MCH 2020: KANSAS MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT

PRIORITIES AND ACTION PLAN, 2016-2020

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The 2016-2020 Kansas Title V Needs Assessment was conducted by the Bureau of Family Health to understand needs and determine priorities for work at the state and local levels to support the health and well-being of women, infants, children, children with special health care needs, adolescents, and individuals over the life course. The Bureau of Family Health's mission is to provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.

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Mission:
To protect and improve the health and environment of all Kansans.

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Executive Summary

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 American history and one of the largest Federal block grant programs. Since its inception, the Maternal and Child Health Services Block Grant has been a key source of support for promoting and improving the health of the nation's mothers and children. With the passing of the Social Security Act of 1935, the federal government, working through Title V, committed its support to states in their efforts to extend and sustain health services for maternal and child health populations. For over 75 years, the Title V Maternal Child Health (MCH) Block Grant remains the only federal program that focuses solely on improving the health of all mothers and children. The Kansas Department of Health and Environment, Bureau of Family Health administers the Kansas program.

Transforming Title V Maternal & Child Health Services

Title V has been amended several times over the years in support of the ongoing commitment to improve the health and well-being of the nation's mothers and children. In 2014, the Health Resources and Services Administration (HRSA) transformed the MCH Block Grant program to increase alignment of state Title V efforts with other MCH investments and to clearly show the role that state Title V programs provide in assuring that state MCH population domain needs will be met. This most recent transformation of the Title V Block Grant application and annual reporting process was designed to, a) reduce burden to states; b) maintain state flexibility, and c) improve accountability.

To more clearly address this, 15 National Performance Measures (NPMs) will be used to track progress on state-selected priorities across six MCH population health domains. This is a key revision in the Block Grant, which now incorporates a life course approach and addresses each domain more specifically than in past years. The revised domains are:

Women/Maternal Health	**Children and Youth with Special Health Care Needs**
Perinatal/Infant Health	**Adolescent Health**
Child Health	**Cross-Cutting or Life Course**

MCH 2020: Title V Needs Assessment

Every five years, states are required to conduct a comprehensive Needs Assessment to receive Title V funding. The Needs Assessment is intended to report on the health status of women and children, identify priority health needs, and adopt measures to monitor improvement. The Needs Assessment

will help to drive decisions related to program goals and objectives and to allocate state and local resources. For Kansas, the Title V Maternal and Child Health (MCH) Needs Assessment is for the 2016-2020 period.

The Kansas Department of Health and Environment (KDHE) Bureau of Family Health (BFH) began the state Needs Assessment with a vision to enhance partnerships and engage new partners for MCH programs across the state. BFH staff coordinated the Needs Assessment process and will administer Title V funds based on the comprehensive analysis of the health status of the state's MCH populations.

The primary goal of the Needs Assessment was to identify priority needs for the Kansas MCH population domains over the next five years in a unique and integrated way through engaging community, stakeholders, KDHE staff and those who work with women, children, adolescents and children with special health care needs in multiple sectors every day.

From May 2014 to July 2015, BFH proactively engaged those partners in a collaborative effort that included stakeholder and community surveys; creative, dynamic regional meetings; partner meetings; internal processes; and, implementation of logic models and action plans. As a result, and after assessing available resources and capacity, great care and thought was put into the emerging needs and recurring themes until the final eight priorities were determined. The BFH's eight Title V MCH priority needs and goals for 2016-2020 are detailed on the following page.

Between 2016 and 2020, strategies and action plans identified through this needs assessment process will be implemented to address the priorities and goals. Results will be monitored and evaluated as KDHE BFH continues to collaborate and form new partnerships to improve the health of women, infants, children, adolescents, and children with special health care needs in Kansas over the next five years and beyond.

Priorities and Measures

STATE PRIORITIES

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

1. Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.
2. Services and supports promote healthy family functioning.
3. Developmentally appropriate care and services are provided across the lifespan.
4. Families are empowered to make educated choices about nutrition and physical activity.
5. Communities and providers support physical, social, and emotional health.
6. Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7. Services are comprehensive and coordinated across systems and providers.
8. Information is available to support informed health decisions and choices.

NATIONAL PERFORMANCE MEASURES (NPM)

States select 8 of 15 that address the state priority needs; at least one per domain.

- NPM1: Well-woman visit (Percent of women with a past year preventive medical visit)
- NPM4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)
- NPM6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- NPM7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)
- NPM9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)
- NPM10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)
- NPM11: Medical home (Percent of children with and without special health care needs having a medical home)
- NPM14: Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy; B. Percent of children who live in households where someone smokes)

Title V Key Definitions & Concepts

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.

Role of Title V

Title V legislation and the MCH Service Block Grant Program enables states to:

1. provide and assure mothers and children access to quality MCH services;
2. reduce infant mortality and the incidence of preventable diseases;
3. provide rehabilitation services for blind and disabled individuals; and
4. provide and promote family-centered, community-based, coordinated care, and facilitate the development of community-based systems of services.

Significant Concepts:

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

MCH Population Health Domains

1. Women's/Maternal Health
2. Perinatal/Infant Health
3. Child Health
4. Children with Special Health Care Needs
5. Adolescent Health
6. Cross-Cutting or Life Course

Definitions

Legislatively-defined state MCH population groups:

1. pregnant women, mothers, and infants up to age 1;
2. children; and
3. children with special health care needs.

Acknowledgments

Many individuals were integral to Kansas' five-year needs assessment. These individuals represent a broad range of expertise and experience in maternal and child health issues, and we appreciate their commitment to improving the health of Kansas' women, infants, children, and adolescents.

The Kansas 2016-2020 MCH Needs Assessment is a comprehensive view of our communities thanks to the participation of nearly 3,000 individuals via surveys, meetings, focus groups, public input, and personal communication. Thanks to all of these individuals for making MCH a priority in Kansas.

Overview of Kansas Maternal & Child Health

Kansas is a state that prioritizes young children and families. Over the past decade, significant investments have been made in building a collaborative environment and in supporting at-risk communities to improve child and family health and well-being. The Kansas Department of Health and Environment's Bureau of Family Health has been a leader in these efforts, especially as they relate to the Title V Maternal and Child Health (MCH) Services Block Grant Program. The Bureau is responsible for the administration of programs carried out with allotments under Title V.

The Title V MCH Block Grant plays a key role in the provision of maternal and child health services in Kansas. Funds from this grant are distributed to a number of organizations and programs across the state which target the improvement of the health of all women and infants, children and adolescents, and children with special health care needs.

As part of Kansas' Block Grant activity requirements, the Bureau of Family Health conducts a statewide needs assessment every five years. The needs assessment provides direction and guidance to Title V activities for the next five years by identifying state maternal and child health priority issues and performance measures that measure state progress and accountability. The most recent needs assessment and State Action Plan address needs and priorities for the period 2016-2020 related to mandated services:

- Preventive and primary care services for all pregnant women, mothers, and infants up to age one;
- Preventive and primary care services for children; and
- Services for CSHCN [as specified in section 501(a)(1)(D) "family-centered, community-based, coordinated care (including care coordination services) 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"].

Unique in its design and scope, the Title V Maternal and Child Health Block Grant to States program uses the following criteria to promote and protect the health of all mothers and children, including CYSHCN: 1) Focuses exclusively on the entire maternal and child health population; 2) Encompasses infrastructure, population-based, enabling, and direct services for the maternal and child health population; 3) Requires a unique partnership arrangement between Federal, State and local entities; 4) Requires each State to work collaboratively with other organizations to conduct a State-wide, comprehensive Needs Assessment every 5 years; 5) Based on the findings of the Needs Assessment, requires each State to identify State priorities to comprehensively address the needs of the MCH population and guide the use of the Maternal and Child Health Block Grant funds; and 6) May serve as the payer of last resort for direct services for the maternal and child health population that are not covered by any other program.

The Title V Needs Assessment for 2016-2020, referred to as MCH 2020, aligns with KDHE's goals, the Governor's Roadmap, MCH 3.0, Healthy Kansas 2020 to inform work over the next five years for women, infants, children, children and youth with special health care needs, adolescents, and life course.

Vision, Mission, and Purpose

Specified in the Title V legislation [Section 501(a)(1) of Title V of the Social Security Act], clearly articulated 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: Title V envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission: 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.

The mission of the Bureau of Family Health is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." KDHE convenes the Kansas Maternal and Child Health Council and contracts with local public health departments (independent entities) across the state to ensure coordination of MCH services within a coordinated, family-centered system.

The BFH's mission and health services philosophy are aligned with the Title V vision and mission, offering an integrated platform for conducting the Needs Assessment through a collaborative process that was participant-driven and assessed for capacity and realistic outcomes as it progressed.

Purpose: 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:

(A) 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;

(B) To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease 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;

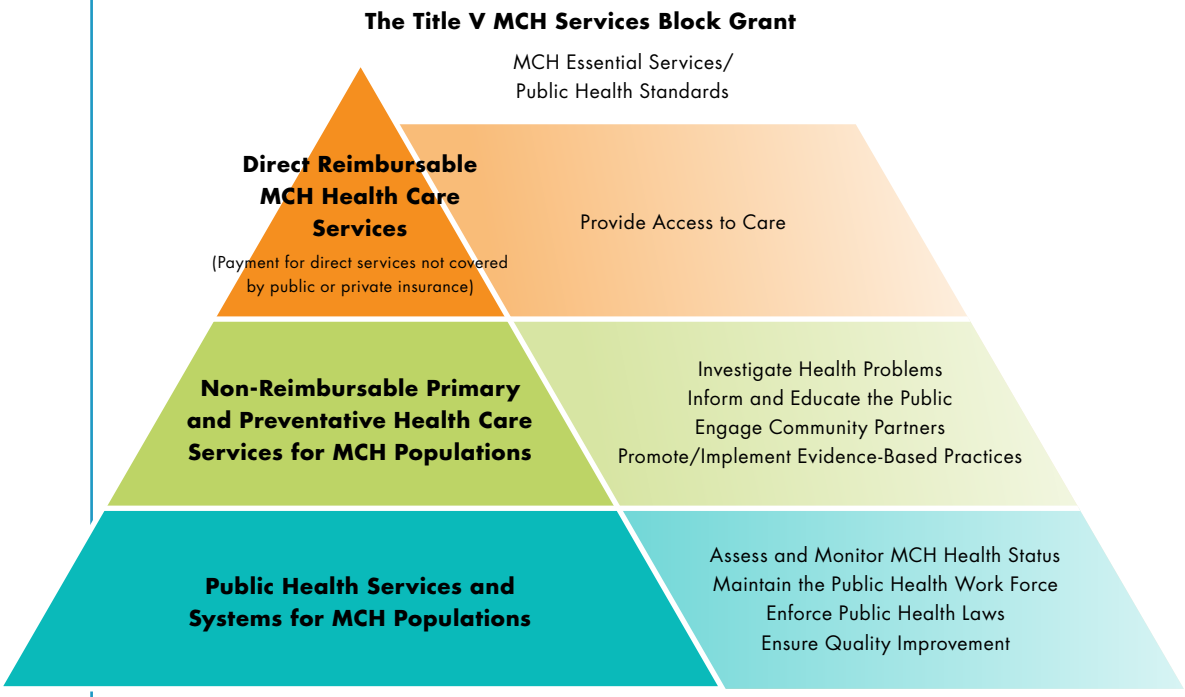
(C) To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

(D) To 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.

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

HEALTH SERVICES PHILOSOPHY: Holistic health services and health promotion for children, youth and their families should be made available and accessible through integrated systems that promote individualized, family-centered, community-based and coordinated care.

This systems level approach is captured in the framework for MCH services, depicted as a Pyramid, which recognizes the continuum of programs, public health services, and supports that are required to move the needle and make a difference in the health of Kansas communities.



MCH Essential Services

In considering potential strategies for implementing the new 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 strategies presented below 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; and
- 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

PREVENTION & WELLNESS. A program of activities directed at improving general well-being while also involving specific protection for selected diseases, such as immunization against measles. A set of organized activities and systematic interventions, offered through workplaces, government, community agencies, etc. whose primary purposes are to provide health education, identify modifiable health risks, and influence health behavior changes.

SOCIAL DETERMINATES OF HEALTH. The conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

LIFE COURSE PERSPECTIVE. A growing awareness in public health research of the long-term impact on health of various events and exposures earlier in life. Early focus on 'life course perspective' concentrated on events and exposures in fetal life, but later studies showed that circumstances throughout childhood and adult age influence health in old age. A number of chronic diseases such as coronary heart disease, stroke, and some cancers seem to be influenced by factors acting across the entire life course. There is increasing evidence that a number of other factors, operating at special critical periods earlier in life, may also influence health at later periods of the life course, such as infections during childhood.

HEALTH EQUITY. Health equity is about building an understanding who is not being served and why. Those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair. When societal resources are distributed unequally by class and by race, population health will be distributed unequally along those lines as well. Public health can be improved by improving the ways in which jobs, working conditions, education, housing, social inclusion, and even political power influence individual and community health.

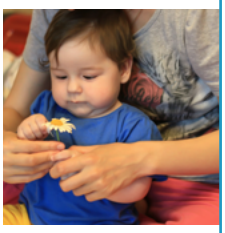
Guiding Principles

The Needs Assessment highlighted the importance of recognizing and understanding the connections between priorities across MCH population domains. The resulting priorities reflect the critical connections that emerged from the Needs Assessment. In addition, three overarching themes were identified as guiding principles that impact Title V work in Kansas. It is important to note that these guiding principles do not stand alone, yet build upon and complement each other, further exemplifying the collaborative approach KDHE MCH envisioned throughout the process. The guiding principles are:

COLLABORATION Creating systems change that reduces barriers to women, infants, children, CYSHCN, and adolescents getting the services that they need – both within and across agencies

RELATIONSHIPS Building collaborative relationships – at the organizational and individual levels – that provide a foundation for service delivery, continuous quality improvement, and positive community change

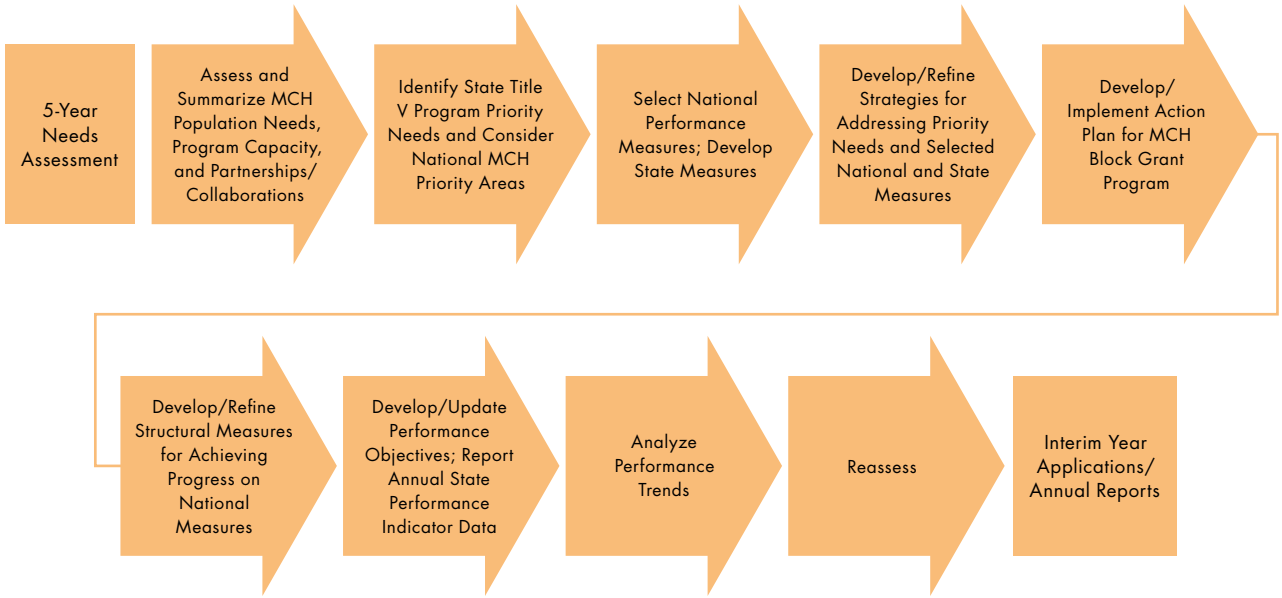
COMMUNITY NORMS Addressing community norms that have created a stigma that is a barrier to people accessing needed services



Logic Model

These guiding principles were continually implemented and adhered to as the Needs Assessment progressed. The principles aligned well with the MCH Block Grant Transformation as KDHE worked in partnership with stakeholders, other MCH leaders, community partners, and families throughout the process. The MCH Logic Model depicts the process that KDHE used, which involves continuously analyzing performance and reassessing strategies as time progressed. This process was exemplified through the regional meeting approach as input was synthesized and defined over time and as KDHE continued to work in partnership to improve the MCH Block Grant and uphold the transformation's principles to reduce burden, maintain flexibility and improve accountability.

TITLE V MCH Block Grant Needs Assessment Framework Logic Model



Agency Capacity

The Kansas Department of Health and Environment 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.

Within the Division of Public Health, the mission of the Bureau of Family Health (BFH) is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH has three goals: 1) Improve access to comprehensive health, developmental and nutritional services for women and children including children with special health care needs; 2) 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; and, 3) Strengthen Kansas' maternal and child health infrastructure and systems to eliminate barriers to care and to reduce health disparities. The BFH has five sections: Nutrition and WIC Services; Children and Families; Special Health Services; Child Care Licensing; and Administration and Policy. This organization provides a unique opportunity for implementing the Title V Five Year Action Plan through collaboration and coordination across a range of family-serving programs. The BFH structure also offers shared capacity to carry out the Plan through the work of the MCH team.

The Children and Families Section serves as the lead for Title V Maternal and Child Health programming as well as Reproductive Health and Family Planning. The Section focuses on promoting optimal health for infants, children, adolescents, and women through systems development activities and grants to local communities. The education, counseling and medical services available in family planning clinics assist individuals in determining the number and spacing of their children, thereby promoting positive birth outcomes and healthy families. 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 and adolescents. Maternal and Child Health Home Visitors provide outreach calls and visits to pregnant women and families with infants through 68 of the local health agencies. Several other state and federal aid to local programs are also administered through Section grants and contracts including the Healthy Start program (Geary County only); Teen Pregnancy Targeted Case Management program; Pregnancy Maintenance Initiative program; Healthy Families Services program; Kansas Abstinence Education program; Maternal, Infant, and Early Childhood Home Visiting program; and Early Childhood Comprehensive Systems initiative. Additionally, these programs assure effective coordination of services and delivery of information related to critical health, development, early learning, child abuse/neglect prevention, and family support. State staff provides technical assistance to communities and agencies on identifying local health issues, developing policies and plans, identifying effective models, professional development opportunities, and monitoring progress.

The **Special Health Services (SHS) Section** includes the Title V Special Health Care Needs (SHCN) Program as well as Newborn Screening, Birth Defects Registry, and Kansas Resource Guide. Special Health Care Needs (SHCN) 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 diagnostic services are available (with prior authorization) to those under the age of 22 years who are at risk for or suspected of having a severe disability or chronic disease, regardless of family income. The program provides assistance in identifying appropriate treatment services including medical specialists, outpatient care, hospitalization, surgery, durable medical equipment, reimbursement for transportation to medical specialty care, interpreter services, and therapy (speech, physical, occupational). Financial assistance may be provided for those with qualifying incomes. Multi-disciplinary clinics are available for a variety of conditions – including selected outreach clinics in an effort to bring specialty diagnosis, consultation, and follow-along care as close to the child's home as possible. The program has selected, and will focus on, the following new priorities: care coordination, family caregiver health, behavioral health, training and education, and direct health services.

Local Agencies – MCH Aid to Local Program

KDHE utilizes an Aid to Local granting mechanism for which Kansas community agencies or organizations are encouraged to apply. These agencies often include local county health departments, but also may include non-profit organizations qualified to provide the above services. These funds must address the above criteria through innovative service deliveries within a community but also have strict requirements concerning how funds are spent. Aid to Local grantees must ensure that: 1) At least thirty percent (30%) must be used for preventive and primary care services for children; 2) At least thirty percent (30%) must be spent for services for Children and Youth with Special Health Care Needs (CYSHCN). These funds are to be spent on: services described as "family-centered, community-based, coordinated care (including care coordination services) and to facilitate the development of community-based systems of services for such children and their families. Not more than ten percent (10%) may be used for administering the funds paid. Funding is also to be spent on preventive and primary care services for pregnant women, mothers and infants up to age one. However, there are no requirements regarding percentage to be spent.

Local MCH grantees across the state provide family-centered, community-based and culturally competent services and care to MCH populations throughout the life course.

1. Women/Maternal: prenatal care, breastfeeding, education, home visiting, depression screening
2. Perinatal/Infant: perinatal/postnatal care, breastfeeding (duration & exclusivity), safe sleep, community outreach and public education (safe haven, text4baby)
3. Child: screenings (vision, hearing, developmental), health education (motor vehicle safety, nutrition), community outreach and public education (child abuse prevention, importance of immunizations)
4. Children & Youth with Special Health Care Needs: care coordination, family caregiver health needs, behavioral health, training and education, early screenings (vision, hearing, developmental), school readiness, collaboration and coordination with early intervention, social services and family support services

5. Adolescent: immunizations (HPV, flu), reproductive health, health education (motor vehicle safety, fitness), community outreach/public education (teen pregnancy, injury, risky behaviors, suicide, abstinence)
6. Cross-cutting: comprehensive, coordinated care; Medicaid outreach and enrollment; preventive care such as well infant/child/adolescent/woman and immunizations; linking families with needed services through screening, referral, and follow up

Key Partnerships

State Program Collaboration and Coordination

The BFH has partnerships at the state and local levels to ensure coordination of health components of the MCH system. Through the MCH council, Blue Ribbon Panel on Infant Mortality, and regular communication with local health departments, the state MCH team provides expertise, gathers feedback, and makes connections to maximize the effectiveness of the MCH system.

A major focus of all the Title V and Family Health policy and program initiatives is collaborative partnerships, so calling on partners, providers and consumers/families to be engaged in the needs assessment was highly successful. Through existing forums, Title V engaged stakeholders through the State MCH Council, State Agencies Early Learning Coordinating Council, Newborn Screening Advisory Council, Family Advisory Council, Blue Ribbon Panel on Infant Mortality, Kansas Breastfeeding Coalition, among others. The Bureau and Title V programs demonstrate strong commitment to coordinating and collaborating to address the emerging and ongoing needs of all MCH populations.

Kansas Maternal & Child Health Council (KMCHC): The KMCHC serves in an advisory capacity to KDHE, Bureau of Family Health, Title V Program; monitors progress; and addresses specific MCH population needs for MCH populations. The Kansas Chapter of the American Academy of Pediatrics (KAAP*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas and improved outcomes. The Title V needs assessment and state action plan is the guiding document as it relates to the ongoing work of the Council. KDHE and KAAP convene the Council at least once each quarter. The Council is comprised of a multidisciplinary team of professionals with expertise in MCH. A decision was made in September 2015 to merge the Blue Ribbon Panel on Infant Mortality (BRPIM) with the KMCHC, resulting in greater coordination and impact. The BRPIM was established in 2009 to develop a set of recommendations to reduce infant mortality in Kansas.

Other Federal Maternal and Child Health Bureau Investments: BFH staff is exploring ways to better coordinate and integrate the Kansas Maternal, Infant and Early Childhood Home Visiting (MIECHV) and Early Childhood Comprehensive Systems (ECCS) program activities with other programs, and strong linkages have been identified between the MIECHV, ECCS, and Title V MCH needs assessment priorities, goals, and strategies. The Kansas MIECHV Program targets at-risk communities in Wyandotte County (urban Kansas City), Montgomery, Labette, and Cherokee counties (rural southeast Kansas). Evidence-based home visiting programs include Early Head Start, Healthy Families America, and Parents as Teachers. Wyandotte County has implemented a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants

**KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas, KAAP is willing to assemble individuals with professional expertise to assist and advise KDHE to achieve the best possible health outcomes for Kansas MCH populations.*

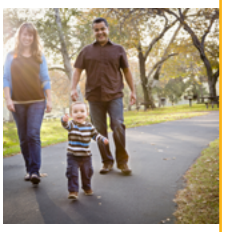
Endangered by Substance Abuse (TIES) Program. A state level Home Visiting Workgroup, composed of representatives from multiple state agencies, organizations, and programs including MCH, child care, and Part C, developed a strategic plan. In August 2013, KDHE BFH was awarded a new three-year ECCS grant focused on strategy two with the goal to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers across early childhood systems including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs (now integrated into the MCH State Action Plan). The project has been named the Kansas Initiative of Developmental Ongoing Screening (KIDOS).

KDHE Title V program staff and leadership collaborates specifically with the following state agencies and organizations:

Partner	Type	Purpose
Kansas Department for Children and Families	Public State Agency	Coordination between child care licensing and subsidy; state level coordination of Maternal Infant and Early Childhood Home Visiting program
Kansas Department on Aging & Disability Services	Public State Agency	Access to behavioral health services
Kansas State Department of Education	Public State Agency	State level coordination of Maternal Infant & Early Childhood Home Visiting (MIECHV) program
Kansas Children's Cabinet and Trust Fund	Legislatively Created Entity	Early childhood programs and services; Children's Initiative Funds
Kansas Maternal & Child Health Council	Public-Private Collaboration	Advisory council for MCH team – serves as key advisory group re: MCH population needs/issues
March of Dimes Kansas Chapter	Private	Initiatives related to preterm/early term birth, early elective deliveries, prematurity, etc. (Ex: ASTHO Challenge); implementation and expansion of the Healthy Babies are Worth the Wait/Becoming a Mom programs
Kansas Chapter of the American Academy of Pediatrics	Private	Systems development for child, school and adolescent health care; convene and facilitates the state MCH Council
Kansas Breastfeeding Coalition, Inc.	Private	Breastfeeding education, training, and community support projects
Geary County Community Healthcare Foundation	Private	Healthy Start project/grant partner and Becoming a Mom Lead
University of Kansas Medical Center (Kansas City) and School of Medicine (Wichita)	Public	Medical specialty care and related services for children and youth with special health care needs

Family-Consumer Partnership

The Kansas Special Health Care Needs Program (KS-SHCN) is involved with many initiatives to engage families as partners and support leadership development. Throughout the KS-SHCN Strategic Planning Process, staff and partners remained focused on assuring any program changes and new initiatives were centered on families and engaging families as partners. *Family Engagement and Partnerships Standards:* In support of this focus, the KS-SHCN Program Manager, who also happens to be a parent and grandparent of individuals with disabilities, participated in the development of the Kansas Family Engagement and Partnerships Standards, an initiative led by the Kansas Coalition for Effective Family Engagement (KCEFE). While the KS-SHCN Program Manager participated, she did so from a Title V standpoint, assisting to bring both a parent and state agency perspective to this collaborative group. The process began in October 2014 with the development of five (5) core standards were, along with indicators and measurable objectives. These standards are:



1. Families as Foundation;
2. Families as Communicators;
3. Families as Advocates;
4. Families as Partners; and
5. Families as Community Members.

Currently, these standards are being piloted in preselected regions across the state based on income disparities. As part of the core team, KS-SHCN co-presented at a statewide conference for early childhood (birth to 5) providers. Two Special Health Services Family Advisory Council (FAC) members also participated to share their personal experience with parents and FAC members. Upon completion of the standards pilot, KS-SHCN will assist with dissemination of these standards to providers, community partners, but most especially, to families. These standards will become a part of the FAC framework, and be key to the development of future parent leadership programs.

Special Health Services Family Advisory Council (FAC): The FAC is in their 5th year and still a very active part of the work done through KS-SHCN. In May 2014, the FAC was expanded from the Special Health Care Needs (SHCN) to the Special Health Services (SHS) Family Advisory Council. This expansion allows focus on the SHS Programs: KS-SHCN, Newborn Metabolic Screening, Newborn Hearing Screening, and Infant-Toddler Early Intervention (Part C of IDEA). This expanded focus has proven to be valuable in providing additional information and support to the FAC members about broader MCH and CYSHCN issues. Another purpose of this expansion is to support cross program collaboration and wider family representation in those other programs.

KS-SHCN staff serve as the agency lead, with support from the Executive Committee, three FAC members who assist in the development of agendas, bringing key issues to the table, and overview of FAC operations. The Executive Committee was created to provide an expanded leadership opportunity and allow interested FAC members to be more engaged, in addition to assuring the meetings remained focused on member interests. FAC meetings in the past year and a half have been primarily focused on the KS-SHCN Strategic Planning Process, and most recently, the Title V Needs Assessment. This was upon request by the agency lead, with approval by the Executive Committee. The FAC provided input throughout the KS-SHCN Strategic Planning Process, assisting with: the selection of five new priority areas; developing definitions and parameters around broader priority areas; participating with a larger stakeholder group in SWOT and gap analyses; assisting with the

creation of objectives within priorities; and input into final strategies for the KS-SHCN Strategic Plan. The FAC holds the responsibility for assuring KS-SHCN is accountable in moving the strategic plan forward with family/consumer partnership as the central focus.

FAC members are encouraged to engage in community initiatives to support their interests. This can include members participating in local peer support groups, community projects and charitable organizations, research and advocacy efforts associated with their child's condition, and as engaged family members of other state agencies or systems, such as part of the Managed Care Organization (MCO) Consumer Groups. While financial support is not offered for these other activities, encouragement, resources, information, and assistance is available from agency staff liaisons and programs. FAC members engaged in these other efforts will share information on these activities with other members, allowing for dialogue and resource sharing during and in-between meetings. Another type of direct support provided to FAC members is assistance with developing and delivering presentation to local and statewide audiences. This past year, multiple FAC members presented at various statewide conferences, including the Governor's Conference for the Prevention of Child Abuse & Neglect. Two FAC members presented independently after receiving support and assistance from the FAC members and agency staff. Other FAC members participated in a panel discussion during the Kansas Division of Early Childhood Conference, with support from the KS-SHCN Program Manager.

Many FAC members have demonstrated interest in legislative advocacy, therefore a guest presenter from Interhab, a statewide association of developmental disability service providers, was offered. Ongoing education and resources are provided based upon trainings by Family-to-Family Health Information Centers. Informational updates are provided by staff and the AMCHP Family Delegate to keep FAC members up to date on anticipated policy changes or need for state or federal advocacy. In the coming year, the FAC will be assisting in the development of a resource review process. This process was recommended by the FAC and will be implemented by agency staff to assure that the resources promoted through SHS programs are vetted for accuracy, appropriate literacy levels, and relevancy. This process will include input and recommendations from both program staff and FAC members. This will also include an opportunity for FAC members to recommend community partners and providers to be included in the Kansas Resource Guide.

While the last two years has been primarily focused on the KS-SHCN strategic planning, the FAC Executive Committee will resume the planning for agendas and the full FAC membership will begin planning for their selected focus area or project for the coming year. This process generally consists of a planning session in the summer, identifying individual interests of FAC members, then prioritizing and selection to occur either that same meeting or the following conference calls. Additionally, per FAC requests, agency staff plan to provide MCH/Title V focused trainings, focused on the MCH Core Competencies and parent/professional partnerships. This coming year, the FAC members have expressed an interest in formalizing a network for FAC Alumni, members who have had to leave the Council due to term limits or personal reasons. Continued engagement opportunities will be offered to these seasoned and motivated family professionals, allowing them to continue their contributions and see the impact of their foundational work. Additionally, we hope to nurture their investment and expand the cross cutting community of Title V family and consumer partners.

Family Engagement and Family Delegate Role/Project: A new Kansas AMCHP Family Delegate appointment process was initiated by the CYSCHN Director in 2013 to increase the opportunities for family leadership within Title V and to ensure comprehensive supports and resources are available for delegates. A competitive application process was developed to involve a mentorship plan resulting a mutually agreed-upon project, advancing the MCH/Title V 5-year plan. Delegates are allowed to continue for two consecutive years, if interested. Donna Yadrich was appointed the first delegate through this process (2013-2014) and has continued on as the 2014-2015 Delegate. The Family Delegate also fully participates in the annual block grant review process and during the in-person site visit in 2014, shared FAC updates and input. The Family Delegate will assist Title V in developing a structured family leadership program using national guidelines and standards.

Integration of Family Representation on Kansas Maternal and Child Health Council (KMCHC): Family representation on the statewide MCH Council began May 2014. This council serves to advise the Kansas Department of Health and Environment on cross-cutting issues across the lifespan of Kansas women, children and families. This is the first time a family representative has been present during these meetings, additional family recruitment efforts will take place this coming year with some significant changes to membership and structure of the Council.

Role of Families/Consumers in the Needs Assessment

Family/consumer partnership throughout the needs assessment focused on input and what is working well within their community, as well as gaps and barriers to accessing services. Primary activities geared toward family and youth engagement included the Communities for Kids (C4K) meetings, the SHCN strategic planning, and the adolescent health assessment. These initiatives focused heavily on families and consumers, with the intent to gain meaningful input and feedback regarding MCH services to support positive outcomes across the lifespan. There were a total of 253 participants across all meetings, and 21.5% self-identified on the sign-in sheet as a parent or parent of a child with special health care needs. Family and consumer partners of all backgrounds, education levels, and ethnicities were invited to participate in the C4K meetings. Specific demographic data regarding race or ethnicity was not collected. The meetings provided an opportunity for participants to register in advance and notify meeting organizers of needed language or disability accommodations; no meeting participants required or requested these accommodations. It stands to reason that everyone in attendance could be counted from a family/consumer partner perspective; however, many were there in a professional capacity. Parents, siblings, and other family members were engaged in public forum discussions, in both large and small groups. It was clear that those in attendance were extremely passionate about improving the health of children and youth. Many participants were in attendance to support both personal and professional interests; however, they often identified which "hat" they were wearing during the discussions, and most often the "parent hat" was more prominent than the "business hat." Approximately 10 participants were identified as having interest in the Special Health Services Family Advisory Council (FAC), 2 of which who have already joined and attended their first meeting. Families associated with the FAC receive valuable training on Title V and MCH core competencies. The input obtained was key in discussions for selecting priorities and objectives for the five year plan.

Topics addressed through these meetings that were also adopted as part of the State Action Plan include: engaged and empowered families, family supports and peer groups, developmental

screenings and follow-up, immunizations, motor vehicle safety, oral health, healthy foods and physical activity for children of all ages, bullying, emotional health and well-being, behavioral health services, training for parents and teachers on child behaviors, care coordination, telemedicine, difficulty accessing services in rural communities, health literacy and system navigation. Additionally, based upon feedback received through these meetings, specific strategies were developed to increase leadership and advocacy among families and consumers, expanding on training of Title V and MCH provided to FAC members.

The primary cohort of family/consumer partners engaged within the KS-SHCN strategic planning process included those on the FAC. Family members of all backgrounds, education levels, and ethnicities are invited to participate in the FAC. The family leaders who participated in the strategic planning process represent a wide variety of diverse backgrounds related to their family member's age, disability, and geographic location of the state. Program staff are constantly working towards recruiting FAC members of more diverse ethnic backgrounds. The engagement of the FAC in the KS-SHCN strategic planning supported the program to develop priorities related to care coordination, family caregiver health, behavioral health, training and education, and direct health care services. The strategies developed were based on input from the FAC, including final approval of the FAC as trusted advisors. The FAC will continue to be involved in the implementation of the KS-SHCN Strategic Plan and will assist in identifying areas of improvement or potential changes throughout the five years, to assure the program remains relevant and a valuable resource to families.

Assessing State Needs

Collective Approach

Early on in the Needs Assessment, a broad approach was taken that captured input from a wide spectrum of state and local partners using in-person meetings and surveys. The input came from stakeholders, local public health, WIC, Healthy Start and other home visiting programs, health care providers, educators, private health care providers, consumers, and other community health programs including injury prevention, safe sleep, breastfeeding, mental health, managed care organizations (MCOs) and Medicaid. The design of the Needs Assessment, including the diversity of perspectives for input, was based on a collaborative approach that:

a) incorporated input from key stakeholders with different perspectives, not only public health professionals;

b) ensured geographical representation across the State; and,

c) built partnerships among stakeholders through participation in the Needs Assessment process.

For nearly a year, the Needs Assessment team covered six regions of the state to:

- Host and facilitate MCH regional meetings
- Attend, facilitate, or present at three MCH council meetings and various strategic planning meetings with MCH staff and stakeholders
- Conduct focus groups with adolescents and their parents
- Gather input through three large scale surveys distributed over 9 months

A key difference from MCH 2015, which also engaged stakeholders and implemented solid action plans, was intentionality during MCH 2020 to build partnerships and initiate collaboration at the state and local levels. The outcomes of this intentionality included new partnerships, cross connections between counties, and presentations that provided education about KDHE MCH services so that the state was well represented and participants were informed and valued through in-person interaction. **Kansas' MCH 2020 also devoted a full year to the process, promoting and practicing collaboration and keeping the door open for continuous input.**

Recognizing the complexity of the Needs Assessment, KDHE worked with key partners to ensure that all domains were adequately addressed and that priorities, objectives and strategies made sense within and across population domains. The key partners in conducting the KDHE Title V 2016-2020 Needs Assessment, and their role in the process, included:

Partner	Role	Domain(s) Addressed
EnVisage Consulting, Inc. Connie Satzler	Facilitator, MCH Council & SHCN Strategic Planning Process/Meetings	Women/Maternal, Perinatal/ Infant, Child, CYSHCN
Kansas State University Research & Extension Dr. Elaine Johannes	Contractor, Adolescent Health Needs Assessment & Report	Adolescent
University of Kansas Dr. Rebecca Gillam	Contractor, Overall Title V Needs Assessment Comprehensive Process & Final Report	Women/Maternal, Perinatal/ Infant, Child, Cross-cutting/Life Course
Kansas Maternal & Child Health Council (variety of organizations represented; facilitated by American Academy of Pediatrics Kansas Chapter)	Advisory Council, recommendations related to existing priorities and need to continue, replace or add priorities (comparison of MCH 2015 with current status/needs)	All domains

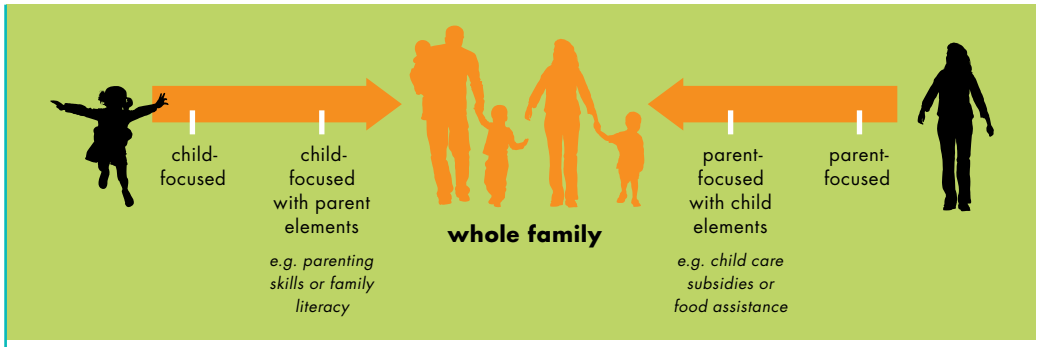
Methodology

Prior to starting information gathering, KDHE examined the relationship between Title V priorities and existing initiatives in Kansas that impact the health and well-being of MCH populations. The Alignment of Key Frameworks document highlighted several things that were core to the Needs Assessment approach throughout the process:

1) While serving as the lead agency for Title V, KDHE is not alone in this work. There are multiple complimentary and supporting efforts across state agencies that, in conjunction with Title V, can lead to population level outcomes for MCH. Partnerships will be key to achieving the goals of the Title V work over the next 5 years.

2) Not all populations are addressed by other initiatives at the same level of intensity. Significant attention has been given to women, infants, and life course issues, likely as a result of infant mortality work that has been done. KDHE may be a lead in ensuring that SHCN, child, and adolescent needs are identified and addressed.

The cross-cutting/life course domain has particular significance in coordinating across initiatives and moving the needle on health across MCH domains. Research indicates the importance of multi-generational approaches to individual and community well-being (Graphic: Aspen Institute, 2015).



The role of life course priorities and strategies has not fully been explored in Kansas, however the Alignment of Key Frameworks indicated the importance of doing so through the Needs Assessment process. With a goal to maximize the input of internal and external partners throughout the process, the KDHE MCH 2020 Needs Assessment utilized a mixed methods approach that relied on the continuous input of a diverse team of key informants and partners, as well as broad public input. From the beginning, the MCH project team approached the Needs Assessment as an opportunity to engage stakeholders and form partnerships through interactive regional meetings and surveys in addition to reviews of national and state data, resulting in KDHE capturing a wide range of input and conscious decision making based on stakeholder, partner, and community knowledge. Not just a listening tour, the meetings enveloped a build upon approach where community voice mattered and were heard as the five health domain needs emerged over time and were defined as priorities. Moreover, KDHE continuously assesses the needs of Kansas Maternal and Child Health populations. This is and will be an ongoing Needs Assessment that stretches beyond the five-year vision.

The MCH Needs Assessment was led by the state's Title V Director and the Bureau of Family, Maternal and Child Health team. This included special health care needs leaders, epidemiologists, and representatives from state maternal and child programs. The team identified and considered a range of needs at the state and community levels through brainstorming, statewide meetings, surveys, data analysis and stakeholder engagement.

The BFH already had an existing strong infrastructure that prioritized ongoing evaluation and programmatic support. Even before the Needs Assessment process began, the Bureau Director, Section Directors, Epidemiologists and key partners had a solid scaffold to build upon. Five guiding questions were identified as the basis for the Needs Assessment process; these questions aligned both with the BFH vision and the Title V guidance:

- How priorities will be determined
- How gaps will be filled
- How expectations for MCH team will be raised
- What is currently offered by KDHE
- How needs will be reassessed at the community level

Once the Needs Assessment team was formed the team outlined the process and defined its goals of reaching out at the community, local, and state levels to collect input from a cross section of organizations, individuals, stakeholders and providers. This comprehensive and inclusive process exemplified the meaningful approach taken by KDHE to insure priorities were addressed from

all angles and that the overarching principles were upheld. Also addressed and woven through the process were the 10 essential MCH services, as noted in the Title V MCH Services Block Grant Pyramid.

Data Sources

Both qualitative and quantitative data were implemented in the Needs Assessment process for MCH 2020. Qualitative data consisted of stakeholder, partner, and community input and feedback at stakeholder meetings as well as three (3) surveys distributed throughout the state. Additionally, recommendations from advisory groups such as the Kansas MCH Council, the CSHCN Family Advisory Committee, and internal KDHE staff itself were reviewed.

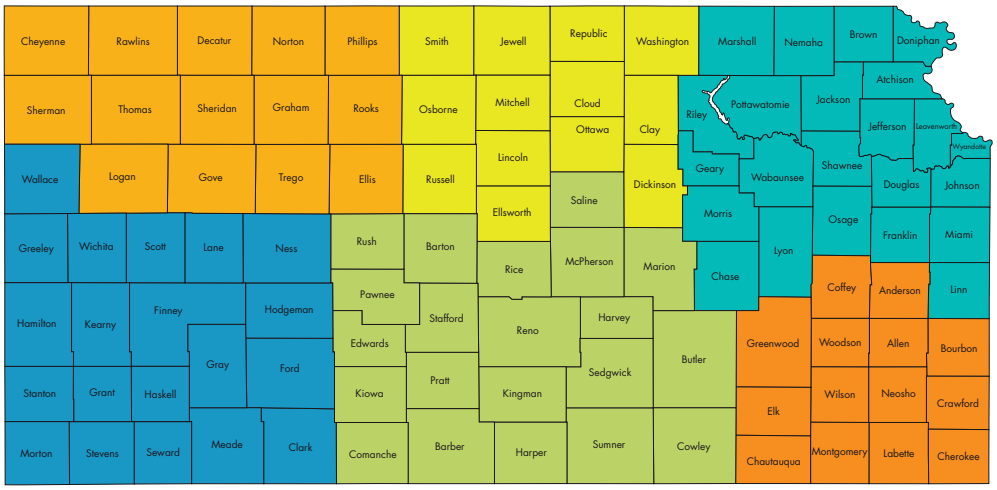
Quantitative indicators were compiled and presented at regional meetings to stakeholders and partners and much of the discussion toward specific needs for each MCH domain came from sharing this data. Limitations were noted as data were disseminated. Data sources included, but not limited to:

- Population level (U.S. Census Bureau; KDHE Vital statistics; MCH epidemiology, including WIC)
- Community specific (AMCHP Regional Meeting inventories; Needs Assessment surveys)

Qualitative data were used to assign meaning to the quantitative data that were reviewed. Data driven decision-making was a key factor in the Needs Assessment process and balanced the degree of data collected through meetings and surveys. This combination of proactive input provided rich and varied data. Data results can be found in appendices.

