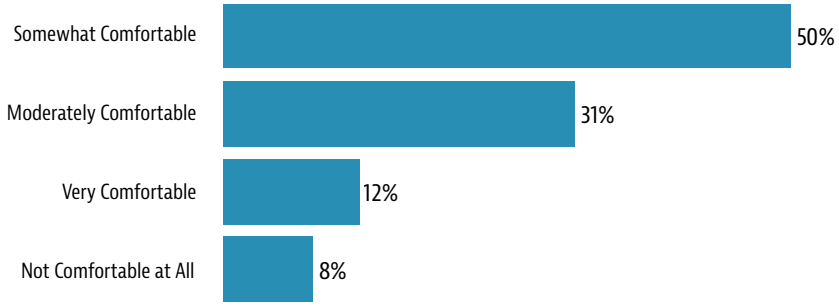
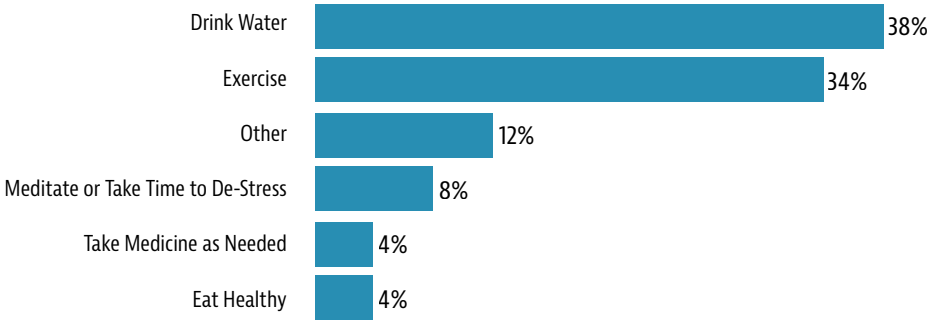


FIGURE H9. HOW DO YOU TAKE CARE OF YOUR HEALTH NEEDS?

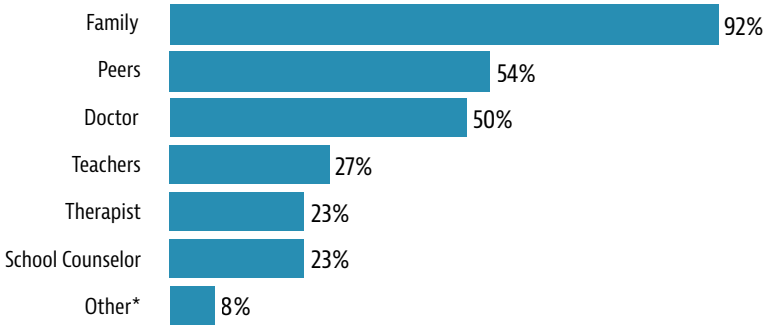
Survey participants were able to check all answers that applied to them.



**Other: I need to make sure I have enough time to do all my work, All of the above, Eat healthy, drink water, exercise*

FIGURE H10. WHO HELPS YOU MEET YOUR HEALTH NEEDS?

Survey participants were able to check all answers that applied to them.



**Other: Coach, Friends*

FIGURE H11. ARE YOU COMFORTABLE WITH THEIR HELP?

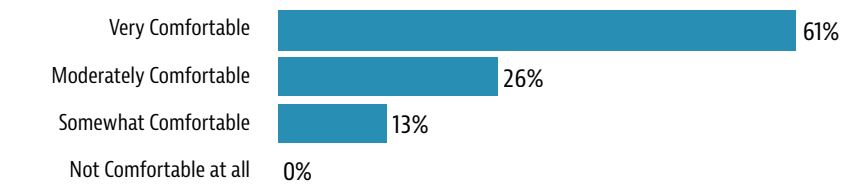


FIGURE H12. WHERE CAN YOU LEARN ABOUT HOW TO BE HEALTHY?

Survey participants were able to check all answers that applied to them.

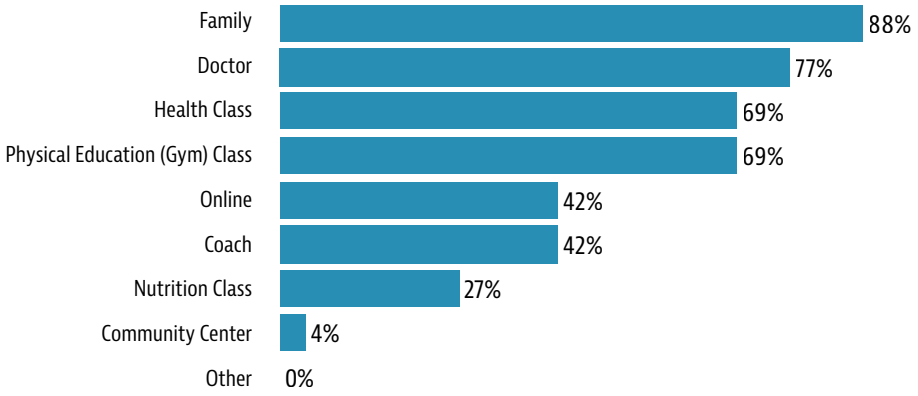
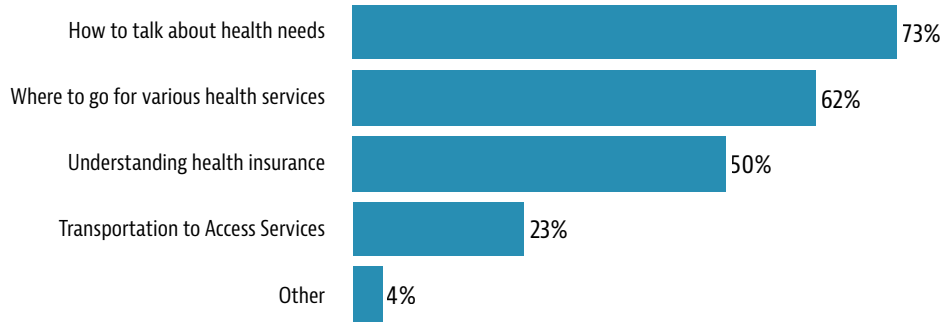


FIGURE H13. WHAT DO YOU NEED TO TAKE CARE OF HEALTH NEEDS?

Survey participants were able to check all answers that applied to them.



Other: Efficient ways to maintain healthy diet

ANYTHING ELSE YOU'D LIKE TO SHARE

- Stress…I don't know if it was said, but test and school stress is terrible
- I think that it is important that kids and teens today have a safe place they can go to talk about mental health. A lot of kids struggle with this and feel like they have no one to turn to.
- I have hypothyroidism
- I think that the main cause of mental health problems for my age is pressure to do good in school and sports. School is so important because it makes up your whole future and you are expected to do so much. Sports are just very important to some of us, and we want to do our best and be the best.

Themes

Youth rely on communication with friends as a primary support for health and wellness needs so we need to provide training and resources for peer to peer support. Youth desire a stronger connection with adults that is based on trust and listening; many youth feel like they cannot rely on adults to help meet their health and wellness needs or that they are not taken seriously by adults.

Lack of trust in others and fear of judgment came up often during the focus groups, particularly related to self-disclosure and mental health. Youth expressed lack of trust in adults and, at times, their peers when getting support for their mental health and wellness needs. Fear of judgment from others came up often during conversations about mental health.

A need for resources to support the transition into young adulthood was expressed by the youth. Education around life skills, financial literacy, insurance navigation, and self-advocacy are among the topics that high school and college youth strongly desired to learn more about.

Participation in sports plays an important role in both physical and mental health for Kansas youth. It was frequently mentioned as one of the most important healthy actions and decisions they make, where they go when they have questions about how to stay healthy, where they get physical activity, how they take care of their health needs, and where they can learn how to be healthy. Coaches were also frequently mentioned when sharing where youth go for someone to talk to, where they can talk about health and how they are feeling, and who helps them meet their health needs. Sports and coaches are a vital avenue for sharing health and wellness resources with youth.

Youth perceive a distinction between physical and mental health. Most youth reported feeling comfortable discussing or seeking support for physical health, while feeling uncomfortable discussing of seeking support for mental health due to the stigma. Similarly, they have a stronger grasp of physical health resources in their communities than mental health resources. Youth report that there is distrust for and an apprehension in school health resources.

Youth reported issues with mental health struggles, time management, procrastination, stress, and sleeping habits. These issues can be interrelated and through the use of learned coping skills could be improved.

Phone usage and other technologies are reported to be both a tool for and a hindrance to health and wellness, so education around responsible technology use is needed. The internet is a key way that youth are accessing information related to health and wellness needs and a resource hub for Kansas youth that contains health and wellness resources could be very effective in engaging and educating youth.

Many youth lacked knowledge about nutrition and reported frequently eating out as their most unhealthy habit. They reported that this is because fast food/junk food is quick, easy, and cheap and is a way to socialize with their friends, particularly in rural communities. Youth appear to want healthy, fast alternatives to eating fast food.

Youth overwhelming reported a need for both accessible health resources and places they feel comfortable spending their free time.

APPENDIX i: HEALTHVIEW PHOTO PROJECT

Introduction

Three groups of Kansas adolescents participated in a photo documentation program to capture images of community factors that contribute to or create barriers to good health. Participants were asked to capture photographs of factors in their communities that influence their health and the health of their families. Youth photographers gathered photos and then shared them with fellow photographers in small teams; these small teams discussed their photos, chose a subset of their photos to include in their presentation, and then developed a written narrative to accompany the chosen photos.

Participating Groups

Fredonia Chapter (USD 484) of Family,
Career and Community Leaders of America
Tricia Couch, faculty supervisor

Hoisington Chapter (USD 431) of Family,
Career and Community Leaders of America
Karla Reisner, faculty supervisor

Young Women on the Move (Kansas City, KS)
Anila Deliu and Mary Beth Gentry, faculty supervisors

Youth Photographers

Aleeya (age15)
Bre'Ajah (age 14)
Bry'Janique (age 11)
Cheyenne (age 16)
Colton (age 16)
Danielle (age 11)
Emma (age 18)
Erin (age 16)
Jaelyn (age 16)
Jana (age 16)
Janiyah (age 13)
Jasmin (age 16)
Lanyia (age 15)
Madison (age 15)
Natalie (age 16)
Randi (14)
Sasha (age 17)
Tyler (age 16)
Zeli (age 16)

Health Care Services

Public Health Department

Having access to a clinic where you can go and not have to worry about a price is a wonderful thing to have in the community. Public Health Department provides many service and they charge based on YOUR income.

Public Health Department is also a good place for teens who are need of condoms, conceptive pills, pregnancy tests, STD check, etc. Teens can go alone without a parent and it's all confidential.

Kansas City

Bethany Medical Office Building

Bethany Medical Office Building is another good clinic that provides many services. They also charge based on your income.

Bethany Medical Office used to be a hospital, but it is now a clinic. A clinic is helpful and resourceful to the community but it's also a downfall because the closest hospitals are Providence Hospital and KU Hospital which is far for many people in the community.

Kansas City

Eye Care Optical

Eye Care Optical is a great place to get glasses/ contacts at a cheap price. They lower the price eye exams if you have any medical condition such as diabetes. They also help you find the best glasses for you if you don't have health insurance.

The negative part is that there's no parking most of the time. This location shares the same street parking spaces with other businesses.

Kansas City

Physical Health/Fitness

The Community Boxing and Fitness Center

The Boxing and Fitness Center is beneficial and serves well in the community because it's a place where many youth can go. It not only serves healthy purposes but also social purposes. It keeps them busy and occupied instead of having them doing something that they're not supposed to be doing and helps youth stay out of trouble.

Kansas City

Corazon Saludable

Corazon Saludable is a good place to get healthy herbs and plant base smoothies and drinks. They also provide weight loss treatments.

A negative would be is that the building is run down. It does not attract many people where as other smoothie places are put well together.

Kansas City

Playground

Park is located at 11th street and Parallel in a spot that is not very nice. The park is old and needs renovations.

Kansas City

Waterpark

This waterpark is unsafe. It's very small, not big enough for kids to run around without get hurt and or injured. There's also not space to sit down and eat such as a picnic table. People have to sit on the floor where it's wet and filled with bugs. The restrooms are also very old and not maintained well. It's slippery in the restrooms and dark.

Kansas City

Cross Country

Running is a good thing for all people as it develops all skills in your body and helps to solve extra weight problems. Also it develops team skills as you run as a team and support each other.

Fredonia

Hiking Trail

The Hiking Trail is a great opportunity for some physical activity and fresh air. That is improving because it makes the community healthier.

Fredonia

Football

We have a variety of sports and physical activities to help students develop healthy habits.

Fredonia

Weight Room

This is a picture of our weight room. This weight room allows students to get exercise and get stronger.

Fredonia

Basketball

Sports helps with reaction time and problem solving skills as well as communication, and team work.

Hoisington

Environmental Health

Liquor Bottle
Finding this bottle of liquor at a public park where kids go to play was very alarming. Parks should have a no drinking zone or trash cans that are easily accessible.

Kansas City

Liquor Bottles
Same issue here

Kansas City

Sewer
This sewer makes the neighborhood smell unpleasant.

The fence is also run down and not high enough.

Kansas City

Run-Down Buildings

There's a lot of run-down houses and apartments in Wyandotte county. These run-down spots makes the community not attractive.

Run down buildings also attack drug users and drug dealers because it's a place where they can hideout since the building is not being used. Not safe.

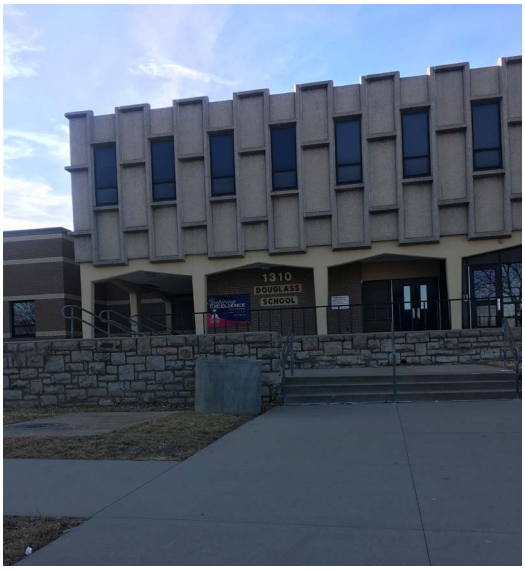
Kansas City

Education

Donnelly College

Donnelly College is a cheap college in the community. Donnelly college is building and expanding its college which is a positive. The new building looks so much nicer and it's a lot bigger.

Kansas City



Douglas School

Douglas School is one of the many schools in Wyandotte county. The building is up-to-date and there's no safety hazards.

Kansas City

North West Middle School

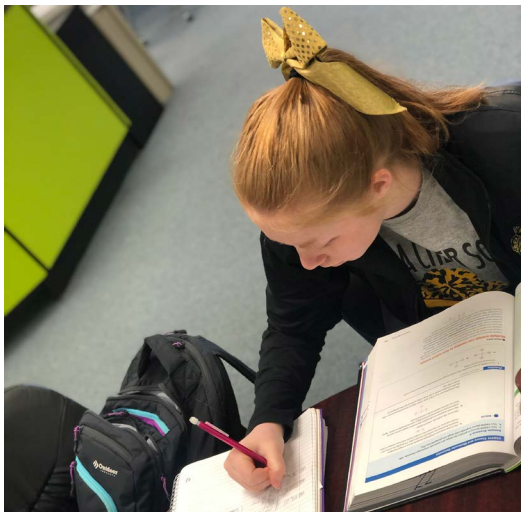
North West is a middle school in Wyandotte county. A new and bigger building is being built for the school. Its old building is very old and run down.

Kansas City

Horsing Around

Many students don't take school as seriously as others. This is showing how students are messing around while they are supposed to be doing schoolwork.

Fredonia



Over Assigning work

This picture is showing how many students do not have any time for themselves. They are usually always having their nose stuck in a book for over assigning assignments for students.

Fredonia

The Welding Shop

This is a picture of our welding shop. This allows students to learn some trade skills. Also it makes students get their OSHA certification.

Fredonia

Community Resources/Connectedness

Breidenthal Youth and Family Community Center
Boys & Girls Club

The Boys & Girls Club is a space where kids and teens can go after school and during the summer. B&G club provides learning and fun activities. This is a necessary resource in our community.

Kansas City

Mt. Carmel Youth Development Center

This Youth Center is another place that tales on challenged youth in our community and provides a safe environment for youth.

Kansas City

Fire Station

It's a good resource to have a station where we have an ambulance vehicle and fire truck services in the same location. It's more coinvented for those who need an ambulance, fire truck, or the rescue team.

The fire station should be updated, its old.

Kansas City

Young Women on the Move

Young Women on the Move is a nonprofit organization that provides the needs of teen girls in the community. Young Women teaches girls the importance of themselves and provides lessons every week about topics over the mind, body, and spirit.

Kansas City

Kansas City, Kansas Housing Authority

KCK Housing Authority helps low income families in Wyandotte County get homes and live in stable environments.

Kansas City

The Wyandotte County Juvenile Department

The Wyandotte Juvenile department is a good public facility. It keeps kids and teens that have committed crimes in a safe environment. Although it's a consequence for bad behavior, it helps provide rehab for young people who get into trouble.

Kansas City

Fredonia Mural

I think the drawings all around town improve the community. It is art which makes the town happier with its bright colors.

Fredonia

Community Outreach

Community projects help communities grow and it gets people active in their community. It also helps students and volunteers connect with their community.

Fredonia

Crowds at a Sporting Event

Our community always supports the students and everything they do.

Fredonia

Access to Healthy Food

Snack Pack

Snack Pack is considered a negative because it's not even a grocery store in the North West part of Wyandotte County. The closest grocery would be Sunfresh which is over a mile away from Snack Pack.

It's helpful for a nearby gas station but it does not proved goods.

Kansas City

El Torito Supermarket

El Torito Supermarket is a grocery store that provides many goods to the community. Torito offers all kinds of meats, chicken, seafood, fruits, vegetables, etc.

The negative part of this supermarket is that it's a safety hazard. There's barely any parking space and it gets packed fast. They new parking lot that they had made to expand the parking space, is tiny. People who drive by the parking lot, don't' respect that cross walk that is used for people to cross from the parking lot to the store.

Kansas City

Spiritual

Forest Grove Baptist Church
Wyandotte county provides many churches for different beliefs and religions.

Kansas City

Showers of Blessings Worship Center
Kansas City

Empowerment Temple
Kansas City

Mental Heath

Above and Beyond Display

This wall is to recognize our students who go above and beyond for other individuals throughout the school and community.

Fredonia)

You are Beautiful Mirror Art

The bathroom mirrors in the school are done by our high school spirit squad. They write positive messages to make people feel good about themselves if they are going through a tough time or just need a little boost of confidence.

Fredonia

Friendships

Friendships help with the mental state and comfortable environment.

Fredonia

Mascot

Students take turns being being the mascot at football games to hype up the crowd.

Fredonia

School Rally

Our school has rallies every other week to hype up students and recognize them for their academic achievements.

Fredonia

The Sting Room

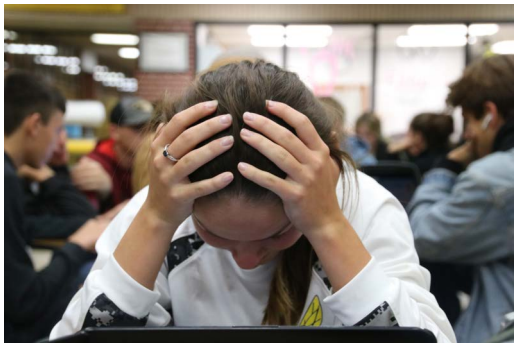
The sting room was created to help students learn how to self-regulate. The Sting Room has helped students become more stable and emotionally well.

Fredonia

The Sensory Walk

The sensory walk is a part of our school-wide PBL projects. This walk is helping people stay mentally and emotionally happy.

Fredonia



School Stressors

Most of our students are stressed on a regular basis. They must juggle schoolwork, extracurricular activities, and life at home.

Fredonia

The Relaxation Station

The relaxation station was created by our FCCLA Chapter to help students relax during finals week. Hopefully, this will help them keep their spirits up emotionally, mentally, and physically.

Fredonia

Shopping with Friends

By spending time with friends outside of school, we laugh and helps our mental/social health.

Hoisington

Catching up On The Latest

Spending time on the phone is okay to catch up, but you must remember to speak to others also.

Hoisington

Vroom! Vroom! with Friends

Relaxation time is to be done to help with mental health and to relax.

Hoisington

Spare Time... Let's Make Up A Game

Don't get bored in down time! Use your creativity to come up with a game. Social.

Hoisington

Visiting

Hoisington

Snack Time with Friends

Mental health is affected by quality time with quality people

Hoisington

Students Tutoring Students

Mental health is a classmate who understands and can explain a problem.

Hoisington

De-Stressing by Coloring

Going back into our childhood and coloring helps us destress and helps Keep us mentally strong and relaxed.

Hoisington

Capturing High School Memories

Spending time together working for a school activity is bonding time for mental health.

Hoisington

Tobacco & Substances

Be the G.O.A.T Sign
In our school, we have many posters and signs about taking down tobacco. Many people put magnets on students' lockers to bring awareness to the issue.

Fredonia

Meth Watch Program Sign
Sadly, we live right by the meth highway, so we must have these signs all over town.

Fredonia

A Goat at School to Promote "End the Trend"
Students bring awareness to Big Tobacco with multiple events at school. Their them was "Be The GOAT (Greatest of all time) and don't smoke." They brought a goat to school for a photo booth.

Fredonia

Cigarette Waste Collection

Multiple students have worked together bring awareness to and fight against Big Tobacco.

Fredonia

Cases of Beer for Sale

Alcohol is in many communities. Most of the time it is easily accessible. Dangerous things like this weaken a community.

Fredonia

Drug Dealing at the Park

While I was on a run on the mound, I witnessed a drug deal.

Fredonia

Dangers of Vape Awareness Poster

Students are vaping more and more, even in our bathrooms. We had to put up posters saying how bad vapes are.

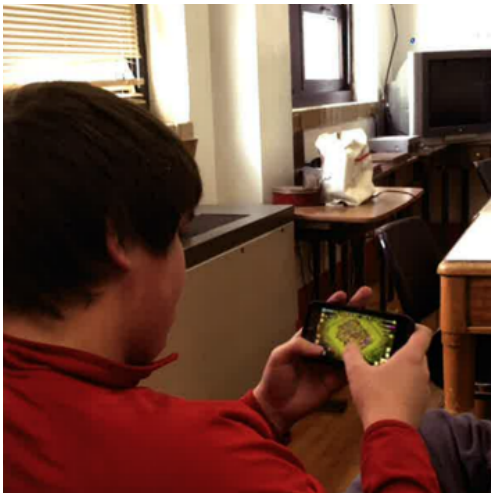
Fredonia

Other

Holiday Decoration at School

Our student-led business always has people helping. In the picture, students at school are helping decorate for Christmas.

Fredonia



Video Gaming

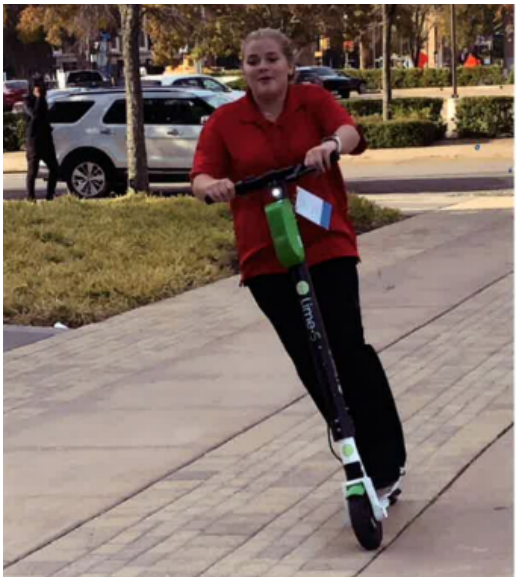
Too much battle time can lead to lack of sleep.

Hoisington

Energy Drink Health Concern

Energy drink are bad for youth, but today's youth uses them as their caffeine drinks. A lot of them are socially asked if they want one because their friends drink them.

Hoisington



Scootering

Trying new and different things is exciting and Thrilling. It will allow you to step out of your Comfort zone.

Hoisington

APPENDIX J: OUR TOMORROWS STORY ANALYSIS

Introduction

One method used to examine information about perceptions of the health of women and children in Kansas was analysis of Our Tomorrows stories pertinent to the five maternal and child health domains. Our Tomorrows was a Kansas project focused on early childhood funded through the Department of Health and Human Services, Administration for Children and Families Every Student Succeeds Act. The project was part of a needs assessment of early childhood care and education coordinated by the Kansas State Department of Education, the Kansas Children's Cabinet and Trust Fund, the Kansas Department for Children and Families, and KDHE in 2019.

Methods

Our Tomorrows collected stories from Kansans from all across the state (from all 105 Kansas counties) using an online platform called Sensemaker®. Sensemaker® is a unique data collection tool designed to collect narrative data in the form of stories, and to help identify and visualize patterns underlying the stories by having each "storyteller" expand on their story through a series of additional questions asked in unique formats including "triads," "dyads" and "stones." Over 2,000 stories were collected through Our Tomorrows as part of the early childhood needs assessment. CPPR staff then identified narratives in the storybank with insights pertinent to the Maternal and Child Health program. A total of 228 stories were identified.

Findings

Demographic Data for Stories (228 stories TOTAL)

FIGURE J1. RESPONDENTS BY GENDER

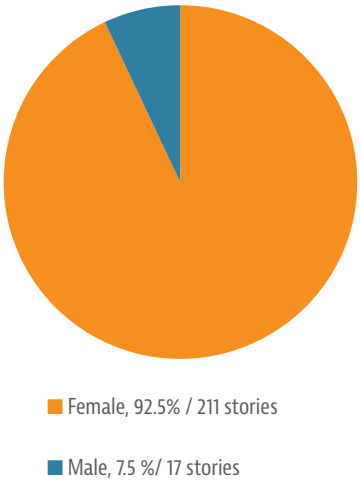


FIGURE J2. RESPONDENTS BY RACE AND ETHNICITY

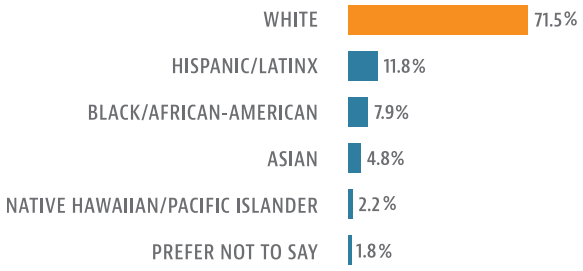


TABLE J3. RESPONDENTS BY FAMILY INCOME

ANNUAL FAMILY INCOME	# OF STORIES	% OF TOTAL STORIES
Less than $20,000	29	12.7%
$20,001 - $39,999	30	13.2%
$40,000 - $59,999	27	11.8%
$60,000 - $79,999	30	13.2%
$80,000 or higher	64	28.1%
(Missing)	48	21.1%

The next table present a breakdown of stories by domain, and indicates how often the experience provided by different people was said to happen (i.e. did their story happen only once, only once in a while, or more often).

TABLE J4. STORIES BY DOMAIN AND FREQUENCY OF OCCURRENCE

DOMAIN	# OF STORIES	% OF TOTAL STORIES	HAPPENED ONCE	ONCE IN AWHILE	HAPPENED OFTEN	ALL THE TIME	(MISSING)
Child Health	45	19.7%	24.4%	13.3%	44.4%	8.9%	8.9%
Adolescent Health	50	21.9%	48.0%	22.0%	22.0%	8.0%	0.0%
Perinatal/Infant Health	46	20.2%	34.8%	28.3%	23.9%	13.0%	0.0%
Women/Maternal Health	36	15.8%	50.0%	8.3%	16.7%	11.1%	13.9%
CSHCN	51	22.4%	19.6%	27.5%	39.2%	9.8%	3.9%
All Domains	228	100.0%	34.6%	20.6%	29.8%	10.1%	4.8%

Patterns of Interest by MCH Domain

Women/Maternal Health domain stories (n=36, or 15.8% of stories for all domains)

- More likely to occur "once" (50.0%, compared to 34.6% for all domains)
- More likely to occur in families making $39,999 annually or less (41.7%, compared to 25.9% for all domains)
- More likely to occur in the Southeast Region (16.7%, compared to 5.3% for all domains)
- More likely to express negative feelings (41.7%, compared to 29.8% for all domains)
- More likely to express concerns about postpartum depression (33.3%, compared to 5.7% for all domains)
- More likely to express concerns that services are unavailable (22.2%, compared to 15.8% for all domains)

Perinatal/Infant Health domain stories (n=46, or 20.2% of stories for all domains)

- More likely to occur in Hispanic/Latinx families (15.2%, compared to 11.8% for all domains)
- More likely to occur in families making $39,999 annually or less (30.4%, compared to 25.9% for all domains)
- More likely to prefer that their experiences are shared with either their local community or everyone in the area (73.9%, compared to 65.8% for all domains)
- More likely to express positive feelings (63.0%, compared to 49.1% for all domains)
- More likely to express concerns about breastfeeding (28.0%, compared to 7.9% for all domains) and access to services (65.2%, compared to 57.5% for all domains)

Child Health domain stories (n=45, or 19.7% of stories for all domains)

- More likely to occur "often" (44.4%, compared to 29.8% for all domains)
- More likely to express negative feelings (35.6%, compared to 29.8% for all domains)
- More likely to express concerns about access to care and affordability (33.3%, compared to 12.7% for all domains) and eligibility for services (29.4%, compared to 19.7% for all domains)
- More likely to indicate they had health insurance (26.7%, compared to 12.3% for all domains)
- More likely to indicate that needed services were not available (20%, compared to 15.8% for all domains)

Adolescent Health domain stories (n=50, or 21.9% of stories for all domains)

- More likely to occur "once" (48.0%, compared to 34.6% for all domains)
- More likely to prefer that their experiences are shared with only their immediate families or with no one at all (18.0%, compared to 12.3% for all domains)
- More likely to express negative feelings (34.0%, compared to 29.8% for all domains)
- More likely to express concerns about mental health (40.0%, compared to 13.6% for all domains) and substance abuse (18%, compared to 7.0% for all domains)

Children & Adolescents with Special Health Needs domain stories (n=51, or 22.4% of stories for all domains)

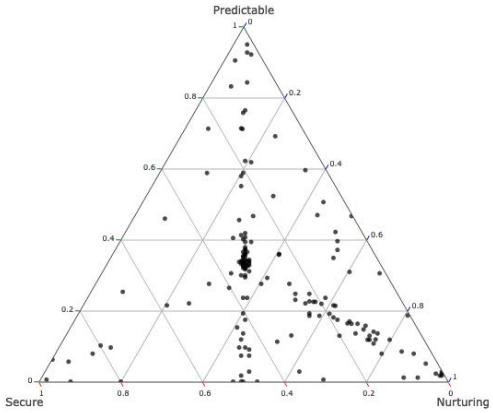
- More likely to occur "often" (39.2%, compared to 29.8% for all domains)
- More likely to prefer that their experiences are shared with either their local community or everyone in the area (72.6%, compared to 65.8% for all domains)
- More likely to occur in Hispanic/Latinx families (17.6%, compared to 11.8% for all domains)
- More likely to occur in the Southwest Region (35.3%, compared to 18.9% for all domains)
- More likely to express concerns about developmental services (52.9%, compared to 18.0% for all domains) and access to services (68.6%, compared to 57.5% for all domains)

Patterns of Interest by Theme

Certain themes from Our Tomorrows stories were consistent with themes that emerged through other data collection methods. This section examines some of the themes in additional detail. This detail includes some of the narrative stories themselves, as well as results of some of the "triad" questions.