State and Local Needs

While the Kansas Title V Priorities reflect the overall needs of the state, the Needs Assessment process incorporated a regional approach, based on the Bureau's recognition of the unique needs of local communities. For nearly a year, the needs assessment team covered 6 regions of the state in person, conducting and facilitating MCH regional meetings, attended, facilitated, or presented at 3 MCH council meetings, the Blue Ribbon Panel on Infant Mortality, and various strategic planning meetings with MCH staff and stakeholders. The broad approach continued with three large scale surveys distributed over 9 months. The Public Input Section provides a detailed breakdown of the data collection process, input methods and level of response.



State Demographics

Geography/Demography

Kansas, spanning 81,759 sq. miles, is divided into 105 counties with 628 cities. The U.S. Census Bureau estimates there are approximately 2,893,957 residents living in the state of Kansas (2013). The state of Kansas has a unique geographic layout that ranges from urban to frontier counties. Within each of the regions throughout the state there are few populous cities intermixed with multiple rural areas. For example, within the South Central regions lays Wichita with a population of 386,552. Within that same region also lays Pratt with a population of 6,986. This is a good example of the diversity of the Kansas population where rural communities are influenced by mid-sized cities and mid-sized cities are therefore influenced by rural communities. This provides challenges to service delivery, but also an opportunity for sharing resources among the populations.

Population Density and Peer Groups (Urban, Semi-Urban, Densely-Settled Rural, Rural, and Frontier)

The population density of Kansas was 35.4 inhabitants per square mile in 2013, a 14.2% increase from 31.2 persons per square mile in 1994. For comparison, the population density of the U.S. increased from 69.8 to 89.4 persons per square mile from 1994 to 2013, a 28.1% increase. In 2013, 36 of the state's 105 counties had population densities of less than 6.0 persons per square mile. The

most sparsely populated counties were Greeley and Wallace, with a density of 1.7 persons per square mile. The most densely populated county was Johnson, with 1,197.6 persons per square mile. Several Kansas counties were re-categorized from one population-density peer group to another, to reflect population shifts indicated by the 2010 U.S. Census. As a result of these changes, the frontier, densely-settled rural, and urban peer groups had increases in population 2009-2013 of 32.1%, 12.2%, and 8.3%, respectively, while the semi-urban and rural peer groups had decreases in population of 16.7% and 12.5%, respectively.

Population Growth/Change

The percent increase in the Kansas total population from 1994-2013 was 13.3%, including a 14.8% increase for Kansas males and an 11.9% increase for Kansas females. Kansas increased in population from 2,885,905 1 residents in 2012 to 2,893,957 residents in 2013, a 0.3% increase. Geary, Pottawatomie, and Stevens Counties had the largest relative increases in population from 2009 to 2013 with percent changes of 17.7, 13.5, and 13.4 respectively. Finney, Elk, and Kearny Counties had the largest relative decreases in population, with changes of 11.8%, 11.5% and 5.9% respectively. In 2013, there were an estimated 39,597 infants living in Kansas or about 1.4% of the total Kansas population (2,893,957). Women of reproductive age 15-44 accounted for 19.3% (558,538) of the Kansas population. The race and ethnicity composition for this group was estimated at 73.8% non-Hispanic white, 6.3% non-Hispanic black, 1.0% non-Hispanic Native American or Alaska Native, 3.7% non-Hispanic Asian and Pacific Islander, 2.4% non-Hispanic multiple race, and 12.8% Hispanic (any race).

In 2013, there were 902,980 children and adolescents aged 1 to 22 years living in Kansas, which represents 31.2% of the Kansas population. The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. About three-in-ten Kansas children and adolescents belong to a racial or ethnic minority. Across the age groups, three-in-ten young children (1 to 5 years) are part of a racial/ethnic minority versus two-in-ten young adults (20 to 22 years). About 14.3% of Kansans age 15 to 22 are Hispanic, compared to 19.1% of young children. Among families with children under 18, 29.1% are single-parent families versus married-couple families (70.5%). According to the 2011/12 National Survey of Children's Health, 19.4% of Kansas children aged 0 to 17 (est. 139,623 children) had special health care needs. These rates represent an increase from the percentage reported in 2009/10 (17.3%) for Kansas. The reasons for this increase are not fully understood. While it is possible that the number of children and youth with special health care needs (CYSHCN) is actually increasing, it is also possible that children's conditions are more likely to be diagnosed, due to increased access to medical care or growing awareness of these conditions on the part of parents and physicians.

Age

The median age of Kansans in 2013 was 36.0 years, a 5.6 percent increase from the median age of 34.1 in 1994.

The median ages of Kansas males and females in 2013 were 34.6 and 37.4 respectively. Shifts in the Kansas population distribution by age from 1994 to 2013 included a decrease in the 35-44 age group of 14.6 percent. An increase of 35.3 percent in residents 45-54 years of age and 75.9 percent in residents 55-64 reflected the aging of the baby boomers. Furthermore, there were 8.7,

2.5, 16.7, 2.4 and 16.0 percent increases in the 0-4, 5-14, 15-24, 25-34 and 65-74 age-groups respectively, and a decrease of 4.8 percent in the 75 and over age-group.

The prevalence of special health care needs within the child population increases with age. Older children in Kansas were twice as likely as younger children to have a special health care need. In Kansas, preschool children (aged 0-5 years) have the lowest prevalence of special health care needs (10.2%), followed by children aged 6-11 years (23.9%). Adolescents (aged 12-17 years) have the highest prevalence of special health care needs (24.3%). The higher prevalence of special health care needs among older children is likely attributable to conditions that are not diagnosed or that do not develop until later in childhood.

Race/Ethnicity

According to the 2013 Census Bureau estimates, 77.1 percent of Kansans were non-Hispanic white and 5.9 percent were non- Hispanic black. Hispanics made up 11.2 percent of Kansas' population. The prevalence of special health care needs varies by the child's race and ethnicity. Kansas Hispanic children (15.2%) were least likely to have a special health care need compared to non-Hispanic white children (19.6%) and non-Hispanic black children (22.3%).

Diversity/Languages

According to the 2011-2013 American Community Survey, in Kansas, 2.4% of the households met the definition of being linguistically isolated compared to 4.5% of U.S. households. In Kansas, the prevalence of linguistic isolation in households varies by language spoken at home. Linguistic isolation among households speaking Spanish was 23.5%, other Indo-European languages 8.9%, Asian and Pacific Island languages 28.0%, and other languages 13.7%. Ninety-three percent (93.2%) of the people living in Kansas in 2011-2013 were native residents of the United States. About 59.2% of these residents were living in the state in which they were born. Seven percent (6.8%) of the people living in Kansas in 2011-2013 were foreign born. Of the foreign born population, 34.7% were naturalized U.S. citizens, and 90.3% entered the country before the year 2010. About 9.7% of the foreign born entered the country in 2010 or later. Foreign born residents of Kansas come from different parts of the world. Among people at least five years old living in Kansas in 2011-2013, 11.1% spoke a language other than English at home. Of those speaking a language other than English at home, 66.4% spoke Spanish and 33.6 % spoke some other language; 39.7% reported that they did not speak English "very well." Notable is a change in Spanish speaking population in Kansas, which has been steadily increasing. The increase mirrors similar trends at the national level.

Education

Kansas compares favorably with the U.S. average in terms of educational attainment with an 89.8% high school graduation rate compared with 86.0% for the U.S. Thirty percent (30.3%) of Kansans have a bachelor's degree or higher compared with 28.8% for the U.S.

Income/Poverty

For 2013, the federal poverty level is $23,550 for a family of four. Children living in families with incomes below the federal poverty level are referred to as poor. Research suggests that, on average,

families need an income of about twice the federal poverty level to meet their basic needs. In 2013, compared to the U.S. population, a lower percentage of Kansans lived in households with incomes below the federal poverty level (13.2% vs. 14.5% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (18.1% vs. 19.9% for the U.S.). While a decreasing trend was observed during 2010-2013, overall the 10 year period (2004-2013), Kansas experienced an increase in the poverty rate for children under age 18. Similar trends were seen in the United States. In 2013, 131,251 Kansas children under 18 years of age were living in poverty. Most of these children live within four population centers: Sedgwick County (Wichita), Wyandotte and Johnson Counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). Five counties accounted for over half of all Kansas children (72,206 children; 55.0%) in poverty: Sedgwick (29,273), Wyandotte (17,136), Johnson (10,079), Shawnee (9,513), and Douglas (3,249). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty.

In 2013, the percent of Kansas' families living at or below the federal poverty level (8.6%) is lower than the U.S. (11.2%). Poverty is more common in Kansas families headed by single females and those with children in the household, regardless of race or ethnicity. In 2013, the Kansas percent of female headed households living below 100% federal poverty level (31.5%) was below the U.S. percent (41.3%). However, for the years 2004-2012, the percent of Kansas female-headed households living in poverty increased and exceeded the U.S. rate.

The prevalence of special health care needs varies by income group in Kansas. CYSHCN prevalence among low income families, 0-99% of the federal poverty level (FPL), was the highest group (26.4%).

Health Insurance Coverage

Data from the U.S. Census Current Population Survey (CPS) show that the percentage of Kansas children under 18 years old without health insurance decreased from 9.4 in 2011 to 6.1 in 2012, a 35.1% decrease. Part of the reason for this finding is an increase in public coverage of Kansas children. This increase suggests factors - such as the weakness in the economy and the state's active outreach efforts to enroll children who need coverage - may be responsible. The U.S. percentage also decreased from 9.4 in 2011 to 8.9 in 2012.

In Kansas, based on the 3-year average CPS estimates (2010-2012), 7.7% of children were uninsured. With an uninsured rate of 8.9%, children in poverty were more likely to be uninsured than children not in poverty (7.4%). About one-third of children (37.6%) were publicly insured by sources such as Medicare, Medicaid, military health care, and the State Children's Health Insurance Program (CHIP). About 10.3% of Hispanic children did not have any health insurance, compared with 8.1% for non-Hispanic white children and 7.8% for non-Hispanic black children. Non- Hispanic white children had high rates of private health insurance coverage (64.9%) compared to non-Hispanic black and Hispanic children (41.0% and 31.8%, respectively). Non-Hispanic black and Hispanic children were the most likely to have public coverage (62.8% and 61.1%, respectively). As family income increases, rates of private coverage increase and rates of public coverage and no coverage decrease. Children with family incomes below 100% of the poverty level were the most likely to have public coverage (77.1%) or be uninsured (8.9%). The majority (94.3%) of children with family incomes of 400% or more of the poverty level were privately insured. The CPS results indicate that a child's insurance status is related to a wide range of child and family characteristics.

Socioeconomic characteristics and parental employment were found to have an especially strong relationship with a child's insurance status. Nearly half (49.8%) of all uninsured Kansas children under age 19 live in the four largest population centers: Sedgwick County (Wichita), Johnson and Wyandotte counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). However, in the southwestern part of the state has many counties with high concentrations of uninsured children under age 19, a largely Hispanic populated area and presumably many are not KanCare (Medicaid or CHIP) eligible. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with high concentrations of children in poverty, as stated above, but the children are less likely to be uninsured than those in the southwestern part of the state. In Kansas, 89.3% of CYSHCN were reported to have been insured for all of the previous 12 months, while the remaining 10.7% were uninsured for all or some part of the year. Overall, almost 96% of CYSHCN were reported to have some type of insurance at the time of the interview: about two-thirds (64.2%) had private coverage, 25.1% had public coverage, 6.2% had both, and 4.6% had no insurance.

Primary Care Access/Workforce

In 2012 (most recent data available), the supply of primary care physicians per 100,000 population (42.5) was not significantly different in Kansas, compared to the national average (46.1). However, in Kansas, the percentage of physicians having physician assistants or nurse practitioners in their practices (74.2%) exceeded the national average (53.0%). KDHE recognizes that while there are needs across the state, there are also unique needs in different areas of the state. Access to care has been recognized as a challenge for the maternal and child health population living in both geographic domains for different reasons. For example, women in rural areas face barriers accessing transportation and getting to providers who may be unavailable in their area. Whereas, women in more densely populated areas, have a wider availability of services yet may not have time off work or the insurance needed to receive services. The CYSHCN population often experiences reduced access due to the lack of pediatric specialists in the state, in addition to the other barriers mentioned. In fact, 14.5% of CYSHCN families reported that they had trouble getting specialist care versus 3.1% of non-CYSHCN families. Overall, KDHE has recognized that programs and providers are an important part of the landscape and the unique needs of the Kansas MCH population are being addressed throughout the state. The Bureau has been, and will continue to be, committed to working with local partners to address those unique needs, and to build on the successes at the local and regional levels in improving maternal and child health.

Public Input

Overview

The Title V Maternal Child Health (MCH) five-year needs assessment is designed to be an opportunity to review data, gather input from stakeholders, build capacity, and identify priorities. Central to the needs assessment planning and process to identify priorities was to work with the KS MCH Council to determine the status of MCH progress since MCH 2015 (2010 Needs Assessment) was implemented. This analysis assisted with identifying which priorities were still priorities five years later and therefore should be continued.

The Kansas Department of Health and Environment (KDHE) spent 18 months conducting the Needs Assessment with an approach focused on not only creating a meaningful, responsive action plan, but also building a strong platform to maximize resources, develop and sustain mutually reinforcing relationships, and deliver outcomes. Early on in the needs assessment, a broad approach was taken in order to capture a wide scope of input from state and local partners using in person meetings and surveys. The input came from stakeholders, local public health, health care providers, educators, consumers, and other community health programs including injury prevention, mental health, and Medicaid. The team covered six regions of the state, in person, facilitating MCH regional meetings and attended, facilitated, or presented at three MCH council meetings, the Blue Ribbon Panel on Infant Mortality, and various meetings with stakeholders. The broad approach continued with three large-scale surveys distributed over nine months. The following provides an overview of the input/data collection process.

The team facilitated 22 regional and community meetings to gain broad public input on the development of priority needs for MCH populations (see Meeting Timeline below). Two forums, Public Health Regional meetings (using the AMCHP Birth Outcomes Compendium as a key resource) and Communities for Kids (C4K) meetings, were utilized to gain input from key partners, stakeholders, service providers, and community members. *NOTE: several Communities for Kids meetings were held twice at the same location – day and evening.*

- October 21, 2014 Regional, Wichita
- November 13, 2014 Regional, Garden City
- December 10, 2014 C4K, Roeland Park
- December 16, 2014 C4K, Great Bend
- December 17, 2014 C4K, Concordia
- January 12, 2015 C4K, Colby
- January 13, 2015 Regional, Colby
- January 14, 2015 C4K, Garden City
- January 21, 2015 C4K, Topeka
- February 10, 2015 C4K, Junction City
- February 11, 2015 Regional, Concordia
- February 19, 2015 C4K, Wichita
- February 25, 2015 Regional, Topeka
- February 26, 2015 C4K, Parsons

The table below provides an overview of the Needs Assessment data collection process. Over the course of the year-long process, nearly 3,000 individuals participated in meetings, surveys, or focus groups to provide input on the needs of Maternal and Child Health populations in Kansas.

Activity	Purpose	Domain Focus	Participation	Timeframe
MCH Services Input Survey	Annual Feedback to KDHE on MCH services and community needs	All	222 respondents	November 20, 2013 - May 15, 2014
Public Health Regional Meetings (AMCHP Compendium served as key planning resource)	Develop partnerships at the local level to improve MCH services; identify needs at the local level related to MCH populations	All	209 (5 meetings)	May 2014 - February 2015
Kansas MCH Council	Advises on Title V/MCH	Women, Infants, Children, Adolescents	17 attendees 20 attendees 19 attendees	September 2014 December 2014 April 2015
Blue Ribbon Panel on Infant Mortality	Through infant mortality CoIIN, reduce infant mortality in the State	Women, Infants	20 attendees	August 2014
Communities for Kids Meetings	Gather broad stakeholder input on needs of MCH populations; provide opportunity for local communities to connect with KDHE staff	All	253 attendees (17 meetings)	November 2014 - February 2015
Adolescent Health Input Survey	Understand needs of youth ages 10-19	Adolescents	854 respondents	Fall 2014
Adolescent Health Focus Groups	Understand needs of youth ages 10-19	Adolescents	401 attendees	Fall 2014
SHCN Strategic Planning Meeting	Identify priority needs and shift work/ realign program as necessary	SHCN	110 attendees (4 meetings)	July 2013, August 2013, November 2013, September 2014
Family Advisory Council (FAC) Meetings	Collect input from existing council/ families and consumers with lived experience, especially families providing care for children and youth with special healthcare needs	SHCN, Children, Adolescents	15 attendees	August 2013, November 2013, February 2014, May 2014, November 2014, February 2015, May 2015
Parent Leadership Conference	Target families and the public, especially parents	All	150 respondents	November 2014 - February 2015
Title V Needs Assessment (Community Norms) Survey	Assess shared understanding of key community issues and beliefs/norms	All	540 respondents	January - February 2015
KDHE MCH State Coordination Meetings	Identify shared priorities and needs, align vision and approach to MCH efforts; align and integrate where appropriate	All Family Health (MCH, WIC, Family Planning, Part C, etc.)	Monthly meetings	Ongoing

Meetings

MCH Council Meetings

The BFH utilized the existing MCH Council in the Needs Assessment process to gather input, test preliminary priorities, and confirm findings. The MCH council is made up of medical professionals, state initiative leads, and community partners with expertise and interest in the Title V populations. On three occasions, the BFH had opportunity to present current work and findings to the MCH council before finalizing priorities. The MCH council was key in serving in an advisory role throughout the Needs Assessment Process, monitoring its progress, ensuring alignment and most importantly, assisting in finalizing priorities.

MCH Council Meeting #1
September 10, 2014
Wichita, KS

KDHE presented at the Kansas Maternal and Child Health Council meeting in September of 2014 on the current status of the Title V Needs Assessment, where they reviewed the MCH 2015 priorities and action steps through discussion and updates. Also addressed were challenges and opportunities, recommendations for the next five year period (2016-2020) and in-depth discussion of how to move forward with the domain priorities.

This meeting occurred after the MCH Input survey and before the Title V Needs Assessment survey, as well as when the momentum of the Regional meetings was occurring, giving the team important feedback and recommendation about a third of the way into the Needs Assessment, with plans to revisit the priorities later during the process. The meeting also continued the efforts of MCH Council to provide possibilities to improve connections to collaborative opportunities.

MCH Council Meeting #2
Title V Needs Assessment Planning Session
December 3, 2014
Topeka, KS

This meeting was a Title V Needs Assessment Planning Session and centered on targeting priority health populations, themes and emerging objectives and was an opportunity for the KDHE team to present and facilitate an interactive meeting where the participants could brainstorm and discuss MCH needs, gaps, and priorities while keeping in mind the Title V objectives. Emerging needs for women and infants that were expressed and what was heard was the need for care coordination, safe sleep and community norms change. Maternal mental health was also discussed as a need. The needs for women and infants were varied, some were specific and others broad, yet as the day continued they were drilled down throughout the day. Some of these included;

- Relationship support
- Parenting behaviors
- Brain/child development
- Toxic stress
- Cultural issues

For adolescents, the needs expressed included a multi-faceted approach for educating parents and teachers and changing behaviors about this population. Addressing youth as a unique population centered on authentic engagement and mentoring with caring adults, were prominent factors in the priority process. This idea was generated from compiling the following during the meeting:

- Education and teaching coping skills
- Help them understand healthy relationships
- Build trust
- Reproductive/sexual health education
- Stress management
- Relationship navigation
- Behavioral and mental health
- Suicide prevention
- Self esteem

In the children's domain, the MCH council meeting participants reported that a medical home incorporates all the objectives and includes safety, promotion of physical activity to address obesity and increased social engagement, annual screening, preventative dental care and ways to help parents increase awareness of toxic stress.

'In this group, it was determined that the most all objectives fit into the medical home. For if there is a strong and understood medical home, then most objectives can be addressed' – MCH council member

At the time of this MCH council meeting, the children and youth with special health care needs priorities were already set by the bureau as result of efforts earlier in the year by the CYSHCN team and in the fall at the strategic planning meeting, but were allowed the same discussion and work at this meeting as the other domains so as to align the objectives and confirm priorities. These were care coordination, family caregiver health, behavioral health, training & education. However, much discussion for this domain centered on strategies to address the priorities, and focused on a family/caregiver support approach that included;

- Online referral/resource access (who to call, what they can help with)
- Service coordination
- Make sure that hospital, nurses, doctors know what is available
- Find the easiest path with least amount of stress
- Central database
- Health literacy
- Outreach where communities convene (sporting events, schools

MCH Council Meeting #3
February 18, 2015

At this meeting KDHE MCH provided the council with an update on the Title V Needs Assessment emerging issues, priorities, and measures. This meeting provided a follow-up to the December 3 meeting, an overview of the continuing process, and any other updates needed. This was also an opportunity to remind the council of the importance and appreciation of their input and what would be asked of them in the future months of finalizing priorities with their input.

KDHE MCH Team Meetings

Initial Priorities Meeting
March 24, 2015

This meeting provided an overview of the initial priorities and laid out the work for the BFH Title V in Kansas over the next five years. This meeting presented the extensive public input gathered throughout Kansas by KDHE during its Needs Assessment process from July 2014 to February 2015. KDHE recognized the importance of, and understanding of, the connections that emerged from the Needs Assessment and presented the three overarching themes that were continuously identified:

- The need for increased collaboration/partnership/integration
- The importance of relationships within families and with service providers
- Addressing community norms that have created a stigma that is a barrier to people accessing needed services.

Participants at this meeting were invited to break into groups and continue to provide input and recommendation on the initial priorities to be revisited later.

KDHE Partner Meeting
April 20, 2015

The purpose of this meeting was to share the Maternal and Child Health Needs Assessment results with key stakeholders and identify opportunities to operationalize the priorities and make connections across programs, populations, and communities. The meeting was facilitated by KDHE and the University of Kansas Center for Public Partnerships and Research. Council members were provided the opportunity to review the compilation of the months of Needs Assessment process work and help to finalize priorities.

AMCHP Regional Meetings

As part of the Needs Assessment process, the MCH 2020 Needs Assessment consisted of several information gathering methods that relied on the continuous input of a diverse team of key informants and partners. From the beginning, the MCH project team approached the Needs Assessment as an opportunity to engage stakeholders and form partnerships through interactive regional meetings and surveys in addition to reviews of national and state data. This resulted in KDHE capturing a wide range of input from five regional meetings based on stakeholder, partner, and community knowledge. The meetings enveloped a build-upon approach where community voice was encouraged as the five health domain needs were discussed and analyzed using various approaches. Each meeting had specific goals and learning objectives, as well as a pre work element for participants for full engagement and awareness. Meetings also featured team building activities and presentations relevant to the communities. All meeting were facilitated by KDHE MCH staff, in coordination with the Kansas Chapter of the March of Dimes and the Center for Public Partnerships and Research at the University of Kansas.

Regional Meetings

The five regional meetings throughout the state of Kansas were an integral part of the Needs Assessment process and philosophy. Although an overarching goal of the series were to hear concerns and issues communities were facing regarding maternal and child health, KDHE MCH learned much more and was able to make multiple connections, raise and hear questions that may not have surfaced without the face to face efforts, and dig much deeper due to the design and implementation of the meetings.

Meetings were held in: Wichita in the south-central region, Garden City in the southwest region, Colby in the northwest region, Concordia in the north central region, and Topeka in the northeast region. Meetings were held sporadically throughout the state to capture the specific maternal and child needs within a variety of demographic areas.

Meeting Overview

Each meeting began with an overview of KDHE MCH Bureau and its provisions, as well as background on Title V and the Block Grant. Key staff presented an overview of the Needs Assessment process, a detailed review of county specific data, and facilitated discussion around which indicators might be most important in defining priority needs. Participants were then assigned to small groups with one of the MCH population groups (women and maternal health, children, perinatal/infant, adolescents and children and youth with special healthcare needs (CHYSN) to address what they thought were the most important needs for each, what the gaps in service were, and who could be engaged to address them.

Within the small groups there was active discussion and written ideas as participants identified the gaps and needs of the population group assigned to table. Each small group had a facilitator from the KDHE team who was able to ensure that every participant's voice was heard, along with making sure that key notes were being taken. Once the allotted time had elapsed for small group discussion, each of the small groups and the facilitators came back to engage in a large group discussion by reporting their findings and receiving feedback. A larger discussion was able to not only aid in further sharing of needs, but also allow participants to expand their awareness of service gaps.

Full meeting agendas for each region are included in the appendix.

Meeting Goals

- Expand the partner base and network for referral across counties to increase and improve maternal and child health services in the State Public Health programs.
- Collectively commit to transforming the model of service delivery in the Kansas MCH Public Health Region by aligning services and programs and identifying existing and potential partnerships to improve birth outcomes in the state.
- Demonstrate a process for assessing and mapping activities within a Public Health region to build our statewide capacity to address and improve community health priorities: sustainable collaborative partnerships, targeted interventions, and services.

Meeting Objectives

- Assess the mother/infant/family supports, services and programs in the state's public health regions to reveal collective strengths as well as potential service gaps.
- Identify opportunities for engaging new partners and approaching our work differently as a result of this process.
- Recommend actions to transform region-wide collaborations based on aligning activities with the Health Impact Pyramid to address individual and population health needs.
- Obtain stakeholder input to inform the Kansas Title V Maternal & Child Health (MCH) priorities for the period 2016-2020.

Learning Objectives

- A clear understanding of the purpose of the efforts of the Kansas Department of Health and Environment to assess activities to improve birth outcomes as well as the role each sector plays in forging a statewide initiative.
- A clear understanding of the MCH programs and services.
- A hope that at least one new potential partner relationship is established to support achieving the mission of their programs.
- Ability to identify how their activities and role contribute to a comprehensive shared agenda to improve birth outcomes in Kansas.

Pre-work for Participants

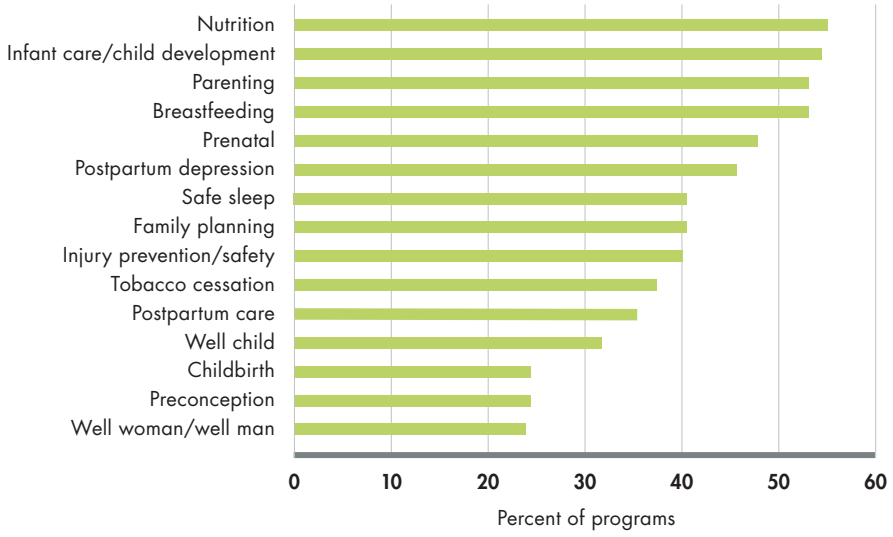
- Review the AMCHP Birth Outcomes Compendium, including the Health Impact Pyramid within, and come prepared to discuss recommendations/actions to be considered for your community.
- Review the Stanford Social Innovation Review on Collective Impact.
- Review the Kansas MCH Block Grant Website.
- Optional: Utilize Kansas Health Matters to review local level data and/or identify gaps in service, health disparities, or other priority issues.

Surveying Local Public Health Partners

Prior to each AMCHP Regional Meeting, local partners were asked to complete an inventory of programs, services, assets, priorities, and partnerships. 192 programs were represented across 5 regions. While there were limitations to the inventory – most notably the low response rate – the results provide an initial picture of MCH services at the regional level. Key findings are presented below.

The inventory indicated both success in strategy implementation and opportunities for growth related to education available to MCH populations through public health. Nutrition, infant care/child development, parenting, breastfeeding, and prenatal care have been given intentional focus, and local partners have responded by providing education in those areas. At the same time, areas that emerged through the current Needs Assessment process as key to progress – including well-visits and preconception health, are less common.

Type of education provided by public health partners, state aggregate (AMCHP Regional Meeting Inventory, 2014-2015)

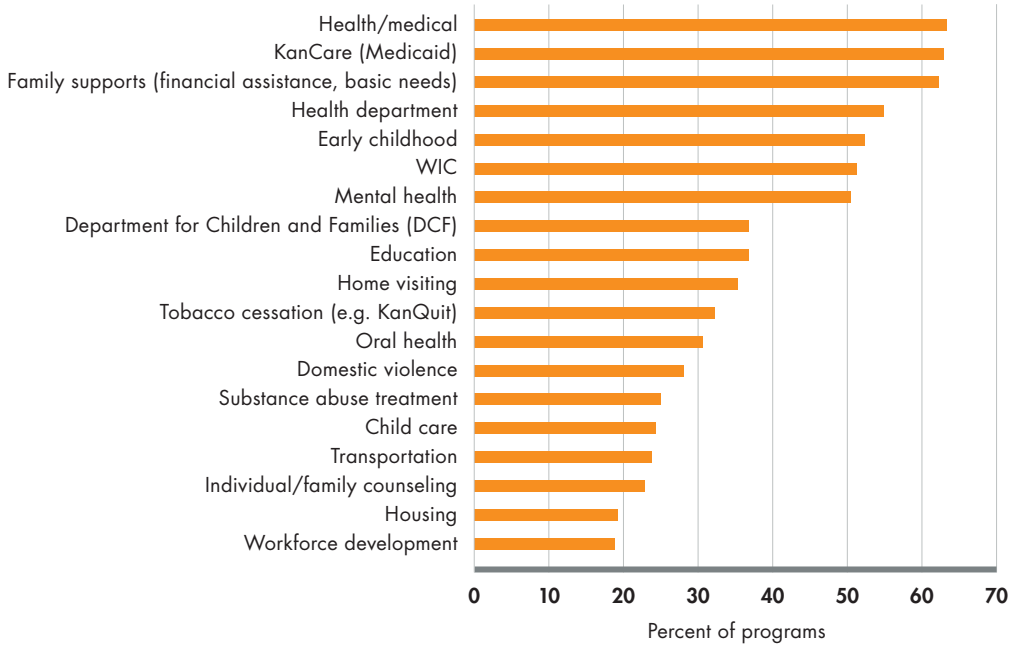


As expected in a survey of public health partners, there is a distribution of programs across the Health Impact Pyramid, with a balance along the continuum of direct services through systems change efforts. In discussions at the regional meetings, participants expressed some confusion about the utility of the Pyramid for their work; this may be an opportunity to build capacity and identify future strategies for improving MCH at the community level.

Number of programs by level of Health Impact Pyramid, state aggregate (AMCHP Regional Meeting Inventory, 2014-2015)		
Tier 5: Education and Counseling Individual or public educational messages and support.	1. Implement Health Promotion Efforts	22
Tier 4: Ongoing Clinical Interventions Evidence-based practices within clinical settings.	2. Ensure Quality of Care for All Women and Infants	46
Tier 3: Protective, Long-lasting Offer long-lasting protection to individuals.	3. Implement Maternal Risk Screening for All Women of Reproductive Age	10
Tier 2: Changing the Context Change the environmental context to making the healthy choice becomes the easy choice.	4. Enhance Service Integration for all Women and Infants 5. Improve Access to Health Care for Women Before, During and After Pregnancy 6. Develop Data Systems to Understand and Inform Efforts (i.e. infrastructure development)	88
Tier 1: Addressing Socioeconomic Factors Address fundamental social conditions.	7. Promote Social Equity	13

Finally, the inventory and the regional meetings indicate a strong connection between public health partners and KanCare (Medicaid). There are regular, intentional efforts to connect MCH populations to Medicaid when necessary and appropriate. Other common referral sources, including family supports, early childhood, and mental health, indicate a strong alignment between core MCH services and key complementary programs and services.

Referral organizations by frequency, state aggregate (AMCHP Regional Meeting Inventory, 2014-2015)



Regional Meetings Summary by Location

South Central Region – Wichita

Participants in this region stated that there is a growing population of refugees and undocumented residents. Accessing services for these populations can pose as challenging.

Building partnerships was also a key theme expressed by participants. By building partnerships within the community, the family can be serviced more effectively as a whole in order to get the needs of the community met. An example given was partnering with grocery stores to help promote healthy choices.

Access to prenatal care was a need voiced by participants as well as transportation needed to access health care appointments. Poverty was a central theme with participants stating that human needs must first be addressed such as feeling safe, having food, etc.

Lastly, other needs include improved mental health services, home visiting services, and coordination of care amongst providers.

Southwest Region – Garden City

Participants in this region voiced that they would like to see consistencies in service areas across the state. It was voiced that poor connections existed throughout the state relating to service providers effectively sharing and communicating information. Improving continuity of care and collaborating with other agencies was a key theme.

In order to help improve continuity of care, cross-county collaboration was identified as a need. Working to build partnerships and informal relationships with service providers and key state representatives, will allow for advocacy and a higher chance that needs will be met.

Improving quality of care for women and infants was also voiced as an area that was lacking attention. Particularly, perinatal and prenatal care and working to improve access to services for these women would be of great benefit to the community. This would ensure that women are not only getting the healthcare that they need for a healthy pre/post pregnancy, but also bringing awareness and education to the mother.

Additionally, improving the negative stigma attached to mental health issues may provide people with a sense of being able to readily access mental health services when they are in need instead of being ashamed.

Cultural awareness and education surrounding cultural perceptions was identified as an area of need. Breastfeeding was seen as a sign of poverty, rather than a healthy option for mothers.

Lastly, it was reported that there is a need for more services geared towards the overall health of the mother rather than just the child. Participants stated that they felt as though services forget about the mother once the child is born instead of treating the two parties as unit when it comes to ensuring both the health of the mother and the child.

Northwest Region – Colby

Participants in this region voiced that there needed to be collaboration/continuity of care across agencies, specifically with sharing data. Other needs include reducing barriers to breastfeeding,

access to developmental screenings, transportation, health and nutrition awareness, and increased adolescent services centered around sex education and independent living skills.

North Central Region – Concordia

Participants in this region reported that they needed more funding for WIC to provide healthier eating options. Lack of nutritious eating options available for children was of concern to the participants.

Mental health, specifically child's mental health services was reported to focus more on the parent's mental health in this region. Having quality mental and behavioral health options available for children was a gap in service needs being met.

The importance of prenatal care was also discussed. Again, having access to quality, affordable prenatal care would assist with ensuring the health of the mother and the child.

Breastfeeding support and education surrounding the duration of how long a mother should breastfeed would be beneficial to the community.

To ensure that appropriate services are being delivered, an active, versus passive, referral system was noted. This also took into consideration access and availability to services as well as accountability on both the parents and service provider's part for active follow-through.

Lastly, working to strengthen families was identified as a need. Through improving collaboration and continuity of care, this could be accomplished.

Northeast Region – Topeka

Key needs within this region that were identified were breastfeeding support, lack of money and the wide-spread issue of poverty for families, accessibility and lack of immunizations being received, access to prenatal care, continuity of care, access to oral health for children, healthy eating and nutrition awareness, instituting mentoring programs, increased access to developmental screenings, and ensuring a woman's overall health is being addressed.

Services in which gaps were identified and there is an increased need include, food pantries, support from faith-based organizations, organizations for those with special needs/disabilities, and family preservation services.

Discussions revolving around how to fill these gaps identified that it was important to build relationships in order to build a sense of trust, not only amongst service providers, but amongst service providers and the families they are working with. Also, collaborating with others will help streamline services and needs being met.

Regional Meetings Comparison

The unique, hands-on method of data collection taken by KDHE MCH through regional meetings provided a way to realize, over time, that each region had their own specific needs, yet also shared many needs. The comparison table at the end of this section shows an overview of each region's expressed needs as data were collected and compiled – a very helpful tool in defining the final priorities for the Needs Assessment.

Communities for Kids Meetings

The Kansas Special Health Care Needs (SHCN) Program promotes the functional skills of persons, who have or are at risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction. SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions. Additionally, the program provides services to persons of all ages with metabolic or genetic conditions screened through the Newborn Screening. Services may include diagnostic evaluations, treatment services or care coordination.

To address the needs of this population and incorporate the actions into the Needs Assessment, The SHCN team continued the unique and comprehensive approach in assessing the MCH2020 needs for children and youth with special health care needs (CYSHCN) by holding *a special series of meetings to address the growing needs of children and youth with special heath care needs and promote inclusion and accessibility for all children.* As the regional meeting progressed, the CYSHCN team overlapped with a series of community based meetings held in small spaces with open forum agendas and invited participants representing various programs in their county such as home visiting, childcare, and local health departments. A summation of each regional meeting is as follows;

Each meeting consisted of a presentation on the state of CYSHC in Kansas as well as the programs goals and philosophy of children first and the Title V Needs Assessment overview. The community meetings were essentially open forum and group process and comments were recorded by staff. Meeting participants actively engaged in discussing what they believed to be were needs or service gaps relating to each of the five domains.

Keeping in mind children with special health care needs are children first and foremost, KDHE SHCN was able to intimately, and in detail, capture the needs of all children, as well as their parents and caregivers. This was an opportunity to learn from families, community and health providers, school professionals, and any member of the community interested in the health of Kansas children to voice the most prevalent maternal and child needs within these communities.

Communities for Kids Meeting Summaries by Region

Roeland Park, Kansas – December 10, 2014

Participants within this community stated that they need greater access to health insurance coverage and treating chronic conditions.

Factors that contribute to services being unmet are lack of funding, transportation issues, and lack of knowledge that the services exist.

Supports needed by parents and families include home-based services, including faith-based services, and telemedicine.

Great Bend, Kansas – December 16, 2014

Needs identified within this community include gaining proper healthcare coverage, and support revolving around mental health and families that feel isolated. Specifically it was noted that

young parents don't have the necessary support and end up developing mental health issues. To help support the family it was identified that evidence-based programs were needed as well as developmental screenings.

Collaboration and coordination of care was identified as a strong need within the community amongst providers.

Concordia, Kansas– December 17, 2014

Participants within this community felt isolated as it was reported that children and parents were left home all day together and need an opportunity to expand social outlets. Particularly home visiting services were reported to be needed for children and youth with special needs. Access to screenings was also identified.

Mentors for families was also voiced as a need as well as availability of childcare, health and nutrition information, relationships skills and sex education for adolescents, and telemedicine.

Parent education around adolescent issues such as birth control, suicide, and sexual identity was also stated as a need.

Garden City, Kansas – January 14, 2015

This community voiced the need for medical homes that incorporate all objectives, a dental home, and navigation of the health care system. It was identified that in order to make this work, collaboration would be needed amongst providers.

Other needs included behavior and mental health screening for children in all age ranges, well-child checks, improving ways to address and increase awareness of toxic stress, as well as a readiness to learn from providers and parents were identified.

Topeka, Kansas – January 21, 2015

Major themes within this community were access to dental providers. Providers that will accept the medical card and pregnant women were specifically needing to be serviced as well as dental care for children and youth with special needs.

Other areas of need were injury prevention, lack of available providers and transportation, as well as working families having trouble maintaining appointments due to their schedules.

Another suggestion included having one centralized area where families can access a variety of services including dental and mental health and maternal and child infant care.

Living in poverty was a central issue that participants voiced as well.

Junction City, Kansas – February 10, 2015

Participants in this community felt that parent education surrounding parenting skills was needed more, as well as home visiting program. Additionally, it was voiced that daycare providers are not trained to have kids with mental health issues. Other areas in which participants felt there was a need was in transportation, access to healthy food, and safe recreation areas.

Reoccurring themes included the need for more providers, accessing services more efficiently and an increase in collaboration amongst providers.

Wichita, Kansas – February 18, 2015

Participants within this area felt that there needed to be increased availability for screenings, transportation, mental health services for mothers and childcare providers that are trained in social/emotional support for children.

Parsons, Kansas – February 26, 2015

Participants in this region voiced several needs that are not being met within their community. Home visiting services were lacking. Home visiting was identified as a need due to the inaccessibly of transportation within the community. Early intervention services were not being met as the county data represented a high number for infant hospitalization.

Lack of providers was also an ongoing theme as well as the need for interdisciplinary education for teachers. Participants voiced that support for evidence-based trainings would help to facilitate quality professionals relating to health care and the school system.

Regarding a positive aspect, it was reported that counties are doing good coalition work where various providers from different backgrounds come to meet and discuss what is going on in the community and how to best service the community's needs.

Community for Kids Meeting Comparisons

It became apparent throughout the Needs Assessment process that many needs were similar from county to county and themes emerged, such as access to healthcare, transportation and home based services. Other areas had specific needs unique to the community backdrop, culture, and location. The comparison table on the next page provides a snapshot of the Community for Kids meetings throughout the state.

Significance of the Regional and Communities for Kids Meetings

The Regional and Community for Kids meetings were a critical part of the Needs Assessment process. The maternal and child needs of each community significantly contributed to discovering themes across regions. **The most prevalent need expressed by participants was the necessity for continuity of care amongst service providers.**

Other areas in which participants expressed similar needs across the regions were access to healthier eating options, improved access to transportation, and the need for developmental screenings. It's important to note that many of these needs are cross-cutting, and when each of the domains are affected, this impacts the entire family unit, thus impacting the community as a whole. While many communities voiced their concerns for improvement in these areas within their communities, they realize this will take a team effort from not only families, but providers across the state.

Comparison Table of Public Health Regional Meetings Themes					
Domains ↓	**South central Region**	**Southwest Region**	**Northwest Region**	**North central Region**	**Northeast Region**
Woman/Maternal Health					
Breastfeeding Support			X	X	X
Quality of Care	X	X			X
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X	X	X	X	X
Healthier eating options (cross cutting)	X		X	X	X
Children					
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X		X	X	X (just children identified)
Healthier eating options (cross cutting)	X		X	X	X
Access to mental health services				X	
Access to oral healthcare					X
Perinatal/Infant					
Quality of care		X		X	
Access to care	X				X
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X		X		X
Healthier eating options (cross cutting)	X		X	X	X
Immunizations					X
Access to developmental screenings			X		X
Adolescents					
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X		X	X	X
Healthier eating options (cross cutting)	X		X	X	X
Mentoring programs					X
Adolescent education				X	
CYSHCN					
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X	X	X	X	X
Healthier eating options (cross cutting)	X		X	X	X

Comparison Table of Communities for Kids Meeting Themes								
	NE		NC		NW	SW	SC	SE
Community →	**Roeland Park**	**Topeka**	**Concordia**	**Junction City**	**Great Bend**	**Garden City**	**Wichita**	**Parsons**
Health insurance	X	X			X			
Access to healthcare	X							
Funding	X							
Transportation	X			X			X	X
Awareness of services	X							
Home-based services	X		X	X		X		X
Access to mental health services					X		X	
Supportive family services			X		X			
Access to developmental screenings			X		X	X	X	
Evidence-based programs					X			X
Collaboration/continuity of care					X	X	X	
Accessible childcare			X					
Access to healthy, nutritious food			X	X				
Adolescent education			X					
Access to healthcare			X					
Parent education			X	X		X		
Access to oral healthcare		X				X		
Navigating healthcare system						X		
Access to well-child checks						X		
Injury prevention		X						
Lack of providers		X						
Access to after-hour clinics		X						
Centralized service agency		X						
Safe recreation areas				X				
Quality childcare				X				
Early Intervention services								X

Children & Youth with Special Health Care Needs Strategic Planning

In alignment with the MCH Block Grant and Title V Needs Assessment process the Kansas Special Health Care Needs (SHCN) Program began an extensive strategic planning process in July 2013 to identify needs and provide new opportunities to a program that had changed very little over the prior decade. It had been identified that program participation was at an all-time low and the director of the SHCN program recognized that a response to the changing health care system, anticipated upcoming changes to the MCH Title V Block Grant and the noted low participation in programs required a review of existing state statues, regulations and policies.

Furthermore, the SHCN program recognized that, though the program had changed very little over time, the state and federal systems had changed dramatically and in order to reflect the commitment to the mission, the SHCN program began the process that would address the new Kansas SCHN priorities created by the program which were identified as:

- Cross-system care coordination
- Behavioral Health Integration
- Addressing Family Caregiver Health
- Direct Health Services and Supports
- Training and Education

Because KDHE has committed to the guiding principles of collaboration and coordination, it only fit that the SHCN program would continue and support this philosophy and provide guidance and encourage input from the state through stakeholders, partners, providers and community members. These entities would assist the SHCN team to identify strengths, weaknesses and opportunities within the proposed priorities. Thus began a process of information gathering that would examine existing services or initiatives to determine assets and potential gaps within the system so that the proposed priorities assured success.

To finalize the priorities, the program conducted a Special Health Care Needs Strategic Planning Meeting in September of 2014 where participants had opportunity to hear an overview of the progress of the SHCN programs work toward priorities, and begin a round-robin objective-setting process that would end with a report out and large group feedback per priority area.

This strategic planning meeting drew on the expertise of stakeholders and partners as well as the Family Advisory Committee inputs and providers from regions of the state. Each priority presented was discussed through facilitation and goal setting, which resulted in a firm confirmation of the proposed priorities. The guidance and recommendations provided on the long-term objectives were crucial to the needs assessment process and the direction that SHCN wanted to take for the overall well-being of children.

The objectives are recorded and integrated into the Title V MCH block grant application and align with the required National Priority Measures.

Focus Groups

More than 400* Kansans shared their perspectives through 26 focus groups conducted in Chanute, Dodge City, Great Bend, Hoisington, and Kansas City. A unique approach was taken in that the focus groups were led and highly attended by adolescents.

The focus groups were conducted with a number of adolescents and adults in areas such as high school FCS/advising/study hall classes, local coalitions, Kansas Partnerships for Health conferees, health departments, Young Women on the Move afterschool members, 4-H councils, ESL mothers group, and Wyandotte High Health Science III class members.

The issues, barriers and challenges that resulted from this comprehensive focus group approach included top health issues such as substance abuse, nutrition/obesity, sexuality and reproductive health, and stress. Social issues also emerged and included bullying and boredom. One strong issue voiced by adolescents that occurred throughout the communities visited was the need for real services and information that are useful and available and wanting to confide and partner with mentors and other reliable adults as adolescents expressed the need for people and services that were pertinent to their unique age group as they enter adult hood. Additionally, commonalities existed between the youth and adult focus group participants as adults reported many of these same concerns.

Adolescents reported barriers as well, which related back to the challenges reported above, and include lack of real and useful information, access to services, and lack of mentors and support. A surprising yet honest barrier that adolescents reported was shame and embarrassment around a number of issues that include seeking services and reaching out for assistance.

An outcome of the survey and focus groups were how self-aware and insightful the adolescents were around their own needs, and how they felt barriers existed to express and address those needs.

Findings and Recommendations

Adolescent Health Needs Assessment and State Plan: In Spring of 2014 KDHE contracted with Kansas State University Research and Extension to conduct a statewide assessment of adolescent health needs and develop a state adolescent health plan. The Adolescent Health Needs Assessment provided state-specific information regarding the adolescent population that was not previously available, including identification of issues of particular interest to adolescents themselves. The assessment process consisted of a review of existing health data, an online community input survey, community focus groups, and gathering of input from key stakeholders. The review of data revealed areas of improvement, including decreasing rates for teen pregnancy, tobacco use, and unintentional injury and increased levels of physical activity. However, negative trends were noted in the areas of increased behavioral/mental health needs and intentional injury (e.g., suicide attempts, bullying) and obesity.

Following the review of population data, an open access, electronic survey was made available for anyone in Kansas over the age of 13 to complete. The survey was disseminated to more than

**324 of the 401 participants were high school students; 60% female, 63% white, 17% Latino/Hispanic, 7% African American; 2% mixed race, <1% Asian, American Indian, etc.*

50 organizational lists, points of contact, and electronic newsletters via email, flyers with URLs and QR codes, and sample copies delivered at conferences, meetings, and public gatherings. A link to the survey was also posted on Facebook and Twitter. The online survey resulted in 854 responses representing 83 of the 105 Kansas counties. Respondents ranged from age 11 to 82 with an average age of 49. In response to the question asking which 2 health issues impact adolescents in their area the most, the top 8 issues identified were substance abuse (56.2%), mental health (35%), Obesity/overweight (30.1%), adolescent pregnancy and parenting (22.2%), sexual health (17.6%), positive health development (17%), adolescent injury (8.7%), and healthcare services (8.5%). In narrative sections of the survey, respondents emphasized concerns about their communities' capacity to diagnose and treat substance abuse issues due to lack of available and accessible services and cited a lack of adolescent substance abuse prevention programs. Many respondents cited mental health care issues such as transition to adulthood, life stressors impacting families, stress management, and suicide. The lack of education about healthy development was an issue raised by multiple respondents with specific reference to the need for education related to injury and violence prevention, substance abuse prevention, obesity and physical education, sexual/reproductive health, and teen pregnancy.

Barriers to services for adolescents identified in the survey included lack of accessible and affordable transportation or lack of awareness about available transportation options, insufficient marketing of services provided in communities, and a lack of doctors or other providers who are trained on and/or address the specific needs of adolescents. Additional information was gathered in 26 focus groups held in 5 communities across Kansas. The 5 communities were strategically selected to obtain information from areas of the state that were not well represented in the online survey responses. Of the 401 focus group participants, 324 were youth ages 12-18. There was an intentional effort to gather the input of adolescents in the focus groups to complement the majority of survey responses received from adults. Participating youth identified the following issues as having great impact on the adolescent population: drug and alcohol use, teen pregnancy, lack of adequate sexual education, bullying, self-inflicted physical harm, depression, dealing with stress and high expectations of adults, and obesity. The participants indicated the need for "real" information about sexuality, sexually transmitted diseases, and life-altering consequences of teen pregnancy. They expressed needing supportive, non-judgmental adults to confide in and provide guidance.

The Adolescent Health Needs Assessment resulted in specific recommendations and strategies to address the needs of adolescents in Kansas. Recommendations were grouped in 5 categories:

1. Address the highest priority heath issues (mental health, substance abuse, reproductive/sexual health, nutrition and physical activity, and injury prevention);
2. Help families support the health and well-being of their adolescents;
3. Provide educational environments that prepare youth for healthy adulthood;
4. Encourage collaborations and increase community support for those working for and with youth; and
5. Improve the responsiveness, availability, and access of health care to youth.

Surveys

Three surveys were distributed over the course of the Needs Assessment. The surveys provided an opportunity to reach a large participant base, yet capture specific needs, based on the survey design and distribution. The first survey, distributed by KDHE to stakeholders was a MCH input survey to get annual feedback from stakeholders on MCH services and community needs. The next survey was created by Kansas State University and geared at the adolescent population domain in Kansas, and the final survey was a Title V Needs Assessment Survey which considered input from the overall process and was aimed at addressing emergent needs.

MCH Services Input Survey

During the development of the 2015 MCH Services Title V Block Grant, KDHE distributed a public input survey to collect on-going input on services, emerging issues, needs, and concerns from informed consumers and partners in Kansas. The purpose of the survey was to collect information and perspectives on the needs and to also involve partners across the state who could assist in assessing needs based on existing services and resources. The survey was open for public input over a 6 month time period and yielded 222 responses, with more than half (56.4%) of respondents being the parent or guardian of a child age 0-21. Over 17% of respondents indicated that they were a parent or guardian of a child with special health care needs of any age, and primary role selection of respondents yielded that over 59% were in a health care professional role. A full report of the MCH input Survey can be found in the Appendix.

Meeting Overview

Each meeting began with an overview of KDHE MCH Bureau and its provisions, as well as background on Title V and the Block Grant. Key staff presented an overview of the Needs Assessment process, a detailed review of county-specific data, and facilitated discussion around which indicators might be most important in defining priority needs. Participants were then assigned to small groups with one of the MCH population groups (women and maternal health, children, perinatal/infant, adolescents and children and youth with special healthcare needs (CHYSN) to address what they thought were the most important needs for each, what the gaps in service were, and who could be engaged to address them.

Adolescent Health Needs Survey

To increase the dialogue about adolescent health needs in the state of Kansas, KDHE enlisted Kansas State University School of Family Studies and Human Services to design, implement, and disseminate data to address the barriers and health needs of this specific population. Adolescents are commonly thought of as a unique population and this survey was able to address that they are unique in their developmental needs just as women, infants, and all children are. Recognizing that many adolescents face challenges in Kansas, this survey was able to capture a wide range of responses and further the research for K-State as well.

The survey distributed between August and September 2014, yielded 854 responses* as well as expanding into a research project that gathered input from focus groups held across the state, for a total of over 1,200 Kansans representing youth and adults. Top health issues affecting adolescents in their area were Substance Abuse (56%), Mental Health (35%), Overweight/Obesity (30%) and Adolescent Pregnancy & Parenting (22%). The survey reported the top barriers facing adolescents as Lack of Knowledge about Service (75%), Cost/Affordability (66%), Embarrassment/Acceptability (64%), and Unaware of Need (46%).

Other concerns were bullying, boredom and access to health services. One finding that emerged was that most issues linked back to mental health concerns. One barrier that stood out was the factor of embarrassment or shame in seeking services, especially in rural communities. Overall this survey and enabled K-State to provide the Needs Assessment with a comprehensive and detailed look at the needs and gaps in services of adolescents in the state, and a large percentage of respondents were voiced from the domain itself. A full report can be found in the Appendix.

Title V Needs Assessment Survey (Community Norms)

To further assess the needs of Kansans maternal and child health, KDHE distributed an online survey midway through the Needs Assessment. The survey was available to stakeholders, professionals, parents and community members throughout the state in January and February of 2015, and yielded a total of 540 responses. The survey was a mixture of open-ended questions and community norms questions. This was intended to capture what survey participants, coming from different backgrounds, choose 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 are specifically useful to help identify what the community feels is of benefit to them and areas in which gaps of services exist.
The survey was distributed toward the end of the Needs Assessment process, after many other forms of data collection, so that questions could address the emergent domain priorities and address specifics so that KDHE could begin to finalize priorities and objectives.

Of the 597 responses, the areas that scored the highest in terms of the most important overall health issues for the MCH population were quality, affordable childcare and learning environments, healthy and affordable food/nutrition, and access to adequate, affordable healthcare. Also, of importance were transportation, immunizations, and affordable housing. Availability of mental health services was also of high concern. Individually, these concerns are of great importance and were often expressed throughout the process by community members and stakeholders alike, yet taken together, these issues confirmed what KDHE had been hearing as concerns in all meetings, surveys and focus groups, which is that these issues are based in community and need to be addressed through education and access and local and state levels with support of KDHE and existing or new programs. An overview of initial results is included in the table below. An executive summary and survey results can be found in the Appendix.

**854 respondents were 86.4% female; average age of 49; 60% rural and small town; 22.7% upper middle income; 85 counties represented. A Spanish version of survey was offered but no Spanish version surveys were received.*

Initial community norms results, KDHE Title V Needs Assessment Survey, 2015		
Survey pairs	**Mean difference**	**Significance**
I believe that women have equal access to health care in KS	.281	.000*
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	-.934	.000*
In my opinion, most adults in my community believe that reproductive health, preconception health, and family planning are important topics.		
I believe that infants and toddlers have equal access to health care in Kansas.	.266	.000*
In my opinion, most adults in my community believe that infants and toddlers have equal access to health care in KS		
I believe that healthy weight and good nutrition for infants and toddlers is a health issue that is being addressed in KS	-.025	.423
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.	-.960	.000*
In my opinion, most adults in my community believe that breastfeeding is an important part of good child health in KS		
I believe that children have equal access to health care in KS	.274	.000*
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.	.015	.610
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 have access to healthy physical activities.	.145	.000*
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.	.190	.000*
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 childcare available in my community for families that need it.	.170	.000*
In my opinion, most adults in my community believe that there is quality childcare for families that need it.		

Ten pairs of questions were asked to better understand the relationship between individual beliefs and collective beliefs, or norms. This process provides insight into perceptions of key issues that may be barriers to service utilization, to identifying risk factors, or to engaging in behaviors that lead to negative outcomes. In interpreting the results, the mean difference is the difference between mean scores for each pair of questions, or the difference between the average score of what "I believe" and the average score of what "most adults in my community believe." When the mean difference is positive, it indicates that the "I believe" statement mean is lower than the "most adults in my community" statement. When the mean difference is negative, it indicates that the "most adults in my community" statement mean is lower than the "I believe" statement. These are indicators of lack of a common understanding of key issues. Each of the pairs had a statistically significant difference between the statements, with the exception of health weight and nutrition for infants and children. Moreover, two areas that were identified as key components of the Five-Year Action Plan, reproductive health and breastfeeding, are the areas with the largest differences between individual and collective perceptions.

Strengths and Weaknesses of the Process

Overall, the process accomplished what it was designed to do:

1. initiate/gather broad stakeholder input; and
2. ensure that all population domains were given adequate time and attention.

The primary strength of the process was the focus on partnerships. These partnerships put Title V in a position to maximize resources. Many partnerships were in place before the Needs Assessment, with many new partnerships developing throughout, and assisted to develop effective programs and policies that address the needs of population. The mixed methods design provided opportunities for a range of input and ensured diverse representation across the state: from youth to adults; parents to providers; and urban to rural and frontier areas.

Finally, the process promoted a life course approach with MCH stakeholders.

The primary weakness was the need for more time. While the process began early and generated buy-in and support from partners, more opportunity to engage in discussions with key partners, including mental/behavioral health systems and schools, may have strengthened strategies related to those issues. These conversations will occur in the coming year and will assist in the revision of state objectives and strategies.

Results

MCH Population Needs

Through the Needs Assessment process, Kansas identified eight priorities that will be the focus of Title V efforts from 2016-2020.

To develop the priorities and create an intended plan of action, the Needs Assessment process consisted of a mixed methods approach that relied on the input of key informants, partners, and community members. For nearly a year, the Needs Assessment team covered regions of the state conducting and facilitating eight AMCHP Regional Meetings, three MCH Council meetings, 17 Communities for Kids meetings, focus groups with 350 adolescents, and strategic planning meetings with MCH staff and stakeholders. This process helped to identify key priorities to ensure an intended plan of action to effectively improve and address maternal and child health. With a better understanding of the needs of Kansas MCH populations, the Needs Assessment team was able to develop a series of questions to be used in initial and follow up conversations with partners, program directors, community service providers, and parents.

Over time, common issues across populations showed repeated connections that exemplified the interconnectedness of the priorities. This led to some original priorities not being a focus when it was realized that they were eventually naturally connected to other priorities, eventually becoming key strategies in the plan, assuring that a number of needs were actually covered within a priority and could be measured over time. It was also realized that the emerging needs that stood out and are now the final priorities, could be measured over time and support the principal of KDHE to continue its role in building partnerships.

The priorities that emerged and the decision-making process, are summarized on the following pages. Criteria used in final selection and categorization of priorities and elements of the plan included:

- Determination of level of impact (priority, objective, strategy)
- Ability of KDHE to impact outcomes
- Role of key partners in delivering outcomes

Women/Maternal Health

Women's health consistently was voiced as a priority. Access to care is a need that was expressed as overarching, not only for the specific community, but providers, programs and families throughout the state; yet was so broad that many other priorities began to emerge as objectives that fit within the need. As stated by one of many stakeholders during community meetings, "What is really needed is a [system] where women can get all the services they need and providers work together and know what each other are doing." This exemplifies the idea there is not necessarily a need for new or additional services, but rather better coordination among existing services. This provides the foundation for the state priority for the women/maternal health domain: *"Women have access to and received coordinated, comprehensive care and services before, during and after pregnancy."*

In 2013, more than 20% of pregnant women in Kansas did not access prenatal care in the first trimester, supporting the need for better coordination and access to care for all women. Recent

NOMs data describe the health status of pregnant women in Kansas:

- 79.4% of pregnant women received prenatal care beginning in the first trimester, a 7.3% increase over the past 5 years;
- the maternal mortality rate per 100,000 live births (5 year rolling average) was 16.5, a 21.3% increase over the past 5 years; and,
- 12.5% of pregnant women smoked during pregnancy, a 17.2% decrease over the past 5 years.

Early prenatal care (i.e., care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.

KDHE has successful programs, resources and services in place to continue striving for more coordination around care and services. The message shared throughout the Needs Assessment process positions KDHE for more engagement with community partners, building on existing programs to address needs. Continuation of, or enhancements to, existing programs and partnerships are likely to impact populations through: improved Healthy Babies are Worth the Wait-HBWW/Becoming a Mom Program-BAM) outcomes; collaborative home visiting; uniform screenings; reduction of smoking in the home; increased breastfeeding; improved access to care (including well woman visits); increased health insurance coverage; better coordination; and increased access to transportation. NPMs addressed through this domain include NPM 01: Well-woman visits and NPM 14-A: smoking during pregnancy.

Perinatal/Infant Health

The perinatal mortality rate has not changed since the previous Needs Assessment, and Sudden Unexplained Infant Death (SUID) mortality has substantially decreased. The rates of deliveries of infants who were preterm or low birth rate have also remained constant, while the rate of non-medically indicated early term deliveries has significantly decreased. Therefore, the strengths and needs of the perinatal/infant population in Kansas is the same or improved from the time period during which the previous Needs Assessment occurred. The related state priority crosses many population domains, "Families are empowered to make educated choices about nutrition and physical activity."

This is supported by NPM 04, the proportion of infants who were ever breastfed. In Kansas, a 6% increase (up to 84.2%) in the previous 5 years has been experienced in this area, however input throughout the Needs Assessment identified a continued need for the existing work around this population health need. The focus was for both infant health, and mother health - one of many priorities crossing MCH domains. Public input also outlined many other areas of focus for the perinatal/infant population, addressed through alignment with other priorities and strategies across domains.

Recent NOMs and NPMs data describe perinatal/infant health in Kansas, during the previous 5 years, has:

- remained relatively constant at 7.0% of deliveries were infants with low birth weight (<2,500 grams);
- slightly increased by 3.3% from 9.2% to 8.9% of births were preterm (<37 weeks);
- decreased by 27.1%, down to 29.3% of non-medically indicated early term deliveries (37-38 weeks) among singleton term deliveries (37-41 weeks);
- remained relatively constant with the perinatal mortality rate of 6.5 per 1,000 live birth, plus fetal deaths.

To address continued risks associated with negative outcomes for this population, strategies that will be employed include:

- uniformly screening and monitoring for high-risk conditions; ensuring that more than 90% of at-risk women receive 17-P;
- refer high-risk deliveries to facilities that provide the appropriate level of care; and expand HBWW/BAM program model, targeting areas with disparities and poor birth outcomes.

Child Health

Healthy development for children was a strong theme, addressing many needs identified in each community. A strong focus was on assuring children were provided opportunities through age-appropriate services, leading to the state priority for this domain – *"Developmentally appropriate care and services are provided across the lifespan"* – directly linked to NPM 06 on developmental screening.

Many identified needs for the child health domain carried over into adolescence and were connected by a common thread: injury and safety. Injury prevention efforts, addressing safety concerns in the home and reducing risk, and selection of safe childcare settings are all areas of interest, focused on reducing non-fatal injury hospitalizations (NPM 07). Statistics indicate the number of Kansas children "excellent or very good" health is slightly higher (86.8%) than the national average (84.2%) and Kansas children receive a preventive medical visit at a rate consistent with the national average.

Data, from OSD and NOMs, related to the health status of Kansas children show:

- the rate of death in children aged 1 through 9 per 100,000 was 23.8, a 9.7% increase over the previous 5 years;
- 6.7% of children were without health insurance, a 18.3% decrease;
- 7.6% of school age children were victims of bullying ;
- 7.2% of school age children were bullies ;
- 59.1% of all children received comprehensive, coordinated care from a medical home, which was higher than the national average of 54.4% ; and
- 79.4%% of children received a preventive dental visit in the previous year, which was slightly higher than the national rate of 77.2%.

Stakeholders provided useful and innovative ideas to improve upon while expanding current initiatives,

many of which are already in the scope of work for Title V. KDHE can further strengthen the guiding principle of collaboration at state and community levels, and create community change by building from existing successes of programs like Safe Kids Kansas, and increasing the number of MCH grantees that serve as a lead agency for local Safe Kids Coalitions. Other identified needs absorbed into the priority of developmentally appropriate care are focused on:

- safety and education opportunities
- safe sleep initiatives
- access to childhood immunizations
- oral health education
- developmental screenings

Combined, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course.

Children & Youth with Special Health Care Needs

As with other population domains, the CYSHCN domain priority need identified was care coordination. In the regional meetings, and particularly in the "Communities for Kids" meetings, it became apparent that family support was emerging as a high need for this population, and that those supports include a need for access to care. In particular, participants mentioned a lack of transportation, particularly in rural communities, and the limited availability of specialists, again, particularly in rural areas. As the assessment progressed, family support also expanded into the need for social-emotional support and respite for caregivers. These issues lead Title V to identify a high need for more coordinated care across systems, reducing duplication of services and providing opportunity for stronger family engagement – the foundation for which led to the state priority, *"Services are comprehensive and coordinated across systems and providers,"* and will be measured through medical home indicators (NPM 12).

Data, from OSD and NPMs, related to medical home indicators for Kansas CYSHCN show:

- 49.4% receive care within a medical home, compared to 43.0% nationally;
- 45.7% receive effective care coordination, when needed;
- 33.1% experience difficulties or delays in getting services for their child because the services needed were not available in their area;
- 32.7% report their current insurance coverage is inadequate; and among families caring for CYSHCN, lack of receiving care within a medical home was associated with 1.7 times increased odds of reporting of financial burden.

Having a medical home is essential to coordinated systems of care. Families are better supported, experience less frustration when accessing services, fewer delays in services, and children tend to be healthier. Medical homes are also critical in successful transition to adult living. Kansas is above the national average of children 10 months to 5 years who received a standardized screening for developmental or behavioral problems (37% in Kansas versus 30.8% nationally). Care coordination efforts, within a medical home or not, can assist in identifying children with potential developmental delays allowing for earlier intervention than for those without this support.

Through the KS-SHCN Strategic Planning, four additional priorities emerged: family caregiver health; behavioral health; training and education; and direct health services. Enhanced services that could be provided by KS-SHCN include increased access to family-centered medical homes through support by KDHE through existing structures, as well as through: assisting families to navigate service systems; engaging MCOs and primary care providers; parent leadership development, increasing community and statewide partnerships, assuring children receive developmentally appropriate assessments and behavioral health screenings, implementing tele-medicine strategies, and professional development training.

Adolescent Health

Central to the discussion was a holistic approach to adolescent well-being, focusing on positive youth development and providing opportunity for young people to thrive. Adolescence is an important developmental stage filled with opportunities as well as health risks, which can be magnified by transitions between systems of care, especially for CYSHCN. Regardless of geographic location, adolescents face common barriers and risks such as bullying, risk taking, poverty, boredom leading to negative choices, lack of skills, and perhaps even the responsibility of attending to other family members. Many youth cope with chronic health conditions and many live in neighborhoods and families that pose health risks. However, with positive supports and opportunities, youth can learn to build their abilities, and develop into contributing adults, leading to the state priority, *"Communities and providers support physical, social, and emotional health."* Bullying (NPM 09) is a key focus within this domain, as is NPM 10: Adolescent well-visit.

The following data describe the health status of Kansas adolescents:

- the death rate ages 10-19 per 100,000 was 31.9, a 21.0% decrease over the past 5 years;
- the rate of suicide deaths ages 15 through 19 per 100,000 (3 year rolling average) was 13.2, a 45.1% increase over the past 5 years;
- 84.6% of adolescents, ages 13-17, have received at least one dose of the Tdap vaccine, a 33.0% increase over the past 5 years; and
- 55.9% of adolescents, ages 13-17, have received at least one dose of the meningococcal conjugate vaccine, a 46.0% increase over the past 5 years.

KDHE desires to address the needs of this population through promoting wellness and addressing serious and pervasive issues that adolescents face such as bullying, suicide, and mental/social health issues. Life skills development is an important objective under this priority. There is a need to promote positive coping mechanisms and assure youth receive annual physical and mental health screenings to promote overall health and social emotional health. Trained adults and mentors can help adolescents navigate life skills and set goals (high school completion, employment, youth development). Adolescents have a natural desire to become active in society and community, this priority will promote community partnerships and engagement, reinforce protective factors, and promote prevention of risky behaviors.

Cross-Cutting/Life Course

Seeking appropriate care for the MCH population is critical to the continued support required to ensure that this populations needs are met. For quality care to be delivered, it is important that the professionals interfacing with this population are properly trained to provide this care. This priority will focus on workforce development and capacity, promoting diversity, inclusion, and integrated supports for all, and supporting providers to address the social-emotional development of children. This includes concerted efforts to support health literacy for MCH consumers. Participants stated that understanding the importance of personal health, how to find services, and how to navigate the health care system promote lifelong habits for well-being and can lead to the reduction of or prevention of many of the health issues discussed throughout the process.

Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains. When asked what could improve services within the community, responses included, "having trained professionals who take the time and listen to our needs." Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and the health impact that it may have on this population. In particular, children and youth with special needs was identified as a population that needed improved support from professionals. This led to a broad state priority, "Professionals have the knowledge and skills to address the needs of the maternal and child health population."

Insurance coverage continuity entails continuous insurance coverage throughout the previous year. In 2011-2012, 11.3% of Kansas residents lacked continuous insurance coverage, which is congruent with the national percentage of 11.3% (The Health & Well Being of Children, 2014). Inconsistent health insurance coverage may keep children and families from receiving the necessary medical care required to maintain a good health status. If health problems go undetected, this may result in more significant health problems at a later date that require longer, intensive, and more costly health services.

References

1. Kansas Health Matters. (2015). http://www.kansashealthmatters.org/modules.php?op=modload&name=NSIndicator&file=indicator&iid=17326490
2. High, Brenda. (2000). Estimates of Children Involved in Bullying State by State. http://www.bullypolice.org/BullyingNumbers.pdf
3. NS-CSHCN Chartbook (2009-2010). http://mchb.hrsa.gov/cshcn0910/state/pages/ks.html
4. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, The Health and Well-Being of Children: A Portrait of States and the Nation, 2011-2012. Rockville, Maryland: U.S. Department of Health and Human Services, 2014.

Building on Current Infrastructure and Successes

The following MCH program highlights/updates reflect major accomplishments by MCH population health domains. Please review the full Title V MCH Block Grant Application to learn more: http://www.kdheks.gov/cf/mch.htm.

Women/Maternal & Perinatal/Infant Health

Infant Mortality Collaborative Innovation and Improvement Network (CoIIN): The Kansas Department of Health & Environment (KDHE) along with several partners and organizations including the March of Dimes and the Kansas Infant Death and SIDS Network is actively engaged in the Infant Mortality CoIIN, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. Each participating state selected two to three strategies to focus on as part of the national platform. Kansas' selections include: 1) Smoking cessation (before, during and after pregnancy) and 2) Early term and preterm birth.

Perinatal Community Collaboratives/Birth Disparities Programs: The Kansas MCH Program, in collaboration with local communities and the broader network of local health care and community service providers are involved in an on-going process of developing grassroots perinatal care collaboratives using the March of Dimes, "Becoming A Mom/Comenzando Bien" as a consistent and proven prenatal care education curriculum. Development of these community collaboratives began in 2010, bringing prenatal education and clinical prenatal care together. There are currently seven established sites in Kansas with plans to expand to five new communities this year. Preliminary birth outcomes data shows statistically significant improvements including fewer preterm births and fewer low-birth weight babies. Sites are reporting increases in breastfeeding initiation rates and lowered infant mortality rates. One community's infant mortality rate has dropped from 10.4 per 1,000 births to 6.6 per 1,000 births in only five years.

Communities Supporting Breastfeeding: The long-term goal of the Communities Supporting Breastfeeding (CSB) project is to improve exclusive breastfeeding rates for infants at three and six months of age in Kansas. The objective of this project is to assist communities with achieving the CSB designation by the Kansas Breastfeeding Coalition (KBC) as defined by the following six criteria needed to provide multifaceted breastfeeding support across several sectors:

1. A local breastfeeding coalition with a page on the KBC website listing local breastfeeding resources;
2. Peer breastfeeding support group(s) such as La Leche League or similar mother-to-mother group;
3. One or more community hospitals participating in High 5 for Mom & Baby or Baby Friendly® USA;
4. One business for every 1000 community citizens* or 25 (whichever is less) participate in the "Breastfeeding Welcome Here" program;
5. One business for every 5000 community citizens or 10 (whichever is less) receive a Breastfeeding Employee Support Award from Kansas Business Case for Breastfeeding; and
6. A minimum of 20 child care providers completing How to Support the Breastfeeding Mother and Family course as provided by an approved training organization.

**Number of community citizens defined by 2010 census.*

Delivering Change (Healthy Start Program): Delivering Change is a comprehensive approach, which includes use of the March of Dimes Becoming a Mom prenatal education curriculum, to eliminating disparities in perinatal health in Geary County, Kansas. This approach focuses on individual/family level health, evidence-based practices, standardized approaches, and quality improvement. KDHE as the lead agency is aligning Delivering Change with Title V and Kansas MCH programs and services to directly support individual participants. Program models include:

- OB Navigator;
- Becoming a Mom;
- Period of PURPLE Crying;
- Triple P-Positive Parenting Program;
- Parents as Teachers.

Child & Adolescent Health

In an effort to address the identified needs and priorities for children and adolescents, a number of initiatives involving state and local programs have been launched. The most recent Maternal and Child Health five-year needs assessment is complete and new priorities and objectives have been identified. The Title V program will remain focused on employing the strategies related to these objectives during the next year and beyond to advance efforts related to the priorities for children and adolescents.

- Promote annual well visits through adolescence into adulthood
- Promote oral health and dental screening and care, with special emphasis on routines in out of home care settings (tooth brushing, increased access to water, reduced sweetened beverages)
- Promote incorporation of behavioral health into well visits
- Develop follow-up protocols for families to be referred for behavioral health services
- Partner with community providers to connect children and adolescents with supports that promote protective factors
- Implement evidence-based/informed practices to support healthy behaviors and choices and the development of positive coping mechanisms
- Promote accessible crisis services through school and out-of-school activities
- Provide services that support reducing the impact of Adverse Childhood Experiences
- Increase awareness of options for educating and reporting unsafe digital content Bullying and Cyberbullying intervention and prevention
- Make connections among schools, families, communities and health providers through programs such as school-based clinics

As part of the comprehensive statewide needs assessment, the MCH Program partnered with Kansas State University, Research and Extension to conduct an adolescent health assessment and a state adolescent health plan.

The Adolescent Health Needs Assessment provided state-specific information regarding the adolescent population that was not previously available, including identification of issues of particular interest to adolescents themselves.

The plan has been aligned with and integrated into the MCH State Action Plan Adolescent domain.

Children & Youth with Special Health Care Needs

A strategic planning process began mid-2013 in an effort to enhance and improve services provided to families through the KS-SHCN program. New priorities have been selected by families, providers, community partners, and other key stakeholders. These five priorities are: cross-system care coordination, behavioral health integration, addressing family caregiver health, direct health services and supports, and training and education. The new priorities align closely in many ways with the 2010-2015 objectives, however, have provided a new direction for the program. The KS-SHCN program was accepted into Cohort 2 of the Association of Maternal and Child Health Programs (AMCHP) Workforce Development Center (WDC) to address the needs of families of CYSHCN through collaboration, systems integration, and increased capacity for telemedicine/telehealth. The target population includes Kansas CYSHCN and their families in rural communities. The primary objective of this project is to increase capacity for utilization of telemedicine in rural communities. This project will support health transformation through improved access to care and systems integration. Utilizing quality improvement and evaluation, this project strives for sustainable and systemic changes for the CYSHCN population. To better meet the unique challenges of CYSHCN and their families, this project will build partnerships and engage key stakeholders to increase capacity for integration, collaboration, and systems change. The leadership team of this project consists of the state Title V CYSHCN Director and KS-SHCN Program Manager as co-leads and includes representation from Medicaid/KanCare, a community hospital partner, and coordinator for the HRSA Regional Telehealth Resource Center.

Cross-Cutting/Life Course

The most recent Needs Assessment revealed concerns that family functioning contributes to stressors across all population domains. Lack of services is an issue as well as lack of knowledge of services and stigma associated with accessing needed programs/services. Plans to address this involve focusing on family functioning in all MCH contacts; promoting the importance of partners (including men and fathers) as active participants in health matters; educating on the importance of future planning as it relates to building strong relationships and health and family considerations (spacing of children); utilizing the KS-SHCN "Family Caregiver Assessment" to identify needs and resources for family members; providing education for families of CYSHCN as to how their role as a caregiver impacts the their own health and ability to care for their loved one; utilizing peer and social networks for women including to promote and support access to preventive health care; developing a progressive family leadership program to empower families and build strong MCH advocates; providing family and sibling peer supports for those interested in being connected to other families with similar experiences (Foster Care, SHCN, other); and using an evidence-based model, provide parenting resources and mentors for adolescent caregivers. The Infant Mortality CoIIN activities will also address cross-cutting issues including smoking during pregnancy and smoking in the household.

NOTE TO REVIEWERS

It is important to note the following pages contain priorities, objectives, and strategies that were developed in DRAFT form as a result of stakeholder input and review of data and input as of June 2015. The information contained in this document by MCH population domain may not match the current priorities, objectives, and strategies contained in the Final MCH State Action Plan as of June 2016. The State Title V MCH team, Kansas Maternal & Child Health Council, and other key partners continued to review and revise the action plan for each population domain during the 12 months from the time the initial plans were drafted.

Priorities and Goals

The state priorities that emerged as well as the selection/decision-making process, are summarized below. A crosswalk of the 2010 priorities and new priorities is also provided in this section. This crosswalk identifies how the previous priorities (focused and narrow) are still being addressed under new priorities as objectives or strategies.

PRIORITY 1

Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
Women/Maternal; Cross-Cutting

Goal. Enhance the health of Kansas Women across the lifespan

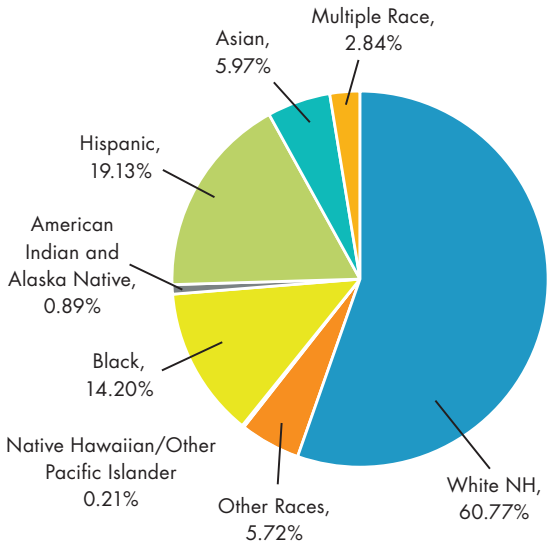
Objective 1.1 All women age 15-44 who access Title V services will receive prenatal risk assessments and well-woman visits at least once annually in order to reduce birth complications and risks, while improving women's health

Objective 1.2 Women will follow through with recommended referral services 100% of the time by attending all recommended screenings and doctor appointments

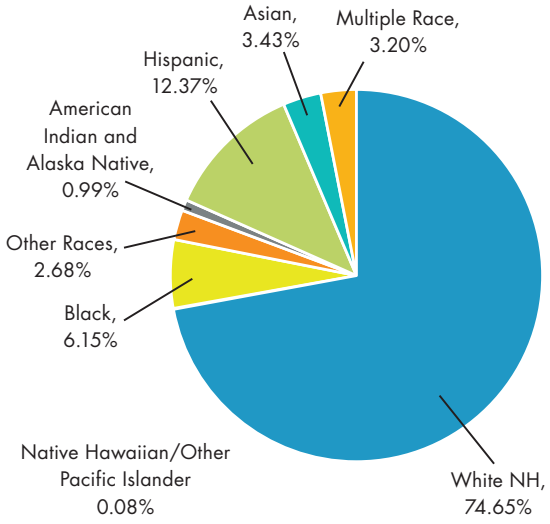
Objective 1.3 There will be an increase in access to services through supplemental resources provided throughout the community to promote education, screening, referral, and treatment for women and families

Priority 1 reflects KDHE's commitment to the MCH guiding principles and current work by addressing the process as the best way to reach positive outcomes. Throughout the process, women's health consistently was voiced as a priority and it became apparent that the recurring themes in this domain reflected the overall needs of the state as well as each region and community. For example, access to care is a need that was expressed consistently as overarching not only for the specific community but providers, programs and families throughout the state yet was so broad that many other priorities began to emerge as objectives that fit within the need. KDHE already has successful programs, resources and services yet is now in a better position to provide more and engage community partners, build on existing programs, and address the needs of the state's maternal population. The following needs are addressed by this priority: expanded community collaborative model (Becoming a Mom program), expanded home visiting, uniform screening, coordinated care, reduced smoking in the home, increased breastfeeding, increased access to care, increased well woman visits, increased coverage, completed referrals (follow-up), and access to transportation.

Women (ages 15-44) by race and ethnicity U.S., 2013

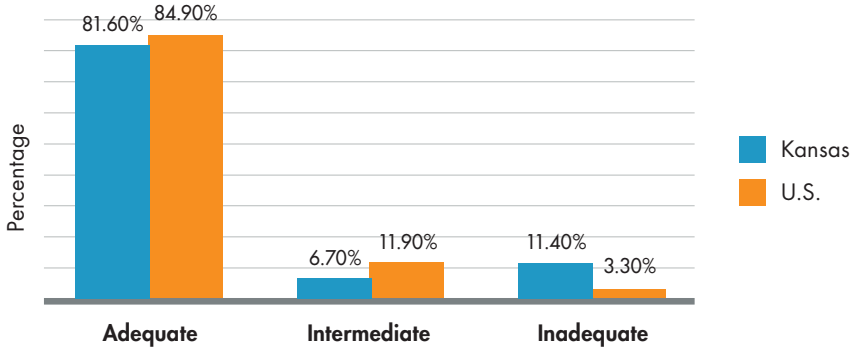


Women (ages 15-44) by race and ethnicity Kansas, 2013

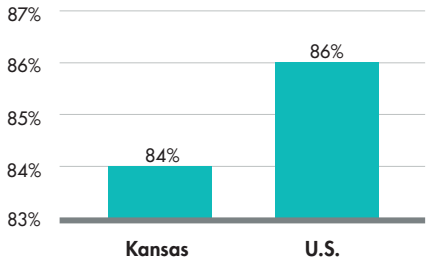


Prenatal care utilization 2013

Percent of women who received adequate prenatal care in Kansas and U.S. "Adequate" refers to prenatal care beginning at the 4th month and 80-109% of recommended visits received.



Children (ages 0-3) whose parents did not receive a new parent home visit



PRIORITY 2

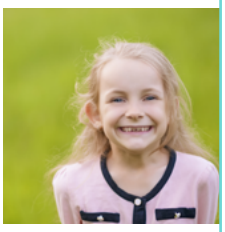
Services and supports promote healthy family functioning. **(Cross-Cutting)**

Goal. Enhance and promote the health of women and infants in Kansas before and after birth

Objective 2.1 Healthy relationships and life skills are evident with women and families through an improvement rate of at least 30% on annual Becoming a Mom program evaluations/indicators

Objective 2.2 Provide and increase in community resource fairs, trainings, and community events that promote and support informed, engaged, and empowered families evident through an increase in referral and service delivery reported in annual program data

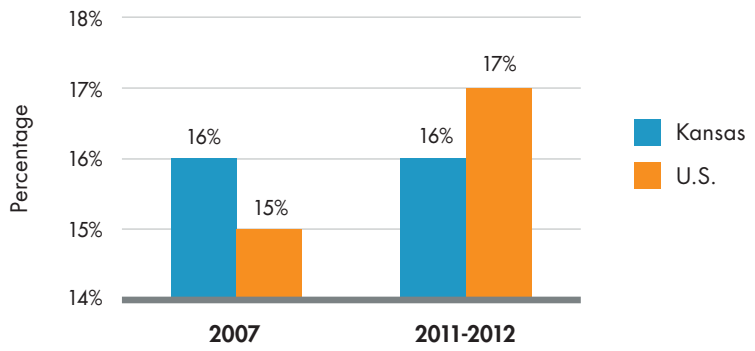
Objective 2.3 Increase client access to services through coordination of home visiting programs and expanding services through informing and referring families to services in order to ensure proper linkage



From all sources of input throughout the needs assessment, promoting and providing services for optimal mental and behavioral health was a critical issue to a healthy family and overall community well-being. During data collection, follow up questions to determine: 1) the nature of mental and behavioral health needs; and 2) the role of MCH in mental and behavioral health helped to inform a broader priority that addressed mental and behavioral health as a component of family functioning.

Parents and providers indicated that family functioning was contributing to stressors across all population domains. Lack of services were an issue, but the bigger issue was lack of knowledge of services and stigma. Teachers expressed feeling overwhelmed with young children's behavioral issues which then connected to a stressful home environment because of potential factors of overworked parents, poor nutrition due to lack of time and money, domestic violence, and unhealthy sleep habits. These factors were pointed out as interconnected and expressed in the child's behavior. This systemic issue suggests the need for resources to manage adult relationships in a healthy way to address the needs of women, and to interrupt the frequency of stressors to promote the child's health all the way from prenatal care into infancy and beyond. Parent education through home visiting, opportunities for community engagement, and life skills classes such as cooking, budgeting and job trainings could be addressed.

Children who have one or more emotional, behavioral, or developmental conditions



Note: Children ages 2 to 17 with a parent who reports that a doctor has told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems.

Data Source: Child Trends analysis of data from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.

Participants shared:

"If something could be written in the state plan around the research of ACEs and trauma informed care and how these experiences are a health issue, behavioral and mental health will be in the priorities somehow. Social emotional health needs to be addressed."

"We need to address stress."

"[We need to] teach teens and families how to manage life skills and empower them."