The first triad is presented for the followup question about storytellers' homelives. Storytellers were asked to position a dot on the triangle that best describes their homelife between three variables: secure, nurturing, or predictable. The dot is placed anywhere on the triangle representing the relative importance of the three variables to the respondents response.

FIGURE J1. POSITIVE HOMELIFE TRIAD



Out of a total of 165 responses to the triad question, 9 responses were highly "weighted" towards the "secure" response. For those 9 respondents noting their homelife was secure, the experience was more likely to:

- be positive (77.8% vs. 49.1% overall)
- have higher family income:
  - $60,000 - $79,999 (22.2% vs. 13.2% overall)
  - $80,000+ (55.6% vs. 28.1% overall)
- occur in:
  - Adolescent health (44.4% vs. 21.9% overall)
  - Perinatal/infant health (33.2% vs. 20.2% overall)
- involve breastfeeding (22.2% vs. 7.5% overall)
- have access to services (88.9% vs. 57.5% overall)
- feel comfortable asking others for help (dyad)
- feel the future is open to possibilities (dyad)
- make decisions with thoughtful planning (triad)
- "grit teeth and move forward" when things got tough (triad)

"Secure" Homelife Stories

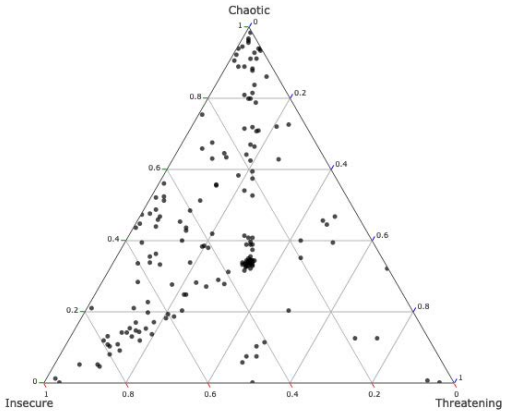
The title to the story is that described by each storyteller (the corresponding number if a code from Sensemaker® included for reference only).

> **A Phone Call Saves the Day (569)**
> *It was early in my breastfeeding experience with my first child, probably day 5, nipples were sore and I was beginning to question should I keep feeding, should I give formula, should I.... and then my phone rang. It was our Healthy Start Home Visitor for our county. She asked how are feedings going? I expressed my concerns, she listened and encouraged me and said keep going, your doing a great job, and she scheduled a time to come by and visit. It was just what I needed to hear, I kept going and made it through! She was instrumental in encouraging me through that time of doubt.*

> **Breastfeeding support is key (645)**
> *We had trouble breastfeeding our first daughter. I had a slow let down and a difficult latch. We ended up in the ER with a dehydrated newborn because I had no support- no one in my family breastfed, no le Lexie league or LCs in my area. My husband felt so helpless because I had no help. I pumped and fed her for the first 6 weeks until she finally learned to latch. She only breastfed for 6 months since my supply was so low but I was so grateful for that time. For our second daughter, we were ready! More knowledge more support. Having a village on the journey is so important. We need to support our breastfeeding moms!!!*

A question was also included for when homelife was viewed more negatively. The three possible responses on the triad were chaotic, insecure, and threatening).

FIGURE J2. NEGATIVE HOMELIFE TRIAD



There were a higher number of responses towards chaotic, followed by insecure. However, there were several stories (n=5) in the threatening corner of the triangle. When homelife was perceived as threatening, the experience was more likely to:

- happen just once (60% vs. 34.6% overall)
- be negative (40% vs. 29.8% overall)
- occur in experiences shared about a/as a child (40% vs. 7.5% overall)
- hope their family knows about it:
  - Immediate family should know (20% vs. 6.6% overall)
  - My family and friends should know (20% vs. 13.6% overall)
- occur in families making between $40,000 - $59,999 annually (80% vs. 11.8% overall)
- occur in Hispanic/Latinx families (40% vs. 11.8% overall)
- occur in:
  - Adolescent health (40% vs. 21.9% overall)
  - Women/maternal health (40% vs. 15.8% overall)
- experience mental health issues (40% vs. 17.5% overall)
- experience bullying (20% vs. 3.1% overall)
- "just survive or barely get by" (dyad)
- experience decisions based on "things beyond the family's control" (triad)

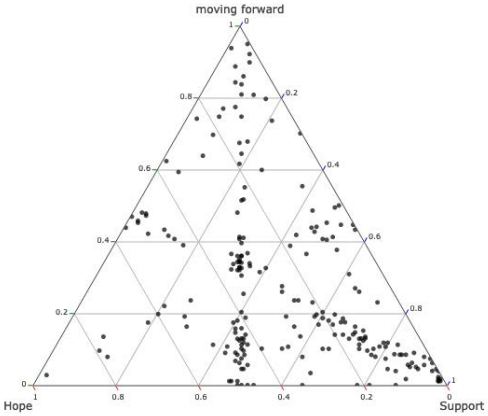
Pregnant (2702)
I remember when I was a first time mom and even though the baby was planned and I was excited my hormones were really messed up and I was just sad all the time and I didn't feel good. I didn't want to tell anyone because I thought something was wrong with me for feeling this way. When I finally did talk to the doctor about this she put me on an anti depressent and it changed everything, I just wish I had done it sooner. When I got pregnant the second time I started out on medication and it made the pregnancy so much better.

Suicidal surviving (1880)
The time when my son was having suicidal thoughts, we as a family were surviving one day at the time, spending time together, me "sleeping by his side" just to make sure he wont wake up and try to hurt his self. Making appointments, calling at schools, enroll him in all types of extra activities, basketball, music, etc.

Living with a parent with mental illness (980)
One of the most impactful times in my life was my senior year of high school. It was a few month before I was due to graduate and my mom started to go into a Manic Episode, as she has been diagnosed as bi-polar shortly before learning she was pregnant with me. During this episode her anger and aggression was so bad that she forced me to leave her house by bringing my belongings to me at my work one day. In one interaction shortly after this to give her the house key back I thought she was going to grab at my throat and choke me so I pushed her away and tried to leave before things got worse. Luckily I was able to stay with a close friend during this ordeal but I feel it has had a lasting impact on my left because it changed the trajectory of my future. Rather than going to college as I had planned I instead went to work so I could move out and live on my own. I am fortunate that I had other supports in place and was able to thrive in adulthood at the age of 18. I do my best to keep the relationship with my mom on good terms but there are times that I feel others do not understand her mental illness and don't understand why I don't cut her off. It's a hard place to be in but I do my best to help keep her mental health in a good state to limit the times we have altercations.

Another triad question asked respondents what helped their family get through when things got tough. They were asked to place the dot on the triad on the location that reflected the degree to which hope, support from others, and just moving forward helped the family get through.

FIGURE J3. THINGS GOT TOUGH TRIAD



A large cluster of responses were located near the apex of "support," with a number of responses closer to "moving forward," and another cluster somewhere between hope and support. There were five responses that were primarily focused on hope. When hoped primarily helped the family get through, the experience was more likely to:

- happen just often (40% vs. 29.8% overall)
- be negative (60% vs. 29.8% overall)
- occur in experiences shared about a/as a parent (80% vs. 59.6% overall)
- want everyone to know about it (80% vs. 45.2% overall)
- occur in stories shared by males (20% vs. 7.5% overall)
- occur in Hispanic/Latinx families (40% vs. 11.8% overall)
- occur when there is access to and availability of services (60% vs. 12.7% overall)
- occur when the government is responsible for making sure kids thrived (triad)
- make decisions based on a "gut feeling" (triad)

"Hope Got the Family Through" Story Examples

Searching for a Medical Expert Within My Financial Means (1846)

My story is one that initially seems broad but is very much applicable to what I see others go through in our community and extended family members' hardships in the area. I would hope that it resonates with people around the country as well. To begin, my husband is a teacher and I am a stay-at-home mother to our 7 children. My husband is paid little which is not surprising when considering how low the pay scale is on average for jobs that are available in rural Kansas. Our family is on governmental health insurance (i.e., Medicaid). An example of an ongoing medical need in our family is that one of my sons has extreme ear issues and has undergone 2 ear surgeries so far. I find myself internally struggling with having Medicaid. At times, it can feel like a lack of independence being so reliant on it. Other moments, I feel great and confident in my family and I being able to receive quality medical care when it's needed. It's a constant tug-of-war between despair and hope in our yearning for both independence as well as good health. I would love my husband's wages to increase, but at the same time, realize that this becomes another financial dilemma since he would then have to purchase health insurance through his work and the costs of this would reduce his paycheck down to what he currently receives. I have many thoughts on several other topics of need in rural Kansas (e.g., post-secondary education, employment opportunities, incentives for large families, population decline), but felt that sharing the above account of struggling for good health care that empowers families takes precedence in order to spark conversation on positive change in our state.

Kancare (618) *Español*

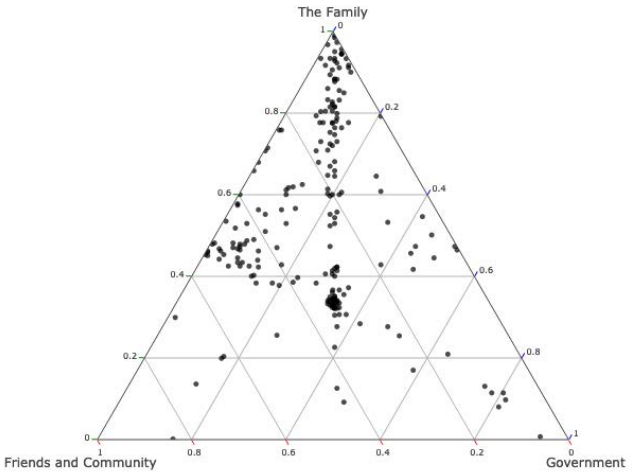
Actualmente estoy embarazada y solicite el Kancare pero aun no escuchado si fue aprobado o no. Ya hace varias semanas que envie mi aplicacion y aun no escucho nada. Trate de llamar para verificar el es estatus de mi aplicacion y estuve varios minutos tratando de comunicarme con alguien pero el numero que proveen con la aplicacion es uno de esos 1 - 800 y me rendi luego de varios intentos hablando con la maquina. Tampoco se si llene mi aplicacion bien ya que no hay nadie que la verifique que uno pueda reunirse con antes de someter la aplicacion para verificacion. Me preocupa ya que mi fecha de parto se acerca y no quiero que me lleguen muchos cargos de parte del hospital.

Kancare (618) *English*

I am currently pregnant and applying for Kancare but still not heard if it was approved or not. It has been several weeks since I sent my application and I still don't hear anything. I tried to call to verify the status of my application and I spent several minutes trying to communicate with someone but the number provided with the application is one of those 1-800 and I gave up after several attempts talking to the machine. I also don't know if I fill out my application well as there is no one to verify that one can meet with before submitting the application for verification. I am concerned that my due date is approaching and I do not want many charges from the hospital.

Another triad question asked storytellers who they felt was most responsible for helping kids thrive. The options were family, friends and community, and the government. Many responses were clustered towards family, with another cluster somewhere between family and friends and community.

FIGURE J4. RESPONSIBILITY TRIAD



A smaller number of responses primarily indicated it was the government responsible for helping kids thrive. When the government was the strongest response (7 stories), the experience was more likely to:

- occur all the time (28.6% vs. 10.1% overall)
- be negative (85.7% vs. 29.8% overall)
- be remembered "for a long time" (42.9% vs. 25.9% overall)
- want everyone to know about it (71.4% vs. 45.2% overall)
- occur in families making:
  - Less than $20,000 (14.3% vs. 12.7% overall) or
  - Between $40,000 - $59,999 annually (28.6% vs. 11.8% overall)
- occur in experiences shared by males (14.3% vs. 7.5% overall)
- occur in experiences shared by:
  - Asians (14.3% vs. 1.8% overall)
  - African Americans (14.3% vs. 4.8% overall)
- occur in:
  - Children with special health needs (28.6% vs. 22.4% overall)
  - Perinatal/infant health (28.6% vs. 20.2% overall)
- occur when services were not available (51.1% vs. 15.8% overall)
- occur when access to and affordability of care were an issue (42.9% vs. 12.7% overall)
- "just survive or barely get by" (dyad)

"Government Was Responsible for Helping Kids Thrive" Story Examples

The I/DD Waiver Wait List Nightmare (1030)

Our family recently received news that has us bracing for survival mode in the next year. Our son, who is completely deaf and blind as a result of being born 14 weeks premature, was put on the I/DD waiver wait list in [Year]. We were shocked and appalled to find out a couple months ago that after 7 years on the wait list, he is still far from the top. Our son will turn [age] next March and will no longer be able to attend the transition program at KSSB. Without the I/DD waiver, we have no way to access a day service program for him at that time, and neither my husband or I can afford to quit our jobs to stay home with him all day. This has put a lot of stress on us as we try to figure out how we will pay for whatever services he needs without any funding as well as our other two childrens' college educations.

Misinformed (1097)

I went to the pharmacy to get a flu shot, on the paperwork it asked if I was pregnant, I said maybe we had been trying to conceive for a while. The pharmacist recommended since I was trying to get pregnant, I should get the Tdap. So 6 months later, I got pregnant, I went in at 27 weeks for my Tdap. The nurse at the health department informed me that I didn't need that shot. It was a waste of time, money and wrong immunization. I trusted the Pharmacist and he was not up to date or understand the CDC recommendations.

Searching for a Medical Expert Within My Financial Means (1846)

My story is one that initially seems broad but is very much applicable to what I see others go through in our community and extended family members' hardships in the area. I would hope that it resonates with people around the country as well. To begin, my husband is a teacher and I am a stay-at-home mother to our 7 children. My husband is paid little which is not surprising when considering how low the pay scale is on average for jobs that are available in rural Kansas. Our family is on governmental health insurance (i.e., Medicaid). An example of an ongoing medical need in our family is that one of my sons has extreme ear issues and has undergone 2 ear surgeries so far. I find myself internally struggling with having Medicaid. At times, it can feel like a lack of independence being so reliant on it. Other moments, I feel great and confident in my family and I being able to receive quality medical care when it's needed. It's a constant tug-of-war between despair and hope in our yearning for both independence as well as good health. I would love my husband's wages to increase, but at the same time, realize that this becomes another financial dilemma since he would then have to purchase health insurance through his work and the costs of this would reduce his paycheck down to what he currently receives. I have many thoughts on several other topics of need in rural Kansas (e.g., post-secondary education, employment opportunities, incentives for large families, population decline), but felt that sharing the above account of struggling for good health care that empowers families takes precedence in order to spark conversation on positive change in our state.

One issue encountered throughout the MCH Needs Assessment were barriers to care that were the result of discrimination, cultural differences, language and immigration status. Below are selected stories that are included to provide insight, in storytellers' words, of some of the barriers and challenges they face.

Stories Shared by Black and African American Families

Searching for a Medical Expert Within My Financial Means (1846)

My story is one that initially seems broad but is very much applicable to what I see others go through in our community and extended family members' hardships in the area. I would hope that it resonates with people around the country as well. To begin, my husband is a teacher and I am a stay-at-home mother to our 7 children. My husband is paid little which is not surprising when considering how low the pay scale is on average for jobs that are available in rural Kansas. Our family is on governmental health insurance (i.e., Medicaid). An example of an ongoing medical need in our family is that one of my sons has extreme ear issues and has undergone 2 ear surgeries so far. I find myself internally struggling with having Medicaid. At times, it can feel like a lack of independence being so reliant on it. Other moments, I feel great and confident in my family and I being able to receive quality medical care when it's needed. It's a constant tug-of-war between despair and hope in our yearning for both independence as well as good health. I would love my husband's wages to increase, but at the same time, realize that this becomes another financial dilemma since he would then have to purchase health insurance through his work and the costs of this would reduce his paycheck down to what he currently receives. I have many thoughts on several other topics of need in rural Kansas (e.g., post-secondary education, employment opportunities, incentives for large families, population decline), but felt that sharing the above account of struggling for good health care that empowers families takes precedence in order to spark conversation on positive change in our state.

Mental Health Struggles for People of Color (2381)

A few years ago, my son was diagnosed on the autism spectrum. We didn't (and still don't) have a lot of support in the community. He was already a junior in high school. We were told that he scored high on the chart when he was in middle school but were also told that we didn't need to worry about it. Even though I questioned it several times through the years, no one really helped us until we got to KU Mental Health. It seemed like we were just going through the motions before then because we didn't understand what it was like for him. We still don't somewhat but we're learning how to cope with it better.

The Struggle (2765)

From the time I was a Sophomore in high school until the time I was a Senior in College, my mother did not have a job. My mother took off of work to be with me as my Sophomore year is when I got my case for sexual abuse. My brother and I worked through high school to provide for our Mother and two younger sisters. This was a huge change in lifestyle due to my Mother always holding a good paying job. We had to budget her savings and the money me and my brother brought in from working after school. The struggle has been continuing as they now live on Section 8 and are on food stamps. I separated myself while going through college and I am now at a point in my life where I can be that helping hand we needed growing up. The struggle is never ending but joy comes in the morning.

Staying above water (615)

I was a single mom trying to provide for my children. I was only working part time and felt like we were just surviving. But was grateful we had a roof over our heads and food in our bellies. I was on WIC, Food Stamps and my children were on State Insurance. I was barley living pay check to pay check. I am happy we are no longer living that way and I work my hardest every day to make sure we never go back there.

My Struggle but I Survived It (2546)

This story and experience is about a time when I was at my lowest point in life with the help of a few people and resources I survived it. I moved to Crawford County about a year ago with 2 young children and 5 months pregnant with a 3rd child. I had noone to help, no job, and nothing for my family as far as our needs. I was sleeping on the floor, eating on the floor and barely able to make it but then I met a lady form an agency that came in lifted me up gave me resources and help me become better in my situation. Thanks Healthy Families!

Services for all immigrants (1715)

I have older children who live in another state but my youngest daughter and I live with a friend in SW Kansas. This is where I could find work, and I have some family members. My daughter is happy and healthy but she does not talk or even try to talk. I heard about services that could be in our friend's home and the teachers come there to help her learn. I am worried about immigration enforcement, so I am not sure about continuing with the services when my daughter turns three, but the staff that works with us now does not seem to be concerned about my immigration status.

In need of healthcare and citizenship (1724)

I am currently receiving services from RCDC for my son with multiple delays. My medicaid has lapsed for him and I need to reinstate his insurance. I also want to apply for citizenship, but was told by my lawyer to not access any government assistance for my family to increase my chances of being approved. I am unsure what to do next. My child is also potentially eligible for disability benefits due to his multiple/ severe developmental delays. We need the insurance and cash assistance to survive, but we do not want to go back to Mexico. We are afraid.

Clarity makes the difference (1800)

I am a home visitor serving families in Southwest Kansas through Russell Child Development Center. Many of my families do not speak English and some from Central America speak Spanish as a second language with a Mayan dialect as a first Language. There are 22 Mayan dialects. Even with a Spanish-English translator it is very difficult for some families to comprehend the important details of a home visit if the Mayan language is their first language. Many time the children know English and Spanish but not much Mayan and as the years go by English takes priority for the children. Because of this language barrier, parents fail to understand parenting strategies, nutrition information, developmental milestones, and how to access community resources. One particular mother that I was working with was needing lots of help with difficult behavior issues from three of her four children. I had given Triple P positive parenting services to her one on one with a translator in Spanish. However, she was still not understanding key points of the strategies, partly due to cultural difference and partly because of words she did not understand in Spanish but only in Mayan. Fortunately RCDC was able to hire a Triple P coach that spoke her dialect of Mayan. When this home visitor worked through the parenting program with the family, the outcome was understood and much more effective. Also, there were other issues uncovered as the Mayan dialect was spoken, The family was then able to be referred to other agencies to address these issues. In the end the children benefited greatly and the home life was much improved.

Mayan Language Barrier (1801)

As a home visitor I work with several families whose first Language is Mayan, second language is Spanish and speak no English. When these families do not know Spanish very well, it becomes very difficult to help them understand how to access resources, healthcare, and how to navigate the school system and expectations for their children. Many children in these families will learn and Spanish but not much Mayan, especially as they get on in school. One family that was in the home visiting program I work with was having difficulty taking advantage of resources available to their children due this very Language barrier. I worked with a Spanish-English translator but the mother who only went to school for a few years never learned very much Spanish. Her two year old was falling behind in language development and fine motor development. There were program free of charge available to him but it was very hard to explain the rationale to the mother of why she needed to pursue these resources. At the time there was not an interpreter available who spoke her rare dialect of Mayan. In the end the mother dropped the home visiting program with me and her child did not get the help he was due.

Future without answers (555) *English*

I'm pregnant and I'm very young to be a mother, I have a lot of fear and I hope I can tell my story to many. I am a single mother and I don't know how to handle all of this. It's a very difficult time for me and I'm afraid.

Future without answers (555) *Español*

Futuro sin respuestas

Estoy embarazada y soy muy joven para ser mamá, tengo mucho temor y espero poder contar de muchos. Soy madre soltera y no se como afrontar todo esto. Es un tiempo muy difícil para mi y tengo miedo.

APPENDIX K: MCH NEEDS ASSESSMENT SURVEY (COMMUNITY NORMS)

Introduction

As part of the needs assessment process, KDHE distributed an online survey to stakeholders, professionals, parents, and community members in February 2020. The survey was distributed at the end of the needs assessment, after many other forms of data collection, to fill in gaps and get responses to questions addressing the emergent domain priorities in order for KDHE to begin finalizing priorities and objectives. This survey also captured individual beliefs on MCH topics as well as their perception of community beliefs as part of a community norms assessment.

Methods

The survey was distributed statewide in February of 2020. A mixture of single answer questions, open-ended questions, and community norms questions made up this survey (the survey instrument can be found at the end of this Appendix). The purpose was to capture what survey participants, coming from different backgrounds, chose to identify as the most significant community needs within their frame of reference. Community or social norm questions were designed to spot common themes of set behaviors expected in a community, based on the community's values, traditions, policies, etc. These community norm questions were specifically useful to help identify what individuals personally felt were important issues and what individuals believed their community at large felt were important issues around maternal and child health.

The survey was distributed near the end of the needs assessment process, after many other forms of data collection, to fill in gaps and get responses to questions addressing the emergent domain priorities in order for KDHE to begin finalizing priorities and objectives. The survey received 532 responses. Responses to questions were not required, so on any given question roughly half of respondents provided a response.

Single answer questions were assessed as is, based on the proportions of answers to each question.

For open-ended response questions, responses were categorized by the MCH data analyst, a Senior MCH epidemiologist, and program staff to best capture the responses as themes as related to the MCH programmatic work. Open-ended response questions were categorized into as many themes as were identified in a response and for final analysis the themes were treated as multiple choice responses. Percentages were calculated for each theme based on the valid responses (invalid responses were those that were not classifiable or not related to the question) and the total percentages may sum to over 100% for open text questions (The assigned themes are provided below and the original questions with responses are provided at the end of this document).

For the analysis of community norms, a Linear-by-Linear analysis (Chi-Square Mantel-Haenszel Test) was used. This test accounts for the ordinal nature of the Likert items. There were four values that could be assessed: strongly agree, agree, disagree, and strongly disagree. These values are reverse scored (4,3,2, and 1). The average score was the weighted mean based on the responses and their Likert position. A hypothetical score of 4 would mean that all responses were "strongly agree" while a score of 1 would mean all responses were "strongly disagree." Some items were excluded from analysis as no pairs were available or the available pairs were not considered to be valid pairs based on item constructs.

The difference in mean score for community norms was assessed by taking the community weighted average score minus the individual weighted average score. Therefore, a positive number means that the community score was higher, and a negative number means that the individual score was higher.

Results

Respondents

Since responses were not required, the summary below is not representative of all survey respondents. Of respondents that answered the respective demographic questions, the following observations can be made:

- 70 counties represented
- 77.1% from rural and small towns
- 41.7 average age
- 93.6% were female
- 92.3% White; 2.9% Black; 2.4% American Indian/Alaska Native
- 8.9% Hispanic
- 53.1% had an income of $75,000 and above
- 19.4% were parents
- 64.2% were a public health employee, a community service provider, or health care professional
- 10.9% reported children in the household with special health care needs

Overview of Findings

The areas that scored the highest in terms of the most important overall health issues for the MCH population were access to healthcare and services, mental health, and social determinants of health (e.g., transportation, socioeconomic status, housing/shelter). Also of importance were reproductive health and family planning, quality of care, and affordable care. Individually, these concerns are of great importance and were often expressed throughout the needs assessment process, highlighting their importance for individuals and communities and confirming what other data collection efforts, including meetings, kiosks and focus groups, had shown.

QUESTION 5: *Keeping in mind the definition of health, what do you think are the most important issues facing women, mothers, infants, children, and children with special health care needs in Kansas? Please be specific.*

WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES FACING
WOMEN OF REPRODUCTIVE AGE *(N=218)*

THEMES	N	PERCENT
Reproductive Health/ Family Planning	101	46.3
Access to Care/Services	88	40.4
Mental Health	28	12.8
Affordable Care	26	11.9
Insurance	19	8.7
Social Determinants of Health	18	8.3
Health Behaviors	13	6
Education	12	5.5
Abortion	9	4.1
Daycare/Childcare	9	4.1
Quality of Care	9	4.1
Nutrition/Food	7	3.2
Socioeconomic Status	7	3.2
Substance Use	6	2.8

THEMES	N	PERCENT
General Health	5	2.3
Food Insecurity	4	1.8
Housing/Shelter	4	1.8
Prenatal Care	4	1.8
Rural Health	3	1.4
Transportation	3	1.4
Breastfeeding	2	0.9
Chronic Conditions	2	0.9
Healthy Relationships	2	0.9
Physical Activity	2	0.9
Adoption	1	0.5
Dental	1	0.5
Employment	1	0.5
Family Friendly Work Places	1	0.5
Health Communication	1	0.5

THEMES	N	PERCENT
Human Trafficking	1	0.5
Maternal Mortality	1	0.5
Mentorship	1	0.5
Privacy	1	0.5
Safe Sleep	1	0.5
Support	1	0.5
Tobacco/Vaping	1	0.5
Trauma	1	0.5
Violence/Abuse	1	0.5

QUESTION 5 *(CONT'D)*

WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES FACING
PREGNANT WOMEN *(N=222)*

THEMES	N	PERCENT
Access to Care/ Services	64	28.8
Prenatal Care	42	18.9
Social Determinants of Health	34	15.3
Mental Health	33	14.9
Breastfeeding	28	12.6
Education	28	12.6
Affordable Care	21	9.5
Daycare/ Childcare	18	8.1
Nutrition/Food	18	8.1
Insurance	17	7.7
Quality of Care	17	7.7
Postpartum Care	16	7.2
Support	14	6.3
Health Behaviors	10	4.5
Maternity/Paternity Leave	9	4.1
Prenatal Education	8	3.6
Socioeconomic Status	8	3.6
Transportation	8	3.6
Healthcare	7	3.2

THEMES	N	PERCENT
General Health	6	2.7
Parenting Help	6	2.7
Rural Health	6	2.7
Substance Use	6	2.7
Housing/Shelter	5	2.3
Resources	5	2.3
Tobacco/Vaping	5	2.3
Work	5	2.3
Cost	4	1.8
Pregnancy	4	1.8
Reproductive Health/ Family Planning	4	1.8
Maternal Health	3	1.4
Sexual Health	3	1.4
Women's Health	3	1.4
Care	2	0.9
Development	2	0.9
Infant Mortality	2	0.9
Maternal Mortality	2	0.9
Safe Sleep	2	0.9
Trauma	2	0.9
Care Initiation	1	0.5

THEMES	N	PERCENT
Chronic Conditions	1	0.5
Dental	1	0.5
Developmental Services	1	0.5
Disparities	1	0.5
Family Planning	1	0.5
Maternal Age	1	0.5
Medical Leave	1	0.5
Mentorship	1	0.5
Nativity/Citizenship	1	0.5
Peers	1	0.5
Personal	1	0.5
Physical Activity	1	0.5
Priorities	1	0.5
Unplanned Pregnancy	1	0.5
Violence/Abuse	1	0.5

QUESTION 5 *(CONT'D)*

WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES FACING **CHILDREN** *(N=221)*

THEMES	N	PERCENT
Access to Care/ Services	54	24.4
Nutrition/Food	47	21.3
Mental Health	35	15.8
Social Determinants of Health	32	14.5
Education	17	7.7
Physical Activity	17	7.7
Daycare/Childcare	16	7.2
Immunizations	16	7.2
General Health	15	6.8
Insurance	15	6.8
Parenting Help	15	6.8
Health Behaviors	13	5.9
Support	11	5
Housing/Shelter	10	4.5
Technology	10	4.5
Dental	9	4.1
Quality of Care	9	4.1
Cost	8	3.6
Bullying	7	3.2

THEMES	N	PERCENT
Preventive Care/Well Visit	7	3.2
Programs	7	3.2
School-Based Services	7	3.2
Socioeconomic Status	7	3.2
Substance Use	7	3.2
Affordable Care	6	2.7
Resources	6	2.7
Safety	6	2.7
Violence/Abuse	5	2.3
Developmental Services	4	1.8
Healthcare	4	1.8
Personal	4	1.8
Rural Health	4	1.8
Behavioral Health	3	1.4
Breastfeeding	3	1.4
School	3	1.4
Trauma	3	1.4
Medical Home	2	0.9
Special Health Care Needs	2	0.9

THEMES	N	PERCENT
Tobacco/Vaping	2	0.9
Transportation	2	0.9
Children	1	0.5
Clothing	1	0.5
Employment	1	0.5
Foster Care	1	0.5
Funding	1	0.5
Healthy Behaviors	1	0.5
Home Visits	1	0.5
Inequality	1	0.5
Literacy	1	0.5
Prevention	1	0.5
Race/Ethnicity	1	0.5
Rights	1	0.5
Trafficking	1	0.5
Work	1	0.5

QUESTION 5 *(CONT'D)*

WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES FACING **ADOLESCENTS** *(N=214)*

THEMES	N	PERCENT
Mental Health	83	38.8
Access to Care/ Services/Activities	65	30.4
Reproductive Health/ Family Planning	29	13.6
Education	22	10.3
Substance Use	22	10.3
Nutrition/Food	16	7.5
Social Determinants of Health	16	7.5
Family Functioning	15	7
Technology	15	7
Physical Activity	14	6.5
Insurance	13	6.1
Food Insecurity	12	5.6
Bullying	9	4.2
Health Behaviors	8	3.7
Quality of Care	8	3.7
Tobacco/Vaping	8	3.7
Immunizations	7	3.3
Suicide	6	2.8

THEMES	N	PERCENT
Violence/Abuse	6	2.8
Dental	5	2.3
Human Trafficking	5	2.3
Housing	4	1.9
Mentorship	4	1.9
Transitions	4	1.9
General Health	3	1.4
Transportation	3	1.4
Trauma	3	1.4
Employment	2	0.9
School-Based Services	2	0.9
Socioeconomic Status	2	0.9
Stress	2	0.9
Cultural Competence	1	0.5
Gender/Sexuality	1	0.5
Healthy relationships	1	0.5
Medical Home	1	0.5
Special Health Care Needs	2	0.9
Tobacco/Vaping	2	0.9

THEMES	N	PERCENT
Transportation	2	0.9
Children	1	0.5
Clothing	1	0.5
Employment	1	0.5
Foster Care	1	0.5
Funding	1	0.5
Healthy Behaviors	1	0.5
Home Visits	1	0.5
Inequality	1	0.5
Literacy	1	0.5
Prevention	1	0.5
Race/Ethnicity	1	0.5
Rights	1	0.5
Trafficking	1	0.5
Work	1	0.5