PRIORITY 3

Developmentally appropriate care and services are provided across the lifespan. **(Children)**

Goal. Enhance the health of all children in Kansas across the lifespan

Objective 3.1 As a result of infants, children and adolescents being in environments where there are safeguards against preventable injury and harm, the infant mortality rate is reduced to a 3 year average of lower than 6.0

Objective 3.2 90% of children receive immunizations according to the recommended schedule

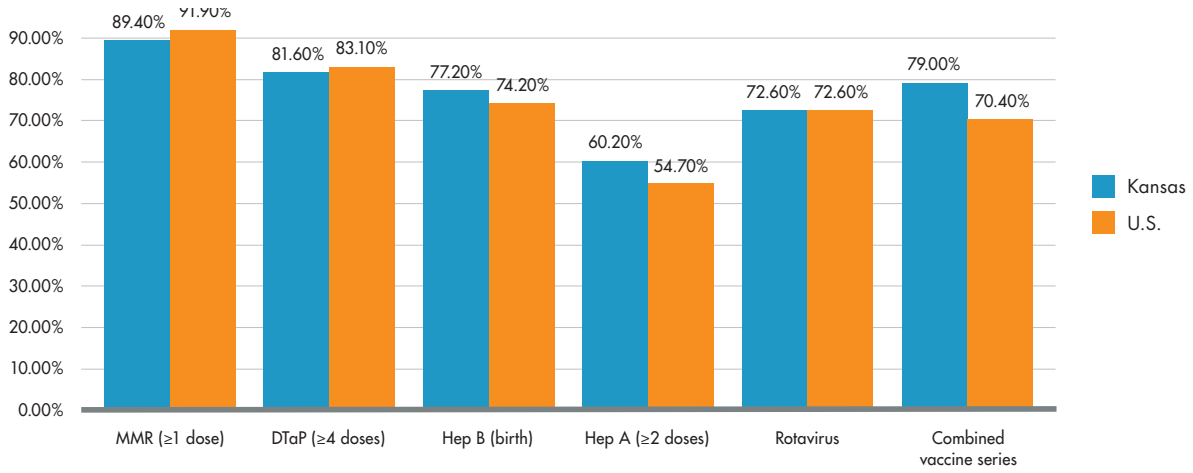
Objective 3.3 Multi-sector (individual, health care and social service providers, community-based organization) approaches are in place to reduce annual SIDS and SUID rates

Objective 3.4 To achieve overall good health and desirable outcomes over the life course, preventative oral health services are integrated into existing programs and services for the MCH population starting in the prenatal and infancy periods

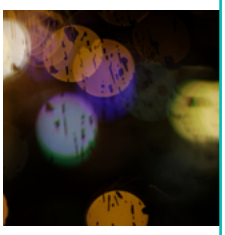
Objective 3.5 All children receive an age appropriate developmental screening annually with a valid and reliable tool

The priority of healthy development for children was a strong theme that addressed many needs in every community that could really stand on their own as priorities. These needs were connected to a common goal of the health of children on many levels and span into the adolescent years: injury prevention efforts, safety concerns in the home, and selection of safe childcare. What is unique is that these needs provide KDHE with the opportunity to focus on cross-cutting goals in programs and practices. By strengthening existing successes of programs like Safe Kids Kansas as well as increase the number of MCH grantees that serve as a lead agency for local safe kids coalitions, KDHE can continue to strengthen the guiding principle of collaboration and creating community change. Additional needs that were absorbed into the priority of developmentally appropriate care focused on essential health, safety and education opportunities by providing prevention practices for parents and providers: safe sleep initiatives, access to childhood immunizations, oral health education and developmental screenings. Taken together, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course. Participants and staff in the meetings provided useful and innovative ideas that KDHE will look forward to implementing and continue to improve upon while expanding current programs. Many of the suggestions and ideas are already in the scope of KDHE's work and will further promote collaboration at state and community levels.

Estimated vaccination coverage among children aged 19–35 months, 2013



Data Source: National Immunization Survey, United States, 2013



PRIORITY 4

Families are empowered to make educated choices about nutrition & physical activity. **(Perinatal/Infant)**

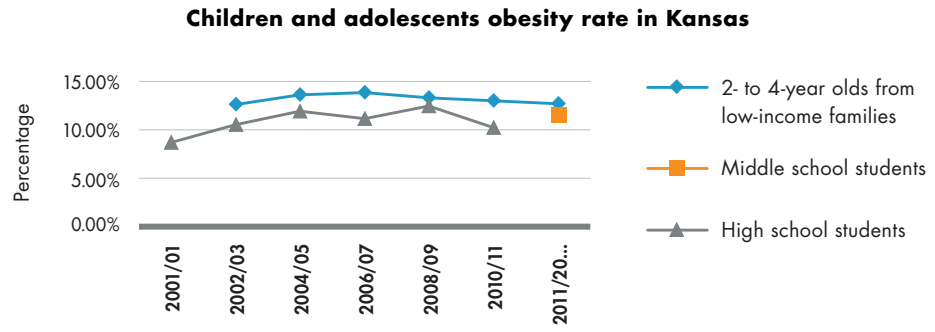
Goal. Enhance the health of all Kansas children and youth with special health care needs across the lifespan

Objective 4.1 Children and adolescents ages 0-17 years old and older have access to healthy foods and increased knowledge of opportunities for physical activity in order to adhere to and achieve optimum lifelong health

Objective 4.2 Parents have access to information and resources on infant nutrition and feeding education in a multifaceted way using existing programs starting in the prenatal period, initiated during the first trimester

Objective 4.3 Increased opportunities for regular physical activity for families are provided through structured environments and improved accessibility to facilities that support physical activity

Discussions during the needs assessment regularly focused on the need to address obesity across population domains. While there was targeted discussion about children, specifically related to school lunches, there was a shift to a broader view of the systemic nature of nutrition and physical activity. Specifically, a change in terminology and definition began to emerge and the priority was reframed. Providing access to healthy food choices was an issue of both availability and knowledge. The need to educate parents and children on what a healthy food choice actually is was clearly reflected in the data. At the same time, the real challenge caused by food deserts in Kansas was discussed. Some families rely on a small grocery or convenience store due to transportation barriers and/or locale, thus connecting other daily issues (poverty, work schedules, children home alone) to unhealthy food choices. Participants and staff suggested the importance of aligning with existing programs including home visiting programs, in schools, and through community campaigns, to promote nutrition education and physical activity.



Data for 2-4 year old obesity rate is from low income families. Other data did not distinguish.

Participants and staff suggested the importance of aligning with existing programs – specifically home visiting programs, in schools, and through community campaigns – to nutrition education and promote physical activity.

Suggested activities across the life course related to nutrition and physical activity		
Home visiting	**Schools**	**Community Campaigns**
• Promote breastfeeding initiation and duration • Engage and support WIC • Align programs to deliver consistent message on breastfeeding and child nutrition	• Offer healthy food choices throughout the day to reduce quick lunch • Promotion of longer or more frequent outdoor time • Provide resources and educational materials to child cares and schools focused on healthy eating and physical activity	• Support local health departments and or community centers to promote physical activity and utilization of walking and biking trails • Provide walking and biking trails • Promote YMCA and other community recreation centers

PRIORITY 5

Communities, providers, and systems of care support physical, social and emotional health. **(Adolescents)**

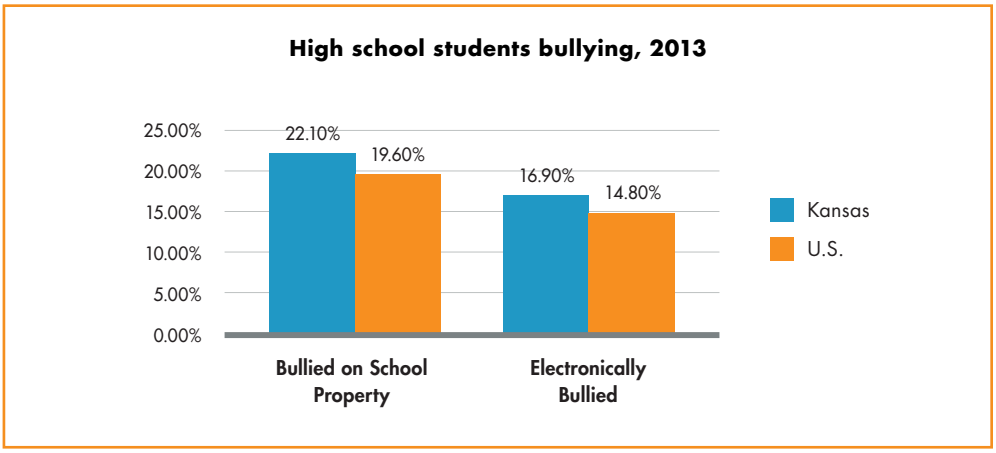
Goal. Enhance the health of all adolescents in Kansas across the lifespan

Objective 5.1 All children and adolescents receive comprehensive preventive health care that addresses social and emotional aspects of health at annual child and adolescent well visits, promoted through a developed cross system partnership (schools, community partners, Health Department)

Objective 5.2 All youth are provided with the support, relationships, and resources they need in order to build and improve coping skills and manage stress through measurable, positive youth development interventions and the implementation of evidence-based practices to prevent suicide

Objective 5.3 Adults, children, and adolescents are aware of and have access to prevention and intervention programs that educate and empower them to practice protective factors to reduce the impact of bullying through MCH community and school trainings provided annually

Life skills development such as budgeting, cooking, job training and healthy recreation are also important objectives under this priority. The need to promote positive coping mechanisms can be accomplished with yearly mental health screenings (Suicide prevention, addressing bullying/bullies). Well visits for adolescents can promote overall health (immunizations, healthy eating, and oral health), and social emotional health can enhanced by trained adults and mentors to help adolescents navigate life skills and set goals (high school completion, employment, youth development). Given that adolescents have a natural desire to become active agents in society and community, this priority can be promoted through community partnerships and engagement, and can reinforce protective factors and promote prevention of risky behaviors. KDHE can support schools and faith based organizations to provide the whole family with education and public awareness campaigns, and implementation of policy and procedures can be explored to promote suicide prevention and address bullying.


High school students bullying, 2013
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
22.10%
19.60%
16.90%
14.80%
Bullied on School Property
Electronically Bullied
Kansas
U.S.

PRIORITY 6

Professionals have the knowledge and skills to address the needs of maternal and child health populations. **(Cross-cutting)**

Goal. Enhance the health of all Kansas children and youth with special health care needs across the lifespan

Objective 6.1 MCH provides on-going support toward the development of a trained and qualified workforce that serves Kansas children and families by providing professionals with up-to-date best practices and evidence-based services using a multi-faceted approach (referral network, mid-level training for home visitors, partnership support)

Objective 6.2 Annual training and education is delivered to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the SHCN population into adulthood

Objective 6.3 MCH provides and ensures availability to on-going, up to date education and training opportunities that promote consistent messages and curriculums for childcare providers in Kansas aimed at the social-emotional development of children

Seeking the appropriate care for the maternal and child health care population is critical to the continued support required to ensure that this population's needs are being met. For quality care to be delivered it's important that the professionals interfacing with this population are properly trained to provide this care. This is an area which impacts not only maternal and child health, but also children, perinatal/infant, adolescents and the children with special needs population. Ensuring professionals, serving MCH populations, have adequate training can impact individuals at birth and continues throughout adulthood. Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains.

When asked what could improve services within the community, responses included *"having trained professionals who take the time and listen to our needs."*

Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and the health impact that it may have on this population. In particular children and youth with special needs was identified as a population that needed improved support from professionals.

Strategies suggested included incorporating evidence-based trainings and mid-level trainings for home based practitioners. Additionally, it was reported that not only an increase in training occur amongst professionals, but coordination of care also increase to enhance delivery of services. Through agencies collaborating with one another, resources are then shared within an

interconnected environment that can help the MCH population be more aware of services and provide the appropriate linkage. This area has been recognized as one of importance. Objectives include: developing a trained, qualified workforce; providing training to providers to promote diversity, inclusion, and supports; and incorporating the support of early childhood service providers.

PRIORITY 7

Services are comprehensive and coordinated across systems and providers. **(CYSHCN)**

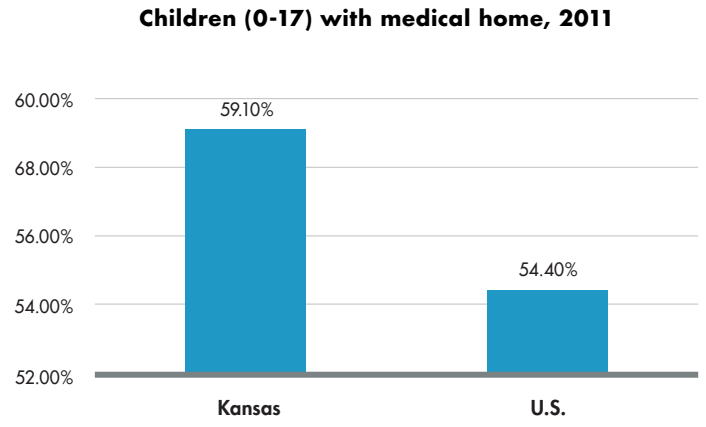
Goal. Professionals have the knowledge and skills to address the needs of maternal and child health populations

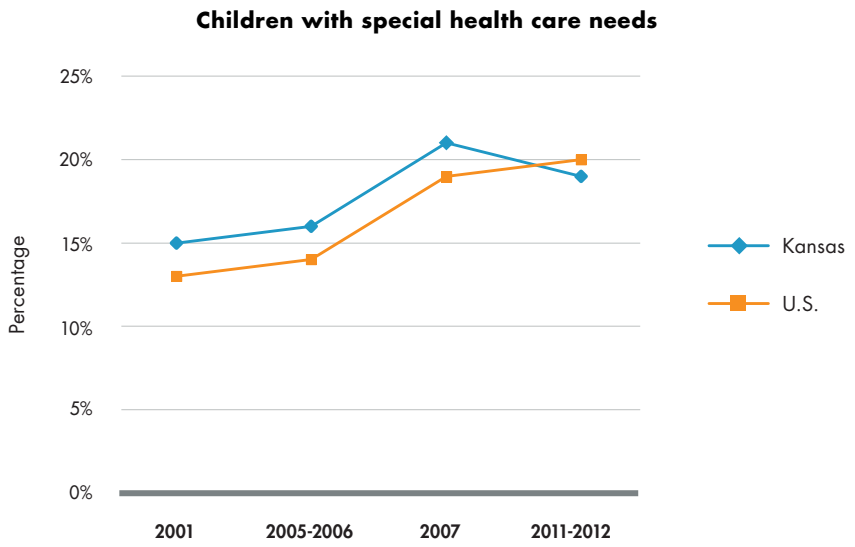
Objective 7.1 By supporting collaborative efforts of partners (MCO's, primary care providers) toward the timely implementation of a family-centered medical home to help with coordination of care, communication and outreach improves among service providers, individuals, and families

Objective 7.2 Systems that support age & are developmentally appropriate, universal behavioral health that increase collaboration efforts through partnerships with existing programs (KDADS, KAIMH) and between primary care and behavioral health providers are continually integrated and reviewed

Objective 7.3 A patient-centered action plan that assists and empowers individuals and families is developed, monitored, and evaluated to help navigate systems for optimal health out¬comes throughout the life course

This priority is specific to the needs of children and youth with special health care needs, though not exclusive, as it addresses all children in the way that KDHE strives; comprehensively and inclusively. One of the main goals of the Special Health Care Needs program is care coordination, so that children and their families can navigate systems to gain optimal health in a consistent and comprehensive way. In the regional meetings and especially the Communities for Kids meetings, it became apparent that family support was emerging as a high need and that those supports include access to care (transportation, especially in rural communities, and providers who will treat CYSHCN, especially oral health). As the assessment progressed, family support also expanded into the need for social-emotional support and respite for caregivers. Providers were also a high need, given many are not specialists and many do not practice near rural communities. Family-centered medical homes need support and partnerships can be explored based on the needs presented. This can include existing structures that KDHE can support as well as engaging MCO's and primary care providers, implementing tele-medicine, and professional development training. This priority exemplifies the collaboration and partnership building principles that KDHE promotes and is willing to sustain so that all children with health care needs are children first.





Definitions: The share of children under age 18 who are at increased risk of a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.

Data Source: National Survey of Children with Special Health Care Needs, Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

PRIORITY 8

Information is available to support informed health decisions and choices. **(Cross-cutting)**

Goal. Enhance the health all Kansans across the lifespan

Objective 8.1 MCH works with existing programs (pediatricians, youth programs, local schools) to increase the number of partnerships that will help parents and youth ages 17 and under understand the importance of and make informed decisions about healthy choices and regular self-care

Objective 8.2 Through collaboration with local school districts to implement and provide youth-focused initiatives & curriculums that include progress measures, children and youth ages 17 and under, and families are better equipped to advocate for all needed services, supports, and family/professional partnerships to achieve 100% of successful and healthy transitions

Objective 8.3 In partnership with local health departments, MCH increases the number of individuals/families with medical insurance by 100% by assisting with locating and enrolling in the appropriate health care coverage, and through outreach by hosting current regional training around service planning, delivery, and navigation of resources to ensure utilization of acquired health care coverage-centered action plan that assists and empowers individuals and families is developed, monitored, and evaluated to help navigate systems for optimal health outcomes throughout the life course

Priority 8 was identified to address the overall needs related to health literacy in the state. Empowering individuals to coordinate their own health care was approached as a cross-cutting priority so that even the very young can understand and practice self-care as well as have a continued awareness into adulthood. Participants stated that understanding the importance of personal health, seeking services, and navigating the health care system promote lifelong habits for well-being and can lead to the reduction or prevention of many of the needs heard throughout the process. Issues such as immunizations, well-woman care, provider availability, qualifying for care, and even showing up for appointments were raised as examples of the need for individual's to understand the systems, having support to help navigate systems, and practicing routine care. In addition to the qualitative and survey data, population level data, including NPMs and other identified key indicators, were examined to guide the prioritization process.

Between 2009 and 2013, Kansas women aged 18-44 who were not covered by health care rose from 16.9% to 22.10%

Percent of Women (Ages 18-44) Without Health Care Coverage					
	2009	**2010**	**2011**	**2012**	**2013**
Kansas	15.90%	17.90%	20.10%	21.30%	22.10%
U.S.	16.90%	18.20%	18.20%	18.30%	18.50%

Health Professional Shortage Areas, Kansas			
	Total Mental Health Care HPSA Designations	**Percent of Need Met**	**Practitioners Needed to Remove HPSA Designation**
Mental Health	63	56.49%	17
Primary Care	155	70.45%	66
Dental Care	134	40.33%	89

Data Sources: Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of April 28, 2014.

National Performance Measurement Framework

Overview of the Framework

The performance measure framework is based on a three-tiered performance measure system: National Outcome Measures (NOMs), National Performance Measures (NPMs), and Evidence-based or -informed Strategy Measures (ESMs).

Measures were considered as NOMs, which are reflective of population health status, if they met one or more of the following criteria: it was mandated by the Title V legislation that the data be collected; it was considered a sentinel health marker for women, infants, or children; it was a major focus of either the Title V legislation or Title V activities; it was considered an important health condition to monitor because the prevalence was increasing, but the reasons for the increase were unclear; or there was a recognized need to move the MCH field forward in this area, even if there was not yet a consensus on how to measure the construct. The latter were considered developmental outcome measures.

Measures were considered as NPMs if they met one or more of the following criteria: there was a large investment of resources as determined by the State narratives; it was considered modifiable through Title V activities; a state could delineate measurable activities to address the performance measures; significant disparities existed among population groups; research had indicated that the condition or activity had large societal costs; or research had indicated that the promotion of certain behaviors, practices or policies had improved outcomes. There also had to be evidence that an NPM was associated with at least one of the NOMs. Fifteen NPMs were identified for the Title V MCH Services Block Grant. Data for NOMs and NPMs will be populated by MCHB from national data sources, as available. NPMs will be stratified by different risk factors, when available.

The ESMs are the key to understanding how a State Title V program tracks programmatic investments designed to impact the NPMs. In the framework, States create ESMs designed to impact the NPMs. These measures would assess the impact of State Title V strategies and activities contained in the State Action Plan. The development of ESMs is guided through an examination of the evidenced-based or evidence-informed practices on what strategies and activities are both practical and measurable. The main criteria for ESMs would be that the activities had to measurable, and there had to be evidence that the activity was related to the NPM chosen. States can determine the number of ESMs that they will use for addressing the selected NPMs but there is a required minimum of one ESM for each NPM. States may also retire an ESM during the five-year reporting cycle, if it has successfully achieved its objective toward the NPM or new ESMs are introduced measuring new, promising practices.

Fifteen NPMs were identified for the Title V MCH Services Block Grant, covering six population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children with Special Health Care Needs, and Cross-cutting or Life Course. In the table below are the 15 national priority areas addressed by the NPMs and the corresponding MCH Population domain(s).

NPMs and MCH Population Domains NPM #	National Performance Priority Areas	MCH Population Domains
1	Well-woman visit	Women/Maternal Health
2	Low-risk cesarean delivery	Women/Maternal Health
3	Perinatal regionalization	Perinatal/Infant Health
4	Breastfeeding	Perinatal/Infant Health
5	Safe sleep	Perinatal/Infant Health
6	Developmental screening	Child Health
7	Injury	Child Health and/or Adolescent Health
8	Physical activity	Child Health and/or Adolescent Health
9	Bullying	Adolescent Health
10	Adolescent well-visit	Adolescent Health
11	Medical home	Children with Special Health Care Needs
12	Transition	Children with Special Health Care Needs
13	Oral health	Cross-cutting/Life course
14	Smoking	Cross-cutting/Life course
15	Adequate insurance coverage	Cross-cutting/Life course

In implementing this framework, states will choose eight (8) out of 15 NPMS for its Title V program to address during the five-year needs assessment cycle. States shall ensure that at least one NPM from each of the six MCH Population domains is selected and that the selected NPMs are based on the findings of the Five-Year Needs Assessment process. There are no mandatory NPMs. For the NPMs on injury and physical activity, they can be selected for either the children's or the adolescent domains or both because the age ranges span both domains, but the interventions to either reduce injuries or increase physical activity are different, depending on the children's ages.

In addition to the qualitative and survey data, population level data, including NPMs and other identified key indicators, were examined to guide the prioritization process.

With the MCH transformation for 2016-2020 an emphasis on performance and accountability includes a transformed national performance measurement system intended to show the contributions for Title V programs in impacting health outcomes while still maintaining flexibility for states. The national performance measurement system is a three-tiered framework, which includes Nationals Outcome Measures (NOMs), National Performance Measures (NPMs) and State-initiated Evidence-based or-informed Strategy Measures (ESMs). The focus is on the establishment of a set of population-based measures (NPMs) which utilize state-level data derived from national data sources, so that the state can track prevalence rates and work toward impact and outcomes. KDHE's approach and MCH 3.0 have created a different framework for Title V work. While the goal and vision have not changed, the transformation has led to a set of priorities that are more systemic and collaborative than previous priorities. Many of the activities and strategies, as presented later in the Five Year

Action Plan, will be unchanged, but KDHE's approach to implementing those activities and strategies will look different. The guiding principles reflect this important change. At the core, MCH continues to focus on reducing disparities. Yet, the MCH team and the Needs Assessment process have indicated that reducing population level disparities will require more: genuine and effective collaboration; focus on relationship building; and, targeted efforts to address community norms. The 2016-2020 priorities reflect these guiding principles, and will allow KDHE to continue to move the needle on maternal and child health. The table on the following page provides an overview of the alignment between 2011-2015 priorities and 2016-2020 priorities.

Alignment of 2011-2015 Priorities and 2016-2020 Priorities

2011-2015 Priorities	2016-2020 Priorities
Women & Infants	
All women receive early and comprehensive care before, during and after pregnancy	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy. (Women/Maternal; Cross-Cutting)
Improve mental health and behavioral health of pregnant women and new mothers	
Reduce preterm births (including low birth weight and infant mortality)	
Increase initiation, duration and exclusivity of breastfeeding	Families are empowered to make educated choices about nutrition & physical activity. (Perinatal/Infant)
Children & Adolescents	
All children and youth receive health care through medical homes	
	Developmentally appropriate care and services are provided across the lifespan. (Children)
Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs	Communities and (providers / systems of care) support physical, social and emotional health. (Adolescents)
All children and youth achieve and maintain healthy weight	
CYSHCN	
All CYSHCN receive coordinated, comprehensive care within a medical home	Services are comprehensive and coordinated across systems and providers. (CYSHCN)
Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence	
Financing for CYSHCN services minimizes financial hardship for their families	
Life course/cross cutting	
	Services and supports promote healthy family functioning. (Cross-cutting)
	Professionals have the knowledge and skills to address the needs of maternal and child health populations. (Cross-cutting)
	Information is available to support informed health decisions and choices. (Cross-cutting)

Linkage of State Selected Priorities with National Performance and Outcome Measures

The Kansas Title V needs assessment process focused primarily on identifying and addressing the issues at the state and local levels; priorities were selected with Title V mission, purpose, and legislation in mind. The top state priority issues that most closely aligned with the National priorities and measures were selected. While most of the priorities align closely with the NPMs, there are several important needs that emerged for which there are not corresponding NPMs. In cases where priorities do not directly link with NPMs, the Bureau and Title V Program will develop SOMs and closely monitor ESMs (once developed) to ensure that progress is being made.

Priority One: Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy

Corresponding NPMs:

1. Well-woman visit (Percent of women with a past year preventive medical visit)

14(A). Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy)

NPM 1 was selected because of the discussion by stakeholders regarding the need for women's gynecological health to be improved. Service coordination among partners should help to ensure that the proportion of women receiving a well-woman visit is increased, as should the provision of consumer education regarding what services are available to them. State ESMs for this priority have a focus on promoting and collaborating with Title X to improve access to well-woman visits; they also include an overall focus on improved screening and care coordination related to physical and mental health issues.

NPM 14(A) was selected in part because more than 13% of Kansas women smoked during pregnancy as recently as 2011-2013 (Kansas Health Matters). Smoking in Kansas is higher than the national average, with 25.3% Kansas smokers, versus 24.1% of smokers throughout the nation (National Survey of Children's Health, 2011-2012).

Smoking during pregnancy affects the mother, unborn child, and all members of the household. Increasing the utilization of the Kansas Quitline and other tobacco cessation programs by pregnant women should improve the health of entire households in Kansas.

Priority Two: Services and supports promote healthy family functioning.

Corresponding NPM:

4(B). Smoking during Pregnancy and Household Smoking (B. Percent of children who live in households where someone smokes)

NPM 14(B) was selected for similar reasons as NPM 14(A). Providing opportunities for families to strengthen their relationships and be educated regarding healthy behaviors will empower households

to make positive changes that should include a decrease in the proportion of adults who smoke. Therefore, a corresponding proportion of children living with smokers will also decrease. Reducing risk factors associated with smoking through education and related interventions is a focus of the strategies for this priority.

Priority Three: Developmentally appropriate care and services are provided across the lifespan (Children)

Corresponding NPMs:

6. Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

7. Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)

NPM 6 was selected because of the many discussions with stakeholders about current gaps in developmentally appropriate care. Strategies focus on care coordination to ensure developmental screenings increase and are accessible through a number of approaches, including via tele-health.

NPM 7 was selected in part because of the high rates of unintentional injury in the state. From 2007-2008, there were 50,525 unintentional injury emergency department visits (Safe Kids Kansas, 2012). In addition, meeting participants discussed the need for prevention activities such as those that reduce motor vehicle crash injuries and deaths through addressing distracted/impaired driving, use of seatbelts, etc. Strategies identified address the most frequent causes of hospitalization that children in Kansas experience.

Priority Four: Families are empowered to make educated choices about nutrition & physical activity. (Perinatal/Infant)

Corresponding NPM:

4. Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)

NPM 4 was selected because of widespread support by meeting participants for breastfeeding resources. ESMs for this priority will strengthen existing infant feeding education for mothers and communities. Efforts related to this priority will also be expanded to improve access to nutrition and increase physical activity.

Priority Five: Communities and (providers / systems of care) support physical, social and emotional health.

Corresponding NPMs:

9. Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

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

NPM 9 was selected because of state statistics that indicate that nearly 8% of school age children in Kansas have been bullied, and more than 7% of Kansas school age children were identified as bullies (U.S. Census, 2000).

Bullying will be addressed by communities and systems of care supporting children's social and emotional health.

ESMs include integrating behavioral health screenings and services into primary care and school settings, as well as enhancing substance abuse services for adolescents.

NPM 10 was selected because of the many discussions regarding barriers to service access that current exist for this population. To increase community/provider support to improve access and use of adolescent well-visit services, ECMs include establishing protocols for follow up on youth not completing annual visits.

Priority Six: Professionals have the knowledge and skills to address the needs of maternal and child health populations.

There is no corresponding NPM for this priority. A State Performance Measure will be developed. This issue was identified as the continued success of maternal and child health services in Kansas. Participants throughout Kansas voiced a need for trained, qualified professionals who could deliver services across domains. Strategies are focused on developing innovative methods for training the provider workforce.

Priority Seven: Services are comprehensive and coordinated across systems and providers.

Corresponding NPM:

11. Medical home (Percent of children with and without special health care needs having a medical home)

NPM 11 was selected because of the current lack of medical homes for children in Kansas. For those with special needs, only 43% reported having a medical home. And for those without special needs, only 59.1% reported having a medical home (BRFSS, 2013). Strategies target providers from a variety of service designations to engage them in supporting efforts to increase the number of children in Kansas with a medical home.

Priority Eight: Information is available to support informed health decisions and choices.

There is no corresponding NPM for this priority. A State Performance Measure will be developed. Health literacy was an issue raised by many stakeholders. In order for the MCH population to successfully navigate the medical system, education regarding benefits and reduced cost services must be provided to Kansas families. Strategies target traditional and nontraditional service providers.

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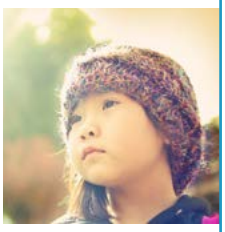
APPENDIX A

National Performance Measure Table



NOM #	National Outcome Measures	Population Health Domain	2008	2009	2010	2011	2012	2013	Trend	HP2020
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	Perinatal/Infant Health								
	All		73.1%	74.0%	75.0%	77.3%	78.8%	79.4%	↑	**77.9%**
	Medicaid*		59.9%	61.6%	61.4%	63.7%	68.0%	68.7%	↑	
	Non-Medicaid*		78.2%	79.3%	82.0%	84.5%	84.5%	84.7%	↑	
2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations	Women/Maternal Health	95.2	103.6	103.3	97.4	111.6	-	↑	-
3	Maternal mortality rate per 100,000 live births (5 year rolling average)	Women/Maternal Health	-	13.6	14.0	14.1	14.7	16.5	↑	**11.4**
4.1	Percent of low birth weight deliveries (<2,500 grams)	Perinatal/Infant Health								
	All		7.2%	7.3%	7.1%	7.2%	7.2%	7.0%	●	**7.8%**
	Medicaid*		8.4%	8.5%	8.8%	8.9%	8.9%	8.6%	↑	
	Non-Medicaid*		6.7%	6.7%	6.3%	6.4%	6.3%	6.3%	↓	
4.2	Percent of very low birth weight deliveries (<1,500 grams)	Perinatal/Infant Health	1.4%	1.4%	1.2%	1.3%	1.4%	1.3%	↓	**1.4%**
4.3	Percent of moderately low birth weight deliveries (1,500-2,499 grams)	Perinatal/Infant Health	5.8%	5.9%	5.9%	5.9%	5.8%	5.8%	●	-
5.1	Percent of preterm births (<37 weeks gestation)	Perinatal/Infant Health	9.3%	9.2%	8.8%	9.1%	9.0%	8.9%	↓	**11.4%**
5.2	Percent of early preterm births (<34 weeks gestation)	Perinatal/Infant Health	2.6%	2.6%	2.5%	2.6%	2.7%	2.7%	↑	**1.8%**
5.3	Percent of late preterm births (34-36 weeks gestation)	Perinatal/Infant Health	6.7%	6.6%	6.3%	6.5%	6.3%	6.2%	↓	**8.1%**
6	Percent of early term births (37,38 weeks gestation)	Perinatal/Infant Health	27.7%	26.8%	25.7%	25.4%	24.6%	23.0%	↓	-
7	Percent of non-medically indicated early elective deliveries	Perinatal/Infant Health	42.8%	40.2%	37.9%	35.8%	33.0%	29.3%	↓	-
8	Perinatal mortality rate per 1,000 live births plus fetal deaths	Perinatal/Infant Health	6.6	6.6	6.2	5.9	6.9	6.5	●	**5.9**

NOM #	National Outcome Measures	Population Health Domain	2008	2009	2010	2011	2012	2013	Trend	HP2020
9.1	Infant mortality rate per 1,000 live births	Perinatal/Infant Health								
	All		7.2	7.0	6.3	6.2	6.3	6.4	↓	**6.0**
	Medicaid*		9.7	9.4	7.3	7.3	9.7	7.2	↓	
	Non-Medicaid*		5.7	5.9	5.5	5.5	4.4	5.8	↓	
9.2	Neonatal mortality rate per 1,000 live births	Perinatal/Infant Health	4.6	4.3	4.2	4.0	4.3	4.3	↓	**4.1**
9.3	Postneonatal mortality rate per 1,000 live births	Perinatal/Infant Health	2.6	2.8	2.3	2.3	2.0	2.1	↓	**2.0**
9.4	Preterm-related mortality rate per 100,000 live births	Perinatal/Infant Health	220.0	229.5	202.8	206.9	208.4	211.3	↓	-
9.5	Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75)	Perinatal/Infant Health	150.7	118.4	103.9	106.0	99.2	131.4	↓	**84.0**
10	Percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy (PRAMS)	Perinatal/Infant Health	-	-	-	-	-	-	-	-
11	The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations	Perinatal/Infant Health	1. 8	2.3	3.4	4.2	4.7	-	↑	-
12	Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)	Perinatal/Infant Health	-	-	-	-	-	-	-	**100.0%**
13	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	Child Health	-	-	-	-	-	-	-	-
14	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	Child Health	-	-	-	-	18.1%	-	●	-
15	Child mortality rate ages 1 through 9 per 100,000	Child Health	22.7	21.7	26.7	22.2	19.4	23.8	↑	-
16.1	Rate of death in adolescents age 10-19 per 100,000	Adolescent Health	41.0	40.4	38.0	32.4	32.3	31.9	↓	-
16.2	Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000 (3 year rolling average)	Adolescent Health	23.3	23.4	22.7	20.0	18.1	14.0	↓	**12.4**
16.3	Adolescent suicide rate ages 15 through 19 per 100,000 (3 year rolling average)	Adolescent Health	11.1	9.1	10.1	10.5	14.0	13.2	↑	**10.2**
17.1	Percent of children with special health care needs (CSHCN)	CSHCN	20.4% (2003)	-	20.7% (2007)	-	19.4%	-	↓	-

NOM #	National Outcome Measures	Population Health Domain	2008	2009	2010	2011	2012	2013	Trend	HP2020
17.2	Percent of children with special health care needs receiving care in a well-functioning system	CSHCN	-	-	22.8%	-	-	-	●	-
17.3	Percent of children diagnosed with an autism spectrum disorder	Child Health and/or CSHCN	-	-	1.0% (2007)	-	1.0%	-	●	-
17.4	Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)	Child Health and/or CSHCN	-	-	7.2% (2007)	-	8.8%	-	▲	-
18	Percent of children with a mental/behavioral condition who receive treatment or counseling	Child and/or Adolescent Health	62.9% (2003)	-	72.2% (2007)	-	72.6%	-	▲	**75.0%**
19	Percent of children in excellent or very good health	Child Health	86.3% (2003)	-	85.3% (2007)	-	86.8%	-	●	-
20	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Child and/or Adolescent Health								
	Children 2 through 4 years		24.2%	24.3%	23.5%	23.2%	23.3%	23.7%	▼	**14.5%**
	Children 10 through 17 years		30.0% (2003)	-	31.1% (2007)	-	30.2%	-	●	**14.5%**
	Adolescents grades 9 through 12		-	25.1%	-	24.1%	-	28.9%	▲	**14.5%**
21	Percent of children without health insurance	Child Health	-	8.2%	7.7%	6.1%	6.9%	6.7%	▼	**0%**
22.1	Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 series of routine vaccinations	Child Health	-	46.0%	54.9%	73.5%	65.0%	68.7%	▲	**80.0%**
22.2	Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	Child and/or Adolescent Health	-	39.0%	47.0%	47.8%	45.9%	57.5%	▲	**70.0%**
22.3	Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	Adolescent Health	30.1%	44.1%	40.2%	37.2%	42.7%	39.9%	▲	**80.0%**
22.4	Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	Adolescent Health	46.8%	63.6%	76.8%	79.1%	92.2%	84.6%	▲	**80.0%**
22.5	Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	Adolescent Health	25.6%	38.3%	50.2%	47.7%	55.9%	55.9%	▲	**80.0%**

NPM #	National Performance Measures	Population Health Domain	2008	2009	2010	2011	2012	2013	Trend	HP2020
1	*Well-Women Visit*: Percent of women with a past year preventive medical visit	Women/Maternal Health	-	-	-	66.7%	66.4%	68.2%	↑	**-**
2	*Low Risk Cesarean Deliveries*: Percent of cesarean deliveries among low-risk first births	Women/Maternal Health	25.3%	25.5%	25.3%	25.0%	24.7%	24.7%	↓	**23.9%**
3	*Perinatal Regionalization*: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Perinatal/Infant Health	78.9%	80.8%	82.3%	86.6%	87.1%	86.6%	↑	**83.7%**
4	*Breastfeeding*: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months	Perinatal/Infant Health								
	A) Percent of infants who are ever breastfed		77.5%	78.0%	77.2%	79.5%	81.7%	84.2%	↑	**81.9%**
	B) Percent of infants breastfed exclusively through 6 months		-	16.2%	14.1%	11.4%	-	-	↓	**25.5%**
5	*Safe Sleep:* Percent of infants placed to sleep on their backs (PRAMS)	Perinatal/Infant Health	-	-	-	-	-	-	-	**75.9%**
6	*Developmental Screening*: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	Child Health	-	-	24.7% (2007)	-	37.0%	-	↑	**-**
7	*Child Injury*: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19	Child Health and/or Adolescent Health								
	Children ages 0 through 9		180.5	160.6	144.7	134.2	136.5	-	↓	**-**
	Adolescents ages 10 through 19		306.3	295.1	260.5	242.2	255.0	-	↓	**-**
8	*Physical Activity*: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day	Child Health and/or Adolescent Health								
	Children ages 6 through 11		29.3% (2003)	-	31.2% (2007)	-	36.0%	-	↑	**-**
	Adolescents ages 12 through 17		22.0% (2003)	-	19.1% (2007)	-	19.9%	-	↓	**20.2%**
	Adolescents grades 9 through 12		-	27.8%	-	30.2%	-	28.3%	↑	**20.2%**

NPM #	National Performance Measures	Population Health Domain	2008	2009	2010	2011	2012	2013	Trend	HP2020
9	*Bullying*: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	Adolescent Health								
	Adolescents ages 12 through 17		-	-	15.4% (2007)	-	11.0%	-	↓	**17.9%`**
	Adolescents grades 9 through 12		-	-	-	26.4%	-	27.9%	↑	**17.9%**
10	*Adolescent Well-Visit*: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	Adolescent Health	78.2% (2003)	-	88.8% (2007)	-	83.4%	-	↑	**75.6%**
11	*Medical Home*: Percent of children with and without special health care needs having a medical home	Child Health and/or CSHCN	-	-	61.3% (2007)		59.1%		↓	**63.3%**
	CSHCN		-	-	49.3% (2007)	-	53.8%	-	↑	**54.8%**
	Non-CSHCN		-	-	64.4% (2007)	-	60.4%	-	↓	**63.3%**
12	*Transition*: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	Child Health and/or CSHCN	-	-	-	-	-	-	-	**-**
	CSHCN		50.3% (2006)	-	52.7%	-	-	-	↑	**45.3%**
	Non-CSHCN		-	-	-	-	-	-	-	**-**
13	*Oral Health*: A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	Cross-Cutting/Life Course								
	A) Percent of women who had a dental visit during pregnancy (PRAMS)		-	-	-	-	-	-	-	**49.0%**
	B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year		-	-	78.8% (2007)	-	79.4%	-	↑	**49.0%**
14	*Smoking During Pregnancy and Household Smoking*: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes	Cross-Cutting/Life Course								
	A) Percent of women who smoke during pregnancy									
	All		16.0%	15.1%	15.0%	14.5%	13.7%	12.5%	↓	**1.4%**

NPM #	National Performance Measures	Population Health Domain	2008	2009	2010	2011	2012	2013	Trend	HP2020
	Medicaid*		33.0%	31.5%	30.0%	29.5%	28.2%	26.7%	↓	
	Non-Medicaid*		10.2%	9.2%	7.6%	6.8%	6.5%	5.6%	↓	
	B) Percent of children who live in households where someone smokes		29.3% (2003)	-	26.4% (2007)		25.3%	-	↓	**47.0%**
15	*Adequate Insurance Coverage*: Percent of children ages 0 through 17 who are adequately insured	Cross-Cutting/Life Course	-	-	78.9% (2007)	-	75.8%	-	↓	**-**

Key and Definitions
An "**-**" indicates the data were not available at the time of reporting.
The **arrow** indicates the direction of the trend, if any, and the color indicates if the direction is positive (**green**) or negative (**red**); A **yellow** dot indicates no definite trend is apparent.
HP2020 - Healthy People 2020 goal
PRAMS - Pregnancy Risk Assessment Monitoring System
*****Based on the "principal source of payment for this delivery" as reported on the birth certificate.

APPENDIX B

Regional Meeting Example

Kansas Statewide Inventory of Birth Outcomes/Infant Mortality Programs

Welcome to the Kansas Statewide Inventory of Maternal and Child Health Prog...

The goal of this survey is to inventory state, regional, and local programs and services related to improving the health of Kansas families. The survey collects basic program information as well as asks you to identify where your program/service aligns with existing state and national Maternal and Child Health (MCH) priorities and performance measures.

The inventory will be used to determine existing partnerships, collaborations, infrastructure, and capacity to support healthy families and communities. The inventory responses will assist in mapping services as well as inform statewide strategic planning and resource allocation. Together we will identify gaps in services/unmet needs and improve coordination across the public health region and the state.

Please complete one survey for each program you conduct that targets women of reproductive age (15-44 years), pregnant women, and/or infants up to one year. One survey takes approximately 10-20 minutes to complete. Thank you for your time and commitment to this process and ongoing work in the best interest of Kansas children and families.

Contact Information

Please provide the following information (Questions 1-15) for each program for which you would like to provide feedback.

1. Name of program:

2. Primary manager or contact person name:

3. Local organization/provider name:

4. County where organization is located (main office):

5. City where organization is located:

6. Phone number for contact person:

7. E-mail address for contact person:

Program Description

Keep in mind that each question refers back to one specific program. If you have multiple programs targeting this population, please complete a separate survey for each.