QUESTION 5 *(CONT'D)*

WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES FACING
CHILDREN WITH SPECIAL HEALTH CARE NEEDS *(N=194)*

THEMES	N	PERCENT
Access to Care/ Services	112	57.7
Quality of Care	26	13.4
Support	25	12.9
Affordable Care	20	10.3
Social Determinants of Health	19	9.8
Mental Health	16	8.2
Insurance	15	7.7
Resources	15	7.7
Education	14	7.2
Rural Health	10	5.2
Care Coordination	9	4.6
Nutrition/Food	8	4.1
Transition	7	3.6
Transportation	7	3.6
Cost	5	2.6
General Health	5	2.6
CSHCN	9	4.1
Themes	n	Percent
Parenting Help	5	2.6

THEMES	N	PERCENT
Preventive Care/Well Visit	4	2.1
Daycare/Childcare	3	1.5
Income	3	1.5
Behavioral Health	2	1
Bullying	2	1
Health Behaviors	2	1
Immunizations	2	1
Interventions	2	1
Programs	2	1
Respite	2	1
Social	2	1
Citizenship	1	0.5
Dental	1	0.5
Developmental Services	1	0.5
Equality	1	0.5
Family	1	0.5
Health Challenges	1	0.5
Health Insurance	1	0.5
Healthcare	1	0.5
Home Visit	1	0.5

THEMES	N	PERCENT
Housing	1	0.5
Housing/Shelter	1	0.5
Medical Home	1	0.5
Nativity/Citizenship	1	0.5
Need	1	0.5
Opportunities	1	0.5
Parenting	1	0.5
Safety	1	0.5
School-Based Services	1	0.5
Substance Use	1	0.5
Trafficking	1	0.5
Trauma	1	0.5
Violence/Abuse	1	0.5
Workforce	1	0.5

QUESTION 6: *In your opinion, what do you think your community believes are the most important health issues facing mothers, infants, children, and children with special health care needs in Kansas? Please be specific.*

WHAT DO YOU THINK YOUR COMMUNITY BELIEVES ARE THE MOST IMPORTANT HEALTH ISSUES FACING
WOMEN OF REPRODUCTIVE AGE *(N=199)*

THEMES	N	PERCENT
Reproductive Health/ Family Planning	71	35.7
Access to Care/Services	57	28.6
Social Determinants of Health	21	10.6
Insurance	15	7.5
Affordable Care	13	6.5
Education	11	5.5
Nutrition/Food	10	5.0
Mental Health	9	4.5
Healthcare	8	4.0
Quality of Care	7	3.5
Don't Know	6	3.0
None	6	3.0
Socioeconomic Status	6	3.0
Abortion	5	2.5
Cost	5	2.5
Employment	4	2.0
Health Behaviors	4	2.0
Substance Use	4	2.0
Chronic Disease	3	1.5

THEMES	N	PERCENT
Daycare/Childcare	3	1.5
General Health	3	1.5
Prenatal Care	3	1.5
Abstinence	2	1.0
Access to Care	2	1.0
Housing/Shelter	2	1.0
Safety	2	1.0
Teen Pregnancy	2	1.0
Tobacco/Vaping	2	1.0
Transportation	2	1.0
Violence/Abuse	2	1.0
Well-Visits	2	1.0
Autonomy	1	0.5
Breastfeeding	1	0.5
Dental	1	0.5
Discrimination	1	0.5
Family Structure	1	0.5
Food Insecurity	1	0.5
Immunizations	1	0.5
Infant Mortality	1	0.5

THEMES	N	PERCENT
Language	1	0.5
Opportunities	1	0.5
Parenting	1	0.5
Privacy	1	0.5
Programs	1	0.5
Race/Ethnicity	1	0.5
Relationships	1	0.5
Sexual Health	1	0.5
Support	1	0.5
Survey	1	0.5
Work-life balance	1	0.5
Youth	1	0.5

QUESTION 6 *(CONT'D)*

WHAT DO YOU THINK YOUR COMMUNITY BELIEVES ARE THE MOST IMPORTANT HEALTH ISSUES FACING **PREGNANT WOMEN** *(N=198)*

THEMES	N	PERCENT
Access to Care/Services	69	34.8
Prenatal Care	32	16.2
Social Determinants of Health	28	14.1
Daycare/Childcare	16	8.1
Mental Health	15	7.6
Affordable Care	13	6.6
Maternal Health	13	6.6
Nutrition/Food	13	6.6
Breastfeeding	11	5.6
Reproductive Health/ Family Planning	10	5.1
Education	9	4.5
Insurance	9	4.5
Quality of Care	8	4.0
Socioeconomic Status	8	4.0
Support	8	4.0
Cost	7	3.5
Postpartum Care	7	3.5
Tobacco/Vaping	7	3.5

THEMES	N	PERCENT
Health Behaviors	6	3.0
Healthcare	6	3.0
Maternity/Paternity Leave	6	3.0
Maternal Mortality	5	2.5
Abortion	4	2.0
Infant Health	4	2.0
Family Structure	3	1.5
None	3	1.5
Parenting	3	1.5
Poverty	3	1.5
Prenatal Education	3	1.5
Substance Use	3	1.5
Employment	2	1.0
Housing/Shelter	2	1.0
Infant Mortality	2	1.0
Benefits	1	0.5
Costs	1	0.5
Discrimination	1	0.5
Income	1	0.5

THEMES	N	PERCENT
Language	1	0.5
Maternal Age	1	0.5
Men's Health	1	0.5
Postpartum	1	0.5
Preconception Health	1	0.5
Pregnancy	1	0.5
Programs	1	0.5
Race/Ethnicity	1	0.5
Rural Health	1	0.5
Transportation	1	0.5
Work-life balance	1	0.5
Workplace Policies	1	0.5

QUESTION 6 *(CONT'D)*

WHAT DO YOU THINK YOUR COMMUNITY BELIEVES ARE THE MOST IMPORTANT HEALTH ISSUES FACING **CHILDREN** *(N=198)*

THEMES	N	PERCENT
Access to Care/ Programs/Services	27	13.6
Nutrition/Food	23	11.6
Social Determinants of Health	20	10.1
Daycare/Childcare	19	9.6
Food Insecurity	19	9.6
Immunization	19	9.6
Mental Health	19	9.6
Affordable Care	16	8.1
Health Behaviors	16	8.1
Physical Activity	13	6.6
Education	12	6.1
Insurance	10	5.1
Socioeconomic Status	9	4.5
Family Functioning	8	4.0
Technology	8	4.0
Schools	7	3.5
Quality of Care	6	3.0
Safety	6	3.0
Dental	5	2.5

THEMES	N	PERCENT
Healthcare	5	2.5
Bullying	4	2.0
Housing/Shelter	4	2.0
General Health	3	1.5
Infant Mortality	3	1.5
Substance Use	3	1.5
Support	3	1.5
Chronic Disease	2	1.0
Developmental Screenings	2	1.0
Parenting	2	1.0
Programs	2	1.0
Stress	2	1.0
Clothing	1	0.5
Cost	1	0.5
CSHCN	1	0.5
Developmental Screening	1	0.5
Family Structure	1	0.5
Gun Control	1	0.5
Health Insurance	1	0.5

THEMES	N	PERCENT
Home Visit	1	0.5
Housing	1	0.5
Immunizations	1	0.5
Influenza	1	0.5
Medicaid	1	0.5
Peer Pressure	1	0.5
Reproductive Health/ Family Planning	1	0.5
Resiliency	1	0.5
School Based Services	1	0.5
School Readiness	1	0.5
Transportation	1	0.5
Violence/Abuse	1	0.5
Vision	1	0.5

QUESTION 6 *(CONT'D)*

WHAT DO YOU THINK YOUR COMMUNITY BELIEVES ARE THE MOST IMPORTANT HEALTH ISSUES FACING **ADOLESCENTS** *(N=187)*

THEMES	N	PERCENT
Mental Health	56	29.9
Access to Care/ Programs/Services	33	17.6
Substance Use	29	15.5
Social Determinants of Health	19	10.2
Reproductive Health/ Family Planning	18	9.6
Tobacco/Vaping	18	9.6
Education	15	8.0
Affordable Care	10	5.3
Health Behaviors	9	4.8
Technology	9	4.8
Nutrition/Food	8	4.3
Food Insecurity	7	3.7
Immunization	7	3.7
Safety	7	3.7
Suicide	7	3.7
Bullying	6	3.2
Dental	5	2.7
Family Functioning	5	2.7

THEMES	N	PERCENT
Healthcare	5	2.7
Physical Activity	5	2.7
Schools	5	2.7
Insurance	4	2.1
Mentorship	4	2.1
Quality of Care	4	2.1
Support	3	1.6
Employment	2	1.1
Housing	2	1.1
Peers	2	1.1
Poverty	2	1.1
School-Based Services	2	1.1
General Health	1	0.5
Guns	1	0.5
Human Trafficking	1	0.5
Parenting	1	0.5
Programs	1	0.5
Social	1	0.5
Socioeconomic Status	1	0.5
Violence	1	0.5

THEMES	N	PERCENT
Vision	1	0.5
Influenza	1	0.5
Medicaid	1	0.5
Peer Pressure	1	0.5
Reproductive Health/ Family Planning	1	0.5
Resiliency	1	0.5
School Based Services	1	0.5
School Readiness	1	0.5
Transportation	1	0.5
Violence/Abuse	1	0.5
Vision	1	0.5

QUESTION 6 *(CONT'D)*

WHAT DO YOU THINK YOUR COMMUNITY BELIEVES ARE THE MOST IMPORTANT HEALTH ISSUES FACING
CHILDREN WITH SPECIAL HEALTH CARE NEEDS *(N=163)*

THEMES	N	PERCENT
Access to Care/Services	99	60.7
Affordable Care	22	13.5
Social Determinants of Health	17	10.4
Support	16	9.8
Education	8	4.9
Quality of Care	8	4.9
Socioeconomic Status	8	4.9
Mental Health	7	4.3
Insurance	6	3.7
Lack of Awareness	5	3.1
Nutrition/Food	4	2.5
Bullying	2	1.2
Care Coordination	2	1.2
Daycare/Childcare	2	1.2

THEMES	N	PERCENT
Family Functioning	2	1.2
Food Insecurity	2	1.2
Health Behaviors	2	1.2
Housing/Shelter	2	1.2
Immunization	2	1.2
Inclusion	2	1.2
Resources	2	1.2
Rural Health	2	1.2
Behavioral Health	1	0.6
Cultural Competence	1	0.6
Diagnoses	1	0.6
Employment	1	0.6
General Health	1	0.6
Healthcare	1	0.6

THEMES	N	PERCENT
Peers	1	0.6
Safety	1	0.6
School-Based Services	1	0.6
Schools	1	0.6
Social	1	0.6
Substance Use	1	0.6
Support Groups	1	0.6
Transition	1	0.6
Transportation	1	0.6
Violence/Abuse	1	0.6

QUESTION 15: *What services in your community have you used to help you, your children, and your family stay healthy? (For example: WIC, family planning, early intervention, home visiting or other parenting support services, health/clinical services, mental health, etc.)*

THEMES (VALID RESPONSES = 242)	N	PERCENT
Health/Clinical Services	111	45.9
WIC	77	31.8
Mental Health	67	27.7
Community Programs/Activities	29	12.0
Intervention Services	29	12.0
Reproductive Health/Family Planning	29	12.0
PAT	26	10.7
Health Department	24	9.9
Home Visiting	23	9.5
None	23	9.5
Breastfeeding Support	12	5.0
Head Start	11	4.5
Immunizations	10	4.1
School-Based Services/Programs/Activities	9	3.7
Parenting Support	8	3.3
Religious Activities	5	2.1
Library	3	1.2
Speech Therapy	3	1.2
Child Care	2	0.8
CSHCN	2	0.8
Dental	2	0.8
Physical Therapy	2	0.8
Work Wellness Program	2	0.8
Kansas Perinatal Community Collaborative/Becoming a Mom	1	0.4
Early Childhood Education	1	0.4
Early Intervention	1	0.4
Education	1	0.4
Food Pantry	1	0.4
Insurance	1	0.4
Local Health Dept	1	0.4
Long-Term Care	1	0.4
Parenting Programs	1	0.4
Physical Activities	1	0.4
Pre-Kindergarten	1	0.4
Safe Kids	1	0.4
SNAP	1	0.4

QUESTION 16: *What services in your community have you referred others to in order to help women, pregnant women, mothers, children, and families stay healthy? (For example: WIC, family planning, early intervention, home visiting or other parenting support services, health/clinical services, mental health, etc.)*

THEMES (VALID RESPONSES = 255)	N	PERCENT
WIC	196	76.9
Mental Health	147	57.6
Health/Clinical Services	127	49.8
Home Visiting	107	42.0
Reproductive Health/Family Planning	104	40.8
Early Intervention	86	33.7
Parental Education/Support	65	25.5
Health Department	43	16.9
Social Services	28	11.0
Food Bank/Food Pantry	18	7.1
Breastfeeding Support	17	6.7
Community Programs	12	4.7
Immunizations	11	4.3
Substance Use	11	4.3
Pregnancy Center	10	3.9
Community Health	9	3.5
CSHCN	9	3.5
Religious Charities/Activities	9	3.5
Early Childhood Education	8	3.1
Tobacco	8	3.1
Dental	7	2.7
Non-Profit	6	2.4
Federally Qualified Health Center	5	2.0
Medicaid	5	2.0
Kansas Perinatal Community Collaborative/Becoming a Mom	3	1.2
Community Health Center	3	1.2
Nutrition	3	1.2

THEMES (VALID RESPONSES = 255)	N	PERCENT
Support Groups/Programs/Systems	3	1.2
Domestic Violence Shelter/Services	2	0.8
Education	2	0.8
Insurance	2	0.8
Parenting Support	2	0.8
Parks & Rec	2	0.8
School	2	0.8
Special Education	2	0.8
Child Care	1	0.4
CPS	1	0.4
Diaper Bank	1	0.4
Doula	1	0.4
Housings	1	0.4
Interpretation	1	0.4
Language/Interpretation	1	0.4
Local Health Dept	1	0.4
Nursing/Long-Term Care	1	0.4
School-Based Services	1	0.4
Social Work	1	0.4
Student Health	1	0.4
Tribal Health Center	1	0.4

QUESTION 17: *What services in your community are you aware of that help women, pregnant women, mothers, children, and families stay healthy?*

THEMES (VALID RESPONSES = 254)	N	PERCENT
WIC	178	70.1
Health Department	82	32.3
Home Visiting	68	26.8
Health/Clinical Services	60	23.6
Parental Education/Support	59	23.2
Reproductive Health/Family Planning	59	23.2
Early Intervention	50	19.7
Mental Health	50	19.7
Community Health	34	13.4
Social Services	32	12.6
Community Programs	29	11.4
Early Childhood Education	27	10.6
Pregnancy Center	20	7.9
Religious Services	20	7.9
Non-Profit	19	7.5
Breastfeeding Support	17	6.7
Food Pantry	14	5.5
Medicaid	13	5.1
Parks & Rec	12	4.7
School-Based Services/Programs	11	4.3
Immunizations	9	3.5
Federally Qualified Health Center	6	2.4

THEMES (VALID RESPONSES = 254)	N	PERCENT
Don't Know	5	2.0
None	5	2.0
Domestic Violence Shelter	4	1.6
Substance Use	4	1.6
Tobacco	4	1.6
Care Coordination	3	1.2
CSHCN	3	1.2
Birth Center	2	0.8
Behavioral Health	1	0.4
Dental	1	0.4
Nursing/Long Term Care	1	0.4
School	1	0.4
School Health Clinic	1	0.4
Special Education	1	0.4
Tribal Clinic	1	0.4
Urgent Care	1	0.4
Word of Mouth	1	0.4

QUESTION 18: *If you have not used a service offered in your community, why not?*

THEMES (VALID RESPONSES = 134)	N	PERCENT
No Need	73	54.5
Don't Qualify/Make Too Much	26	19.4
Unaware	16	11.9
Availability	8	6.0
Operating Hours/Work Schedule	8	6.0
Cost	5	3.7
Quality	4	3.0
Stigma	4	3.0
No Time	1	0.7
None Available for Needs	1	0.7
Physically and Emotionally Taxing	1	0.7
Waiting list	1	0.7
Won't Take Medicaid	1	0.7

QUESTION 19: *If you have not referred a service offered in your community, why not?*

THEMES (VALID RESPONSES = 42)	N	PERCENT
Unaware	23	54.8
Quality	7	16.7
Availability	5	11.9
Don't Qualify/Make Too Much	3	7.1
No Need	3	7.1
Unable	3	7.1
Cultural Competency	2	4.8
Lack of Access	1	2.4
Language	1	2.4
Not Requested	1	2.4
Too Difficult	1	2.4
Transportation	1	2.4

QUESTION 20: *In some communities, transportation has been identified as a barrier to families having access to services. What suggestions do you have to improve access to transportation in your community?*

THEMES (VALID RESPONSES = 232)	N	PERCENT
Transportation Options (expand schedule, availability, improve transportation stops, reliable)	65	28.0
Low Cost Transportation	61	26.3
Expand the Route of Existing Public Transportation	42	18.1
Establish Public Transportation	25	10.8
Accessibility of Transportation	24	10.3
Education/Advertisement	22	9.5
Encourage Transportation Services (Uber, Taxi, Lift, etc)	18	7.8
Agency Coordinated Transportation	15	6.5
Not A Problem/No Change	14	6.0
Infrastructure (Sidewalks, Bike Paths, etc)	11	4.7
Medicaid Transportation	9	3.9
Expand the Availability of Existing Public Transportation	8	3.4
Funding	7	3.0
Don't Know	6	2.6
Improve Public Transportation	4	1.7
Telehealth	4	1.7
Bus Passes	3	1.3
Child Care	3	1.3
Mobile Clinic	2	0.9
Reduce Stigma	2	0.9
Reimbursement for Services	2	0.9
Word of Mouth	2	0.9

THEMES (VALID RESPONSES = 232)	N	PERCENT
Community	1	0.4
Community Input	1	0.4
Daycare/Childcare	1	0.4
Employment	1	0.4
End Punitive Measures	1	0.4
Expand Medical Card Program	1	0.4
Expand Transportation Workforce	1	0.4
Extend Hours/Days of Existing Public Transportation	1	0.4
Functional Transit	1	0.4
Home-Based Services	1	0.4
Home Visiting	1	0.4
LULAC	1	0.4
Medical Cards	1	0.4
No Recommendations	1	0.4
Non-Profit	1	0.4
Promotion of Public Transportation	1	0.4
Religious Services	1	0.4
Resources	1	0.4
Senior Bus	1	0.4
Taxi	1	0.4
Transportation	1	0.4
Transportation Navigators	1	0.4
Volunteer Transportation	1	0.4

QUESTION 21: *In previous surveys, parent education has been identified as an important way of meeting needs of mothers, fathers and children. Please share what activities you think work best for providing parent education? (check all that apply), Other (Please Specify)*

THEMES (VALID RESPONSES = 24)	N	PERCENT
Community Programs/Groups	5	20.8
Language/Interpretation	3	12.5
Community Baby Shower	2	8.3
One to One Management/ Education	2	8.3
Church	1	4.2
Classes	1	4.2
Community Action	1	4.2
Don't Know	1	4.2
Health Care Action	1	4.2
Home Visiting Safety/Hygiene	1	4.2
Local Health Department	1	4.2

THEMES (VALID RESPONSES = 24)	N	PERCENT
Local News	1	4.2
Mentor/Peer Program	1	4.2
No One Size Fits All Approach	1	4.2
Parental Requirements Through Schools	1	4.2
Parenting Education	1	4.2
State Action	1	4.2
Subsidized Child Care	1	4.2
Technology/Digital Content	1	4.2
Universal Home Visiting	1	4.2
Welcome Basket	1	4.2
Word of Mouth	1	4.2

QUESTION 24: *What would improve the coordination of health services in your community? (Valid Responses = 209)*

THEMES	N	%
Care Coordination	40	19.1
Communication	28	13.4
Interagency Communication	23	11.0
Access to Care/Services	22	10.5
Centralized Access to Services/Resources	17	8.1
Resource Knowledge	17	8.1
Collaboration	15	7.2
Don't Know	14	6.7
Referrals	11	5.3
Online/Electronic Referral	9	4.3
Follow-up	7	3.3
Education	6	2.9
Affordable Care	5	2.4
Personalized Care	5	2.4
Provider-Community Relations	5	2.4
Cost Transparency	4	1.9
Transportation	4	1.9
Community Engagement	3	1.4
Language/Interpretation	3	1.4
None	3	1.4
Streamlined Care/ Processes	3	1.4
Coordinated Care	2	1.0
EHR Adoption	2	1.0
EHR Compatibility	2	1.0
Funding	2	1.0
Insurance Access/Coverage	2	1.0

THEMES	N	%
Local Services	2	1.0
Mental Health	2	1.0
More Advertisements/PSAs	2	1.0
More Doctors	2	1.0
Resource Guide	2	1.0
Scheduling	2	1.0
School-Provider Care Coordination	2	1.0
Social Workers	2	1.0
Telehealth	2	1.0
Access to Health Coverage	1	0.5
Affordable Health Coverage	1	0.5
Asking for Help	1	0.5
Baby Friendly Hospital	1	0.5
Better Record Keeping	1	0.5
Better Record Systems	1	0.5
Case Management System Improvement	1	0.5
Community-Based Services	1	0.5
Community Health Workers	1	0.5
Consistency of Care	1	0.5
Consistent Schedule	1	0.5
Continuity of Services	1	0.5
Dental Care	1	0.5
Equal Access	1	0.5
Equality	1	0.5
Expand Medicaid Services	1	0.5
Expanded Care Availability	1	0.5

THEMES	N	%
Flexible Spending	1	0.5
Hand-off Services	1	0.5
Health Navigator	1	0.5
HIPAA exemptions/ exceptions	1	0.5
Immunizations	1	0.5
Improved Funding Mechanisms	1	0.5
Improved Options for Care	1	0.5
Improved Options for Families	1	0.5
Improved Retention Strategies	1	0.5
Increase Medicaid Providers	1	0.5
Increased Case Management Resources	1	0.5
Increased Community Effort	1	0.5
Increased Compensation for Social Workers	1	0.5
Increased Services	1	0.5
Increased Social Workers	1	0.5
Lack of Competition	1	0.5
Mail/Online Communication	1	0.5
Medicaid Expansion	1	0.5
Medicaid Improvements	1	0.5
More Options	1	0.5
More Specialty Care	1	0.5
Neighborhood Centers	1	0.5
Not Aware/No Need	1	0.5

THEMES	N	%
OBGYN	1	0.5
Online Care Coordination	1	0.5
Online/Electronic Referral	1	0.5
Organization	1	0.5
Pediatrics	1	0.5
Pop-Up Services	1	0.5
Provider Engagement	1	0.5
Quality of Care	1	0.5
Racial/Ethnic Populations	1	0.5
Rural Health	1	0.5
School-Based Services	1	0.5
Senior/Adult Care	1	0.5
Service Updates	1	0.5
Social Media	1	0.5
Social Options	1	0.5
Socioeconomic Status	1	0.5
Stigma	1	0.5
Streamline Care/Processes	1	0.5
Too Many Coordinators	1	0.5
Transparency	1	0.5
Transportation Options	1	0.5
Uniform Services Across Insurance	1	0.5
Warm Hand-Off	1	0.5
Wider Acceptance of Coverage Types	1	0.5
Workforce Retention	1	0.5
Wraparound Services	1	0.5

QUESTION 25: *Do you have an idea for something new or different you would like to see in your community to help women, pregnant women, mothers, infants, children, and children and youth with special health care needs to be healthier?*

THEMES (VALID RESPONSES = 143)	N	PERCENT
Daycare/Childcare (Affordable, Available, Quality, Resources)	11	7.7
Emotional/Social Support Groups	11	7.7
Mental Health Services/Resources	11	7.7
Food Availability	10	7.0
Healthy Lifestyle Education/Activities	10	7.0
Free/Low Cost Care/Services/ Education	7	4.9
Community-Based Activities/ Programs	6	4.2
Medicaid Expansion	5	3.5
Access to Care/Services	4	2.8
Breastfeeding Support Groups	4	2.8
Education	4	2.8
Postpartum Education, Support/Care	4	2.8
Transportation	4	2.8
Case Management	3	2.1
Centralized Access to Services/ Resources	3	2.1
Culturally Responsive Services	3	2.1
Home Visiting	3	2.1
Language/Interpretation	3	2.1
Parenting Classes	3	2.1
School-Based Programs	3	2.1
Screen Time	3	2.1
Youth Education	3	2.1
Affordable/Available Care	2	1.4
After School Programs/Activities	2	1.4
Cooking Classes	2	1.4
CSHCN Providers	2	1.4
Expand WIC Eligibility	2	1.4
Family Center	2	1.4
Incentives/Contingency Management Programs	2	1.4
Increase Health Department Staff	2	1.4
Indoor Swimming/Fitness Center	2	1.4
Infrastructure (e.g., walking paths, bike/roll paths)	2	1.4
Interagency Communication	2	1.4
Maternal/Paternal Leave & Education	2	1.4

THEMES (VALID RESPONSES = 143)	N	PERCENT
Mobile Services/Clinics	2	1.4
Parental Engagement	2	1.4
Parental Support/Childcare Center	2	1.4
Personal Engagement	2	1.4
Prenatal Education	2	1.4
Quality of Care	2	1.4
Resource Center/Guide	2	1.4
School Nurse Program	2	1.4
Advertising/PSA	1	0.7
Baby at Work	1	0.7
Collaboration	1	0.7
Communication	1	0.7
Community Center	1	0.7
Community Health Center	1	0.7
Community Mental Health Center	1	0.7
County Health Department w/ Clinical/MCH Services	1	0.7
CSHCN Parks/Facilities	1	0.7
Decreased Food/Grocery Tax	1	0.7
Dolly Parton Imagination Library	1	0.7
EHR w/ Social Services Integration	1	0.7
Electronic/Online Referral	1	0.7
Evening/After Hours Support Groups	1	0.7
Expand Health Department Services	1	0.7
Expand Medicaid Postpartum Coverage	1	0.7
Expand Nurse Practitioner Staffing	1	0.7
Expanded DCF Eligibility	1	0.7
Expanded Medicaid Eligibility	1	0.7
Expanding Breastfeeding Services	1	0.7
Extended Care/Service Hours	1	0.7
Extended Mental Health Service Scheduling (Evenings/Weekends)	1	0.7
Faith-Based Services	1	0.7
Family Activities	1	0.7
Family Inclusive Programming	1	0.7
Farmer's Markets	1	0.7

THEMES (VALID RESPONSES = 143)	N	PERCENT
Free Advertisement for Midwifery Services	1	0.7
Funding/Grants	1	0.7
Governor's Proclamation Reproductive Rights	1	0.7
HUD/Subsidized Housing Based Services	1	0.7
Improved Sick Leave	1	0.7
Increase Contraceptive Access	1	0.7
Increase Public Breastfeeding Areas	1	0.7
Increased Access to CSHCN Funds	1	0.7
Increased KanCare Reimbursement Rates	1	0.7
Increased Maternal/Paternal Leave	1	0.7
Increased Mental Health Staffing	1	0.7
Increased Options for Care, Prevention, and Education	1	0.7
Increased Young Child Literacy	1	0.7
Indoor Play Opportunities	1	0.7
IRIS	1	0.7
Junk Food Tax	1	0.7
Lactation Services	1	0.7
Mandatory Attendance for At-Risk/ Low Income Populations	1	0.7
Mandatory Breastfeeding Spaces	1	0.7
Maternal-Fetal Medicine	1	0.7
Medicaid Navigators	1	0.7
Medical Homes	1	0.7
Mental Health Funding	1	0.7
Midwife Practice/Clinics	1	0.7
More Classes	1	0.7
New Parent Navigator	1	0.7
Newborn Starter Kits	1	0.7
OB Navigators	1	0.7
OB Services	1	0.7
Open Billing Codes	1	0.7
Outreach Options	1	0.7
Parent Educator Funding	1	0.7

THEMES (VALID RESPONSES = 143)	N	PERCENT
Parental Counseling/Support	1	0.7
Paternal Support/Services	1	0.7
Paternal/Partner Involvement	1	0.7
Patient Outreach/Management	1	0.7
Postpartum Mental Health Services	1	0.7
Poverty	1	0.7
Promotion of Midwives	1	0.7
Provider Knowledge/Education	1	0.7
Public-Private Investment	1	0.7
Public Education of CSHCN	1	0.7
Quality Mental Health Services	1	0.7
Raise Minimum Wage	1	0.7
Recognition of Certified Nurse Midwives/Certified Professional Midwives	1	0.7
Referrals	1	0.7
Refugee/Immigrant Program	1	0.7
Resiliency Education	1	0.7
School-Based Counselors	1	0.7
School-Health Department Preconception Health	1	0.7
School Liaisons	1	0.7
Service Eligibility Expansion	1	0.7
Sleep	1	0.7
Social Activities	1	0.7
Social Media	1	0.7
Social Workers	1	0.7
Subsidized Daycare/Childcare	1	0.7
Universal EHR	1	0.7
WIC Expansion	1	0.7
Workforce Shortage	1	0.7
Youth-Based Activities	1	0.7
Youth and Community Development	1	0.7

QUESTION 27: *Have you or someone in your household used behavioral health services? If yes, what services?*

THEMES (VALID RESPONSES = 108)	N	PERCENT
Therapy/Counseling	81	75.0
Psychiatrist/Medication Management	23	21.3
Community Mental Health Center	13	12.0
General Practitioner	5	4.6
Behavioral Health	4	3.7
Suicide Prevention	3	2.8
Marriage Counseling	2	1.9
Psychiatric Outpatient	2	1.9
Psychotherapist	2	1.9
Rehabilitation	2	1.9
Substance Use	2	1.9
College Mental Health Services	1	0.9
Court Order Therapy/Counseling	1	0.9
Employee Assistance	1	0.9
Forensic Mental Health Exam	1	0.9
Psychiatric Inpatient	1	0.9
Yoga	1	0.9
Youth Mental Health Services	1	0.9

QUESTION 28: *Have you referred for behavioral health services? If yes, what services?*

THEMES (VALID RESPONSES = 131)	N	PERCENT
Therapy/Counseling	88	67.2
Community Mental Health Center	37	28.2
Psychiatrist/Medication Management	28	21.4
Substance Use	26	19.8
Behavioral Health	10	7.6
Psychiatric Inpatient	5	3.8
Suicide Prevention	5	3.8
Trauma	5	3.8
General Practitioner	4	3.1
Parenting Classes	3	2.3
Psychiatric Outpatient	3	2.3
Safety Net	3	2.3
Developmental Services	2	1.5
Emotional/Social Support	2	1.5
Grief Counseling	2	1.5
Support Groups	2	1.5
Tobacco	2	1.5
Youth Mental Health Services	2	1.5
Attendant Care	1	0.8
Domestic Violence	1	0.8
Federally Qualified Health Center	1	0.8
Mental Health Evaluation/Treatment	1	0.8
Outpatient Psychiatric	1	0.8
Private Service	1	0.8
Public Health	1	0.8
School-Based Services	1	0.8
Social Worker	1	0.8
Technology	1	0.8