8. Select the county(ies) served by your program:

- ☐ Allen
- ☐ Anderson
- ☐ Atchison
- ☐ Barber
- ☐ Barton
- ☐ Bourbon
- ☐ Brown
- ☐ Butler
- ☐ Chase
- ☐ Chautauqua
- ☐ Cherokee
- ☐ Cheyenne
- ☐ Clark
- ☐ Clay
- ☐ Cloud
- ☐ Coffey
- ☐ Comanche
- ☐ Cowley
- ☐ Crawford
- ☐ Decatur
- ☐ Dickinson
- ☐ Doniphan
- ☐ Douglas
- ☐ Edwards
- ☐ Elk
- ☐ Ellis
- ☐ Ellsworth
- ☐ Finney
- ☐ Ford
- ☐ Franklin
- ☐ Geary

- [ ] Gove
- [ ] Graham
- [ ] Grant
- [ ] Gray
- [ ] Greeley
- [ ] Greenwood
- [ ] Hamilton
- [ ] Harper
- [ ] Harvey
- [ ] Haskell
- [ ] Hodgeman
- [ ] Jackson
- [ ] Jefferson
- [ ] Jewell
- [ ] Johnson
- [ ] Kearny
- [ ] Kingman
- [ ] Kiowa
- [ ] Labette
- [ ] Lane
- [ ] Leavenworth
- [ ] Lincoln
- [ ] Linn
- [ ] Logan
- [ ] Lyon
- [ ] Marion
- [ ] Marshall
- [ ] McPherson
- [ ] Meade
- [ ] Miami
- [ ] Mitchell
- [ ] Montgomery

- [ ] Morris
- [ ] Morton
- [ ] Nemaha
- [ ] Neosho
- [ ] Ness
- [ ] Norton
- [ ] Osage
- [ ] Osborne
- [ ] Ottawa
- [ ] Pawnee
- [ ] Phillips
- [ ] Pottawatomie
- [ ] Pratt
- [ ] Rawlins
- [ ] Reno
- [ ] Republic
- [ ] Rice
- [ ] Riley
- [ ] Rooks
- [ ] Rush
- [ ] Russell
- [ ] Saline
- [ ] Scott
- [ ] Sedgwick
- [ ] Seward
- [ ] Shawnee
- [ ] Sheridan
- [ ] Sherman
- [ ] Smith
- [ ] Stafford
- [ ] Stanton

- [ ] Stevens
- [ ] Sumner
- [ ] Thomas
- [ ] Trego
- [ ] Wabaunsee
- [ ] Wallace
- [ ] Washington
- [ ] Wichita
- [ ] Wilson
- [ ] Woodson
- [ ] Wyandotte

Other (please specify) (examples: specific zip code, city or town, Fort Riley, etc.)

9. Select up to five partners/organizations that are CRITICAL to the implementation of your program:

- ☐ Community mental health center(s)
- ☐ College/university
- ☐ Department for Children and Families (DCF)
- ☐ Domestic violence program
- ☐ Faith based organizations
- ☐ Faith communities
- ☐ Home visiting programs
- ☐ Hospital(s)
- ☐ Law enforcement
- ☐ Local elected officials
- ☐ Local foundation(s)
- ☐ Local health department
- ☐ Local non-profit organization(s)
- ☐ Local government
- ☐ Managed care organizations
- ☐ Media
- ☐ Primary care clinics
- ☐ Private practice physicians
- ☐ Private business(es)
- ☐ Substance abuse prevention
- ☐ Substance abuse treatment
- ☐ School district(s)
- ☐ WIC
- ☐ Workforce development organization

Other (please specify)

10. Please list by name up to FIVE partners/service providers you work with on a regular basis (these do not need to tie directly to what you checked above).

1

2

3

4

5

11. Select primary funding sources for the specific program identified at the beginning of the survey (select all that apply):

- [ ] Federal
- [ ] Fee for service
- [ ] Medicaid
- [ ] Title V (MCH)
- [ ] Title X Family Planning
- [ ] WIC
- [ ] Home Visiting (MIECHV--Maternal Infant and Early Childhood Home Visiting)
- [ ] Part C
- [ ] Other state
- [ ] County
- [ ] Other (e.g. private/foundations, etc.)

12. Select the main services provided through the program (select all that apply):

- [ ] Breastfeeding support
- [ ] Case management/care coordination
- [ ] Counseling
- [ ] Data collection
- [ ] Direct service--clinical
- [ ] Economic, employment and/or education supports
- [ ] Education
- [ ] Home visitation
- [ ] Outreach to target populations
- [ ] Public awareness/health promotion
- [ ] Referrals to other organizations
- [ ] Risk factor screening

Other (please specify)

Program Description

13. If you provide education as part of this program, please specify what types (select all that apply):

- [ ] Breastfeeding
- [ ] Childbirth
- [ ] Family planning
- [ ] Infant care/child development
- [ ] Injury prevention/safety
- [ ] Nutrition
- [ ] Parenting
- [ ] Postpartum care
- [ ] Postpartum depression
- [ ] Preconception
- [ ] Prenatal
- [ ] Safe sleep
- [ ] Tobacco cessation
- [ ] Well child
- [ ] Well woman/well man
- [ ] Other (please specify)

Program Description

14. If you refer to other organizations, to which types of organizations do you most commonly refer? (select all that apply)

- [ ] Not applicable
- [ ] Child care
- [ ] Department for Children and Families (DCF)
- [ ] Domestic violence
- [ ] Early childhood
- [ ] Education
- [ ] Family supports (including financial assistance, basic needs--e.g. food banks)
- [ ] Health department
- [ ] Health/Medical
- [ ] Home visiting
- [ ] Housing
- [ ] KanCare (Medicaid)
- [ ] Individual/family counseling
- [ ] Mental health
- [ ] Oral health
- [ ] Substance abuse treatment
- [ ] Tobacco cessation (e.g. KanQuit)
- [ ] Transportation
- [ ] WIC
- [ ] Workforce development
- [ ] Other (please specify)

Target Populations

15. Which populations do you serve (select all that apply)?

- [ ] Women of reproductive age (15-44)
- [ ] Pregnant women/mothers
- [ ] Infants under one
- [ ] Men/fathers
- [ ] Youth or adults with special health care needs

16. Rank the insurance status of the populations you serve (1=highest percentage of those served; 3=lowest percentage of population served)

	KanCare (Medicaid)
	Uninsured
	Private insurance

17. Do you serve refugees?

- ○ Yes
- ○ No

18. Do you serve undocumented residents?

- ○ Yes
- ○ No

19. Select the primary races/ethnicities of those you serve (select all that apply).

- [ ] White
- [ ] Black or African American
- [ ] American Indian or Native Alaskan
- [ ] Asian
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Hispanic or Latino

Alignment with State and National MCH Priorities

20. Select the MCH State Priority need(s) with which your program most directly aligns (select all that apply): [Source: MCH 2015 Statewide Needs Assessment]

- ☐ Increase early and comprehensive health care before, during and after pregnancy for all women
- ☐ Improve mental/behavioral health of all pregnant women and new mothers
- ☐ Reduce low birth weight and preterm births and infant mortality
- ☐ Increase initiation, duration and exclusivity of breastfeeding
- ☐ Not applicable

21. Please indicate which Title V MCH measures relate to your program goals/work (select all that apply):

- ☐ The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
- ☐ Percentage of women who smoke in the last three months of pregnancy.
- ☐ The percent of live births that are born preterm less than 37 weeks of gestation.
- ☐ The percent of mothers who breastfeed their infants at 6 months of age.
- ☐ The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.
- ☐ The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.
- ☐ The rate of birth (per 1,000) for teenagers aged 15-17 years.
- ☐ The percent of children without health insurance.
- ☐ Not applicable

22. The following are key priorities from Healthy Kansans 2020. Please indicate which priorities your program is working to improve (select all that apply):

- [ ] Promote physical activity
- [ ] Promote healthy eating
- [ ] Equip and incentivize Kansans to participate in culturally competent health and wellness programs and access appropriate health care
- [ ] Promote tobacco use prevention and control
- [ ] Improve supports for the social and emotional development of children and families
- [ ] Promote access to healthy foods and support policies that promote healthy food choices
- [ ] Support policies that make the default choice the healthy choice
- [ ] Promote environments and community design that impact health and support healthy behaviors
- [ ] Improve access to services that address the root causes to poor health
- [ ] Effective and efficient use of health information technology (HIT) for population health improvement
- [ ] Promote integrated health care delivery, including integrated behavioral health, social services and medical care
- [ ] Not applicable

Data Sources

23. Select the primary data source(s) for the indicators used to assess, measure performance and evaluate your program/service/activity/system (select all that apply):

- [ ] Behavioral Risk Factor Surveillance System (BRFSS)
- [ ] County Health Rankings
- [ ] Census/American Community Survey
- [ ] Kansas Health Institute
- [ ] Kansas Health Matters
- [ ] Kids Count
- [ ] Kansas Information for Communities (KIC)
- [ ] Kansas Integrated Public Health System (KIPHS)
- [ ] Kansas WIC Database (KWIC)
- [ ] Vital statistics (birth and death certificate data)
- [ ] Youth tobacco survey
- [ ] WebMCH (KDHE MCH program database)
- [ ] Custom database/survey
- [ ] Not applicable/do not track data
- [ ] Other (please specify)

Focus Areas for Birth Outcomes

24. From your program's perspective, identify the top three most important areas of focus to improve birth outcomes in your region.

	Top priority	Second priority	Third priority
Implement health promotion efforts	◯	◯	◯
Ensure quality of care for all women and infants	◯	◯	◯
Improve maternal risk screening for all women of reproductive age	◯	◯	◯
Enhance service integration for women and infants	◯	◯	◯
Improve access to health care for women before, during and after pregnancy	◯	◯	◯
Develop data systems to understand and inform efforts	◯	◯	◯
Promote social equity (fair access to livelihood, education, and resources such as food, housing, and transportation; full participation in the political and cultural life of the community; and self-determination in meeting fundamental needs)	◯	◯	◯

Additional Information

25. Provide any additional information or resources about your program/service/activity/system including websites, links to reports or newsletters, or other information which highlights your work:

Community Health Assessments

Please answer the following questions regarding your participation in community health assessments. This will help in identifying where community health assessments align with our findings to assist with planning and prioritizing.

26. Has your organization participated in a community health assessment?

◯ Yes

◯ No

27. Have you selected your priorities?

- ◯ Yes
- ◯ No

28. Please describe your priorities:

29. Do you plan to attend the South Central public health region partner meeting with KDHE and March of Dimes on October 21st at the American Red Cross in Wichita?

- ◯ Yes
- ◯ No

If you would like to complete a survey for another program, please use the ...

AMCHP

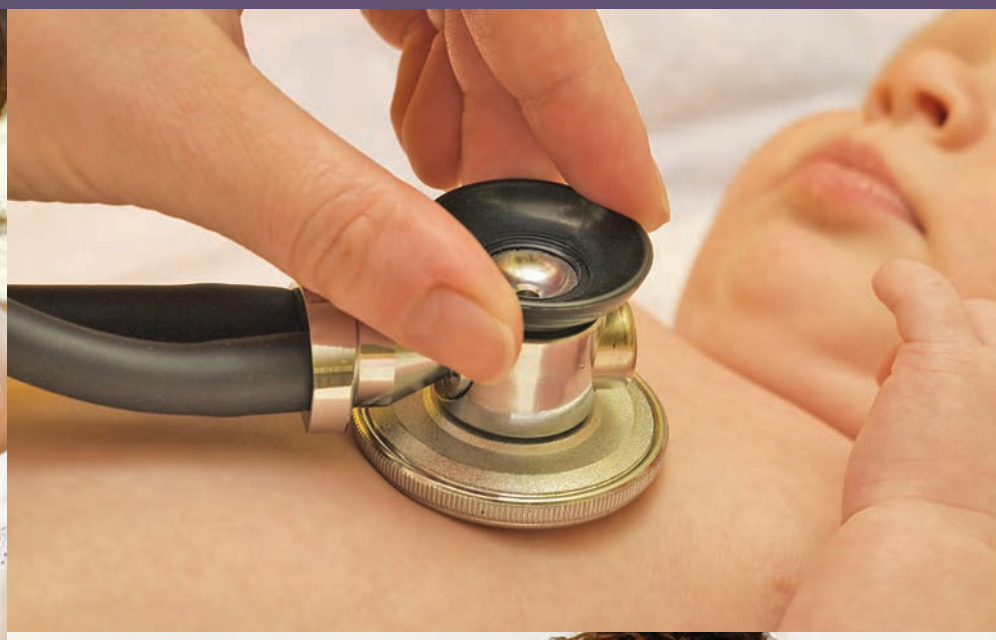
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

JULY 2012

COMPENDIUM

Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality:

Policy and Program Options for State Planning



A Message from the AMCHP President

Since the inception of Title V of the *Social Security Act,* state and territorial programs have been working hard to address the causes of poor birth outcomes throughout the United States. Recently, national momentum has been growing to coordinate efforts addressing stagnating declines in infant mortality and persistent disparities among populations within the United States. With new initiatives and expanding evidence, state health departments and their partners have an opportunity to seize the moment, build on our past success and develop invigorated, strategic approaches to improving birth outcomes.

Currently, AMCHP is an active partner in several national initiatives such as the Health Resources and Services Administration Infant Mortality Collaborative, the Association of State and Territorial Health Official Healthy Babies Project and Presidential Challenge to Reduce Premature Births, and the March of Dimes Healthy Babies Are Worth the Wait. Other federal efforts, such as the US Department of Health and Human Services Secretary's Advisory Committee on Infant Mortality – which is preparing updated recommendations to guide national planning on infant mortality reduction – and the Centers for Medicare and Medicaid Services Strong Start Initiative, are identifying and promoting effective models to reduce infant mortality and improve birth outcomes. We are at a truly exciting and unprecedented time for maternal and child health, where we have the opportunity to accelerate our work, draw from each of these efforts, expand our partnerships and grow our evidence base so that we can realize our shared goal of healthy birth outcomes for all women and infants in the United States.

To help state-level stakeholders strengthen and accelerate comprehensive initiatives to prevent infant mortality and improve birth outcomes, AMCHP has developed *Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality* to provide a synthesis of policy and program options for state planning. This resource is intended as a review, not a prescription, of strategies states can consider throughout their efforts. The recommendations provided in the compendium are extensive; not every strategy is appropriate for every state. We hope this compendium helps focus your efforts by providing specific, actionable ways to improve birth outcomes and facilitates learning about strategies and approaches from other states. Let's seize upon the national energy and build on the legacy of state maternal and child health programs to reduce infant mortality and improve the health of all of our nation's women and infants!

Sincerley,

Stephanie Birch, RNC, MPH, MS, FNP
AMCHP President
Section Chief, Women's Children's and Family Health
MCH Title V and CSHCN Director
Division of Public Health
Alaska Department of Health and Social Services

What is the AMCHP Compendium?

- **It is a menu of options.** The AMCHP compendium is a menu of program and policy options states can consider when planning to improve birth outcomes and reduce infant mortality.
- **It is a comprehensive source of recommendations and specific action steps.** AMCHP staff reviewed leading state and national reports on improving birth outcomes and synthesized the recommendations and action steps across all the reports into the AMCHP compendium.
- **It is a summary of the current efforts across the nation to improve birth outcomes.** The AMCHP compendium is a collection of what select state task forces, blue ribbon panels and other thought leaders are recommending states do to address infant mortality, supplemented by specific action steps, state examples and state case studies.

How to use the AMCHP Compendium:

- Assess the current initiatives of your state to improve birth outcomes. Determine the current gaps and identify recommendations to address those areas.
- Review the recommendations and action steps for ideas that align with your population needs, programs, staff and state leadership.
- Review the Health Impact Pyramid. Apply these concepts to your own assessment and planning of comprehensive initiatives to improve birth outcomes.
- Select multiple strategic policy and program options in order to build a comprehensive approach. You do not have to implement all the recommendations highlighted in this compendium in order to improve birth outcomes; some may not be feasible or relevant for your state. Select options that make the most sense. The recommendations and specific strategies suggested may not be the only actions state-level initiatives take to improve birth outcomes.
- Learn how to bring multiple approaches together in order to form a comprehensive plan from the case studies.

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Introduction

Infant mortality is an international measure of how well a society ensures the health of its people, particularly its women and youngest citizens. The World Health Organization defines infant mortality as the number of deaths occurring in the first year of life per 1,000 live births.

The United States currently ranks 30th in infant mortality rates among all industrialized nations.[i] Within the United States, disparities persist between populations. Infant mortality among African American babies is double, and in some places triple, the rate for whites.[ii] Despite decades of work to expand coverage and early access to prenatal care, the preterm birth rate in America remains high. Excess premature births and infant losses have enormous costs to our families, our health care system, our schools and our national prosperity.

Research shows that prenatal care may not be enough to improve the health of many mothers and babies.[iii] A comprehensive approach to improving birth outcomes and reducing infant mortality follows a life course approach, acknowledging and accounting for the interplay of biological, behavioral, psychological, social, economic and environmental influences on one's health across the course of their life. Before and between pregnancies, many women of childbearing age have untreated diabetes, continue to use tobacco, are obese and need better access to primary care and reproductive health services. The greatest impact of several risk behaviors occurs early in pregnancy. Thus, promoting the health of women before they become pregnant has great potential to improve the health of mothers and infants. Accordingly, many of the options included in this compendium focus on the health of women before, during and between pregnancies.

Providing quality, affordable health coverage for the four out of ten low-income women who are currently uninsured (unless they become pregnant or disabled) can go a long way in improving birth outcomes and reducing infant mortality. The *Patient Protection and Affordable Care Act* (ACA) expands health insurance coverage and provides states with tools and resources to improve access to quality care for women, infants and children. Under the ACA, several provisions have the potential to help improve birth outcomes. For example, the ACA expands coverage for uninsured adults through an expansion of Medicaid and the establishment of health insurance exchanges. . On Jan. 1, 2014, states have the option to expand eligibility to uninsured women with incomes up to 133 percent of the federal poverty level (FPL), potentially resulting in millions of uninsured women gaining coverage. Women who lack employer-sponsored health insurance and who earn incomes between 133 to 400 percent of the FPL – levels too high to qualify for Medicaid – will be eligible for coverage through new state health insurance exchanges beginning in 2014.

In spite of new opportunities under the ACA, national data show coverage for prenatal care and maternity care are necessary but not sufficient to achieve significant improvements in birth outcomes and reduce infant mortality. Beyond medical coverage, comprehensive public health and social equity interventions are needed to reduce prematurity and infant mortality in order to make a difference. Therefore, this compendium highlights recommendations and strategic actions that address public health, health care and social equity throughout communities and states.

This AMCHP compendium provides a synthesis of several leading state efforts and national reports. The AMCHP compendium is also a menu of state policy and programmatic options to begin or expand a comprehensive state approach to improving birth outcomes. These options are organized under the following seven broad recommendations:

1) Implement Health Promotion Efforts
2) Ensure Quality of Care for All Women and Infants
3) Improve Maternal Risk Screening for All Women of Reproductive Age
4) Enhance Service Integration for Women and Infants
5) Improve Access to Health Care for Women Before, During and After Pregnancy
6) Develop Data Systems to Understand and Inform Efforts
7) Promote Social Equity

Methodology

AMCHP identified reports from state infant mortality task forces, work groups, consortia and other panels that have studied infant mortality and made recommendations for action based on their findings. In a parallel effort, reports, position papers and documents indicating a plan or vision for improving birth outcomes (including reducing infant mortality) from national organizations and researchers were identified.

Appendix A includes a list of the source documents from state and national organizations and the number of recommendations from each source. A total of seven national reports, which included 60 separate recommendations, and eight state reports, which included 62 recommendations, were reviewed.

These source documents from state and national entities were examined for recommendations and strategic action steps. The recommendations were categorized by AMCHP staff to describe the suggested issue addressed by the recommendation or strategic action suggested. From this review, an overarching set of recommendation categories was proposed. These were as follows: address issues around access to care, address the social determinants of health, apply the life course theory, enhance education and training efforts, ensure quality, ensure sustainability and accountability, focus on vulnerable populations, implement targeted interventions, provide care and support to patient populations, use data to inform activities, use evidence-based practices and use a systems approach. From these categories, a set of seven broad recommendations were developed that form the basis of the compendium.

Program and policy examples are offered to highlight specific, actionable ways to address these recommendations. Examples were collected through multiple mechanisms, including best practices already included in the AMCHP Innovation Station; programs and policies highlighted at the AMCHP Annual Conference, through AMCHP webinars and other maternal and child health forums; and through communication and solicitation from Title V directors. Where possible, examples are grounded in evidence. Other examples, however, may not have been formally evaluated to date but show promising or emerging impact on improving birth outcomes. State examples and case studies were collected from October 2011 through April 2012. It is possible that over time some of the highlighted examples may lose funding or be eliminated for various reasons but should still be considered programs with promise.

Program and policy examples marked with the AMCHP Innovation Station icon ( ) are available in more detail in the AMCHP searchable database of emerging, promising and best practices in MCH, available at: amchp.org/programsandtopics/BestPractices/InnovationStation. Practices highlighted in the Innovation Station have been reviewed by an objective review panel of AMCHP members, partners and other experts in the public health field to determine if a practice meets the designated criteria (i.e. emerging, promising or best practice).

Conceptual Framework

The AMCHP compendium uses the Health Impact Pyramid as a framework to understand comprehensive approaches to improving birth outcomes and reducing infant mortality. In 2010, Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention (CDC), outlined a five-tiered pyramid to categorize the impacts of the different types of public health interventions.[iv] Frieden's Health Impact Pyramid is a conceptual model that organizes health interventions along dual continuums: population impact and increasing individual effort needed. At the top of the pyramid are interventions with the smallest population impact and the largest individual effort required. As you move down the pyramid, population impact increases and individual effort needed decreases. Comprehensive approaches to public health problems, including improving birth outcomes and reducing infant mortality, will include interventions that address all levels of the pyramid.

Tier 5: Counseling and Health Education

Summary: Tier 5 is the top of the pyramid and represents individual public health education. When applied consistently and repeatedly these interventions can have large impacts. These interventions require the highest amount of individual effort as they involve individual choices to change behavior. Furthermore, a population-level impact from counseling and health education may take longer to reach and be harder to measure. The impact of individualized messages and relationships on individual health choices, however, cannot be underestimated. (Examples: peer education about reducing HIV risk, personalized smoking cessation advice.)

Tier 4: Clinical Interventions

Summary: Tier 4 interventions are individual and require an ongoing clinical component (low population impact and high requirement of individual effort). There are many evidence-based clinical interventions that are proven to have a large health impact on the individual level, but non-adherence can be problematic so rigorous oversight and accountability are required to make sure interventions are implemented as intended. (Examples: medications for treating hypertension, hyperlipidemia and diabetes.)

Tier 3: Long-Lasting Protective Interventions

Summary: Tier 3 interventions have broad population impact, but require outreach to individuals. Interventions at this level are not clinical, they do not require ongoing relationships between an individual and the health care system, but they may involve a *singular* clinical intervention that makes a *permanent* change. (Examples: immunization, smoking cessation.)

Tier 2: Changing the Context to Make Individuals' Default Decisions Healthy

Summary: Tier 2 represents interventions that change the environmental context – so making the healthy choice becomes the easy choice. These interventions have high population impact and still require little individual effort. (Examples: clean environments (water, air, food), eliminating toxic exposures in building materials, improving public health infrastructure, developing the public health workforce.)

Tier 1: The Socioeconomic Factors

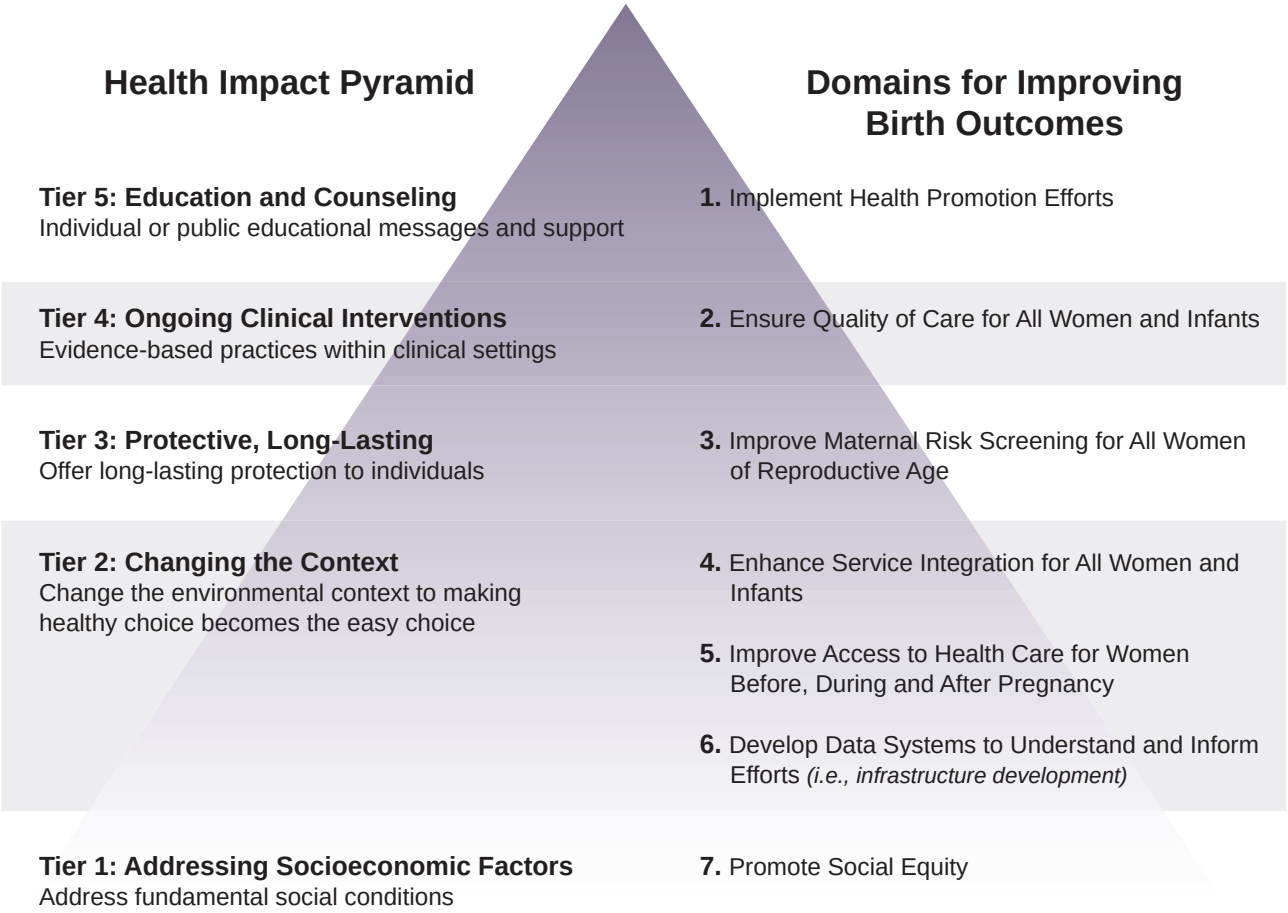
Summary: Tier 1 represents the bottom of the pyramid, which means interventions have the largest population impact and require the smallest individual effort. Health interventions at this level include fundamental social restructuring. (Examples: ending educational gaps, eliminating racism.)

Improving Birth Outcomes through Comprehensive Approaches: Using the Health Impact Pyramid

Poor birth outcomes are not caused by just one factor; therefore improving birth outcomes within states and communities will require comprehensive approaches. Using the Health Impact Pyramid to categorize interventions for improving birth outcomes helps clarify the type of impact a recommended action may have. Selecting strategic directions and interventions from multiple levels of the pyramid is central to building comprehensive approaches to improving birth outcomes. The seven recommendations to improve birth outcomes detailed throughout this document can be aligned to the Health Impact Pyramid to categorize the intended public health impact for each broad recommendation and the action steps within.

Building an effective response to infant mortality in states or territories will require assembling a strong Health Impact Pyramid. States can use the pyramid as a guiding framework to develop actions across multiple tiers of intervention to guarantee a comprehensive approach. Figure 1 offers a schematic that aligns the pyramid to the recommendations included in this compendium. Appendix A is a worksheet that states can use to map their own health pyramid for improving birth outcomes and reducing infant mortality.

FIGURE 1: The core recommendations for improving birth outcomes align with the Health Impact Pyramid.



The Role of the Title V Maternal and Child Health Services Block Grant

State Title V MCH programs have a 77-year history of building comprehensive, integrated systems to ensure the health and well-being of women, children, including children with special health care needs (CSHCN) and their families. All U.S. states and territories receive funds from the federal Title V Maternal and Child Health Services Block Grant program (Title V Block Grant). This federal program provides critical funds to states for programs, services, supports and leadership in areas that include improving infant and child health outcomes, reducing infant and maternal mortality rates, and providing prenatal care to low-income pregnant women.

Leveraging the Title V Block Grant can help advance state efforts to improve birth outcomes and reduce infant mortality. This statute authorizes funds for all states and territories to:

> " (A) provide and assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services; and
>
> (B) reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children..."

The federal Title V Block Grant also includes important requirements for coordination between state Title V and Medicaid programs. These requirements include:

- Assisting with coordination of Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Establishing coordination agreements with their State Medicaid programs
- Providing a toll-free number for families seeking Title V or Medicaid providers
- Providing outreach and facilitated enrollment of Medicaid eligible children and pregnant women
- Sharing data collection responsibilities[vi]

Initial Considerations

Striving for Collective Impact

Approaching a comprehensive initiative to improve birth outcomes and reduce infant mortality requires decisions and actions that develop strong partnerships and yield system-wide progress. Partnerships will be at the core of any comprehensive initiative. Yet partnerships for improving birth outcomes should go beyond traditional collaborations and public-private partnerships. In order to make further progress on improving birth outcomes, partnerships should embody a 'collective impact' approach to improving social outcomes. Collective impact is the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem.[vii] Social innovation researchers have found successful collective impact initiatives have five core characteristics:

- **Common Agenda** – a shared vision for change that includes a common understanding of the problem and a joint approach (i.e. agreed upon actions) to solving the problem. In order to reach a common agenda, disagreements and differences in the definition of 'the problem' or 'the goal' must be addressed.
- **Shared Measurement Systems** – agreed upon ways in which success will be measured and reported. Ensuring measures are aligned and all participating organizations can hold each other accountable and evaluate successes and failures along the way.
- **Mutually Reinforcing Activities** – the efforts of each stakeholder must fit into an overarching plan of action. Collective impact does not require all stakeholders to do the same thing, rather each stakeholder should undertake a specific set of activities in which they are apt to excel, which is coordinated with the actions of others.
- **Continuous Communication** – a shared vocabulary and, eventually, trust will develop through regular meetings. Stakeholders need to have constant contact with one another in order to recognize and appreciate common motivations, see their own interests will be treated fairly, and believe that collective decisions will be made based on the best possible solution to the problem.
- **Backbone Support Organizations** – collaboration requires a support infrastructure. The most effective examples of collective impact have staff dedicated to the planning, management and support of the initiative. Staffing requirements for large collective impact initiatives may be as simple as: project manager, data manager and meeting facilitator.

Enhancing Partnerships

Before developing and implementing a formal statewide initiative to improve birth outcomes, states should ensure work will be undertaken through a collection of statewide partnerships. Applying the principles and lessons of a collective impact approach will maximize the impact of collaborative efforts. Statewide partnerships may already be established. These stakeholder groups, however, may need to be re-energized or refocused.

States should consider the following agencies or organizations as potential partners in initiatives to improve birth outcomes:

- Medicaid agencies (including Children's Health Insurance Programs (CHIP) or Children's Medicaid) and other payers
- Offices/programs focused on CYSHCN, chronic disease, infectious disease, reproductive health, occupational health and environmental health
- Offices/programs focused on surveillance and assessment of community health and well-being, including Fetal and Infant Mortality Reviews and Child Death Review Committees
- Offices/programs implementing home visiting programs with families
- Women, Infants, and Children (WIC) supplemental nutrition programs
- State agencies focused on education, environment, housing, community development and health care delivery
- Parent education, advocacy and consumer groups
- Established coalitions focused on the health of women, children or families
- Established quality health care collaboratives
- Local or state chapters of the March of Dimes, Family Voices, and medical providers, such as the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG)
- Early childhood care providers
- Healthy Start Programs
- Women's health providers
- State/regional hospital systems
- Family planning clinics
- Community health centers
- Legislative staff and cabinet agencies
- Academia
- Emergency services (including fire and police departments)
- Civic organizations

Preliminary Actions

Building on broad partnerships, preliminary actions toward building a comprehensive initiative to improve birth outcomes include:

1. Conducting an environmental scan of current data, programs and resources at the national, state and local levels

Understanding the current programs and resources in your state, including the current health status and birth outcomes data, provides a critical first step in assessing needs and opportunities. Collecting and analyzing a wide range of data to understand reproductive and infant health, as well as contextual information about health care systems, neighborhoods, and the environment, will help to define the extent, causes, and contributors to infant mortality and poor birth outcomes.

Strategies states could use to conduct an environmental scan include:

- Reviewing the state Title V needs assessment and annual block grant application, as well as other MCH data sources, such as Title X, chronic disease, quality improvement and community assessments
- Compiling a synthesis of state and community-based programs
- Sharing and discussing the environmental scan with both state- and community-level stakeholders to help identify strengths and areas of need
- Creating mechanisms for ongoing monitoring

2. Establishing accountability for a continued focus on reducing infant mortality and improving birth outcomes

Accountability is a crucial factor to the success of any effort, especially those involving multiple interventions and strategies by many partners and organizations. Establishing clear roles and expectations, as well as feedback and quality improvement mechanisms, will help provide a clear direction and vision for the initiative and strengthen collaborations so that combined efforts effectively and efficiently address and improve the health of infants and families.

Strategies states could use to ensure accountability include:

- Establishing a committee/consortium/task force to implement and monitor recommendations
- Engaging a broad range of stakeholders, including state leadership, families and consumers
- Establishing committee workgroups, objectives, bylaws, members and other structures and functions necessary to carry out the work of the committee/consortium/task force
- Developing a strategic plan that details recommendations, strategies, action steps, and persons/agencies responsible for implementation, timelines and evaluation measures
- Disseminating regular reports to stakeholders on progress and ongoing needs
- Conducting ongoing needs assessment in infant mortality as part of or coordinated with the Title V Maternal and Child Health Services Block Grant activities

3. Maximizing and building on existing knowledge in designing programs and interventions

Use evidenced-based programs where possible to meet the needs of your state and community. There is a great need to maximize and build on existing knowledge in designing programs and interventions. Demonstrate to policymakers and the public that resources are being invested in programs that will work and that incorporate the best available evidence. It is important to be able to show evidence of impact to ensure continued investment of resources and that program resources are being used most effectively. Where research is still evolving, balance using evidence with innovation to grow the field.

Examples of ways states can ensure the use of evidence-based practices in their plans to improve birth outcomes include:

- Promoting effective models of public health interventions. Many information sources exist to help identify established evidence-based programs, the following is a short list of sources:
  - The U.S. Preventive Services Task Force: uspreventiveservicestaskforce.org/recommendations.htm
  - The Guide to Community Preventive Services: thecommunityguide.org
  - The U.S. Department of Health and Human Services Office of Women's Health Bright Futures for Women's Health and Wellness tools: mchb.hrsa.gov/womenshealth/resources.html#bright
  - AMCHP Innovation Station: amchp.org/programsandtopics/BestPractices/InnovationStation

- National Governor's Association (NGA) Center for Best Practices (Health Division): nga.org/cms/center/health
- Promising Practices Network: promisingpractices.net/search.asp#searchprograms

- Requiring evaluation of maternal and child health funded programs to capture the success of innovative models and contribute knowledge on emerging practice
- Establishing communication and reporting tools to ensure programmatic outcomes, successes and challenges are regularly shared with all stakeholders

4. Ensuring programs reach the persons most in need

Given limited resources, it may be easier to focus on interventions that may not be as costly or time intensive. Efforts that target the most at-risk, hardest to reach individuals, who have the most barriers to good outcomes can also lead to sustained reductions in infant mortality and improved birth outcomes. Programs and activities should consider a sufficient scope and reach (such as extended hours for services, accommodation of transportation barriers, wide geographic presence); be culturally responsive; and have adequate capacity to reach a meaningful proportion of the population at highest risk.

Recommendations

Analysis of state action plans and national reports on reducing infant mortality led to seven broad recommendations for building a comprehensive plan to improve birth outcomes. These recommendations outline core areas for focus and planning among states and partners. These recommendations are:

1) Implement Health Promotion Efforts
2) Ensure Quality of Care for All Women and Infants
3) Improve Maternal Risk Screening for All Women of Reproductive Age
4) Enhance Service Integration for Women and Infants
5) Improve Access to Health Care for Women Before, During and After Pregnancy
6) Develop Data Systems to Understand and Inform Efforts
7) Promote Social Equity

The following section explores each of these recommendations and provides specific action steps that state agencies and partners can take to improve birth outcomes. Each recommendation is supplemented with state-level programs or policies exemplifying aspects of the overall recommendations. Detailed case studies of seven state initiatives to improve birth outcomes are also featured (pages 54-72) as a way to illustrate how comprehensive approaches can vary across differing states and communities.

Recommendation 1: Implement Health Promotion Efforts

Health promotion is the art and science of helping individuals understand influences of health, become motivated to strive for optimal health and change their lifestyle to move toward a state of optimal health.[viii] Health promotion leads to individual level change through education, enhanced awareness and increased skills and self efficacy. Health promotion can also be achieved through establishing opportunities and environments that make positive health behaviors the easiest choice, thus creating individual health promotion at the population level.

Health promotion is an effective strategy to modify individual behaviors that directly impact health. Behavior change at the individual level can lead to better health outcomes for infants, women and families. Education about behaviors, their impact on health and how to change or reduce risk associated with behaviors is central to many health promotion activities. Health promotion and behavior change at the individual level is sustained as communities institutionalize health policy, systems and environmental changes that ensure healthy choices are the easiest choice (i.e., laws that require car seats, workplaces that support breastfeeding).

Health promotion activities can directly improve birth outcomes and influence the causes of infant morbidity and mortality by educating on health behaviors that prevent Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID). SIDS/SUID is the leading cause of death among infants aged one to 12 months, and the third leading cause overall of infant mortality.[ix] In the early 1990s, health education campaigns, such as Back to Sleep, promoted safe sleep positions and environments for infants in order to reduce the occurrence of SIDS. Since then, the overall rate of SIDS in the United States has declined by more than 50 percent.[x] Research has shown promoting health behaviors, such as breastfeeding, immunizations and reducing substance use, also lower the risk of SIDS.[xi]

Another direct cause of infant morbidity and mortality are neural tube defects (NTDs), or birth defects of the brain and spinal cord. Spina bifida and anencephaly are the most common NTDs in the United States. According to the CDC, each year 1,500 babies are born with spina bifida and nearly one in every 5,000 babies are born with anencephaly. Over the past few decades, reductions in birth defects have been achieved through use of promotion of healthy preconception and prenatal behaviors, as well as proper health care before and during pregnancy. For example, there has been a 27 percent decline in pregnancies affected by NTDs since the United States began fortifying enriched grains with folic acid.[xii] Folic acid intake and folic acid fortification can prevent 50 to 70 percent of neural tube defects.[xiii] In addition, controlling teraterogenic medications[xiv], obesity[xv] and diabetes[xvi, xvii], can help prevent NTDs.

The health of a mother *as a woman* should be a priority focus area in order to reduce the impact maternal health behaviors can have on infant morbidity and mortality. Not only is women's health promotion important for community health outcomes, general women's health promotion as a strategy can be used to target birth outcomes through the preconception period. A preconception health framework espouses that the maternal health status before pregnancy plays an important role in the health of women and infants during pregnancy. Preconception health behaviors that can impact pregnancy and infant related health include substance use and weight management. Smoking by pregnant women is associated with 30 percent of small-for-gestational-age infants, 10 percent of preterm infants and

5 percent of infant deaths.[xviii, xix] Although smoking rates among women have been decreasing, the CDC estimates that 22 percent of women of reproductive age continue to smoke.[xx] In addition, 4.9 percent report heavy drinking on a regular basis.[xxi] Many women also are generally not at a healthy weight before pregnancy, 24.7 percent of women of reproductive age are obese[xxii] and 23 percent have insufficient physical activity throughout their daily routines.[xxiii] Positive health behaviors, such as smoking cessation and maintaining a healthy weight, as well as establishing good oral health, reducing stress and choosing to breastfeed, are choices a woman can make in order to improve her health and the birth outcomes of her children.

Furthermore, a focus on individual parental behaviors should not be reserved for women alone. Fathers, partners, family members and other members of a women's support network should be included in health promotion activities when appropriate in order to establish a social support system that encourages healthy behaviors.

Finally, the broader communities and environments in which individuals live also play a role in birth outcomes. For example, even though infant safety seats reduce the risk of death in passenger cars by 71 percent for infants, motor vehicle crashes are a leading cause of injury deaths for children 14 and under.[xxiv] Population health promotion strategies such as child safety seat laws, safety seat distribution and education programs, community-wide education and enforcement campaigns and incentive-plus-education programs are effective in increasing child safety seat use.[xxv]

Comprehensive health promotion programs rely on communications. Health promotion programs and activities provide messages to families, providers and communities to ensure increased awareness and reinforcement of individual health behaviors and practices. New technologies and social media opportunities should be considered in broader health promotion programming. As messages are created and communicated, materials and campaigns should always be available in the languages of the target population.

Actions states and partners can consider taking to implement health promotion efforts to improve birth outcomes and reduce infant mortality include the following:

Develop messages about preconception and interconception health to promote women's health before and after pregnancy. Specific strategies include:

- Incorporating preconception and interconception health messages into social media campaigns that promote women's health and wellness.
- Developing and implementing comprehensive educational curricula to help adolescents and young adults understand reproductive health and the impact of choices/behaviors to their own health and to the health of future children.
- Developing and implementing social marketing strategies to help women and men of reproductive age understand the link between lifestyle choices and healthy pregnancies.
- Supporting reproductive life planning for all women of reproductive age, including adolescents.
- Establishing tools on the Web or via telephone so women and men are able to obtain general health coaching information and services.
- Supporting and promoting access to information about health services through 311-baby, 211 and other easy to use information sources.

Recommendation 1 *continued*

Incorporate messages on healthy pregnancies and healthy infant care into social marketing and education campaigns. Specific strategies include:

- Targeting messages to first-time mothers.
- Promoting text4baby (text4baby.org) to provide health and safety messages to pregnant women, families and parents of infants.
- Establishing social networking/educational tools on the Web or via telephone so women and men are able to obtain pregnancy health coaching information and services.
- As messages are created and communicated, materials and campaigns should be available in the languages of the target population.

Expand preconception and interconception health planning among women and providers. Specific strategies include:

- Working with health care providers to understand and implement preconception health care, including evidence-based practices on preconception health as defined in "The Clinical Content of Preconception Care."[xxvi, 1]
- Promoting comprehensive, culturally appropriate reproductive health life plans for all women, including adolescents. Promoting reproductive life plans in family planning clinics and other medical and public health settings where women discuss contraceptives with providers and school health classes for teens.
- Providing culturally appropriate fact sheets for providers and consumers about preconception care visits, folic acid and vitamins, smoking and alcohol cessation, healthy weight and the use of contraceptives or other methods to plan the timing of a pregnancy.
- Providing preconception health education and services to adolescents and young adults (including men) in school-based clinics, family planning programs and through university programs.

Promote daily folic acid for women of childbearing age. Specific strategies include:

- Working with partners, specifically state chapters of the March of Dimes, family planning clinics, WIC, community health centers and other women's health professionals, to deliver messages and vitamins containing the recommended amounts of folic acid to women of child bearing age.
- Including messages about folic acid in social marketing campaigns targeting women of reproductive age. Deliver messages through mass media, articles, community activities and promotion.

Reduce the use of and exposure to harmful substances among all women. Specific strategies focusing on pregnant and post-partum women include:

- Coordinating with existing smoking cessation efforts (e.g., tobacco control programs, providers, WIC, Medicaid, community health centers and local organizations) to target cessation programs for pregnant women.
- Promoting resources around smoking cessation and drug treatment programs for pregnant women (e.g., a quit line devoted specifically for pregnant women).
- Implementing reminders for providers (including dental providers) to identify and intervene with tobacco-using women.
- Providing awareness and training in tobacco cessation to obstetric and neonatal providers and other public health and social service providers who see pregnant women.
- Partnering with Medicaid to develop strategies for increasing reimbursement for cessation programs for pregnant and postpartum women.
- Partnering with Environmental Health and Healthy Homes programs to reduce women's exposure to secondhand smoke through prohibiting smoking in public places.
- Working with insurers to provide interventions to pregnant women addicted to drugs.
- Educating women on the dangers of using alcohol and other substances, including safe medication use during pregnancy to prevent birth defects or other possible problems.
- Educating pregnant women about a safe environment, including food safety messages in pregnancy, avoidance of harmful household substances such as insecticides, lead, mercury, strong chemicals and avoiding handling soiled cat litter, mice, rats, hamsters and guinea pigs.