QUESTION 30: *What would improve behavioral health services in your community?*

THEMES (VALID RESPONSES = 209)	N	PERCENT
Access to Care/Services	49	23.4
Increased Capacity/Shorter Wait Periods	38	18.2
Less Stigma/Increased Acceptance	18	8.6
Community-Based Providers	17	8.1
Awareness/Education	16	7.7
Affordable Care/Services	15	7.2
Insurance Coverage	10	4.8
Better Quality of Care/Services	9	4.3
Don't Know/Unsure	8	3.8
Free/Low Cost Care	8	3.8
Care Coordination	7	3.3
More Options	7	3.3
School-Based Services	5	2.4
Work-Flexible Scheduling (e.g., Evenings/ Wknds)	5	2.4
Youth Services	5	2.4
Availability of Resources	4	1.9
Resource Knowledge	4	1.9
Support Groups	4	1.9
Teletherapy	4	1.9
Better Advertisement/Promotion	3	1.4
Communication	3	1.4
Funding	3	1.4
Provider Education/Training	3	1.4
Trauma-Informed Care	3	1.4
Better Compensation for Providers	2	1.0
Centralized Location	2	1.0
Education/Awareness	2	1.0
Home-Based Services	2	1.0
Income Based Payment	2	1.0
Language/Interpretation Support	2	1.0
Mandatory Services/Screenings (age appropriate)	2	1.0
Medicaid Expansion	2	1.0
More Providers	2	1.0
No Change	2	1.0
Parental Engagement	2	1.0
Prevention	2	1.0
Provider-School Coordination	2	1.0
Transportation	2	1.0

THEMES (VALID RESPONSES = 209)	N	PERCENT
Anything	1	0.5
Better Access to Insurance	1	0.5
Better Foster Care	1	0.5
Billing/Reimbursement Changes	1	0.5
Block Fund to Cover Out of Pocket Expenses	1	0.5
Childcare	1	0.5
Collaboration	1	0.5
Cost of Health Insurance	1	0.5
Court-Ordered Services	1	0.5
Early Childhood Intervention	1	0.5
General Practitioner Training	1	0.5
Gun Control	1	0.5
In-Person Care	1	0.5
Increased Funding	1	0.5
Increased Medicaid Acceptance	1	0.5
Increased SUD Punitive Measures	1	0.5
Infant Mental Health	1	0.5
Integrated Care	1	0.5
Men's Services	1	0.5
Mental Health First Aid	1	0.5
Mental Health Screening for Juvenile Offenders	1	0.5
More Homeless Services	1	0.5
More Service Types	1	0.5
Outreach	1	0.5
Postpartum Care	1	0.5
Provider-Parent Collaboration	1	0.5
Provider Knowledge of Pay Sources	1	0.5
Public Facility Outreach (e.g., libraries)	1	0.5
Referral Improvements	1	0.5
Religious Activities	1	0.5
Rural Access	1	0.5
School Staffing	1	0.5
Social Workers	1	0.5
Substance Use Treatment	1	0.5
Too Much Reliance on Pharmaceuticals	1	0.5
Trauma/Abuse Screening	1	0.5
Universal Healthcare	1	0.5
Visiting Provider	1	0.5

QUESTION 32: *Have you or someone in your household received a referral as a result of a health and/or developmental screening? If yes, please indicate the service(s).*

THEMES (VALID RESPONSES = 47)	N	PERCENT
Early Intervention	18	38.3
Developmental Screening	12	25.5
Speech Therapy	8	17.0
Early Childhood Education	6	12.8
Behavioral Testing	3	6.4
Hearing Screening	3	6.4
Non-Profit	3	6.4
Ophthalmologist	3	6.4
Special Health Care Needs	3	6.4
Therapy/Counseling	3	6.4
Children	2	4.3
Home Visiting	2	4.3
Community Mental Health Center	1	2.1
Ear, Nose, and Throat (ENT) Services	1	2.1
Health Services	1	2.1
Kan Be Healthy	1	2.1
Medical Center	1	2.1
Occupational Therapy	1	2.1
Physical Therapy	1	2.1
Special Education	1	2.1
Themes (Valid Responses = 47)	n	Percent
Specialist	1	2.1

QUESTION 33: *Have you referred others to a service for developmental screening? If yes, please describe the service(s).*

THEMES (VALID RESPONSES = 111)	N	PERCENT
Early Intervention	75	67.6
Early Childhood Education	12	10.8
Home Visiting	11	9.9
Parenting Classes	10	9.0
School-Based Services	10	9.0
Speech	8	7.2
CSHCN	7	6.3
Hearing	7	6.3
Behavioral Health	5	4.5
Community Mental Health Center	4	3.6
Kan Be Healthy	4	3.6
Developmental Pediatrician	3	2.7
Early Childhood Development Screening	3	2.7
Multiple Services	2	1.8
Public Health Department	2	1.8
Vision	2	1.8
WIC	2	1.8
Behavioral Screenings/Health	1	0.9
Cognitive	1	0.9
Community Services	1	0.9
Disability Services	1	0.9
Ear, Nose, and Throat (ENT)	1	0.9
Family Planning	1	0.9
General Practitioner	1	0.9
Maternal Mental Health and Wellness	1	0.9
Religious	1	0.9
Therapy/Counseling	1	0.9

QUESTION 34: *What population in your community, if any, do you believe needs access to health screenings and developmental screenings the most?*

THEMES (VALID RESPONSES = 214)	N	PERCENT
Children (0-19)	50	23.4
Children (0-4)	23	10.7
Everyone	20	9.3
Low Income/Impoverished People, Families, Communities	19	8.9
Infants	13	6.1
Adolescents (10-19)	12	5.6
Children (0-5)	10	4.7
Young Children	9	4.2
Children (0-10)	7	3.3
Don't Know	7	3.3
Immigrants/Refugees	6	2.8
Racial-Ethnic Minority (e.g. Hispanic, African American, American Indian/Alaska Native)	6	2.8
Uninsured/Underinsured	6	2.8
Seniors	5	2.3
Adults	4	1.9
Non-English Speaking	4	1.9
Pregnant Women	4	1.9
All Children	3	1.4
Children (0-18)	3	1.4
Homeless	3	1.4
School Age Children	3	1.4
Unclassifiable	3	1.4
Children (0-3)	2	0.9
CSHCN	2	0.9
Medicaid Gap	2	0.9
Special Health Needs Populations	2	0.9
Women	2	0.9
Adolescents (12-15)	1	0.5
Adolescents (15-19)	1	0.5
Already Have Access - Don't Keep Appointments	1	0.5
At Risk Women	1	0.5
Caucasians	1	0.5
Children (0-17)	1	0.5

THEMES (VALID RESPONSES = 214)	N	PERCENT
Children (0-20)	1	0.5
Children (0-7)	1	0.5
Children (0-8)	1	0.5
Children (1-4)	1	0.5
Children (2-8)	1	0.5
Children (3-5)	1	0.5
Children in At-Risk Families	1	0.5
College Age	1	0.5
Criminal Offenders	1	0.5
Five Year Olds	1	0.5
Foster Children	1	0.5
Infant through Preschool	1	0.5
Infants Exposed to Substances (e.g., Tobacco, Drugs, Alcohol)	1	0.5
Infants through preK	1	0.5
Low Literacy	1	0.5
Lower Education	1	0.5
Medicaid Children	1	0.5
Middle and Upper Class	1	0.5
Most People	1	0.5
New Parents	1	0.5
Non-compliant Parents w/ Children	1	0.5
None	1	0.5
Parents w/ Young Children	1	0.5
Postpartum Women	1	0.5
Single Parents	1	0.5
SUD Populations (including children/ families)	1	0.5
Those w/ Developmental Delays	1	0.5
Workplace Policies for Screenings	1	0.5
Young Adults	1	0.5
Young Adults (20-24)	1	0.5
Young Parents	1	0.5

QUESTION 35: *What is your community doing that is working for the health of mothers, children and their families? Please describe the bright spots.*

THEMES (VALID RESPONSES = 199)	N	PERCENT
WIC	58	29.1
Community Programs/Activities	31	15.6
Early Intervention	29	14.6
Parental Education	23	11.6
Home Visiting	21	10.6
Public Health Department	18	9.0
Don't Know	17	8.5
Breastfeeding Support	16	8.0
School-Based Programs/Services	15	7.5
Early Childhood Education	13	6.5
Referrals	13	6.5
Access to Care/Services	10	5.0
Family Planning	9	4.5
Support Groups	9	4.5
Collaboration	8	4.0
Community Collaboration	8	4.0
Immunizations	8	4.0
Mental Health	8	4.0
None	7	3.5
Community Baby Shower	6	3.0
Community Involvement	6	3.0
Low Cost/No Cost Care	5	2.5
Clinical Care	4	2.0
Education	4	2.0
Federally Qualified Health Center	4	2.0
Resources	4	2.0
Community Health	3	1.5
Developmental Screenings	3	1.5
Free/Low Cost Events	3	1.5
Interagency Collaboration	3	1.5
Non-Profit	3	1.5
Quality of Care	3	1.5
Religious Services	3	1.5
Safety	3	1.5
Services/Resources	3	1.5
Support	3	1.5
Variety of Services	3	1.5
Community Mental Health Center	2	1.0
CSHCN	2	1.0
Doulas	2	1.0
Evening/Weekend Clinics	2	1.0
Health Department	2	1.0
Hospital Involvement	2	1.0
Income-Based Payment	2	1.0
Kan Be Healthy	2	1.0
Pregnancy Center	2	1.0
Social Services	2	1.0
Therapy/Counseling	2	1.0
Behavioral Screening	1	0.5
Cancer Screening (e.g., breast, cervical)	1	0.5
Case Management	1	0.5
CHIPs	1	0.5
Coordination	1	0.5
Daycare/Childcare	1	0.5
Equity	1	0.5
ER Access	1	0.5
Food Pantry	1	0.5
Funding	1	0.5
In-Depth Evaluation	1	0.5
Integrated Care	1	0.5
Language Support/Interpretation Services	1	0.5
Mental Health First Aid	1	0.5
Midwives	1	0.5
Minimal Supports and Services	1	0.5
Not Much	1	0.5
Park & Rec	1	0.5
Postpartum Care	1	0.5
Prenatal Care	1	0.5
Prevention	1	0.5
Provider Education/Training	1	0.5
Racial-Ethnic Minority (e.g. Hispanic, African American, American Indian/Alaska Native)	1	0.5
Social Workers	1	0.5
Telehealth	1	0.5
Transportation	1	0.5
Trauma Informed Care/Services	1	0.5
Traveling Services	1	0.5
Well Visits	1	0.5
Work-Flexible Scheduling for Care (e.g., Wknds/Evenings)	1	0.5

QUESTION 36: *What is something you believe your community needs to improve the health of mothers, children, and families? Please describe your greatest area of need. (VALID RESPONSES = 200)*

THEMES	N	PERCENT
Access to Care/Services	37	18.5
Mental Health	28	14.0
Daycare/Childcare	20	10.0
Parental Education and Engagement	16	8.0
Food/Nutrition	13	6.5
Funding	12	6.0
Breastfeeding Support	11	5.5
Don't Know	10	5.0
Education	10	5.0
Emotional/Social Support Groups	10	5.0
Resources/Knowledge	10	5.0
Low/No Cost Care	9	4.5
Transportation Options	8	4.0
Affordable Care/Services	7	3.5
Shelter/Housing	7	3.5
Community-Based Providers	6	3.0
Increased Capacity/ Shorter Wait Periods	6	3.0
Parks & Rec	6	3.0
Provider Education and Engagement	6	3.0
Quality of Care	6	3.0
Advertisement/PSA	5	2.5
Community Activities/ Events	5	2.5
Interagency Communication	5	2.5
Care Coordination	4	2.0
Health Behaviors	4	2.0
Home Visiting	4	2.0
Referrals	4	2.0
Behavioral Health	3	1.5
Dental	3	1.5
Early Intervention	3	1.5
Equality	3	1.5
Insurance	3	1.5
Medicaid/Medicaid Expansion	3	1.5
School-Based Services	3	1.5
Substance Use	3	1.5
WIC	3	1.5
Work-Flexible Scheduling (e.g., Evenings/Weekends)	3	1.5
Address Eligibility Gap	2	1.0
Community Mental Health Center	2	1.0
Culturally-Responsive Care	2	1.0
Healthcare	2	1.0
Language/ Interpretation Services	2	1.0
Maternal Mental Health	2	1.0
Maternal/Paternal Leave	2	1.0
Postpartum Depression/ Screening	2	1.0
Social Determinants of Health	2	1.0
Therapy/Counseling	2	1.0
Unified Messaging	2	1.0
Vision	2	1.0
Access for All	1	0.5
Adolescent Mental Health	1	0.5
Advocacy	1	0.5
Car Seats	1	0.5
Case Coordination	1	0.5
Child Discipline	1	0.5
Collaboration	1	0.5
Community Collaboration	1	0.5
Community Engagement	1	0.5
Community Investment	1	0.5
Continuity of Care	1	0.5
CSHCN	1	0.5
Developmental	1	0.5
Developmental Screening	1	0.5
Don't Use Incentive Programs	1	0.5
Door-to-Door Interaction	1	0.5
Early Childhood Education	1	0.5
Equity	1	0.5
Expand Beyond Traditional MCH	1	0.5
Financial Support	1	0.5
Follow-Up	1	0.5
Genetics	1	0.5
Gun Control	1	0.5
Health Department	1	0.5
Income-Based Programs	1	0.5
Increase Workforce	1	0.5
Infant Health	1	0.5
Infant Mortality	1	0.5
Infrastructure (e.g., walking trails, sidewalks, etc)	1	0.5
Less Childcare Regulations	1	0.5
Local Resources	1	0.5
Mothers and Infants	1	0.5
None	1	0.5
Outreach	1	0.5
Patient Advocates	1	0.5
Pediatric Mental Health	1	0.5
Prenatal Care	1	0.5
Realistic Expectations	1	0.5
Religious Activities	1	0.5
Remove Barriers	1	0.5
Reproductive Health/ Family Planning	1	0.5
Research	1	0.5
Sexual Education	1	0.5
Social Services	1	0.5
Support	1	0.5
Trauma-Informed Care	1	0.5

Community Norms Survey Pairs Analysis

Community norms results, KDHE MCH Needs Assessment Survey, 2020

SURVEY PAIR * *"I believe…" statements*	SURVEY PAIR* *"In my opinion…" statements*	MEAN DIFFERENCE	SIGNIFICANCE
I believe that women have equal access to health care in Kansas. (2.47)	**In my opinion, most adults in my community believe that women have equal access to health care in Kansas. (2.76)**	0.29	.000*
I believe that reproductive health, preconception health, and family planning are important topics. (3.69)	**In my opinion, most adults in my community believe that reproductive health, preconception health, and family planning are important topics. (2.79)**	-.90	.000*
I believe that pregnant women and mothers have equal access to health care in Kansas. (2.38)	**In my opinion, most adults in my community believe that pregnant women and mothers have equal access to health care in Kansas. (2.74)**	0.36	.000*
I believe that prenatal education, prenatal care, screening for risks (smoking, substance use, depression/anxiety, mental illness, basic needs, etc.) is important to health and well-being. (3.79)	**In my opinion, most adults in my community believe that prenatal education, prenatal care, screening for risks (smoking, substance use, depression/anxiety, mental illness, basic needs, etc.) is important to health and well-being. (3.04)**	-0.75	.000*
I believe fathers in my community are given opportunities to be engaged and involved in their partners' pregnancy and delivery to support positive birth outcomes. (2.84)	**In my opinion, most adults in my community believe that fathers in my community are given opportunities to be engaged and involved in their partners' pregnancy and delivery to support positive birth outcomes. (2.81)**	-0.03	.579
I believe fathers in my community are engaged in their child's life to support healthy child development and strong families. (2.63)	**In my opinion, most adults in my community believe that fathers are engaged in their child's life to support healthy child development and strong families. (2.66)**	0.03	. 573
I believe that infants and toddlers have equal access to health care in Kansas. (2.59)	**In my opinion, most adults in my community believe that infants and toddlers have equal access to health care in Kansas. (2.89)**	0.30	.000*
I believe that healthy weight and good nutrition for infants and toddlers is a health issue that is being addressed in Kansas. (2.9)	**In my opinion, most adults in my community believe that healthy weight and good nutrition for infants and toddlers is a health issue that is being addressed in Kansas. (2.82)**	-0.08	.173
I believe that breastfeeding is an important part of good child health in Kansas. (3.68)	**In my opinion, most adults in my community believe that breastfeeding is an important part of good child health in Kansas. (2.88)**	-0.80	.000*
I believe that children have equal access to health care in Kansas. (2.59)	**In my opinion, most adults in my community believe that children have equal access to health care in Kansas. (2.86)**	0.27	.000*
I believe that healthy weight and good nutrition for children is a health issue that is being addressed in Kansas. (2.85)	**In my opinion, most adults in my community believe that healthy weight and good nutrition for children is a health issue that is being addressed in Kansas. (2.87)**	0.02	0.812
I believe teachers and school environments are prepared to support children's success in school. (2.75)	**In my opinion, my community believes teachers and school environments are prepared to support children's success in school. (2.94)**	0.19	.001*
I believe that children in Kansas have access to healthy physical activities. (2.72)	**In my opinion, most adults in my community believe that children in Kansas have access to healthy physical activities. (2.87)**	0.15	.006*
I believe that children in Kansas have access to healthy social activities. (2.63)	**In my opinion, most adults in my community believe that children in Kansas have access to healthy social activities. (2.77)**	0.14	.010*
I believe that there is quality child care available in my community for families that need it. (2.11)	**In my opinion, most adults in my community believe that there is quality child care for families that need it. (2.36)**	0.25	.000*

** Weighted mean for each Likert item is presented in the parentheses. Mean difference is the weighted average of the community minus the weighted average of the individual.*

Significance was assessed using a Chi Square Linear-By-Linear Test of Association (Mantel-Haenszal) with p <.05.

Community Norms Survey Pair Response Proportions

QUESTION 7: *Women ages 15-44 years were considered when answering these questions.*

strongly agree *agree* *disagree* *strongly disagree*

I BELIEVE THAT WOMEN HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT WOMEN HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

I BELIEVE THAT REPRODUCTIVE HEALTH, PRECONCEPTION HEALTH, AND FAMILY PLANNING ARE IMPORTANT TOPICS.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT REPRODUCTIVE HEALTH, PRECONCEPTION HEALTH, AND FAMILY PLANNING ARE IMPORTANT TOPICS.

QUESTION 8: *Pregnant women and mothers that delivered within the last year (child under 1 year of age) were considered when answering these questions.*

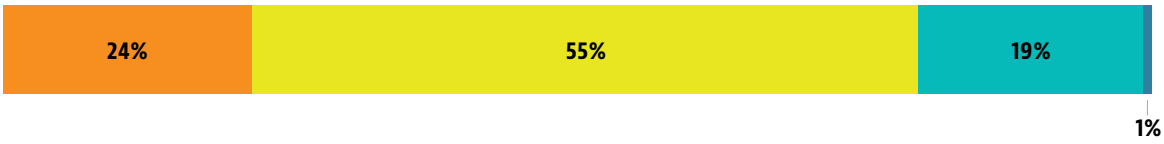
strongly agree *agree* *disagree* *strongly disagree*

I BELIEVE THAT PREGNANT WOMEN AND MOTHERS HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT PREGNANT WOMEN AND MOTHERS HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

I BELIEVE THAT PRENATAL EDUCATION, PRENATAL CARE, SCREENING FOR RISKS (SMOKING, SUBSTANCE USE, DEPRESSION/ANXIETY, MENTAL ILLNESS, BASIC NEEDS, ETC.) IS IMPORTANT TO HEALTH AND WELL-BEING.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT PRENATAL EDUCATION, PRENATAL CARE, SCREENING FOR RISKS (SMOKING, SUBSTANCE USE, DEPRESSION/ANXIETY, MENTAL ILLNESS, BASIC NEEDS, ETC.) IS IMPORTANT TO HEALTH AND WELL-BEING.



I BELIEVE THAT FAMILIES BENEFIT FROM CARE COORDINATION SERVICES TO ENSURE THEY ARE CONNECTED TO SERVICES AND SUPPORTS THEY NEED.

I BELIEVE THAT MY COMMUNITY DOES PROVIDE ACCESS TO CARE COORDINATION SERVICES TO ENSURE FAMILIES ARE CONNECTED TO SERVICES AND SUPPORTS THEY NEED.

QUESTION 9: *The involvement/engagement and experiences of fathers in the community was considered when answering these questions.*

■ *strongly agree* ■ *agree* ■ *disagree* ■ *strongly disagree*

I BELIEVE FATHERS IN MY COMMUNITY ARE GIVEN OPPORTUNITIES TO BE ENGAGED AND INVOLVED IN THEIR PARTNERS' PREGNANCY AND DELIVERY TO SUPPORT POSITIVE BIRTH OUTCOMES.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT FATHERS IN MY COMMUNITY ARE GIVEN OPPORTUNITIES TO BE ENGAGED AND INVOLVED IN THEIR PARTNERS' PREGNANCY AND DELIVERY TO SUPPORT POSITIVE BIRTH OUTCOMES.

I BELIEVE FATHERS IN MY COMMUNITY ARE ENGAGED IN THEIR CHILD'S LIFE TO SUPPORT HEALTHY CHILD DEVELOPMENT AND STRONG FAMILIES.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT FATHERS ARE ENGAGED IN THEIR CHILD'S LIFE TO SUPPORT HEALTHY CHILD DEVELOPMENT AND STRONG FAMILIES.

I BELIEVE MY COMMUNITY VALUES FATHERS AND PROMOTES THE IMPORTANCE OF INVOLVEMENT AND BEING PRESENT DURING HEALTH CARE VISITS, PARENT SUPPORT VISITS, COMMUNITY AND SCHOOL EVENTS, ETC.

I BELIEVE FATHERS IN MY COMMUNITY ARE GENERALLY SATISFIED WITH THE AMOUNT OF CONTACT THEY HAVE WITH THEIR CHILDREN.

I BELIEVE FATHERS IN MY COMMUNITY ARE GENERALLY SATISFIED WITH THE QUALITY OF INTERACTION THEY HAVE WITH THEIR CHILDREN.

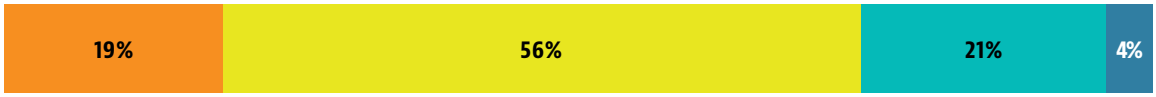
QUESTION 10: *Infants and toddlers ages birth to 3 years were considered when answering these questions.*

strongly agree *agree* *disagree* *strongly disagree*

I BELIEVE THAT INFANTS AND TODDLERS HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT INFANTS AND TODDLERS HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

I BELIEVE THAT HEALTHY WEIGHT AND GOOD NUTRITION FOR INFANTS AND TODDLERS IS A HEALTH ISSUE THAT IS BEING ADDRESSED IN KANSAS.



IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT HEALTHY WEIGHT AND GOOD NUTRITION FOR INFANTS AND TODDLERS IS A HEALTH ISSUE THAT IS BEING ADDRESSED IN KANSAS.

I BELIEVE THAT BREASTFEEDING IS AN IMPORTANT PART OF GOOD CHILD HEALTH IN KANSAS.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT BREASTFEEDING IS AN IMPORTANT PART OF GOOD CHILD HEALTH IN KANSAS.

QUESTION 11: *Children ages 4-10 years were considered when answering these questions.*

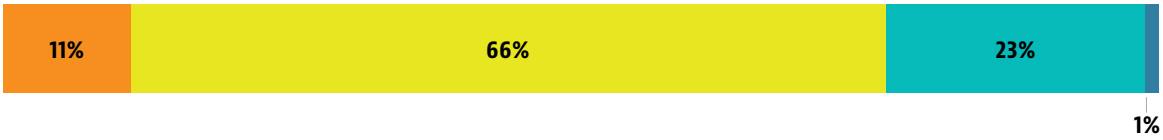
strongly agree *agree* *disagree* *strongly disagree*

I BELIEVE THAT CHILDREN HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT CHILDREN HAVE EQUAL ACCESS TO HEALTH CARE IN KANSAS.

I BELIEVE THAT HEALTHY WEIGHT AND GOOD NUTRITION FOR CHILDREN IS A HEALTH ISSUE THAT IS BEING ADDRESSED IN KANSAS

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT HEALTHY WEIGHT AND GOOD NUTRITION FOR CHILDREN IS A HEALTH ISSUE THAT IS BEING ADDRESSED IN KANSAS.

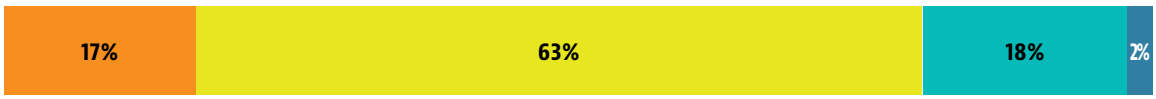


I BELIEVE THAT CHILDREN IN KANSAS ENTER SCHOOL READY TO LEARN.

IN MY OPINION, MY COMMUNITY SUPPORTS CHILDREN ENTERING SCHOOL READY TO LEARN.

I BELIEVE TEACHERS AND SCHOOL ENVIRONMENTS ARE PREPARED TO SUPPORT CHILDREN'S SUCCESS IN SCHOOL.

IN MY OPINION, MY COMMUNITY BELIEVES TEACHERS AND SCHOOL ENVIRONMENTS ARE PREPARED TO SUPPORT CHILDREN'S SUCCESS IN SCHOOL.



QUESTION 12: *Both infants and children ages birth to 10 were considered when answering these questions.*

strongly agree *agree* *disagree* *strongly disagree*

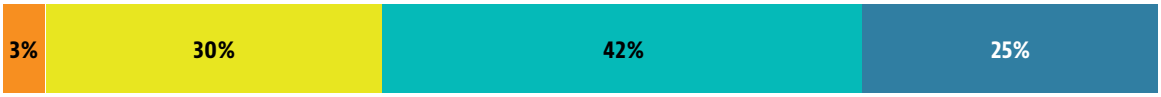
I BELIEVE THAT CHILDREN IN KANSAS HAVE ACCESS TO HEALTHY PHYSICAL ACTIVITIES.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT CHILDREN IN KANSAS HAVE ACCESS TO HEALTHY PHYSICAL ACTIVITIES.

I BELIEVE THAT CHILDREN IN KANSAS HAVE ACCESS TO HEALTHY SOCIAL ACTIVITIES.

IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT CHILDREN IN KANSAS HAVE ACCESS TO HEALTHY SOCIAL ACTIVITIES.

I BELIEVE THAT THERE IS QUALITY CHILD CARE AVAILABLE IN MY COMMUNITY FOR FAMILIES THAT NEED IT.



IN MY OPINION, MOST ADULTS IN MY COMMUNITY BELIEVE THAT THERE IS QUALITY CHILD CARE FOR FAMILIES THAT NEED IT.

APPENDIX L: KEY INFORMANT INTERVIEWS AND FOCUS GROUP

Introduction

In December 2019 and January 2020 staff of CPPR conducted a series of key informant interviews and one focus group with key provider organizations, social service agencies, specialty providers, and other stakeholders. Participants were presented with a high-level overview of information collected through the MCH Needs Assessment process. The goal was to collect experiences related to already emerging issues, while also seeking new or fresh opinions on needs that had not have been previously mentioned and might warrant additional investigation and discussion. Eleven interviews and one focus group (with five organizational representatives) were conducted. CPPR gathered feedback from stakeholders across a variety of fields, representing unique perspectives on the needs of mothers and children in Kansas. Included in this process were medical, educational, research, and public health organizations who work throughout the state with both urban and rural populations (see list at the end of this section).

Health Care Access

Overwhelmingly, reported barriers to health care for both mothers and children centered around cost, availability, and transportation. Families struggle to find providers, particularly in specialized medical areas such as OB/GYN or Physical Therapy, and often must drive great distances to access care. Many providers do not accept Medicaid, narrowing the choices even further for those who rely on KanCare. Families who have private health insurance report there is still difficulty with coverage for certain conditions, long waiting times for appointments, and costs associated with travel for some services. For parents whose children have special health care needs, the time and effort involved with care coordination is extraordinarily complex, given their care involves a wide array of providers (not all of whom are located in the same community), ongoing challenges around scheduling, and lack of care coordination within the medical system. Pediatric specialists pointed out that reimbursement for some very specialized care is not adequately funded, there is insufficient capacity to provide those services statewide (which means families have to travel great distances and/or may forego care all together), and the current system is likely not sustainable. Many of the interviewees indicated that telemedicine is one of the more promising future remedies for these struggles (although not a panacea), but current technology, funding, and laws/regulations are a hindrance to progress.

Mental Health

Stakeholders repeatedly highlighted mental health concerns across all fields of service, as it intersects with every aspect of families' lives. Lack of mental health providers is a key issue in Kansas, with even fewer options available for pediatric or adolescent patients. Maternal depression screenings and referrals are integral to the goals of MCH, but long waits, long distances, and a workforce with frequent turnover are significant barriers to effectively addressing postpartum mental health. It is also noteworthy that fully addressing community mental health includes the self-care and stability of providers, caregivers, and extended families of patients.

Oral Health

Access to dental services for women and children is a concern. Very few pregnant women utilize dental services, and many dental providers are uncomfortable working with young children. As a result, about 25% of kids have some type of dental decay by age 2. The number of dental providers who offer services to children with special health care needs is very limited.

Tobacco Usage & Substance Abuse

While tobacco-cessation programs seem to be a lesser focus in recent years, there is agreement across organizations that vaping, particularly among young people, is fast-growing area of concern with little research from which to draw for guidance. Similarly, as substance abuse programs of the past decade zeroed in on methamphetamines, treatment for opiate addiction is now emerging as the greater need. Programs expressed that through MCH, we have the opportunity to intervene during the critical prenatal period to help expectant mothers who are using or at risk of using substances. Marijuana legalization is also seen as a possible issue on the horizon.

Breastfeeding

A true bright spot exists in the high percentage – 90% – of Kansas mothers who are initiating breastfeeding. Goals for the future focus on extending the duration, reducing stigma across populations, increasing cooperation from employers, and extending the workforce of support in local areas.

Obesity & Nutrition

In a similar manner to tobacco-cessation, public health efforts to combat obesity have reportedly lessened in recent years. Several interviewees expressed the opinion that intensive case management is needed to truly effect change in this area, and efforts must include a generational and community-wide approach for success. The issue is also inextricable from larger socio-economic determinants. Many urban and rural areas have a lack of options for fresh, healthy foods – instead relying on small convenience chains offering only preserved, boxed, and canned goods.

Developmental Screenings

Emphasized as a bright spot across the state, the increased awareness and usage of developmental screenings is a positive trend with some drawbacks. The repeated theme of too few specialty providers and too many barriers to access their services emerged here as well. It is not enough to just conduct screenings; there must be adequate options available to address the results and serve the families in need. Goals for the future include improving the recording, sharing, and tracking of screenings so that providers are more efficient and families are less burdened.

Additional Themes

Through the interview process, several other themes arose frequently related to barriers and needs across maternal and child health. There is a consensus that collaboration between sectors, improved referral systems, and funds devoted to care coordination should be at the forefront of goals for improvement. Addressing larger economic pressures such as housing, transportation, and child care must also be considered, with a growing focus on telemedicine to alleviate some of these. Lastly, developing a more robust workforce with training and education in the areas of cultural competence, ACES, and trauma-informed care is essential, while also addressing the unique needs of Kansas' bilingual families.

Organizations Included

- Cerebral Palsy Research Foundation
- Community Care Network of Kansas (Primary Care Association)
- Kansas Health Foundation
- United Methodist Health Ministry Foundation
- American Academy of Pediatrics, Kansas Chapter
- Kansas Hospital Association
- University of Kansas Medical Center-Wichita Department of Pediatrics
- University of Kansas Healthy System Pediatrics – Kansas City
- American College of Obstetricians and Gynecologists, Kansas Chapter
- Kansas Health Institute
- Kansas Academy of Family Physicians
- Focus Group –Kansas Enrichment Network
- Kansas Breastfeeding Coalition
- Oral Health Kansas
- Child Care Aware
- Kansas Child Care Training Opportunities