Promote safe sleep campaigns. Specific strategies include:

- Distributing information and education about sleep related deaths.
- Supporting programs that provide cribs for low-income families.

[1]To access the supplement articles, visit beforeandbeyond.org/?page=key-articles-and-studies#AJOG

- Working with retailers, such as grocery and baby stores, to promote safe sleep messages in baby-product aisles.
- Working with hospitals to create standard safe sleep and SIDS risk reduction curricula for providers, including training on the American Academy of Pediatrics (AAP) safe sleep guidelines.
- Partnering with community service providers and other agencies to conduct trainings on infant safe sleep that target parents, child care providers, grandparents, home health care professionals and staff of obstetric and pediatric clinics.
- Creating safe sleep bassinet cards for nursery staff, child care providers and families.
- Also see strategies under tobacco cessation on page 12.

Promote healthy weight among women of childbearing age. Chronic disease and obesity prevention programs may be partners who are particularly engaged in healthy weight policy and program development. Specific strategies include:

- Developing a community-specific report identifying culturally appropriate strategies for promoting healthy weight.
- Promoting screening for chronic diseases, such as heart disease and diabetes, during preconception or pregnancy-related care.
- Including messages about healthy weight gain and loss during pregnancy in population-based obesity prevention and 'healthy weight' programs.
- Implementing 'healthy weight' programming for pregnant women; WIC and home visiting programs may be partners to engage in order to increase reach of programs.
- Partnering with youth organizations that reach girls and teens to teach key obesity prevention messages.

Increase awareness among pregnant women, families and providers on the importance of carrying an infant full term. Specific strategies include:

- Increasing education and use of progesterone for the prevention of preterm birth, utilizing either 17 alpha hydroxyprogesterone caproate (17P) or vaginal progesterone to reduce prematurity.
- Working with obstetric provider associations, state chapters of the March of Dimes, insurers and hospitals to educate providers about the use of 17P injections or vaginal progesterone starting at 16-18 weeks gestation in women with history of preterm delivery or vaginal progesterone for women with short cervix (See **Recommendation 5 – Improve Access to Health Care for Women Before, During and After Pregnancy** for additional access strategic actions).
- Providing educational materials to pregnant women, families and health care providers on the benefits of delivery after 39 weeks and on the risks of delivery to both pregnant women and their infants prior to 39 weeks.
- Using individual patient education, including messages in birthing classes, to create public awareness on the importance of carrying an infant full term.

Improve public and professional awareness of benefits and risks of newly developed and available contraceptive technologies – keeping in mind the wants and desires of the woman and her family/partner (including cultural considerations).

Educate communities and service providers on the issues and impact of infant mortality within the community in order to develop additional champions for improving birth outcomes. Specific strategies include:

- Promoting educational opportunities through continuing education courses and grand rounds at birthing hospitals and with health care provider associations on infant mortality reduction, including safe sleep, the optimum minimum pregnancy interval, birth defects prevention and abusive head trauma (shaken baby syndrome).
- Preparing "packaged" PowerPoint presentations relevant to the issues that drive infant mortality in the community that can be easily used by partners when educational opportunities arise.

Reduce unintentional injuries to women and infants in the home and child care settings. Injury prevention messages and services can be delivered through multiple programs and partners

Recommendation 1 *continued*

serving pregnant women and families. Emergency services (i.e. poison control centers, local fire and police departments) may be a particularly strong partner for dissemination of injury prevention messages. Specific strategies include:

- Distributing home safety checklists to pregnant women and families to assess the risk of injury in their homes through health care providers, child care centers and community partners.
- Increasing access to free or low-cost preventive measures through give away (low- or no-cost) programs for smoke alarms, carbon monoxide alarms and safety latches.
- Providing information about poison control centers to families and child care providers.
- Providing education on abusive head trauma (shaken baby syndrome) to parents and other family members through videos that can be viewed in the hospital before discharge, posted to YouTube and other websites, and through continuing education to providers on best practice for reviewing with parents and caregivers the dangers of shaking infants.
- Providing resources and information for domestic violence shelters and interventions.
- Encouraging treatment for depression and other mental disorders.
- Also see strategies under safe sleep on pages 12-13.

Reduce injuries and death related to motor vehicle crashes. State transportation and traffic safety agencies, public safety agencies, health and automobile insurance plans, Safe Kids coalitions, law enforcement agencies and civic organizations may be particularly strong partners for dissemination of motor vehicle safety messages. Specific strategies include:

- Providing free or low-cost child safety seats to families.
- Providing safety seat checkpoints for families, including education about the proper use and installation of child restraints in automobiles.
- Promoting laws or hospital policies that require a properly installed car seat prior to post-delivery discharge from a hospital or birthing center.

Promote oral health, particularly the prevention and treatment of periodontal disease, as a component of comprehensive perinatal health programs. Specific strategies include:

- Ensuring oral health education is integrated into outreach programs for perinatal care.
- Educating health care providers (i.e. primary care and maternity care doctors) on how to diagnose treat and refer pregnant women with severe periodontal disease.
- Disseminating resources on dental care for women of childbearing age to clinicians and health educators.
- Incorporating messages about the importance of visiting a dental provider to pregnant women.
- Ensuring access to dental care by providing lists of dentists who accept Medicaid.

Support breastfeeding promotion for all mothers. Local breastfeeding coalitions, WIC programs, birthing hospitals, health professionals who see pregnant and post-partum women, home visitors, and local employers (businesses) may be particularly strong partners in breastfeeding promotion initiatives. Specific strategies include:

- Implementing culturally sensitive breastfeeding education and promotion to families, health care and child care providers, and employers.
- Working with birthing hospitals, breastfeeding coalitions and communities to expand the number of Mother and Baby Friendly hospitals.
- Providing lactation consultation and peer-support resources in hospitals and communities, utilizing WIC programs and other resources.
- Ensuring availability of breast pumps for low-income women through WIC and other resources.
- Strengthening workplace programs to support breastfeeding, including paid maternity leave and implementing policies, such as provision of a designated place for pumping, to support lactation during the work day.
- Disseminating resources, such as The Business Case for Breastfeeding Toolkit,[2] to help businesses and employers promote breastfeeding in a supportive workplace.

[2] For more information, visit: womenshealth.gov/breastfeeding/government-in-action/business-case-for-breastfeeding/

Educate expectant parents about newborn screening as a life-saving intervention for infants. Specific strategies include:

- Providing information and resources to families such as Baby's First Test.[3]

Include male partners in services, education and programs to reduce infant mortality. Specific strategies include:

- Increasing and/or developing prenatal and parenting classes and information for fathers.
- Ensuring programs on parental development address the perspective and needs of fathers.
- Establishing programmatic focuses on improving the relationships between men and women, including marriage/relationship counseling, family therapy or skills training in communication and conflict resolution.
- Increasing the use of male trainers in parenting classes.
- Sharing information on infant mortality with local Fathers Networks or other fatherhood advocates.
- Partnering with educational programs, employment-related services, and legal and social services for males to promote healthy baby messages.
- Encouraging churches, universities and media to take leadership roles in the fatherhood movement.
- Championing public policy that supports the ability of families to stay together.

[3] For more information, visit: babysfirsttest.org

Examples

Adolescent Reproductive Health Plan (Delaware)

dhss.delaware.gov/dhss/dph/chca/dphahtpp01.html

Data on teen pregnancy from Delaware indicate that Delaware teens are more likely to have sex at an early age, have more frequent sexual activity, have more sexual partners and may be less likely to use protection than adolescents in other states. In order to address the issue of teen pregnancy prevention, the Teen Pregnancy Prevention Advisory Board drafted the Delaware Adolescent Sexual Health State Plan based on Healthy People 2020 goals for adolescent and reproductive health. The plan was released in August 2011 and includes two evidence-based health education programs targeting both the school-based and community-based adolescent populations in reducing teenage pregnancy statewide ("Making Proud Choices!" and "Be Proud! Be Responsible!"). Targeted sites include areas with high rates of social and economic risks, teen birth rates, and sexually-transmitted infection (STI) and HIV/AIDS infection rates. The plan emphasizes coordination and collaboration between Delaware state agencies and community organizations serving adolescents. These partners will influence the implementation strategies identified in the work plan by working with the education providers and providing feedback. The education providers are school teachers from all 19 school districts in the state who will participate in training provided by the Sexuality Training Institute.

Always on Saturdays – Hartford Action Plan on Infant Health, Inc. (Connecticut)

teenpregnancyhartford.org/aos.htm

teenpregnancyhartford.org/

Always on Saturdays (AOS) is a nationally recognized teen pregnancy prevention program operating in Hartford neighborhoods since 1986. AOS facilitates workshops and activities for its program participants every Saturday. The AOS program directly provides young men with health education and reproductive health services. AOS also works in collaboration with other agencies in Hartford to provide employment training, tutoring and recreational activities. Each male in the program participates in four types of services that will lead them through the "Passage to Success." These four service areas include health and education, employment, special skills, and education and tutoring. The program uses small group discussion sessions, field trips and adult mentoring to teach males about sexual responsibility and reproductive health. The male program participants are separated into two groups ages 9 to 13 and ages 14 to 18 in order to provide age-appropriate discussions of human development issues.

Recommendation 1 Examples *continued*

Baby Blossoms Collaborative Preconception Health Program – Now and Beyond (Nebraska)

babyblossomsomaha.org

A joint effort of eight local agencies, this collaborative aimed to improve the health of women and infants by eliminating disparities and reducing fetal infant mortality in Omaha, Nebraska. Title V funding was received for a preconception health program entitled Now and Beyond, which educated 80 women across seven sites about the importance of a healthy lifestyle and the value of planning a pregnancy. From 2005 to 2008, maternal health andprematurity was addressed through the Now and Beyond preconception health program. First, a train-the-trainers approach was used to train Baby Blossoms Collaborative partners on how to use components of the Now and Beyond toolkit to educate clients in a clinic setting. The training tools (flip books) emphasized planning for a healthy pregnancy before becoming pregnant and a healthy lifestyle throughout pregnancy. The tool contains 22 risk-reduction strategies for healthy birth outcomes. The collaborative developed a brief intervention message focused on the top three health issues determined by the participants.

Back to Sleep Public Education Campaign; Louisiana Floor Talker Program

nichd.nih.gov/sids; sidscenter.org

The 'Back to Sleep' campaign began in 1994 as a way to educate parents, caregivers and health care providers about ways to reduce the risk for Sudden Infant Death Syndrome (SIDS). The campaign was named for its recommendation to place babies on their backs to sleep. Since the campaign started, the percentage of infants placed on their backs to sleep has increased dramatically and the SIDS rates across the United States have declined by more than 50 percent. A database of promising practices submitted by local programs can be found at suid-im-projectimpact.org. One example from Louisiana describes a "Floor Talker" program. Local safe sleep advocates place decals with safe sleep messages on the floor aisles of grocery stores and baby supply stores used by their target audience. The goal of the "Floor Talker" program was to ensure that the target population has a clear understanding of the SIDS Risk Reduction and Safe Sleep tips and put them into practice.

California Breastfeeding Coalition

californiabreastfeeding.org

The California Breastfeeding Coalition (CBC), formed in May 2003, serves as an umbrella organization for the 43 regional breastfeeding coalitions located throughout California. The CBC aims, through collaborative efforts, to create a more healthful California through the promotion and support of breastfeeding. The CBC website serves as a clearinghouse for information on promoting breastfeeding and state laws impacting the rights of breastfeeding women. The CBS also promotes breastfeeding by helping hospitals obtain 'Baby Friendly' status and administering 'Mother-Baby Friendly' workplace awards. In addition, the CBC runs the Breastfeeding Ambassador Program, which coordinates volunteer breastfeeding ambassadors who communicate breastfeeding promotion messages and positions on legislative bills or regulations to members of Congress, Assembly and Senate; local government and/or their staffs at key times; hospital administrators; employers; and local media.

California Male Involvement Program

urban.org/publications/307327.html

The California Male Involvement Program (MIP) started as a demonstration project in 1995 for teen pregnancy prevention programming directed to adolescent and young adult males 12 to 24 years of age. In 2003, the California State Legislature began supporting MIP through general funds across the state in teen pregnancy 'hot spots.' Specific goals of MIP included promoting the roles of males in the prevention of teen and unintended pregnancies, increasing the number of fathers who support the economic, social, and emotional well-being of their children and supporting the development of self-assured, future oriented youth capable of navigating through adolescence to responsible adulthood and contributing positively to society. MIP used a wide variety of strategies appropriate for their community. Required strategies include comprehensive sexuality education and clinical linkage services. Other strategies included education and support for teen fathers, service-learning, peer-provided services (peer-educators), and mentoring. Overtime, MIP saw multiple accomplishments across the state. Program evaluations showed increases in knowledge of the risk pregnancy, where to obtain birth control and awareness of statutory rape laws among participants. In addition, activities were institutionalized over time as school districts began offering MIP classes for credit. State funding for MIPs was eliminated in 2008 with the California budget crisis, however, agencies continue to implement the intervention model. Information on the MIPs intervention model can be found in Brindis CD, et al. (2005) *Let's Hear It for the Guys: California's Male Involvement Program.* International Journal of Men's Health, 4(1), 29-53.

Connecticut Breastfeeding Coalition

breastfeedingct.org

In July 2001, the Connecticut Department of Public Health convened representatives from local health departments, WIC, American Academy of Pediatrics, hospitals, community

health centers, La Leche League of Connecticut, lactation consultants, nurses, nutritionists, parent educators, and consumers to form the Connecticut Breastfeeding Coalition (CBC), which promotes and supports breastfeeding as the norm for infant and child feeding in Connecticut. CBC distributes resources and education on their website, promotes 'Breastfeeding-Friendly' business and employer awards and administers a program to assist Connecticut hospitals obtain 'Baby-Friendly' recognition.

Healthy Women, Healthy Futures (Oklahoma)

nursing.ouhsc.edu/HWHF/healthy_women_healthy_futures.htm

Offered at early childhood education centers, Healthy Women, Healthy Futures (HWHF) aims to improve the physical, emotional, social, dental and vision health of at-risk women living in poverty before they become pregnant again, thereby minimizing their risk of future premature birth or infant death in Oklahoma. Led by the University of Oklahoma College of Nursing, HWHF attempts to reduce participant risk factors, which diminish health, and improve their protective factors by improving their equity to primary care and other health services through health education and care coordination. Participants attend weekly one-hour classes offered in Spanish and English on-site at early childhood education centers, and develop health and reproductive life plans while consulting with HWHF staff during home visitation. Evaluation data to this point have shown health improvements due to improved knowledge and resultant behavior change; lifestyle improvements, such as increased exercise and better nutrition; and healthy, full-term or late preterm pregnancies among participants. Additionally the program has an 85 percent retention rate in a population frequently characterized as non-compliant, apathetic, disinterested, mobile and difficult to retain in a program. Originally funded by the George Kaiser Family Foundation (GKFF), HWHF is currently funded by GKFF and Blue Cross Blue Shield of Oklahoma.

Honey Child Prenatal Education Program (Texas)

marchofdimes.com/texas/programs_honeychild.html

According to the March of Dimes Peristats, the rate of preterm births in the United States is highest among African-American infants at 17.8 percent (18.6 percent in Texas – the highest among any subgroup in the state). To address this disparity, the March of Dimes Texas Chapter launched the Honey Child Prenatal Education Program in 2006. The Honey Child Prenatal Education Program has been designed to provide African-American women with the culturally appropriate information and support needed to have the healthiest possible

Recommendation 1 Examples *continued*

pregnancy and birth outcome. The intervention targets African-American women of childbearing age with a specific focus on women ages 17 to 44. In 2008, the March of Dimes Texas Chapter piloted Honey Child in five Texas churches.

Honey Child has two core program components: 1) group prenatal education sessions: a cognitive component, designed to provide accurate and timely information in the area of prenatal care and pregnancy; and 2) mentoring: a social support component designed to empower and promote participants to make behavior changes in those areas that need improvement (e.g., seeking prenatal health care) – or to support existing behaviors that promote healthy pregnancies.

Honey Child uses a faith-based approach to promote prenatal health. The curriculum incorporates interactive group activities, such as prenatal yoga and exercise, as well as individual reflection and spiritual messaging, making it an appropriate prenatal health education program for the church setting. The Honey Child curriculum includes six sessions of two hours each. Topics include: nutrition, relaxation and exercise, prenatal care, self-esteem, preterm birth, and labor and delivery. Each group consists of 6-12 women who share similar due dates. The women participate in monthly group discussions led by a facilitator. The mentor provides weekly one-on-one social support in addition to reinforcing positive health behaviors discussed in the groupHost churches have embraced the Honey Child program and increased awareness of the prematurity problem in the community and with referral organizations. Churches have also expanded prematurity awareness by participating and hosting prematurity awareness month activities in their churches which included prematurity awareness summits, Honey Child baby showers and prematurity awareness sunday activities.

The program expanded to two new sites in 2010 for a total of six sites across the state (Arlington, Austin, Dallas, Fort Worth, Houston and San Antonio). The March of Dimes partnered with the Tarrant County Health Department to conduct a statewide evaluation. Results reported in 2011 cover the time period of November 2007 to March 2011. Evaluation has shown increases in knowledge on prenatal health topics, increases in social support, and decreases in maternal stress. In a pilot study, 89% of women had infants that were born full-term, and only 4% were born less than 32 weeks gestation.

Illinois Council on Responsible Fatherhood

responsiblefatherhood.com

The Illinois Council on Responsible Fatherhood is a state commission established by the Illinois State Legislature to promote the positive involvement of both parents in the lives of their children. The mission of the Illinois Council on Responsible Fatherhood is to significantly increase the number of children in Illinois that grow up with a responsible father in their lives. The council seeks to do this through raising public awareness of the impact of father absence on children; assisting state agencies and other service providers the resources they need to promote responsible fatherhood; reforming perceptions within state agencies and other service providers regarding the role of fathers as parents; and advocating for programs, policies and legislation that will encourage the positive involvement of fathers.

New York State Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines

health.ny.gov/prevention/dental/oral_health_care_pregnancy_early_childhood.htm

Several national organizations, such as the American Dental Association, American Academy of Pediatric Dentistry and American Academy of Pediatrics, issued recommendations for improving the oral health of pregnant women and young children. To reinforce these recommendations and provide guidance, in 2006, the New York State Department of Health convened an expert panel of health care professionals who are involved in promoting the health of pregnant women and children. The panel reviewed literature; identified existing interventions; practices and guidelines; assessed issues of concern; and developed recommendations. The guidelines can be used by prenatal care providers to integrate oral health risk assessment and referral into routine prenatal care; by oral health professionals to provide appropriate treatment for pregnant women; by child health professionals to include oral health risk assessment as part of well-child care; and to provide referral. These guidelines will enable health care professionals to work together as a team to improve the care delivered to mothers and children. This improved integration of care is expected to have significant health benefits.

North Carolina Folic Acid Campaign

everywomannc.com

The North Carolina Folic Acid Campaign is a statewide, multi-component program. The overall goal is a reduction in the number of pregnancies affected by neural tube defects (NTDs) by promoting the benefits and consumption of folic acid. The program includes staff working statewide to implement community and provider education. The campaign has developed materials in English and Spanish, as well as implemented social media marketing. Evaluation of the campaign has shown a nearly 40 percent decline in NTD prevalence in North Carolina between 1995 and 1996 (9.5 per 10,000 live births) and 2004 and 2005 (6.05 per 10,000 live births). In 2010, the campaign became the North Carolina Preconception Health Campaign. The intent of this transformation was to expand the campaign mission beyond

folic acid education to include other preconception health messages, such as healthy weight and reproductive life planning. The campaign has had multiple funding sources – state appropriations, federal Medicaid administrative match, grants and contracts, and funds from a Vita Grant Settlement.

North Carolina 17P Initiative

mombaby.org (click on 17P)

In 2006, the North Carolina General Assembly appropriated funds to reduce preterm birth by improving access to and appropriate use of 17 alpha hydroxyprogesterone caproate (17P). The funds were used to expand education for physicians and consumers about 17P, as well as to increase access to the medication by making it available to low-income women free of charge. The 17P Project was born out of the concern of many about the increasing numbers of babies being born too soon. A key goal of this initiative is to ensure all women in North Carolina who meet the clinical criteria for 17P will have access to this intervention to reduce their risk of a recurring preterm birth. Proper use of 17P has shown a 33 percent reduction in the rate of preterm delivery prior to 35 weeks gestation and a 42 percent reduction prior to 32 weeks gestation. The 17P Project has recently partnered with the new Pregnancy Medical Home program and is featured as one of the four core quality improvement measures. This focus has provided important supports to this work, including case management to facilitate full compliance with the treatment. North Carolina continues to provide 17P free of charge to women who are uninsured. The initiative continues to ask for a small amount of funding again from the General Assembly (state funding) for this medication but has been able to sustain much of the work by fully integrating 17P into practice across the state.

Oklahoma Breastfeeding Hotline

1- 877-271-MILK

ok.gov/health/Child_and_Family_Health/Breastfeeding/Where_to_Call_for_Help/

The Oklahoma Breastfeeding Hotline (OBH) was launched in 2008 as a partnership between the Oklahoma State Department of Health (Maternal and Child Health Service), the University of Oklahoma Health Sciences Center Department of OB/GYN, and OU Medical Center. With funding from the Title V Maternal and Child Health Services Block Grant, as well as personnel and in-kind support from the OB/GYN department, the OBH is a 24/7 telephone hotline providing professional breastfeeding support to Oklahoma mothers, families and health care providers. All calls are handled by an International Board Certified Lactation Consultant (IBCLC). Urgent calls are returned within one hour while nonurgent calls are returned during business hours. Mothers, families and health care providers receive free, timely telephone access to IBCLCs who provide accurate breastfeeding information, address concerns and provide any needed referrals to community breastfeeding resources.

PASOs (South Carolina)

scpasos.org

PASOs (or “steps” in Spanish) aims to improve health of Latino families in South Carolina by educating Latino parents, caregivers, and parents-to-be on issues related to healthy pregnancies and prenatal care, as well as appropriate child development and resources for child health, and by advocating for better, more accessible services for Latinos. The PASOs program began in two counties in South Carolina in 2005 and now operates in 13 counties across the state. PASOs provides free, comprehensive prenatal classes (a 14-hour prenatal empowerment course), community health outreach and individual interventions to Latino families, as well as consultative services for maternal and child health providers and policymakers throughout the state. Evaluation results show significant increases in indicators such as what to do with preterm symptoms; level of satisfaction with communication with doctor; reasons for going to prenatal care; knowledge of preterm labor definition and signs of preterm labor; knowledge of types of cheese to avoid during pregnancy; knowledge of folic acid use, including when to begin taking folic acid and daily intake of multivitamins with folic acid; knowledge of iron-rich foods; knowledge of normal fetal movement; knowledge of right moment to go to the hospital for delivery; knowledge that it is normal to feel sad after delivery; and knowledge of the type of anesthesia to use during delivery.

Power Your Life Preconception Campaign (Utah)

poweryourlife.org

Power Your Life is a social marketing campaign to raise awareness of preconception health and increase consumption of folic acid. Developed for the Utah Department of Health, the campaign ran from June 2010 through January 2011. During that time, radio, television, print, and Web advertisements on Spanish/English media outlets were used to promote the Power Your Life website as a resource for health information. Women visiting the site had the opportunity to register for a 90-day supply of vitamins. Approximately 10,000 Power Bags with a 90-day supply of folic acid vitamins and other resources, such as a health magazine (derived from life course topics) and campaign bracelets were distributed through the campaign. Community outreach was conducted through health fairs, cultural celebrations and community partnerships. Additionally, a continuing medical education workshop was held for health care professionals to help them promote preconception health and consumption of folic acid in their daily practice. A statewide telephone survey found awareness of folic acid advertisements increased

Recommendation 1 Examples *continued*

after the campaign. Respondents aware of the campaign were three times more likely to consider taking folic acid important and seven times more likely to be taking a daily vitamin with folic acid than those who were not aware of the campaign. Findings also showed increases in daily vitamin intake for 18 to 25 year olds, non-white minority groups and pregnant women.

Project CHOICES

cdc.gov/ncbddd/fasd/research-preventing.html

CHOICES (Changing High-Risk AlcOhol Use and Increasing Contraception Effectiveness Study) is a brief intervention model aimed at preventing alcohol-exposed pregnancies (AEP) among nonpregnant women of childbearing age. Through a randomized control trial, CDC and researchers at three universities tested the efficacy of this brief motivational intervention by focusing on risky drinking and ineffective contraceptive use. The brief motivational intervention included an in-depth assessment of current alcohol and birth control use, counseling about the effects of alcohol use during pregnancy, brief advice and counseling to reduce alcohol use, and a birth control visit to discuss methods and provide birth control services. Results showed that women receiving the intervention were more than twice as likely to have reduced their risk for an AEP compared with women who did not receive the intervention. Implementation and evaluation of the CHOICES intervention is currently underway in sexually transmitted infection clinics, family planning clinics, community health centers and in American Indian communities. CDC also developed a CHOICES curriculum package designed for use by behavioral health professionals conducting the CHOICES program. These materials are available for download at cdc.gov/ncbddd/fasd/freematerials.html. CDC is currently developing strategies to disseminate CHOICES on a broader scale to systems of care serving women at risk for an AEP.

Women Together for Health (Arizona)

Women Together for Health (WTFH) was a free, community-based program that addresses modifiable lifestyle behaviors to improve the health of women and their families in Arizona, including healthy weight, physical activity, proper nutrition, stress management and tobacco use in women of childbearing age. WTFH was offered though a 10-hour (one day per week for eight to ten weeks) format available in English or Spanish, and was cofacilitated by a registered dietitian and a health educator. The curriculum focused on women learning skills to make sustainable lifestyle changes for health improvement by emphasizing physical activity and proper nutrition. All WTFH lessons were designed for low-income families. Of the women that completed the program in 2008, 65 percent reported increasing physical activity by 2,000 steps or more over the course of the program; 100 percent made at least one dietary improvement; more than 60 percent of women either maintained or decreased their body mass index over the course of the program; and 71 percent maintained regular physical activity, healthy eating habits and regularly used stress management techniques three months after the completion of the program. The 2008 percentages of change were consistent with other years.

You Quit Two Quit (North Carolina)

YouQuitTwoQuit.com

The You Quit Two Quit Project was launched in 2008 and is implemented by the University of North Carolina Center for Maternal and Infant Health (CMIH) in partnership with the Women and Tobacco Coalition for Health and the North Carolina Division of Public Health Tobacco Prevention and Control Branch. The goal of the project has been to ensure that there is a comprehensive system in place to screen and treat tobacco use in pregnant and postpartum mothers. The many project activities include operating quality improvement initiatives focused on tobacco cessation screening and counseling in partnership with four county health departments and distributing patient and provider education materials statewide, including outreach to neonatal intensive care units (NICUs) in hospitals and a special focus on billing and reimbursement. In 2011, the CMIH received funding from the federal Office of Women's Health for a project directed specifically at low-income women of childbearing age. The project focuses on implementing screening and treatment processes within the eight diverse practices in Community Care North Carolina Network. The project offers training to practices and chronic disease and pregnancy care managers within the network. The project is also working closely with the North Carolina Pregnancy Medical Home on training providers and care managers on this issue, as well as in developing care pathways. Funding has been provided from the Tobacco Settlement – state funds; also Title V Maternal and Child Health Services Block Grant funding has been utilized to print materials.

Recommendation 2: Ensure Quality of Health Care for All Women and Infants

Implementing measures to ensure high-quality and effective health care for all pregnant women and infants can have a positive impact on improving birth outcomes and lowering health care costs. In *Toward Improving the Outcome of Pregnancy: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives,* the March of Dimes states that improving the quality of perinatal care depends on applying evidence-based practice and clinical guidelines throughout the course of a woman's life.[4]

Leading perinatal health indicators show the need for improvement. Rates of labor induction have increased dramatically from 9 percent in 1989 to 21.2 percent in 2004,[xxvii] reflecting a particular increase in elective inductions. In 2008, late preterm births represented 8.8 percent of all live births, a nearly 9 percent increase since 1998.[xxviii] Increases in deliveries between 37 and 39 weeks have been associated with an increase in obstetrical interventions, such as induction of labor and cesarean sections.[xxix] Related to this rise, cesarean deliveries have also increased. According to the National Center for Health Statistics, the cesarean section rate has more than doubled since 1996, accounting for 32.3 percent of all births in 2009.[xxx] Research indicates elective deliveries at less than 39 weeks pose significant risk for the infant, including increased NICU admissions, increased respiratory distress syndrome (RDS), increased use of ventilator support and increased newborn feeding issues. Additionally, late preterm delivery may increase infants' risk of brain injury and long-term neurodevelopmental abnormalities.[xxxi]

Perinatal regionalization is a system of care linking each facility to a network of education and interhospital transport to provide risk-appropriate care across the continuum of perinatal care. Studies indicate very low birth weight (VLBW) and preterm infants born outside of a level III hospital are associated with an increased likelihood of neonatal or postdischarge mortality.[xxxii] A review of state models of perinatal regionalized systems revealed variability in the models themselves, as well as the various mechanisms for measuring and improving risk-appropriate care. Regulation of regionalization programs, data surveillance, review of adverse events and consideration of geography and demographics were identified as mechanisms facilitating better measurement of risk-appropriate care.

The same review noted that antenatal or neonatal transfer arrangements, telemedicine networks, acquisition of funding, provision of financial incentives and patient education comprised state actions for improving risk-appropriate care.[xxxiii]

A critical aspect of improving quality is ensuring that all care is patient and/or family centered. According to the Institute for Patient and Family-Centered Care, patient and family-centered care is an approach to the planning, delivery and evaluation of health care grounded in mutually beneficial partnerships, that involve comprehensive assessments and shared decision making, among health care providers, consumers and families.[xxxiv] Thinking about a woman-centered approach, Childbirth Connections offers a woman-centered framework, defined as care that respects the values, culture, choices and preferences of the woman and her family, as relevant, within the context of promoting optimal health outcomes. It means all childbearing women are treated with kindness, respect, dignity and cultural sensitivity, throughout their maternity care experiences.[xxxv]

[4] For more information or to access the March of Dimes publication *Toward Improving the Outcome of Pregnancy: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives* (TIOP III) visit: marchofdimes.com/TIOPIII_FinalManuscript.pdf

Recommendation 2 *continued*

Performance measurement is another essential part of ensuring quality of care for childbearing women and newborns. Nationally, there are efforts to promote consistent measures for maternity and newborn care. Public reporting of such measures can promote accountability, transparency, informed decision making, value-based purchasing and improvement. The Joint Commission currently supports five measures in its perinatal care core measure set: the cesarean rate for low-risk first-birth women; elective delivery before 39 weeks gestation; use of antenatal steroids; health care associated bloodstream infections in newborns; and the extent of exclusive breastfeeding at hospital discharge. In April 2012, the National Quality Forum approved for endorsement 14 maternity care performance measures for assessing the quality of maternity care. These voluntary consensus standards for perinatal care can be used as benchmarks for improving care for childbearing women and newborns.[xxxvi]

Lastly, promoting innovative practices for providing maternity care and parenting support hold promise for improving birth outcomes and quality of care. CenteringPregnancy is a multifaceted model of group care that integrates health assessment, education and support into a unified prenatal care program within a group setting. Groups of women with similar gestational ages meet together, learn care skills, participate in a facilitated discussion and develop a support network with other group members throughout pregnancy and early postpartum. The practitioner, within the group space, completes standard physical health assessments with each participant. This is followed by a facilitated discussion in the group setting. Research on the positive impact of CenteringPregnancy and group prenatal care is still evolving. Evaluation data from one CenteringPregnancy program indicates higher knowledge about pregnancy among women who participated in group prenatal care versus traditional prenatal care, and higher perception of social support.[xxxvii] In one demonstration project of CenteringPregnancy for adolescents, adolescents who participated in group prenatal care showed higher compliance with health care, higher satisfaction with prenatal care, low rates of low birth weight babies and higher rates of breastfeeding at discharge.[xxxviii]

CenteringParenting is an emerging model of group care for new parents that integrates health assessment, education and support into a group setting. Through this program, mother/baby dyads come together in a group setting to learn care skills, participate in facilitated discussion and develop a support network through the infant's first year of life. Parenting support programs may also include or link to well-child visits.

Actions states and partners can consider taking to ensure quality of care for all women and infants include the following:

Create or partner with a statewide perinatal quality collaborative to study and address perinatal outcomes across the state. Key stakeholders include the state Title V program, state Medicaid and CHIP programs, birthing hospitals, state chapters of medical associations such as ACOG, AAP and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), the March of Dimes, Healthy Start, state health care authorities, health insurers, community health centers, other health improvement partners and consumers.

Understand and share perinatal health data. Specific strategies include:

- Collecting key perinatal data at state, perinatal region and hospital levels. Use the Joint Commission and the National Quality Forum endorsements to guide data collection. Measures may include elective inductions less than 39 weeks with no documented medical risk factors, elective caesarean sections less than 39 weeks with no documented medical risk factor or complication, NICU admissions and neonatal outcomes, rates of exclusive breastfeeding and neonatal bloodstream infections, in order to focus perinatal quality improvement efforts. (See **Recommendation 6: Develop Data Systems to Understand and Inform Efforts** for additional strategies on using data to reduce infant mortality.)
- Supporting efforts to ensure consistency and accuracy of birth certificate data by providing training to staff on recording and entering birth certificate data to increase consistency and accuracy of birth data.
- Ensuring all maternal, pregnancy-related and infant deaths are reviewed. (**See Recommendation 6: Develop Data Systems to Understand and Inform Efforts** for strategies on using data to reduce infant mortality.)

Ensure the best available evidence guides maternity care decisions and that the family partners with their health care providers to make decisions about their care. Specific strategies include:

- Increasing performance measurement of maternity and neonatal health care through Medicaid, accrediting bodies and other entities with purchasing power.
- Disseminating information on maternity and perinatal measures to stakeholders by creating consumer-friendly reports for women of childbearing age and communities that highlight hospital, clinic and provider performance

in maternity and newborn quality to promote informed decision making around maternity care and promote equal access to efficacious treatments.

- Promoting shared decision making between providers and patients to support health care decisions that conform to patient values and preferences where there is more than one clinically appropriate intervention or management strategy.

Implement policies to decrease rates of elective deliveries prior to 39 weeks in all birthing hospitals. Work with hospitals that represent the majority of the deliveries in the state. Specific strategies include:

- Supporting medical record reviews and peer reviews of all elective deliveries less than 39 weeks with no maternal risk factors and share results with providers.
- Working with hospitals to implement induction reservations and delivery scheduling forms that delineate standards and guidelines for inductions and cesarean sections, including providing checklists and flow sheets.
- Creating and implementing policies that use incentives, such as "hard stops" by denying Medicaid payment for any deliveries that are not medically indicated prior to 39 weeks.
- Ensuring leadership support policies that allow induction schedulers and other staff to enforce induction guidelines and include mechanisms for continuous quality improvement.

Create or strengthen a perinatal regionalized system of care to ensure ongoing review of the appropriateness of deliveries and level of care for newborns based on maternity licensure levels of care. Specific strategies include:

- Ensuring every newborn is transported to the facility where he or she can receive the highest level of care needed.
- Adopting perinatal guidelines/levels of care and promoting guidelines among hospitals and providers.
- Adopting state regulations requiring all obstetric hospitals to have affiliation with a regionalized perinatal center and an agreement that outlines the parameters for consult and transportation for high-risk mothers and neonates.

Ensuring access to appropriate consultation and referral for pregnant women to a higher level of care when indicated. Pursue telemedicine and other mechanisms to connect women with specialists as indicated for women in rural or underserved areas to increase access to risk-appropriate care.

Implement neonatal quality improvement initiatives to improve care for infants in the NICU and reduce variation in NICU outcomes. The National Initiative for Children's Healthcare Quality developed a resource Toolkit for the Follow-Up Care of the Premature Infant (found at preemietoolkit.com) that provides tools and references for providers and families the management of preterm infants. Specific strategies include:

- Focusing on reducing central line-associated bloodstream infections, increasing use of antenatal steroids for preterm fetal lung development; and implementing uniform discharge and follow up protocols to link NICU graduates with a medical home.
- Supporting families during NICU stays through support services, such as the March of Dimes NICU Family Support Programs.

Implement uniform postpartum discharge programs and ensure access to comprehensive postdelivery follow up care. Offer postdelivery services to all women, not just those with poor birth outcomes. Specific strategies include:

- Working with hospitals, providers, local health departments, home visitation programs and other community groups, such as Healthy Start, to ensure women and families receive timely and appropriate follow up for safe sleep instruction, breastfeeding support, prevention of abusive head trauma/shaken baby, mental health and substance abuse services, domestic violence support, smoking cessation services, family planning and other services.

Recommendation 2 *continued*

- Using the postpartum discharge process as an opportunity to ensure women are connected with family planning services and primary care to promote appropriate interpregnancy intervals, facilitate access to a medical home, including referral for specialty care as needed.
- Working with health care providers and partners to improve the uptake of the postpartum visit and to enhance the content of the postpartum visit, in particular for women who have had a previous poor pregnancy outcome.
- Working with partners and parent consultants and parent navigators to support families during the transition from the NICU to the home, including providing links to medical and social services, such as Early Intervention, home visiting and other follow up services (See **Recommendation 4: Enhance Service Integration for Women and Infants** for additional information).

Support expansion of Mother- and Baby-Friendly Hospital programs to promote immediate and sustained breastfeeding. Specific strategies include:

- Providing training materials on successful breastfeeding, including disseminating patient and staff education materials.
- Offering individual facility consultation toward obtaining the Baby-Friendly designation.
- Working with partners to provide incentives and offer financial support for Baby-Friendly USA maternity hospital fees.
- Providing lactation support for all mothers, including information about the benefits of breastfeeding, lactation consultation and breastfeeding support groups.

Implement electronic medical records for women and infants to allow easy access to reproductive health data for health care providers, which may increase the safety and quality of care for pregnant women and infants.

Study, disseminate and increase the adoption of innovative, evidence-informed prenatal-care models (e.g. home visiting, community health workers, group pregnancy care, use of doulas) in obstetric practices, including certified nurse midwifery settings and community health centers, that provide prenatal care in a group setting.

Implement group parenting classes to promote parenting skills, infant health and wellness, injury prevention and create a network for new parents.

Examples

Arkansas Telehealth

ruralhealth.uams.edu/?id=8078&sid=32

Arkansas uses telecommunication to improve patient access to risk-appropriate care. Arkansas has a well-established telemedicine program created for a rural and widely dispersed population. The majority of resources for high-risk pregnancies are concentrated in one urban center and not easily accessible to all citizens. However, perinatal specialists at the University of Arkansas for Medical Sciences host monthly teleconferences with practitioners from more than 25 rural communities. Three days a week, specialists conduct telenursery rounds with large nurseries in the state. This program builds rapport between physicians and promotes consultations. Subsequent transportation to appropriate facilities has increased. A study of the Arkansas system reveals presence of a telemedicine site increased the probability of antenatal transport to a level III facility.

California Perinatal Transport System

perinatal.org

California has created the California Perinatal Transport System for transports of critically ill infants and mothers with high-risk conditions to regional NICUs and Perinatal High Risk Units. The system also collects and analyzes the perinatal and neonatal transport data for regional planning, outreach program development, and outcome analysis. This information is reported back to the participating hospitals and the California Department of Health Division of Maternal and Child Health.

Connecticut Baby-Friendly Hospital Initiative

breastfeedingct.org/images/CBI_Project_Summary_Final.pdf

breastfeedingct.org/index.php/calendar-of-events/64

Globally, the Baby-Friendly Hospital Initiative (BFHI) encourages and recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding. The BFHI assists hospitals in giving mothers information and skills needed to successful initiative and continue breastfeeding their babies or feeding formula safely, and gives special recognition to hospitals that have done so. In 2010, the Connecticut Department of Public Health and the Connecticut Breastfeeding Coalition formed a joint

collaboration to drive Baby-Friendly Hospital Designation throughout the state. The joint collaboration, named the Connecticut Breastfeeding Initiative, is funded through CDC Communities Putting Prevention to Work funding. The initiative assists 10 Connecticut maternity hospitals by delivering training on successful breastfeeding, offering individual facility consultation toward obtaining the Baby-Friendly designation, fostering collaboration and support between the 10 maternity hospitals, disseminating patient and staff education materials, and offering financial support for Baby-Friend USA maternity hospital fees.

Maryland Perinatal Standards

fha.dhmh.maryland.gov/mch/SitePages/perinatal_standards.aspx

The Maryland Department of Health and Mental Hygiene is building on existing quality improvement work, including the Maryland Perinatal Standards, to develop a standardized hospital postpartum discharge process. Partners include the Maryland Institute for Emergency Medical Services Systems, the Maryland Patient Safety Center and all birthing hospitals in the state. The intent of this effort is to ensure risk-appropriate follow up for women and infants, particularly those with poor pregnancy outcomes. This will include linkages to hospitals, local health departments, and community resources around safe sleep, breastfeeding, family planning and other prevention services.

New York State Perinatal Quality Collaborative

The New York State Department of Health (NYSDOH) launched the New York State Perinatal Quality Collaborative (NYSPQC) in 2010 in collaboration with the New York Regional Perinatal Centers (RPCs) and the National Initiative for Children's Healthcare Quality. The NYSPQC aims to improve maternal and newborn outcomes, and improve capacity within New York for ongoing quality improvement and transformation of health care by applying evidence-based health care system change interventions in RPC Obstetrical and Neonatal Intensive Care Units (NICUs). The NYSDOH initially focused on two interventions to reach the goals of the NYSPQC:

- The first intervention aimed to reduce the number of scheduled deliveries performed without appropriate indication in women of between 36 and less than 39 weeks gestation. Initial intervention activities included collecting and submitting data on scheduled inductions and caesarean deliveries without medical indication, revising admitting practices, employing processes to ensure that only elective deliveries with acceptable medical indicators were scheduled including 'hard stop,' and educating providers and patients.
- The second intervention aimed to reduce the statewide percentage of newborns less than 31 weeks gestational age that are discharged from the NICU below the tenth percentile for growth based on the Fenton scale. Initial intervention activities included optimizing early enteral nutrition in preterm babies in the NICU. Both arms of the collaborative utilized data collected by the department to analyze success in achieving collaborative objectives.

In October 2011, the NYSDOH was one of three national recipients of a three-year grant from CDC that is supporting expansion of the NYSPQC beyond the RPCs. To build upon its initial success, both the obstetrical and neonatal interventions are expanding to include RPC-affiliate birthing hospitals in New York. In addition to expanding the project reach to affiliate hospitals, the initiative will also expand its focus to include preventing central line-associated blood stream infections in NICU patients, and identifying opportunities for MCH prevention activities through maternal mortality review.

Ohio Perinatal Quality Collaborative

opqc.net

Using quality improvement methods, the Ohio Perinatal Quality Collaborative (OPQC) is reducing preterm births and improving outcomes of preterm newborns. Using the Institute for Healthcare Improvement Breakthrough Series, OPQC worked with 20 maternity hospitals (47 percent of all births in the state) through a collaborative focused on several obstetric improvement projects. Efforts included documenting method of pregnancy dating, documenting reasons for scheduled delivery prior to 39 weeks, as well as discussion with the patient the risks of delivery before 39 weeks, implementing a scheduled delivery form, establishing direct communication with pediatricians, promoting early ultrasound and conducting ongoing monitoring of clinical data using birth certificate data. OPQC reports more than 9,000 births have moved occurring prior to the due date to full term (39 to 41 weeks), and that approximately 250 NICU admissions have been avoided. OPQC estimates approximately $10 million in annual health care cost savings.

Perinatal Connect to Care (West Virginia)

wvperinatal.org/teleconsultation.htm

In early 2010, West Virginia formally launched the Connect to Care Project. The telecommunications project links rural health facilities with tertiary care centers housing perinatal specialists. Live telecommunications infrastructure allows pregnant women and their local health care providers to obtain medical advice from specialists without traveling. The

Recommendation 2 Examples *continued*

project also supports continuing education for rural medical practitioners and access to obstetrical referrals. Currently, Connect to Care is operating in 15 rural health care sites as a pilot program. The project is funded by a Rural Utilities Service Grant from the U.S. Department of Agriculture and matching funds from 18 partnering West Virginia hospitals and community health centers.

Texas Policy on Elective Inductions/C-Sections

As of Oct. 1, 2011, Texas Medicaid no longer reimburses hospitals for elective deliveries occurring before 39 weeks that are not medically necessary and properly documented as such. The Medicaid policy change is the result of recent state legislation (Texas House Bill 1983). The state legislature was compelled to act after research from a pilot program limiting elective c-sections demonstrated reductions in premature births and subsequent cost savings of approximately $4 million a year.

West Virginia Health Care Authority

www.hcawv.org/

The West Virginia Health Care Authority, in partnership with the West Virginia Health Improvement Institute, the West Virginia Perinatal Partnership and the West Virginia Chapter of the March of Dimes, developed and implemented a collaborative to study and address the issue of non-medically indicated elective deliveries prior to 39 weeks gestation. West Virginia used the Institute for Healthcare Improvement Breakthrough Series methodology to support hospital-based teams. Six months after the collaborative implementation, the rate of elective deliveries prior to 39 weeks without a medical indication decreased by more than 50 percent.

Washington Shared Decision Making Policy

Shared decision making is a process undertaken between providers and patients with a condition using more than one clinically appropriate management strategy. Decision aids are used to facilitate the shared decision-making process. Washington state has the broadest reaching legislation related to shared decision making. In 2007, a bill was enacted that mandated the Washington health care state agency to implement a shared decision-making demonstration project at one or more multispecialty practice sites, and recognized the state law on informed consent by establishing shared decision making. The bill provides more legal protection for physicians who engage in shared decision making. In addition, a 2011 bill called for the governor to appoint a collaborative to improve health care quality, cost effectiveness and outcomes called for shared decision making to be a strategy for the collaborative to promote. In early 2012, legislation was proposed to establish a certification process for decision aids. If successful, this legislation would establish a certification process by ensuring decision aids meet the International Patient Decision Aid Standards. A resource on current advancements in shared-decision-making policy, the National Academy for State Health Policy report *Shared Decision Making: Advancing Patient-Centered Care through State and Federal Implementation,* is available online at: nashp.org/sites/default/files/shared.decision.making.report.pdf.

View a full copy of the legislation pertaining to shared decision making, E2S Senate Bill 5930 at apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Session%20Law%202007/5930-S2.SL.pdf. Pages 3 to 5 pertain specifically to shared decision making. In addition, access two Revised Codes of Washington (RCWs) that pertain to the shared decision-making legislation by visiting:

- RCW 41.05.033: Shared decision-making demonstration project | Preference-sensitive care. apps.leg.wa.gov/rcw/default.aspx?cite=41.05.033
- RCW 7.70.060: Shared decision making | Patient decision aid | Failure to use. apps.leg.wa.gov/RCW/default.aspx?cite=7.70.060

Recommendation 3: Improve Maternal Risk Screening for All Women of Reproductive Age

Several modifiable risk factors and chronic conditions can cause significant disease and death during pregnancy and lead to the development of lifelong chronic disease. According to the CDC Recommendations to Improve Preconception Health and Health Care,[xxxix] women of childbearing age suffer from various chronic conditions and are exposed to or consume substances that can have an adverse effect on pregnancy outcomes leading to pregnancy loss, infant death, birth defects or other complications for mothers or infants.[xl] Preventing and managing these risk factors, such as tobacco and substance use, maternal depression, physical inactivity and poor nutrition, can prevent poor birth outcomes and reduce rates of chronic disease in women overall. These factors can best be addressed prior to pregnancy, or between pregnancies, rather than waiting until the pregnancy to intervene.

Since approximately 50 percent of all pregnancies in the United States are unintended, screening all women of reproductive age for chronic conditions and other psychosocial risk factors for poor birth outcomes can have a positive effect on improving women's health and birth outcomes. Comprehensive risk assessment and screening for all women can identify risk factors for poor birth outcomes and allow for recognition and intervention prior to pregnancy.

Although prenatal pregnancy tobacco use rates have declined over recent years, more than 10 percent of women continue to use tobacco while pregnant, with higher prevalence rates of tobacco use among younger women.[xli] Tobacco use increases the risk of pregnancy complications, preterm birth and low birth weight. Tobacco use is associated with 30 percent of small-for-gestational-age infants, 10 percent of preterm infants and 5 percent of infant deaths. From 2006 t0 2008, nearly one in five recent mothers in a 29-state area reported binge drinking (consumed five or more drinks in a sitting) at least once within the three months prior to pregnancy (18.8 percent) and 22.3 percent reported smoking.[xlii] The U.S. Preventive Services Task Force has evaluated the effectiveness of interventions in primary care settings related to smoking, alcohol misuse and obesity, "that were not complicated by the additional delivery of multiple components of preconception care."[xliii] Effective methods include 5As (ask, assess, advise, assist, arrange) for smoking cessation[xliv] and brief interventions to reduce alcohol misuse.

Diabetes and hypertension are the most commonly reported health conditions among pregnant women.[xlv] Diabetes,

both chronic and gestational (developing only during pregnancy), may pose health risks to a woman and her baby. Women with gestational diabetes are at increased risk for developing diabetes later in life.[xlvi] In addition, only about half of new mothers (51.1 percent) reported a healthy or normal prepregnancy weight for their height.[xlvii]

A woman experiencing psychosocial stress during pregnancy may be more susceptible to a number of pregnancy complications, including preterm birth. Depression during pregnancy, especially if untreated, carries risks of poor prenatal care, preeclampsia, poor weight gain, unhealthy eating habits, use of drugs or alcohol to self-medicate or suicide.[xlviii, xlix] In addition, roughly one out of every eight new mothers may experience major or minor depression in the first few months after birth.[l] Among other factors, postpartum depression may make a woman less likely to breastfeed or bond with her baby. Finally, postpartum depression is consistently associated with intimate partner violence.[li] The Community Guide for Preventive Services recommends evidence-based guidelines for treatment of depression, including collaborative care for the management

Recommendation 3 *continued*

of depressive disorders using case managers to link primary care providers, consumers and mental health specialists.

Beginning on or after Aug. 1, 2012, new health insurance plans will be required to cover eight preventive health services without charging a copayment, coinsurance or a deductible identified by the Institute of Medicine (IOM), which include certain maternal screens and opportunities for screening, such as a well-woman visit, screening for gestational diabetes, human papillomavirus (HPV) DNA testing for women 30 years and older, STI counseling, HIV screening and counseling and domestic violence screening and counseling (See **Recommendation 5: Improve Access to Health Care for Women Before, During and After Pregnancy** for additional information).

Actions states can consider taking to improve maternal risk screening for all pregnant and postpartum women to improve women's health and birth outcomes include the following:

Increase the number of women who are screened and monitored for chronic disease, infections and other high-risk conditions that may impact pregnancy or birth outcomes, including hypertension, obesity, gestational diabetes, HIV, STIs, previous poor birth outcomes or preterm birth, unsafe medication use during pregnancy, violence and depression. Specific strategies include:

- Expanding the number of providers who emphasize preconception care, conduct medical and psychosocial risk assessment at the initial prenatal visit and throughout pregnancy; who provide counseling about preterm birth prevention, drug, alcohol and tobacco cessation, healthy weight/obesity, domestic violence, mental health, STIs and birth spacing.
- Increasing the capacity of providers and other health professionals who are able and willing to provide brief motivational interviewing to reduce alcohol use and other substance use during pregnancy.
- Providing awareness and training in evidence-based models of tobacco cessation counseling to obstetric and neonatal providers and other public health and social service providers who see pregnant and postpartum women.
- Expanding screening for intimate partner violence and violence prevention screening in all settings where women access care, including family planning clinics, primary care and OB/GYN visits.
- Implementing uniform screening tools that can be used with women before and during pregnancy in obstetric or preconception health visits.
- Screening all pregnant and postpartum women for depression as part of prenatal and postpartum care. Women should be screened using reliable, valid and culturally responsive instruments in multiple settings, such as well-child visits.

Ensure that women who are at-risk or screen positive are linked to programs and services. Specific strategies include:

- Supporting collaborative care for the management of depressive disorders using case managers to link primary care providers, consumers and mental health specialists. (See **Recommendation 4: Enhance Service Integration for Women and Infants**, for more information.)

Examples

Adverse Childhood Experiences Screening Tool (Washington)

The Adverse Childhood Experiences (ACE) screening tool helps identify persistent, complex trauma. In Jefferson County, Washington, public health nurses have incorporated ACE screening questions into the comprehensive risk screening offered to all clients – mothers, fathers and caregivers – across several public health programs, including WIC, family planning, First Steps, Maternity Case Management and Nurse-Family Partnership. The ACE screening outcomes are used to discuss life course impacts of adverse childhood experiences with parents and make appropriate referrals to mental health and social services. In addition, conversations with parents help link their adverse experiences with protecting their children from having similar ACE scores. Information about the Jefferson County experience, including full version of their comprehensive screening tool, can be found at: nwcphp.org/training/courses/maternal-child-health-mch-training-for-professionals. (Session 6: Adverse Childhood Experiences and Public Health Practice).

Alaska Family Violence Prevention Project

hss.state.ak.us/dph/chronic/AKFVPP/

The Alaska Family Violence Prevention Project (AFVPP), within the Alaska Department of Health and Human Services Division of Chronic Disease Prevention and Health Promotion, provides ongoing training and support to health care providers on the use of intimate partner violence screening tools and intervention strategies. The AFVPP provides free access to resources online through the AFVPP Clearinghouse.

Georgia HIV Pregnancy Screening Act of 2007

legis.ga.gov/legis/2007_08/pdf/hb429.pdf

In 2007, the Georgia State Legislature passed the Georgia HIV Pregnancy Screening Act. The law requires physicians to test pregnant women for HIV. Prior to 2007, women in Georgia had to give their consent for HIV testing, known as an 'opt-in' policy. The Georgia HIV Pregnancy Screening Act of 2007 changed the system to an 'opt-out' policy; now women must be tested unless they refuse. 'Opt-out' testing eliminates requirements for pretest counseling, informed consent and post-test counseling. Furthermore, CDC believes 'opt-out' testing helps more people know their HIV status, helps those infected with HIV find out their status earlier, further reduces the stigma associated with HIV testing, and enables those who are infected to take steps to protect their babies and partners.

Louisiana Health Assessment Referral and Treatment (LaHART)

The Louisiana Health Assessment Referral and Treatment (LaHART) tool is a Web-based prenatal behavioral health screen created by the Department of Health and Hospitals (DHH) Birth Outcomes Initiative. LaHART was created to streamline the screening and referral process for pregnant Medicaid eligible women in need of treatment for substance use during pregnancy. The Birth Outcomes Initiative partnered with the Office of Behavioral Health to leverage funding to activate Medicaid billing codes. Louisiana providers are now paid $50 for conducting prenatal behavioral health screening and brief behavioral intervention.

The tool screens for prenatal alcohol, drug and tobacco use, as well as domestic violence. Through the Louisiana Behavioral Health Partnership, DHH has created the infrastructure that the state can use to build a network of providers who will be able to treat women screened and referred through the LaHART tool. In addition, Text4Baby enrollment, automated referral to the state's tobacco quitline and the domestic violence hotline number have been built into the site. The tool has been successfully piloted in New Orleans. The Birth Outcomes Initiative and Office of Public Health are conducting the first phase of LaHART outreach and orientation through June 2012.

The Clinic and Community Connections Project (Minnesota)

co.hennepin.mn.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=c23684e035f23210VgnVCM10000049114689RCRD

This project is designed to bring health care providers into fetal alcohol spectrum disorder (FASD) prevention by assisting and training clinical staff to incorporate comprehensive maternal alcohol screening, counseling, support and referrals. The project was developed by Hennepin County (Minnesota) with the Native American Community Clinic. The program identifies health care providers within clinics who are interested in enhancing the alcohol screening practices and provides FASD training for the health care providers. This includes introducing the Maternal Alcohol Screening Tool, assisting clinics in implementing the new screening protocol, providing selected FASD patient teaching materials and assisting clinics in developing a follow-up protocol for children exposed to prenatal alcohol. Additionally, a connections workgroup made up of regional partners was formed to assess the gap in community treatment services for pregnant women who need help to stop drinking alcohol. Results have shown a marked increase in the rates of maternal alcohol screening and advisement at initial and subsequent prenatal visits in the participating clinics. Eight community clinics and seven WIC clinics have successfully implemented maternal alcohol screening protocols.

Uniform Maternal Risk Screening in West Virginia

wvperinatal.org/risk.htm

In 2009, the West Virginia Legislature passed comprehensive maternal-risk screening (Senate Bill 307: "Uniform Maternal Screening Act"). The bill required the West Virginia Department of Health and Human Resources, Office of Maternal, Child and Family Health (the State Title V agency) to convene an advisory council to develop a uniform maternal-risk screening tool to help identify pregnant women with potential at-risk pregnancies. The advisory council is also legislated to meet annually to revise the tool as needed. Throughout 2010, the advisory committee worked to modify the West Virginia Prenatal Risk Screening Instrument (PRSI), the risk screening tool developed by the Right From the Start Program, the state perinatal home visiting initiative. The expanded PRSI contains the 4Ps, an opt-in/opt-out for client referral services, and an alert to the prenatal provider that the client may need referral for a maternal fetal medicine consultation. The committee also developed a statewide data collection process to measure the incidents of high-risk pregnancies. The modified PRSI was implemented statewide with all West Virginia maternity service providers on Jan. 1, 2011. The advisory committee continues to meet as necessary to monitor the utilization of the tool and the incidence of high-risk pregnancies. Maternity service providers can access the tool free of charge, online at: wvdhhr.org/mcfh/WV_PrentalRiskScreeningInstrument2010.pdf.

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Recommendation 4: Enhance Service Integration for Women and Infants

Integrated service delivery is an approach to meet the health and well-being needs of women, children and families by providing access to a quality, comprehensive and coordinated community-based system of services. For women of reproductive age, this may mean providing and coordinating maternity, reproductive health, primary care and child health services. Service integration is guided by a life course approach to health and well-being, which recognizes the interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress and nutrition, as well as their influence on the health of an individual over the course of their life. In addition, advancing the concept of a medical home, or health home, for all women and children is a key feature of service integration.

As defined by the American Academy of Pediatrics, the medical home for children is a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective to every child and adolescent. Further, a family-centered medical home is a trusting partnership between a child, their family and the pediatric primary care team that oversees the health and well-being of the child within a community-based system that provides uninterrupted care with appropriate payments to support and sustain optimal health outcomes. The concept of a patient-centered medical home that provides comprehensive, coordinated, culturally sensitive care is also being applied to pregnancy medical homes. These medical homes embrace the team concept of comprehensive care for pregnant women and can extend to interconception care.

Beyond the medical home, specific models that promote service integration and target healthy birth outcomes and infant mortality reduction include colocation of reproductive and other health care services, federal Healthy Start, home visiting and parenting programs.

Pursuing strategies that use a “no wrong door” approach to provide women with comprehensive health services and/or to link women to appropriate health and social services have been shown to improve women’s health and birth outcomes. Models that integrate women’s preventive health services into family planning settings also have shown effectiveness. Given that 50 percent of pregnancies in the United States are unintended,[liii] integrating primary care, preconception health and reproductive health services at any visit for a young adult or woman of reproductive age is logical, can minimize barriers to accessing care from multiple settings and can maximize health care resources.

The federal Healthy Start program, administered by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB), is an initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes through grants to areas with high annual rates of infant mortality. Healthy Start projects address the disparities in the health of mothers and babies due in part to inadequate access to care through direct outreach and client recruitment, health education, case management, depression screening and referral and interconception care services.[liii] Healthy Start Projects also use community and peer outreach, provide medical care and help women and their families meet basic human needs, such as food and housing. Compared to the overall national infant mortality rate of 6.7/1000 live births in 2006, the infant mortality rate for Healthy Start program participants was 5.7/1000.[liv]

Authorized by the Affordable Care Act, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is providing funding to all 50 states, the District of Columbia and six jurisdictions to support evidence-based home visiting programs to improve the well-being of families with young children. Through MIECHV, states can respond to the diverse needs of children and families in communities at risk and provides an unprecedented opportunity for collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. Many states also are implementing home visiting programs supported through other mechanisms.

Through comprehensive home visiting programs, nurses, social workers or other professionals and paraprofessionals meet with at-risk families in their homes, typically beginning in pregnancy and assess the strengths and challenges of the family. Home visiting programs work with families to provide education and links to services that can make a real difference in a child’s health, development and ability to learn, such as health care, developmental services for children, early education, parenting skills, child abuse prevention and nutrition education or assistance. Home visiting programs typically deliver services and supports in the home, where knowledge about the daily life of a family can ensure appropriate and needed services are being provided and promote a supportive one-to-one contact and relationship between provider and family.[lv] Home visiting programs can help prevent more long-term costs and promote healthy social and emotional development in later years.

Other federal initiatives, such as the Early Childhood Comprehensive Systems (ECCS) program and Project

LAUNCH have also led to improved early childhood systems. Since 2003, MCHB supported 49 states, the District of Columbia, Guam, the Republic of Palau and the commonwealths of Puerto Rico and the Mariana Islands through the ECCS program to build and integrate early childhood service systems that better meet the needs of children and families. ECCS focuses on five key components – access to care and medical homes; social-emotional development and mental health; early care and education; parenting education; and family support. Each state ECCS program developed a state plan to incorporate all early childhood systems building and can be an important asset in state efforts to improve birth outcomes and reduce infant mortality.

Project LAUNCH is a grant program of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) which seeks to promote the wellness of young children from birth to age eight. Project LAUNCH focuses on improving the systems that serve young children and address their physical, emotional, social, cognitive and behavioral growth. Project LAUNCH aims to have all young children reach their developmental potential, enter school ready to learn and experience success in the early grades. SAMHSA currently funds 16 states, one tribe, the District of Columbia and six other local communities through Project LAUNCH to work in a designated community over five years, testing evidence-based practices, improving collaboration among child-serving organizations and integrating physical and mental health and substance abuse prevention strategies for children and their families.

Actions that states can consider to integrate care for women and infants include the following:

Ensure access to a medical home for all women and infants that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective (See *Recommendation 5: Improve Access to Health Care for Women Before, During and After Pregnancy* for additional information).

Create health services that provide comprehensive care, connecting medical and social services with the goal of improving perinatal outcomes. Specific strategies include:

- Expanding family planning clinics to provide or link to comprehensive preventive health care for women.
- Providing multi-faceted care coordination that includes health and parenting education.

Implement innovative models for comprehensive, coordinated prenatal and interconception care. Specific strategies include:

- Exploring the feasibility of creating a pregnancy (maternity) medical home model.
- Linking high-risk women (including women who had a poor birth outcome) to medical, social and other services following pregnancy to promote health in the interconception period.

Recommendation 4 *continued*

Supporting a continuum of early childhood services to address family needs. Specific strategies include:

- Supporting comprehensive home visiting programs for all families at risk for poor birth outcomes that address the family health, social and emotional needs. The programs can support interagency and cross-program coordination to promote entry early in the pregnancy and ensure that families the best benefits for their needs, including a central point of intake.
- Integrating home visiting with other programs and supports, such as with other child and family services, particularly those focused on the well-being and healthy development of the child.

Examples

Central Hillsborough Healthy Start Project (Florida)

reachupincorporated.org/chhs.php

Central Hillsborough Healthy Start (CHHS) Project serves 500 moms and 350 babies per year with intensive case management services. CHHS offers a unique delivery system of health and social services to pregnant and parenting (interconception) women while simultaneously providing home visiting promising practices that implement standardized core services developed by MCHB. The CHHS program reduced low birth weight and preterm delivery by roughly 30 percent among service recipients as compared to nonrecipients.[lvi] Additionally, CHHS has worked with other community organizations to focus on East Tampa social capital and assets, particularly on building community capacity in grassroots community organizations and creating avenues for gainful and creative employment. Since inception, CHHS has hired and trained more than 50 indigenous nurses, doulas, outreach workers and clerical staff.

DC Developing Families Center

developingfamilies.org

The DC Develop Families Center is a collaboration of three non-profit service providers in District of Columbia. The Center model recognizes the complex and interconnected factors that contribute to families' health and well-being through offering health care (prenatal and birth care, immunizations, childbirth education, optional out-of-hospital birth setting, Medicaid enrollment services for pregnant women, postpartum care, breastfeeding education, family planning, STI screening), family support (case management and nurse home visits, teen parenting empowerment program, effective Black Parenting programs, fatherhood programs, social service assistance) and early childhood development (age-appropriate education) services in a wrap-around model. These services are offered under one roof, encouraging families to build strong relationships with their providers and opening up opportunities for comprehensive care. Central to the model is the empowerment of women and families with the tools and resources they need to be active in their own health care and raise healthy children. In addition, the model incorporates community members in planning and implementation through a Community Advisory Board that meets monthly to recommend changes and inform new policies.

Denver Interconception Health Promotion Initiative (Colorado)

coloradotrust.org/attachments/0000/3168/IHPIFinalReport04.pdf

The Interconception Health Promotion Initiative was a demonstration project funded by The Colorado Trust and developed at Denver Health from 1995 to 2001. The purpose was to develop a home-based case management program for women who previously had a low birth weight baby, a fetal demise or a baby with congenital anomalies, and who planned on having more children. The goal was to improve future pregnancy outcomes. Patients were recruited at the time of the delivery of a qualifying infant and received a comprehensive evaluation, followed by intensive, relationship-based home visitation services. Home visitation focused on a variety of domains, including maternal role, follow-up of medical and reproductive health issues, contraception, and life course. Compared to qualified women who declined the program, women who participated were more likely to follow through on their postpartum care and birth control use. In addition, they had

a longer interconception period than women who declined to participate and their subsequent babies were heavier, less likely to be low birth weight and less likely to require a stay in the NICU.

Every Child Succeeds (Ohio)

everychildsucceeds.org

Every Child Succeeds (ECS) is a collaborative program that provides home visits focused on proper child development for first-time, at-risk mothers, their babies and families on a regular basis from the time of pregnancy until the child turns three. Founded in 1999, ECS uses two national models of home visiting (Healthy Families America and Nurse-Family Partnership) that are augmented by organizational enhancements, including continuous quality improvement, a strong public-private partnership, community collaboration and integrated supplemental interventions (e.g., Maternal Depression Treatment Program). An especially telling measure of ECS effectiveness is the demonstrated reduction in infant mortality for ECS children. In a 2007 study, authors reported a 60 percent reduction in the infant mortality rate for ECS participants, compared to matched controls. Unlike in the general population, there are no differences in infant mortality between African-American and Caucasian children participating in Every Child Succeeds. Other studies have found improvements in developmental and language delays, reductions in the number of parents with high-risk parenting attitudes and beliefs, and increases in safe-home environments.

Kentucky HANDS

chfs.ky.gov/dph/mch/ecd/hands.htm

The Health Access Nurturing Development Services (HANDS) program is a statewide home visitation program in Kentucky that provides services to first-time parents who are at risk or overburdened. Established in 1998 to address high rates of child abuse, the program goals are to increase positive pregnancy and child health outcomes, optimize child growth and development, reduce child maltreatment, and improve family functioning. Previous evaluation studies have shown lower rates of preterm birth, child abuse/neglect and infant mortality among participants. In fiscal year 2011, HANDS served 10,614 families in Kentucky.

Magnolia Project (Florida)

nefhealthystart.org/for-women/magnolia-project

The Magnolia Project is a federally-funded Healthy Start initiative to improve the health and well-being of women during their childbearing years (15 to 44 years old) and reduce infant mortality rates in Jacksonville, Florida. The project offers health education, outreach, well-woman and prenatal care, case management, and related services to more than 700 women annually who are at risk of a poor birth outcome when they become pregnant. Risk factors addressed by the project include infections, short birth intervals, alcohol and drug abuse, poor nutrition, and previous pregnancy loss. Beyond individual services, the Magnolia Project focuses attention on improving the health of the entire community through education, outreach and neighborhood engagement activities. A longitudinal evaluation found clients who received preconception and interconception case management showed improved birth outcomes following case management, including decreases in low birth weight and infant death and a decrease in failed interconception periods. Magnolia case management clients were also more likely to have a decrease in low birth weight, infant mortality and STIs.

Northern Manhattan Perinatal Partnership (New York)

sisterlink.com

The Northern Manhattan Perinatal Partnership (NMPP) and its Central Harlem Healthy Start program consists of clinical and group education interventions, as well as initiatives to address structural reforms in the built environment in order to reduce infant mortality. Through NMPP, more than 9,500 women and their children have been linked and maintained in care. The program addresses sustained economic and physical well-being through a job readiness program that has placed more than 890 women in full- and part-time employment. At the policy level, NMPP supports the empowerment-zone legislation, which infused Harlem with up to $300 million in block grants for community revitalization and job-creation projects and actively advocated for reforms in urban services, such as reducing the number of bus depots to improve air quality and supporting the building of supermarkets that provide healthier food. Since the program inception in 1990, when the infant mortality rate was 27.7 infant deaths per 1,000 live births, the infant mortality rate in Central Harlem has plummeted to 5.2 in 2004.

Parent Child Assistance Program (Washington)

depts.washington.edu/pcapuw/

The Parent-Child Assistance Program (PCAP) is an evidence-based home visitation case-management model for mothers who abuse alcohol or drugs during pregnancy. Its goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs. PCAP began in 1991 at the University of Washington as a federally funded research demonstration

Recommendation 4 Examples *continued*

designed to test the efficacy of an intensive, three-year advocacy/case management model with high-risk mothers and their children. Research findings demonstrated the efficacy of the model, and the Washington state legislature subsequently funded PCAP to develop sites throughout the state. Since 1991, PCAP has served more than 2,000 families in Washington state and has been replicated in other locations across the United States. The PCAP approach is two-pronged: paraprofessional case managers provide extensive role modeling and practical assistance directly in the home with the client, and they connect clients to a comprehensive variety of services in the community, ensuring that clients actually receive the services they need. PCAP case managers work with a caseload of 15 to 16 families each, for a three-year period beginning during pregnancy or within six months after the birth of an index child. A complete implementation toolkit, including a program operations manual and the PCAP evidence base, is available online.

Partners in Pregnancy (Virginia)

members.optimahealth.com/health-and-wellness/mlmp-partners-pregancy/Pages/default.aspx

Partners in Pregnancy aims to improve adverse pregnancy outcomes by decreasing NICU days and dollars. The program involves home visits and case management for high-risk pregnant women and their infants in eastern Virginia by CHIP nurses and outreach workers, in combination with a medical home and regular nurse consultations. CHIP nurses were trained according to the March of Dimes recommendations for the care of high-risk pregnant women; Great Beginnings Start Before Birth prenatal training also was offered to all outreach workers. Bright Futures Guidelines were used by all CHIP nurses and outreach workers as a basis for health supervision activities conducted in the family home after the child is born. The intervention infants spent less time in the hospital. Healthy behaviors among mothers were also impacted by participation in the program, with a 55 percent decrease in maternal smoking, a 100 percent decrease in maternal alcohol use and a 70 percent decrease in stress levels for those who reported high stress levels when they entered into the program. Program evaluation also showed a net savings of $2,287 per pregnancy and an overall return on investment of 1.26. CHIP babies spent 44 percent fewer days in the hospital than the control babies, as well as fewer days in the NICU.

Prenatal Plus Program (Colorado)

colorado.gov/cs/Satellite/HCPF/HCPF/1251594936298

Prenatal Plus is a Medicaid-funded program that provides care coordination, nutrition and mental health counseling to Medicaid-eligible pregnant women in Colorado who are at a high risk for delivering low birth weight infants. The program uses the client-centered counseling approach with all participants to address a variety of issues that have been shown to have a negative impact on birth outcomes. The key health areas targeted by this program are healthy weight, smoking cessation and depression. In order to encourage providers to offer model care for all women in the program, the Medicaid reimbursement structure has been adapted to offer a greater monetary incentive for completing the required number of visits (10) for model care. In 2010, the low-birth-weight rate for infants born to Prenatal Plus participants who remained in the program through delivery was 10.6 percent. Reductions in the low-birth-weight rate are directly related to the decreases in risk achieved by the women enrolled in Prenatal Plus. Six out of 10 (63 percent) Prenatal Plus Program participants were able to resolve all of their risks, and the resulting low-birth-weight rate for their infants was 8.2 percent. In 2010, this reduction in the low-birth-weight rate saved Medicaid an estimated $3.3 million in health care costs for the 2,089 women who received Prenatal Plus services and their infants through their first year of life. The program also has shown success in reducing smoking rates, substance use, and in maintaining healthy weight among participants.

Women Enjoying Life Longer Project (Maryland)

fha.dhmh.maryland.gov/mch/SitePages/women.aspx

The Women Enjoying Life Longer (WELL) Project was piloted by the Maryland Department of Health and Mental Hygiene (DHMH) as a women's health integration project at the Title X family planning clinics in Baltimore County. The primary objective was to improve the general health of young women and, if they later became pregnant, to help them enter pregnancy in a healthier state. WELL provides a model for the integration of health services, such as smoking cessation, weight management, domestic violence counseling, depression screening, medical screening, immunizations, to promote wellness among Maryland women. WELL Project participants live at or below the federal poverty level and are uninsured. Patient volume at WELL clinics has increased dramatically during the project period. Evaluation has documented WELL Project participants have positively responded to services offered and have identified many of the services as ones they would not have received if they were not in the program. The Center for Maternal and Child Health, DHMH, was awarded funding for this project by the MCHB.

Recommendation 5: Improve Access to Health Care for Women Before, During and After Pregnancy

Access to health care coverage is a crucial component of ensuring healthy birth outcomes for women and infants. More than one in five reproductive-age women are uninsured. In 2010, the 13 million women of reproductive age (15 to 44 years) without health insurance accounted for more than one quarter of the 50 million U.S. residents who were uninsured.[lvii] Lack of health care often means late or no entry into prenatal care for women, which can result in pregnancy complications and delayed diagnosis of treatable conditions. Furthermore, science indicates that prenatal care may be too late to intervene to fully assure the health of mothers and babies.[lviii] Comprehensive medical services for women before, during and between pregnancies are a proven intervention for improving birth outcomes.[lix]

The Patient Protection and Affordable Care Act (ACA) expands health insurance coverage and provides states with tools and resources to improve access to quality care for women. Coupled together these reforms can ultimately help improve birth outcomes. Under the ACA, several provisions have the potential to significantly enhance preconception health.

First, the ACA expands coverage for uninsured adults through an expansion of Medicaid and the establishment of health insurance exchanges. Currently, under Medicaid law, as of 2012, women must meet both categorical and income criteria to qualify for Medicaid. States must cover pregnant women with incomes up to 133 percent of the FPL for up to 60 days postpartum and can extend coverage up to 185 percent of FPL and beyond. Medicaid eligibility levels for pregnant women range from 133 percent of FPL in nine states to 300 percent FPL in three states; all other states fall somewhere in between these thresholds.[lx] Those barriers to Medicaid coverage for very low-income women will potentially change with Medicaid expansion in 2014 when some women under 133 percent of the FPL will qualify for Medicaid.[5] It is estimated that as many as 10 million currently uninsured women could qualify for Medicaid by 2014.

Women who lack employer-sponsored health insurance and who earn incomes between 133 to 400 percent of the FPL – levels too high to qualify for Medicaid – will be eligible for coverage through new state health insurance exchanges beginning in 2014.

Another important provision is the extension of coverage for young adults on the plans of their parents. Any group health plan or plan in the individual market that provides dependent coverage for children is required to make that coverage available for young adults up to age 26 even if the young adult no longer lives with his or her parents, is not a dependent on a parental tax return or is no longer a student. More than one quarter (29 percent) of women between the ages of 19 and 25 are uninsured and could potentially benefit from this expansion.[lxii]

In addition to these coverage expansions, the ACA also included several insurance market reforms, including a ban on pre-existing condition exclusions (e.g. pregnancy), no lifetime or unreasonable annual limits, prohibits discriminatory premium rates and provision for guaranteed availability of coverage.

The ACA also makes important strides toward improving the benefits that a woman receives. The law requires a core set of 10 essential health benefits, including but not limited to preventive services, maternity and newborn care, to be part of the comprehensive benefits package for those qualified health plans sold in the exchange and for Medicaid benchmark plans. Moreover, this provision of the law eliminated co-pays for services recommended by the U.S. Preventive Services Task Force (USPSTF) and immunizations recommended by the CDC.

[5]On July 5, 2012 the US Supreme Court upheld the Affordable Care Act as constitutional, but ruled that states couldn't be coerced into agreeing to the Medicaid expansion. Instead, states may decide not to participate in the expansion, which is 100% financed with federal funds for the first three years and then 90% covered for the next seven. As of the date of this publication it is unclear how this ruling will impact expansion of Medicaid.

Recommendation 5 *continued*

On Dec. 16, 2011. the U.S. Department of Health and Human Services (HHS) issued a bulletin providing guidance to the states on their approach to essential health benefits. Essentially, this bulletin proposed that states utilize a benchmark approach to define the essential health benefits.[lxiii] If a state selects a benchmark plan that does not cover all 10 categories of care, the state will have the option to examine other insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that must be included in the essential health benefits package.[lxiv] This is the benchmark that states will likely be held to in terms of implementation of Essential Health Benefits for State Insurance Exchanges and newly insured adults under Medicaid.

While many women today lack access to health care services, there are also many gaps in services for women who do have basic health care. Women may receive appropriate care during a pregnancy but lack access to comprehensive services before and after. Among women who have unintended pregnancies, more than half or 53 percent report no use of family planning methods prior to conception.[lxv] Lack of contraceptive use may be a result of individual behaviors and/or a lack of education and access to contraceptive services, particularly for women living in rural or other underserved areas. Currently, only 85 percent of U.S. counties have at least one publically funded family planning clinic.[lxvi]

One of the most notable accomplishments of the ACA relative to improving women's health occurred on Aug. 1, 2011, when HRSA issued guidelines to ensure that women have coverage for eight preventive health services identified by the Institute of Medicine (IOM) as critical gaps, as well as measures to further ensure women's health and well-being. The guidelines require new health insurance plans beginning on or after Aug. 1, 2012, to cover these services without charging a copayment, coinsurance or a deductible. These services are:

- Well-woman visit (preventive visit)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing for women ages 30 years and older
- Sexually-transmitted infection counseling
- Food and Drug Administration approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Human Immunodeficiency Virus (HIV) screening and counseling
- Domestic violence screening and counseling

Specifically, the IOM recommended coverage for at least one well-woman preventive care visit annually for adult women to obtain the recommended preventive services, including preconception and prenatal care. The committee

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also recognized that several visits may be needed to obtain all necessary recommended preventive services, depending on health status, health needs and other risk factors. As part of the list of preventive services to be obtained during well-woman preventive visits, the IOM recommended that the preconception component of the visit include an opportunity for the health care provider to conduct, "evidence-based tests, procedures, and screening for nonpregnant women to optimize reproductive outcomes and prevent or optimize treatment for chronic conditions, as well as topics for counseling and guidance for preconception health."

Medicaid already requires that states cover family planning services without cost sharing. States that decide to offer newly eligible Medicaid enrollees a benchmark benefit plan must include coverage of family planning services to all qualifying individuals. The ACA also allows states to extend eligibility for family planning services to women with incomes below 185 percent of poverty without going through a federal waiver process. States can accomplish this by changing their Medicaid rules through a state plan amendment.

Access to comprehensive health care should also include access to oral health care. Good oral health enhances an the ability of an individual to speak, smile, smell, taste, touch, chew, swallow, and convey feelings and emotions through facial expressions.[lxvii] Preventable oral diseases, from oral cavities to oral cancer, are common in the United States. The CDC estimates tooth decay affects more than one-fourth of U.S. children ages 2-5 years and half of those ages 12-15 years, and advanced gum disease affects 4 percent to 12 percent of U.S. adults. Among women, diet and hormonal changes that occur during pregnancy may increase their risk for tooth decay and gum disease. Furthermore, surveillance suggests oral bacteria and poor oral health play a causal role in adverse pregnancy outcomes.[lxviii] Finally, pregnancy-related health care may be an opportune time to address oral health needs for women who may not otherwise be routinely accessing health care. It is important to note that the ACA establishes a minimum set of required benefits that includes pediatric dental coverage for the health insurance exchanges but not adult dental coverage.

Investments in prevention including the Prevention and Public Health Fund and programs such as the Maternal, Infant, and Early Childhood Home Visiting Program, which provides resources to states for home visiting programs, offer additional important resources to strengthen supports and services to women, infants and children.

Health systems reform – whether through implementation of the ACA or other means – provides an important opportunity to states and communities for ensuring that preconception health is a central part of these system transformations.

In coordination with new opportunities provided by the ACA, states can consider taking the following actions to improve access to health care for women before, during and after pregnancy:

Navigate the opportunities of the ACA which includes the expansion of coverage of comprehensive reproductive health services, including family planning for the uninsured and underinsured populations. Specific strategies include:

- Engaging with health insurance exchange boards to provide guidance in the development and strengthening of outreach and enrollment processes to ensure that the unique needs of maternal and child health populations are considered in the development of a single streamlined and coordinated eligibility and enrollment process, and that where relevant, eligibility for other public health programs (e.g., Children with Special Health Care Needs programs, high risk prenatal care coordination, Early Intervention (Part C of IDEA), WIC child nutrition programs, Family Planning, etc) is considered and integrated into these systems.
- Partnering with the state Medicaid agency to develop and obtain a family planning state plan amendment to expand coverage for family planning services to all uninsured persons, whether or not they have ever participated in the Medicaid program.
- Encouraging partners to provide free or low-cost family planning services for uninsured and underinsured populations.

Ensure prenatal, family planning and other health services are accessible to all women, particularly women living in underserved areas. Strategies include the following:

- Providing incentives to providers, such as enhanced reimbursement, health information technology benefits and pay-for-performance, to increase availability of providers who accept Medicaid and provide family planning services and care for high-risk pregnancies.
- Providing family planning, prenatal, well-woman, adolescent-health and well-child services that are accessible to the target population (e.g. location such as on bus routes and walking distance for metro or bus stops, flexible hours of operation, walk-in hours, and teen centers or teen-centered hours) and provide services in a culturally appropriate manner, including translation services.
- Assessing the availability of family planning and prenatal care needs and service sites to ensure statewide access especially in targeted high-risk areas.

Recommendation 5 *continued*

- Working with Federally Qualified Health Centers, state Offices of Primary Care, state Primary Care Associations and local health plans to maximize resources to provide primary care for uninsured women.
- Ensuring all Medicaid-eligible pregnant women have access to comprehensive holistic Family Practice Team Model care.[6]
- Promote social media efforts that to help inform women, children and families about enrollment in Medicaid, CHIP or the health insurance exchanges..

Support mechanisms to facilitate easy enrollment into Medicaid so providers can directly enroll eligible clients, based on declaration of income and family size. Strategies include:

- Ensuring that the organizations and agencies that serve low-income women are trained and able to help facilitate enrollment into Medicaid.
- Expediting Medicaid application processes by placing Medicaid eligibility workers in local health clinics, local health department, local social service department locations, and all other points of service to facilitate health coverage and earlier entry into prenatal care.
- Implementing and supporting several, simultaneous strategies of outreach and enrollment.[7]

Strengthen the workforce to ensure access to providers for all women of reproductive age. Specific strategies include:

- Building partnerships with academic centers, community hospitals, local health departments, Federally Qualified Health Centers and other community health centers, professional organizations, and other community-based organizations in order to help ensure and improve access to obstetrical providers.
- Developing telemedicine systems so women in rural, underserved areas can access medical specialists (See **Recommendation 2: Ensure Quality of Care for All Women and Infants** for more information and specific examples).
- Encouraging the adequate reimbursement of providers for reproductive health services.
- Evaluating the potential for third-party reimbursement for doula and community health worker services and health navigators.

Promote comprehensive oral health care, particularly the prevention and treatment of periodontal disease, as a component of perinatal health programs. Specific strategies include:

- Ensuring oral health education is integrated into outreach programs for perinatal care.
- Educating providers on how to screen and refer women for comprehensive oral health care, including periodontal disease.
- Disseminating resources on the importance of dental care for women of childbearing age to clinicians and health educators.
- Educating pregnant women about the importance of visiting a dental provider.
- Exploring ways to establish a dental home for women to ensure that they have access to dental care during and after pregnancy. One model would be to partner with dental managaed care programs.
- Increasing payment options for gap-filling dental services.

Increase access to interconception care for women with prior adverse pregnancy outcomes. Core services include family planning, screening for maternal depression and intimate partner violence, assessing social support for the pregnant woman, smoking cessation and substance treatment programs, physical activity and nutritional education and intervention, management of chronic diseases, and education on back-to-sleep and parenting skills.

Examples

California Family Planning Waiver: Family PACT Program

familypact.org

Family PACT (Planning, Access, Care, Treatment) is a program that provides no-cost family planning services to

[6] For more information on Family Practice Team Model care, visit the American Academy of Family Physicians resource article on team-based, proactive care at aafp.org/fpm/2005/0500/p59.html.

[7] More information and ideas for additional strategies are presented in State of Art of Medicaid Outreach and Enrollment (2009), available at urban.org/UploadedPDF/411898_pregnant_women.pdf

low-income men and women, including teens. Family PACT was established by the California legislature in 1996 and implementation began in January 1997. The program objectives are to reduce the rate of unintended pregnancies, increase access to publicly funded family planning services for low-income Californians, increase the use of effective contraceptive methods by clients, promote improved reproductive health, and reduce the overall number and cost of unintended pregnancies. Initially funded only by the state, California received a Centers for Medicare and Medicaid Services (CMS) federal Medicaid Section 1115 Waiver in 1999, enabling the program to receive federal matching funds. Special features of the program, such as broad client eligibility criteria, on-site enrollment, and inclusion of private providers and pharmacies, have improved access to and quality of services. As a result, Family PACT has achieved a reduction in unintended pregnancy and saved millions of dollars in public expenses.

Maryland Medicaid Accelerated Certification of Eligibility/Quickstart Prenatal Care Visit

fha.dhmh.maryland.gov/mch/SitePages/postpartum-referral.aspx

Through close partnership with Medicaid, a new Accelerated Certification of Eligibility (ACE) process assures Medicaid-eligible women that they will have access to prenatal care as early as possible and a quickstart prenatal care visit is offered at health departments in target jurisdictions. To ensure that high-risk babies and mothers receive postpartum follow up, a statewide standardized postpartum discharge referral process is being developed and a postpartum Infant and Maternal Referral Form was implemented statewide.

Mississippi Interpregnancy Care Project

Modeling the program implemented in Georgia (Grady Memorial Hospital), the Mississippi State Department of Health (MSDH) implemented pilot programs in two communities among women who delivered a very-low-birth-weight infant. The pilot communities are predominantly African American with high rates of poverty, low-birth-weight (LBW) deliveries, infant mortality and morbidity, and low rates of health insurance coverage and restricted access to primary care services. The Metropolitan Infant Mortality Elimination (MIME) and Delta Infant Mortality Elimination (DIME) programs give varying perspectives – urban and rural – of implementing interpregnancy care in Mississippi. Early data suggest improved outcomes and achievement of adequate child spacing.

Perinatal Connect to Care (West Virginia)

wvperinatal.org/teleconsultation.htm

In early 2010, West Virginia formally launched the Connect to Care Project. The project is a telecommunications project linking rural health facilities with tertiary care centers housing perinatal specialists. Live telecommunications infrastructure allows pregnant women and their local health care providers to obtain medical advice from specialists without traveling. The project also supports continuing education for rural medical practitioners and access to obstetrical referrals. Currently, Connect to Care is operating in 15 rural health care sites as a pilot program. The project is funded by a Rural Utilities Service Grant from the U.S. Department of Agriculture and matching funds from 18 partnering West Virginia hospitals and community health centers.

Plan First: Michigan Family Planning Waiver

michigan.gov/mdch/0,1607,7-132--146295--,00.html

On Mar. 1, 2006, CMS approved the Michigan submission of a Section 1115 demonstration waiver to provide family planning services to Michigan citizens meeting certain

Recommendation 5 Examples *continued*

eligibility requirements. This program enables the Michigan Department of Community Health (MDCH) to provide family planning services to women who otherwise would not have medical coverage for these services. Through this waiver, MDCH offers family planning services to women ages 19 to 44, who are not currently Medicaid eligible, who have family income at or below 185 percent of the FPL. It is estimated at least 200,000 women meet this criteria.

Planning for Healthy Babies, Georgia Family Planning Waiver

p4hb.org

In 2010, the Georgia Department of Community Health (DCH) received approval for an 1115 Family Planning demonstration waiver to implement the Planning for Healthy Babies (P4HB) program. The P4HB program offers family planning services to women who previously did not qualify for Medicaid benefits. The P4HB program aims to improve very-low-birth rate (VLBW) and low-birth-weight (LBW) rates in Georgia by providing family planning services to women, increasing child spacing intervals through effective contraceptive use, increasing prenatal planning and vitamin intake among women, and providing interpregnancy care services to women with a previous VLBW infant. The program was implemented in January 2011. Evaluation of the program was contracted to Emory University. Overall, the P4HB program plans to evaluate based on reductions in pregnancy rates, improved birth outcomes, member and provider satisfaction, and overall cost savings. Federal Medicaid provides 90 percent of the cost and state funds are appropriated to DCH for the remaining 10 percent.

Take Charge, Louisiana Family Planning Waiver

new.dhh.louisiana.gov/index.cfm/page/232

Since October 2006, Louisiana Medicaid has offered family planning services to women, ages 19 to 44 who do not have health insurance that covers family services and who are not eligible for any other Medicaid program with the exception of the Greater New Orleans Community Health Connection (GNOCHC). All must meet income requirements that are at or below 200% of the federal poverty level. The goal of the program is to reduce unintended pregnancies by providing access to family planning services. The Take Charge program includes the following services: up to four (4) physical examinations or necessary re-visits for the purpose of family planning per calendar year, laboratory tests for the purpose of family planning, Pap Smear Screening for the purpose of family planning, Sterilizations, and certain approved family planning medications and supplies (i.e. contraceptives). The program is a Family Planning Research and Demonstration Project under the authority of Section 1115 Demonstration Waiver.

Tampa Bay Doula Program (Florida)

achievetampabay.org/ProgramServices/doulaservices.aspx

The Tampa Bay Doula Program provides free perinatal services to low-income pregnant women at risk for poor birth outcomes. Program services include community-based childbirth education classes, labor and delivery support, postpartum mom/baby care and instruction focusing on mom/baby attachment, extension of breastfeeding duration, and interconception care. A pregnant client can sign up for doula services at any time prior to delivery, however, the average young woman begins attending classes in her first trimester and stays with the program through three to six months postpartum. Clients are able to participate and receive doula services if they are low income and socially/medically at risk. In comparison to the Hillsborough County average of 12.4 black infant deaths per 1,000 births from 2005 to 2007, black participants in the Doula Program experienced a lower infant mortality rate (1 per 1,000 black infant deaths reported). The program Client Satisfaction Survey found that: 99 percent of doula clients receiving postpartum support report and demonstrate positive transition relating to mother and infant bonding; 98 percent of clients receiving clinic-based doula instructions demonstrate competence of pregnancy related topics; and 97 percent of delivering mothers that were provided supportive labor/delivery services report positive birth experiences.

Recommendation 6: Develop Data Systems to Understand and Inform Efforts

Understanding and using data transcends all of the recommendations, strategies and examples presented throughout the AMCHP compendium. Developing and using *data systems*, however, is a specific recommendation because building data infrastructure is foundational to understanding a problem, implementing interventions and evaluating comprehensive efforts.

Collecting and analyzing a wide range of data to understand reproductive and infant health, as well as contextual information about health care systems, neighborhoods and the environment will help to define the extent, causes and contributors to infant mortality and poor birth outcomes. Creating a comprehensive picture of infant mortality requires working with a range of agencies and partners to share data across systems and programs, and create data linkages where possible. Key partners in developing data systems may include Medicaid and other health insurers, vital statistics, chronic disease programs, Fetal and Infant Mortality Review (FIMR) programs, birth defects registries, and hospitals. Enhancing and supporting ongoing data collection and monitoring systems through linkage of birth certificates with infant death certificates, newborn screening (blood spot and hearing), immunization registries and maternal and infant hospitalizations, Medicaid claims, and WIC program data are crucial next steps to developing a comprehensive picture of infant mortality and strategies to improve birth outcomes.

Critical components of a comprehensive data system to improve birth outcomes and reduce infant mortality include the Title V MCH Services Block Grant performance measures, the Pregnancy Risk Assessment Monitoring System (PRAMS), FIMR, and/or child fatality reviews, maternal mortality reviews and birth defects registries. In addition, there are several effective approaches that state and local health agencies have used to identify the drivers of poor birth outcomes and share information across stakeholders, including examination of causes of death, Perinatal Periods of Risk (PPOR)[lxix, lxx, lxxi] and Kitagawa analyses.[lxxii]

As a comprehensive, linked data system is established, translating data into information for action to facilitate the design of targeted interventions and gauge the impact of these interventions is a crucial next step. Assessing and sharing data related to infant mortality and birth outcomes with key stakeholders, including families, can help to build consensus about the strategies to pursue to improve birth outcomes and monitor progress.

Actions states can consider taking to develop data systems to understand and inform efforts include the following:

Conduct a thorough assessment of existing data systems to determine what currently exists and what data systems may need to be developed. Specific strategies include:

- Identifying what programs already exist and what data is collected. In order to have a comprehensive picture of all efforts to reduce infant mortality and improve birth outcomes, create a mechanism to document and share data from new and established programs that address infant mortality within the state. While vital statistics data often lag by a year or two, program data can capture more current trends for specific populations served.
- Evaluating existing surveillance systems. In order to rely on surveillance systems for information about infant mortality, evaluate existing sources of data for factors such as data quality, representativeness and timeliness.[8]

[8] For more information and the updated CDC guidelines for evaluating surveillance systems, visit cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm

Recommendation 6 *continued*

Strengthen epidemiology capacity focused specifically on maternal and child health. Specific strategies include:

- Supporting MCH epidemiologist positions at the state health department.
- Enhancing current MCH epidemiology skills and workforce capacity.
- Pursuing opportunities such as Council of State and Territorial Epidemiologists (CSTE)[9] Applied Epidemiology Fellows, Public Health Prevention Service (PHPS)[10] fellows, Graduate Student Intern Program placements (GSIP)[11] and CDC MCH Epidemiology Field Assignees[12] to increase capacity for MCH epidemiology and surveillance.
- Partnering with local or regional academic public health programs to increase MCH epidemiology research and surveillance.

Create formal data-sharing partnerships to facilitate timely and ongoing data sharing. Specific strategies include:

- Creating formal documents such as a memorandum of agreement or a memorandum of understanding between agencies to facilitate timely and ongoing data sharing and gain access to needed data.
- Ensuring contracts with Medicaid Managed Care Organizations provide timely data for all pregnancy outcomes in the Medicaid program.

Create a linked database system or conduct strategic data linkages to enhance birth and death certificate information and facilitate identification of additional risk and protective factors for infant mortality and other poor birth outcomes. Key datasets include vital records, hospital discharges, newborn screening (blood spot and hearing), the immunization registry and the birth defects registry. In addition, Medicaid and other insurer data, program data and surveys, such as PRAMS, can provide a wealth of information on the health of women and infants.

Use effective methods to understand infant mortality in your state and communities. Using analytic methods will assist in identifying root causes of poor birth outcomes and infant mortality and clarify underlying issues in geographic areas of high infant mortality to help in targeting interventions and setting a baseline for improvement. Specific strategies include:

- Utilizing PPOR methods to focus strategies and resources to address trends and disparities in fetal and infant mortality.[13]
- Utilizing mapping tools and techniques, including Geographic Information Systems (GIS), to conduct an in-depth assessment of geographic areas with high infant mortality. Use data to identify communities and neighborhoods at highest risk of poor outcomes. Create maps that help stakeholders visualize poor birth outcomes.
- Using available census and other community-level data on risk factors for poor birth outcomes to identify and monitor progress over time in reducing infant mortality in communities and special population groups, such as migrant workers and immigrant populations.

Examine environmental influences on birth outcomes and infant mortality. Specific strategies include:

- Partnering with environmental tracking programs that have begun incorporating reproductive and birth outcomes into their data portals to look at the impact of environmental exposures and stressors on birth outcomes.[14]

Conduct a comprehensive review of all fetal, infant and child deaths. Specific strategies include:

- Educating hospitals and health care providers on public health surveillance legislation and the authority of public health agencies to access health information as necessary to conduct death reviews.
- Implementing or enhancing a FIMR program. Key elements for a successful FIMR program include a case review team; access to sources of, data including a family/maternal interview and hospital records; a population/community focus; feedback mechanisms; multidisciplinary involvement; a community action team; continuous quality improvement; and a regular mechanism to share recommendations with key stakeholders.[lxxiii] FIMR programs should include investigation of all stillbirths occurring after 20 weeks' gestation.[15]

[9] For more information about the opportunity to host a CSTE fellow, visit: cste.org/dnn/ProgramsandActivities/FellowshipPrograms/tabid/259/Default.aspx
[10] For more information about the opportunity to host a PHPS fellow, visit: cdc.gov/PHPS
[11] For more information about the opportunity to be a GSIP placement, visit: mchb.hrsa.gov/researchdata/mchirc/gsip/index.html
[12] For more information about the opportunity to host a CDC MCH Epidemiology field assignee, visit: cdc.gov/reproductivehealth/mchepi/index.htm
[13] To access material on PPOR, visit: cdc.gov/reproductivehealth/mchepi/index.htm
[14] For more information about the CDC Environmental Tracking Network, visit: ephtracking.cdc.gov/showHome.action
[15] For more information on establishing NFIMR programs, visit: nfimr.org

- Establishing a SIDS/SUIDS case registry. Key elements for a successful SIDS/SUIDS case registry include a standardized diagnosis of sudden unexpected infant deaths and examination of the dynamics between declines in deaths attributed to SIDS and increases in SUID.[16]

- Implementing or enhancing comprehensive child fatality reviews.[17] Key elements for a successful child fatality review program include multidisciplinary participation from the community and a review of comprehensive information in order to understand risks of child death and establish effective recommendations to prevent further child death.

Expand information collected through birth and fetal death certificates. Specific strategies include:

- Adopting the revised (2003) birth certificate to collect enhanced information on topics such as assisted reproductive technologies, body mass index (BMI) before pregnancy and at delivery, more detailed smoking data, gestational diabetes, and breastfeeding at hospital discharge following labor and delivery. More information on the revised certificates is available at cdc.gov/nchs/nvss/vital_certificate_revisions.htm.

- Partnering with Vital Statistics departments to devise and implement strategies to improve data quality from birth and death certificates.

- Adopting the 2003 National Center for Health Statistics Fetal Death Certificate and computerize state fetal death records to allow analysis of causes of fetal death. In combination with data on births and neonatal deaths, fetal death data provide a more complete picture of pregnancy outcomes and their risks. Surveillance of all perinatal deaths can help elucidate causes of death common to fetal and neonatal deaths.[lxxiv]

Conduct a comprehensive review of all maternal and pregnancy-related deaths. Although states may pursue different structures, each pregnancy-related mortality surveillance should include identification of pregnancy-related deaths, review of the medical and non-medical causes of death, analysis and interpretation of the findings, and action on the findings.[lxxv] This comprehensive review should include de-identified case summaries for each maternal or suspected pregnancy-related death, a case review team that makes a determination for each death regarding relationship to pregnancy and identification of opportunities for reducing maternal mortality. In order to successfully conduct reviews, state partners may need to educate hospitals and health care providers on public health surveillance legislation and the authority of public health agencies to access health information as necessary to conduct death reviews.

Establish a PRAMS survey. PRAMS is a surveillance project conducted in partnership with states by the CDC. PRAMS collects state-specific, population-based data on maternal attitudes, experiences, and behaviors before, during and shortly after pregnancy. PRAMS provides data that are not available from any other data source, including topics such as unintended pregnancy, post-discharge breastfeeding practices, services received during prenatal care and substance use. PRAMS data enhances information from the birth certificate and should be used to monitor changes in maternal and child health indicators, make comparisons across states and identify women and infants at higher risk for health problems. Additional information is available at cdc.gov/PRAMS/.

Establish or expand birth defect registry surveillance. Specific strategies include:

- Implementing active or enhanced case finding to supplement existing passive reporting such as birth and death certificates and hospital discharge data.[18]

- Increasing provider, partner and family education about reporting requirements and benefits of the registry.

Establish or expand collection of qualitative data to help enhance surveillance data with information on the lived experience of women and communities. Specific strategies include:

- Partnering with specialists in qualitative data collection and analysis to enhance collection and use of qualitative data.

- Conducting focus groups to collect information from women and families on health behaviors, possible communication messages or intervention strategies. Focus groups can also be a venue for sharing information with community members and testing core messages on current data for the lay public.

- Using qualitative research methods to better understand barriers to care for families and communities.

- Utilizing PRAMS comments, when available, to further explain quantitative data collected through surveillance.

- Highlighting programmatic case studies, as appropriate, throughout data dissemination materials.

[16] For more information on establishing SIDS/SUIDS case registries, visit: cdc.gov/sids/CaseRegistry.htm
[17] For more information on establishing Child Death Review, visit: childdeathreview.org
[18] For NBDPN birth defects surveillance guidelines, visit: nbdpn.org

Recommendation 6 *continued*

Measure women's reproductive health status. Specific strategies include:

- Implementing and use the Core Preconception Health Indicators.[19, lxxvi]
- Developing State Title V performance measures on preconception health measurement and tracking.
- Including preconception metrics in the reporting requirement structure of new statewide managed care networks.

Evaluate all programs aimed at reducing infant mortality. If feasible, conduct meta-evaluations to summarize the collective impact of programs and identify areas for improvement. Evaluations should identify and assist in eliminating/filling gaps in services and areas of disparity to improve care and outcomes.[20]

Publish birth outcomes data annually to stakeholders, including through accessible reports for consumers. Specific strategies include:

- Obtaining provisional data to facilitate early assessment of trends and to improve follow-up for screening, tracking and mortality review programs.
- Making data publicly available through an online, user-friendly Web page.
- Publishing periodic data briefs for stakeholders, including consumers.

Examples

Alaska MCH Data Books

epi.alaska.gov/mchepi/mchdatabook/default.htm

MCH Data Books provide Alaskan health care providers, public health program managers and policymakers with detailed information on important maternal and child health status indicators. Alaska MCH Data Books are published by the MCH Epidemiology Unit. Beginning in 2003 and published about every other year, the data book features a comprehensive look at maternal and child health indicators for Alaska. In alternate years, data books focus on specific MCH topics, presenting the findings of public health surveillance programs operated by the MCH Epidemiology Unit, including PRAMS and the Alaska Birth Defects Registry.

Attitudes and Practices Focus Group Research (North Carolina)

Using qualitative research methods, the North Carolina Infant Mortality Collaborative conducted focus groups in 2005 to help inform maternal and child health programming. The explicit goal of the qualitative research was to help understand the link between women's health, self-care and infant mortality. Two overarching questions guided the research: (1) why do women adopt (or not adopt) preventative health behaviors? And (2) why do women use (or not use) preventative health services? The research elucidated key conclusions, including a primary theme that awareness was not enough to change behaviors in the state (i.e. women were aware of many of the public health messages that were being communicated, but the messages alone were not enough to change people's behaviors). Another theme of the research findings was empowerment. A key factor that emerged over all the focus groups was the ways that structural violence, including poverty, lack of education, racism and sexism, impacts people's access to health care in general, and preventative health care in particular. Insights were shared across the state with MCH partners and used to inform continued public health efforts.

Full report, including survey questions and interview guides, available at: nchealthystart.org/downloads2/SIMS%20Final%20Report%20web.pdf.

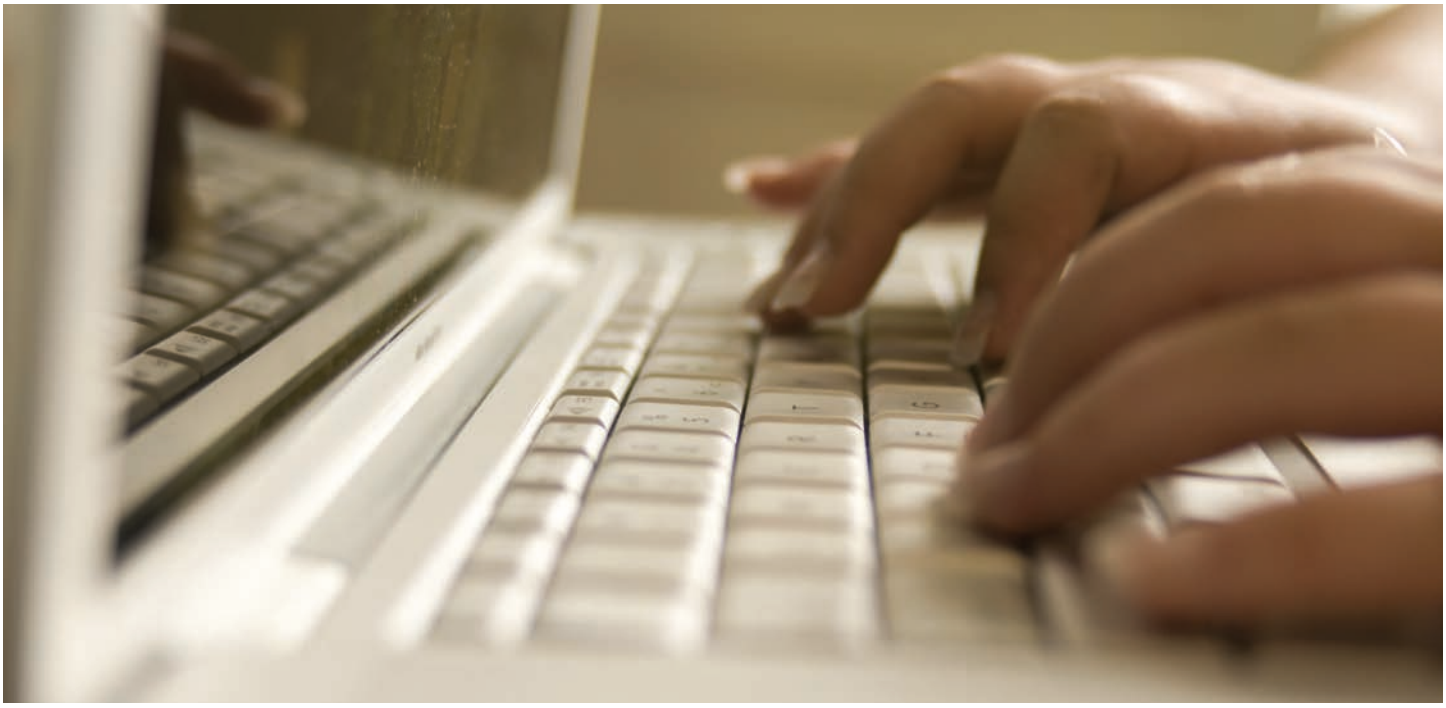
California Pregnancy-Associated Mortality Review (CA-PAMR)

cdph.ca.gov/data/statistics/Pages/CaliforniaPregnancy-AssociatedMortalityReview.aspx

The California Pregnancy-Associated Mortality Review (CA-PAMR) began in 2004 by the California Department of Public Health to investigate the rise in maternal deaths and the widening racial and ethnic disparity in maternal morbidity and mortality. CA-PAMR identifies maternal deaths using enhanced surveillance methodology and conducts an in-depth review of medical records by an expert panel of maternity care and public health professionals. CA-PAMR seeks to identify pregnancy-related deaths, causation and associated risks, and issues recommendations to improve the quality of maternity care. The California Department of Public Health collaborates with the California Maternal Quality Care Collaborative at Stanford University and the Public Health Institute.

[19] To access a full list of the Core State Preconception Health Indicators, visit: cste.org/dnn/ProgramsandActivities/ChronicDiseaseMCHandOralHealth/MCHIndicators/tabid/337/Default.aspx

[20] For information on the CDC evaluation framework, visit: cdc.gov/eval/framework/index.htm



Florida CHARTS

floridacharts.com

The Florida Community Health Assessment Resource Tool Set (CHARTS) is publicly available data that can be used to find Florida health statistics in order to identify health problems in the community. The goal of Florida CHARTS is to provide communities with data and products that assist them with community health assessment. CHARTS includes such health statistics as births, deaths, disease morbidity, population and behavioral risk factors. Data for selected health indicators is provided through maps, profile reports, data queries and other products.

Florida PAMR

doh.state.fl.us/Family/mch/pamr/pamr_info.html

In 1996, the Florida Department of Health initiated the Pregnancy-Associated Mortality Review (PAMR) to improve surveillance and analysis of pregnancy-related deaths in Florida. Once the pregnancy-associated deaths are identified, they are sorted by a physician/nurse subcommittee and initially deemed pregnancy-related, possibly pregnancy-related or not pregnancy-related. The focus of PAMR is to ensure that all deaths identified as pregnancy-related deaths are reviewed. This case review program seeks to reveal gaps in care, identify systemic service delivery issues and make recommendations to facilitate improvements in the overall systems of care. The Florida PAMR project is funded by the Title V MCH Services Block Grant.

Integrating Preconception Health Indicators into Title V Monitoring and Evaluation (Ohio)

Ohio has used the Core Preconception Health Indicators[lxxvii] to develop an Ohio Preconception Care Databook. The resource is intended to provide information about maternal and child health in Ohio and guide policy and decision making with the goal of improving health outcomes for women of reproductive age and their children. In addition, one Ohio state Title V performance measures calls for the development and implementation of a core set of preconception health indicators to monitor the health of reproductive women and evaluate preconception health effects.

LA Moms and Babies Study (California)

publichealth.lacounty.gov/mch/lamb/LAMB.html

The Los Angeles Mommy and Baby (LAMB) Project is sponsored by the Los Angeles County Department of Public Health. It is both a population-based surveillance tool and a community outreach project. The LAMB survey asks mothers who recently delivered a baby about events that happened before, during, and after their pregnancy. The LAMB Project provided and will continue to provide detailed information and high quality data to assist policymakers, community stakeholders and other essential strategic partners to: monitor the health status of thousands of mothers and their newly delivered babies; identify strategies to address perinatal issues faced by our communities; evaluate perinatal services in order to maximize the health and quality of health and human services for mothers, infants and their families; and assess the environments in which families live and thrive.

Recommendation 6 Examples *continued*

Massachusetts PELL Data System

sph.bu.edu/menu-id-452.html#overviewpercent20ofpercent20pell

The Pregnancy to Early Life Longitudinal (PELL) Data System represents a public-private partnership between the Boston University School of Public Health (BUSPH), the Massachusetts Department of Public Health (MDPH) and CDC. PELL is a unique, innovative, population-based, longitudinal reproductive data system, with multiple linked data sets that can be used for cross-sectional and longitudinal analyses. PELL data is well suited for the study of morbidity and mortality among children, mothers and families; hospital and program utilization and associated costs; evaluation of state MCH programs (e.g., Early Intervention); and enhancement of statewide surveillance systems (e.g., pregnancy-associated mortality, MA Birth Defects Monitoring Program). PELL is a relational data system composed of individual data sets that are linked together by randomly generated unique IDs for mother and infant. These unique IDs enable the creation of de-identified analytic files.

Metropolitan Atlanta Congenital Defects Program (Georgia)

cdc.gov/ncbddd/birthdefects/MACDP.html

The Metropolitan Atlanta Congenital Defects Program (MACDP) is a population-based tracking system for birth defects. MACDP was established in 1967 by the CDC, Emory University and the Georgia Mental Health Institute. It was the nation's first population-based system for active collection of information about birth defects. Population-based means researchers look at all babies with birth defects that live in the study region to get a complete picture of what is happening within the population. Since that time, the program tracked birth defects among infants and children born to mothers living in metropolitan Atlanta using active case-finding methods and multiple sources of information. The purpose of MACDP is to track the occurrence of birth defects; maintain data for use in epidemiologic studies (studies that look at health effects within the population); understand other health outcomes, such as mortality or death rates, associated with birth defects; provide data for education and health policy decisions leading to prevention of birth defects; serve as a model for help other programs develop and implement new tracking methods; collaborate with state and international birth defects programs in tracking prevention efforts; provide a training ground for public health scientists in tracking and epidemiologic methods.

New York State Maternal Mortality Review Initiative

In 2010, the New York State Department of Health implemented a Maternal Mortality Review (MMR) Initiative. All maternal deaths across the state will have a record review conducted by the quality improvement organization, IPRO. Maternal death cases are identified through the New York Patient Occurrence and Tracking System (NYPORTS); maternal death certificates; and, the Statewide Planning and Research Cooperative System (SPARCS), which provides information on discharges from hospitals, linked to birth and death records. During the first meeting of the MMR committee in 2010, preliminary data was presented based on an initial review of 70 maternal deaths obtained from NYPORTS from 2006 to 2008. This review showed the leading causes of death to be: hypertension (20 percent), hemorrhage (19 percent) and embolism (17 percent). A history of chronic illness and prenatal risk factors was frequently found in the mothers. In 59 percent of the cases, the mother was obese.

The MMR committee recommended that guidance regarding hypertension in pregnancy should be developed. A subcommittee is currently working on a guidance document on hypertensive disorders in pregnancy. The document will summarize existing guidelines for the diagnosis, evaluation and management of hypertensive disorders in pregnancy. The guidance document is intended for health care providers who care for pregnant women in a variety of clinical settings.

Oklahoma PRAMS Data Briefs

ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/Data_and_Evaluation/Pregnancy_Risk_Assessment_Monitoring_System_(PRAMS)/

On a monthly basis, Oklahoma PRAMS randomly samples between 200 and 250 new mothers using Oklahoma birth certificates. Oklahoma currently collects PRAMS data on the following topics: health insurance, prenatal care, breastfeeding, maternal smoking and secondhand smoke exposure, alcohol use, social support and family planning. Oklahoma PRAMS publishes information briefs to help disseminate data on pregnancy related health.

The Oklahoma Toddler Survey (TOTS)

ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/Data_and_Evaluation/The_Oklahoma_Toddler_Survey_(TOTS)/index.html

Oklahoma developed a follow-back survey to PRAMS called The Oklahoma Toddler Survey (TOTS). This model has been replicated by at least four additional states since its inception in 1994. Oklahoma sends surveys to PRAMS respondents the month the child turns two years old. TOTS is a dual mode survey, meaning participants have the opportunity to participate by either mail or phone. The current TOTS survey measures several agency and Title V MCH Services Block Grant priorities relating to infant mortality reduction, including maternal depression and breastfeeding during the child's first year of life.

Recommendation 7: Promote Social Equity

Different populations across the United States experience different burdens of infant mortality and poor birth outcomes. Disparate burden is typically manifested as differences in sociodemographic risk factors, such as race or ethnic group, income level and educational attainment. Furthermore, many of the gaps in birth outcomes between racial, ethnic and socioeconomic groups have not substantially changed in over half a century.[lxxviii, lxxix]

Race and ethnicity is a central factor in risks for poor birth outcomes. As previously noted, there are major disparities in infant mortality rates between racial or ethnic populations.[lxxx] In addition, disparities are also complex within racial or ethnic groups. For example, while the overall infant mortality rate for infants born to Hispanic mothers (5.3) is lower than the overall rate in the United States, the infant mortality rate for infants born to mothers of Mexican (5.1) and Central or South American descent (3.3) are considerably lower than the rate of death for infants born to Hispanics that are not classified, 'other or unknown Hispanic' (13.5).[lxxxi]

Poverty and education are also important factors associated with poor birth outcomes. In general, people with higher incomes are in better health.[lxxxii] This inverse relationship between income and health means women with lower incomes are more likely to have an infant die than women with high incomes. Poverty often correlates with educational attainment. The U.S. Census data documents people with lower income levels often have less education attainment. Educational attainment has also been analyzed in relation to infant mortality and shows a similarly inverse pattern of decreasing infant mortality rates as education level increases. In the United States, the infant mortality rate among populations of mothers who complete less than a high school diploma is more than two times higher than among mothers who have at least a bachelor's degree.[lxxxiii]

While health differences can be delineated across racial, ethnic or socioeconomic populations, the mechanisms responsible for these associations have yet to be fully explored by public health research. Research has shown, however, that historical segregation[lxxxiv], social bias (i.e. racism, classism, sexism, nativism),[lxxxv] stress[lxxxvi] and discrimination[lxxxvii] contribute to the disparate burden experienced by some populations. A life course approach is helpful for understanding the causal pathways of these factors. Over the life span of an individual, race, ethnicity, poverty and education intersect with health factors and social influences to produce cumulative impacts on health.[lxxxviii, lxxxix] The association between stress and poor health outcomes is particularly hard to quantify and can be equally hard to explain. Stress, however, can impact individual health both directly and indirectly through its effect on health behavior. While everyone experiences stress, populations that already experience social bias, discrimination, lower educational attainment and poverty may experience greater stress. Research has identified factors, such as economic strain, insecure employment, low control at work, social isolation and stressful life events, that contribute to greater stress experienced by populations of lower socioeconomic status.[xc, xci]

Addressing the causes of health disparities will take complex, multicomponent approaches. In addition, eradicating health disparities will require a commitment to social equity and a recognition that the contexts in which we live our lives are shaped by historical injustices and contemporary structures that perpetuate historical injustices.[xcii] Health disparities can

Recommendation 7 *continued*

only be addressed with strategies related to both health and social programs and interventions that work more broadly and support equitable access to health care services and economic, educational and housing opportunities.

In addition, social equity requires honoring and respecting the dignity and culture of all people involved and ultimately empowering communities. States and partners may have to make systemic changes in order to include families and communities as equal partners in health interventions from start to finish. These defining characteristics and values should be included in all policy, program, service and research work related to eliminating health disparities.

States can consider the following the options to promote social equity to reduce infant mortality and improve birth outcomes:

Support working mothers and families. Specific strategies include:

- Providing child-care vouchers with a reimbursement rate that increases with the developmental quality of child care purchased.
- Supporting parental leave coverage, extending the duration of leave allowed or providing more opportunities for parents of young children to return to work part time, and make provisions for income replacement during leave. Public financing can come from unemployment insurance, temporary disability insurance programs, new social insurance programs and new cash benefit programs.

Raise awareness on the effects of racism. Racism is multidimensional: intrapersonal, interpersonal and institutional. The public health community must raise awareness of and actively address racism in all its forms. Specific strategies include:

- Promoting cultural pride by participating in cultural and community celebrations.
- Implementing statewide diversity training programs for health and social service providers that include the potential effects of racism on health care and infant mortality.
- Developing public service announcements that address the effects of racism in general and the impact of racism on infant mortality.
- Making addressing racism a leading public health issue among public health departments, divisions and staff. Including collecting data on racism in population and community health assessments, ensuring equal access to quality health care, monitoring for discriminatory practices and making policies to ensure equal access to goods, services and opportunities vital to maternal and child health.
- Identifying other state health program strategies to improve minority health and elimination of health disparities, collaborate and build on combined efforts across the state.
- Actively confronting institutionalized racism within public health agency/agencies by conducting self-assessments within each division or branch; compiling instructional materials based on successful models such as the AMCHP/CityMatCH/National Healthy Start Partnership to Eliminate Disparities in Infant Mortality;[21] requiring public health partners to begin dialogue for reducing institutional racism and incorporating ongoing cultural competence training within their facilities; reviewing training and curriculum on addressing institutionalized racism; and conducting Undoing Racism/Health Disparities/Health Equity trainings with staff and partners at public health agencies.
- Monitoring for discriminatory practices and promoting racial equity in all state policies.
- Developing an agenda for reducing racial disparities.

Invest in community rebuilding and urban renewal. Specific strategies include:

- Building community networks and mobilizing civic participation.
- Promoting the establishment or development of neighborhood associations.
- Supporting implementation of anti-poverty initiatives, such as providing job-skills training (including training in social entrepreneurship), establishing community gardens and urban farms, restricting 'payday loan' establishments and promoting financial literacy, and developing healthy housing options.

Ensure health care services are provided in a manner compatible with the cultural beliefs, practices and preferred language of the consumer. Specific strategies include:

- Implementing Federal Standards for Culturally and Linguistically Appropriate Services (CLAS).[22]

[21] For more information (tools and reports) from the Partnership to Eliminate Disparities in Infant Mortality, visit amchp.org/programsandtopics/womens-health/infant-mortality/Pages/default.aspx

[22] For more information: minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

- Conducting organizational assessments of CLAS activities and integrating cultural and linguistic competence-related measures into internal audits, performance improvement programs and patient satisfaction assessments.
- Training health care and social service providers in culturally and linguistically appropriate service delivery.
- Maintaining a current demographic, cultural and epidemiologic profile of the community, as well as a needs assessment to accurately plan and implement services that respond to the cultural and linguistic characteristics of the service areas.
- Offering technical assistance and training to providers to improve the quality of care to high-risk pregnant women and the level of cultural competence in health care delivery.

Create reproductive social capital actively supporting and celebrating pregnant women and promoting reproductive health within a community. Specific strategies include:

- Disseminating information through creative marketing materials on intentional acts of kindness toward pregnant women and new mothers to engage families, friends and communities in fostering healthier pregnancies. Acts of kindness should highlight ways to offer emotional and instrumental support, and promote acts of respect and common courtesy to reduce social stress experienced by pregnant women.

Develop, recruit and train a diverse network of culturally competent health professionals statewide. Specific strategies include:

- Developing a statewide program to encourage high school and college students, especially minority populations, to explore the variety of career opportunities in health care and public health.
- Establishing appropriate financial support and incentive programs to increase the number of minority health professionals, including recruitment and training participants from the community being served, for example former Healthy Start participants.
- Considering increasing funding for minority/underserved areas (e.g., Appalachia) loan repayment initiatives and other programs encouraging racial or ethnic minority health professionals to continue serving predominately racial or ethnic minority patient populations.
- Identifying and enhancing appropriate incentives to attract providers of all backgrounds in areas of need.

Examples

100 Intentional Act of Kindness Toward a Pregnant Woman

haafii.org/100_Acts_of_Kindness.html

One Hundred Intentional Acts of Kindness toward a Pregnant Woman was conceived by Healthy African-American Families II (HAAF II) as a media campaign to create reproductive social capital for pregnant women. Pregnant women were asked to identify through focus groups actions that families, friends and even strangers could do to make their pregnancies better.

Birthing Project USA

birthingprojectusa.org

Birthing Project USA is the only national African-American maternal and child health program in the United States, and is a volunteer effort to encourage better birth outcomes by providing practical support to women during pregnancy and for one year after the birth of their children. The mission is to assist local communities in improving their health status by addressing the systemic causes of their lack of well-being. The systemic causes usually include, lack of education, lack of social justice and economic disparities compounded by institutional political and personal barriers. Birthing Projects actively engage community residents in identifying their needs; planning, implementing and evaluating services; and working collaboratively with other agencies, organizations and individuals. The innovative programs used by the model allows projects to identify potential clients before the baby is born, keep a watchful eye on the infant during their childhood, invite children to participate with their mothers in risk-reduction programs when they are in sixth and seventh grades and participate in the Academy of Dreams during their high school years. The projects also provide guidance and support to their fathers. The first Birthing Project began

Recommendation 7 Examples *continued*

in Sacramento, CA in 1988 as a community service project comprised of volunteer sister friends who provided one-on-one support to pregnant teens and women to lower infant mortality. Since then, the Birthing Project concept has grown into a nationally recognized model which has been replicated in more than 90 communities in the United States, Canada and Honduras.

Black Health Coalition of Wisconsin

bhcw.org

Incorporated in 1988, the Black Health Coalition of Wisconsin (BHCW) is comprised of organizations committed to forming a black health alliance for a change. The BHCW includes 26 organizations and 19 individual members, and includes health care professionals, social service agencies, professional organizations and grassroots organizations. BHCW has provided many services to the African-American community including research on the health status in areas such as infant mortality, family resiliency and cultural competency. BHCW provides assistance to agencies in developing, implementing and evaluating their service-delivery system, and provides individualized, on-site, community health training to health and human services workers. Specific tools were developed to provide institutional assessments measuring cultural competency among facilities providing services to people of color. Additionally, BHCW develop policies and programs to inform African Americans about the importance of the special health problems they confront and what measures can be taken to improve health. BHCW intercedes when necessary, to help them access the health care services needed. The BHCW houses the federal Healthy Start program, Milwaukee Healthy Beginnings Project (MHBP). MHBP strives to give a child a healthy start by helping women and their families access services in the community, with early entry into prenatal care, receive culturally sensitive and family centered care, by increasing community awareness of infant mortality, and making the populations an integral part of the decision making process. BHCW resides in one of the highest risk areas of the City of Milwaukee.

Boston Disparities Project (Massachusetts)

bphc.org/ches

In 2003, Boston Mayor Thomas Menino unveiled a plan to establish a working blue print to address racial and ethnic disparities in health. Coordinated by the mayor and the Boston Public Health Commission (BPHC), community residents and other key stakeholders were convened from across multiple sectors to develop strategies to close the gap between white residents and residents of color. Strategies were documented in public reports with specific short and intermediate action steps. Pilot money was given to hospitals and community agencies to move strategies from paper to action. With support from local academic institutions, community interventions were evaluated to identify impacts and potential replicability. In addition, the BPHC has linked the elimination of health disparities to its core and ongoing public health functions. Currently, the Boston Disparities Project has folded into the work of the BPHC Center for Health Equity and Social Justice. The center expanded efforts to reduce racial and ethnic health disparities by coordinating a Health Equity Training Center that provides education, training and technical assistance; developing training curricula and materials to educate community health workers, health care providers, and public health professionals about the social determinants of health and racial and ethnic disparities; establishing a learning collaborative among New England communities engaged in health equity work; and advocating to eliminate racial and ethnic health disparities through data collection, policy, and strategy development at the local, state and federal level.

California Black Infant Health Program

cdph.ca.gov/programs/bih/Pages/default.aspx

The Black Infant Health (BIH) program serves pregnant and parenting African-American women through a group intervention, as well as complementary case management in order to improve the health and social conditions for African-American women and their families. The BIH group intervention is a 20-session intervention – 10 sessions prenatally and 10 postpartum. The sessions offer engaging activities from a women's health perspective that will explore pregnancy-related and newborn-parent-related topics, as well as personal empowerment skills. By participating in the group process, this helps mothers create a life plan for the future, which will ultimately improve the health of women across the life course. The BIH program is located in 15 Local Health Jurisdictions where more than 75 percent of California African-American live births occur.

Coming of the Blessing© (Alaska)

comingoftheblessing.com

This initiative addresses the high rate of infant deaths and premature births among American Indians and Alaska Native babies. It came about as a partnership between the March of Dimes and the American Indian/Alaska Native Women's Committee. This group of women, representing 10 different tribes, developed health education resources that embrace the cultural and spiritual beliefs related to pregnancy and childbirth shared by many native people. Mothers from this population have the highest rate (23.8 percent) of inadequate prenatal care of all racial ethnic groups. However, 88 percent of the moms who received prenatal education through

this program attended all their prenatal appointments. The preterm birth rate of more than 14 percent dropped to 7 percent among women who participated in the "The Coming of the Blessing" and gained a "promising practice" seal from the Indian Health Services.

Community Health Worker Program (New York)

health.ny.gov/community/pregnancy/health_care/prenatal/community_health_worker

The New York Department of Health Community Health Worker Program provides one-on-one outreach, education and home-visiting services to pregnant and parenting women and families at highest risk for poor birth outcomes. The program is targeted to specific communities with high rates of low-birth-weight births, infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women. The program focuses on getting pregnant women into early and consistent prenatal care and ensuring their families receive primary and preventive health care services. Home-visiting and care-coordination services are provided by paraprofessionals who live in the area they serve and are trained to provide referrals for a wide range of services, and to provide support and assistance for families trying to obtain needed services, including advocacy and accompaniment to scheduled visits when needed. There are currently 23 Community Health Worker Programs throughout the state.

Empowering Families of Milwaukee

city.milwaukee.gov/Empowering-Families-of-Milwaukee.htm

Empowering Families of Milwaukee (EFM) uses evidence-based models and partners with the community to provide frequent and long-term home visits to the most vulnerable families in Milwaukee. The project goals are to improve birth outcomes, enhance family functioning, support child health, safety and development and to prevent child abuse and neglect. Using an evidence-based curriculum and model, home visiting staff consisting of public health nurses, social workers and community health workers, provide frequent and long-term home visits to the most vulnerable and at risk families in Milwaukee from the prenatal period up to the child's third birthday. EFM home visitors partner with families to provide: health assessments and information; goal setting and care planning; developmental screenings, information, and activities; home safety assessments; referrals to community resources and invitations to community events.

Fatherhood Initiative (Connecticut)

ct.gov/fatherhood/site/default.asp

The John S. Martinez Fatherhood Initiative of Connecticut is a broad-based, multi-agency, statewide program led by the Department of Social Services that is focused on changing the systems that can improve the ability of fathers to be fully and positively involved in the lives of their children. The objectives of the initiative are to provide dads with the skills and supports they need to get involved in the lives of their children and stay connected by promoting public education concerning the financial and emotional responsibilities of fatherhood; assisting men in preparation for the legal, financial and emotional responsibilities of fatherhood; promoting the establishment of paternity at childbirth; encouraging fathers, regardless of marital status, to foster their emotional connection to and financial support of their children; establishing support mechanisms for fathers in their relationship with their children, regardless of their marital and financial status; and integrating state and local services available for families.

Genessee County REACH 2010 (Michigan)

gchd.us/Services/PersonalHealth/REACH/about.asp

The Genesee County (Michigan) REACH US Coalition is building on a successful foundation of REACH 2010 work to reduce African American health disparity in infant mortality through its designation as a Center of Excellence in the Elimination of Health Disparities (CEED). REACH US is a national program of the CDC in an effort to eliminate racial and ethnic health disparities in the United States. The Genesee County REACH 2010 Team implemented a Community Action Plan (CAP) based on a socioecological model of health designed to: foster community mobilization; enhance the "babycare" system; and reduce racism. During the REACH 2010 initiative, the African American infant mortality rate in Genesee County dropped from a high of 23.5 deaths per 1,000 live births to an all time low of 15.2. The white rate dropped from a high of 13.1 to 8.9, with the over-all Genesee County rate dropping from 13.1 to 8.9. The disparity

Recommendation 7 Examples *continued*

ratio dropped from a high of 3.6 African American infant deaths for every white infant death to 2.4. As a CEED, the Genesee County REACH US project will be actively engaged in training, translation and dissemination of CAP activities to other communities in Michigan and across the United States.

Harlem Children's Zone (New York)

hcz.org

The Harlem Children's Zone is a nonprofit organization working to end the cycles of generational poverty in Harlem, New York. The organization works through a coordinated effort to address the needs of an entire community. Beginning in the early 1990s as a pilot project, the Zone implemented comprehensive support services to a one-block area. The idea was to address all the problems that poor families were facing, from crumbling apartments to failing school, violent crime and chronic health problems. By 2007, the organization had expanded to serve almost 100 blocks. Currently, the organization offers programming in the form of parenting workshops, early childhood development programs, public charter schools, afterschool programs, college success programs and community health programs.

Healthy African American Families (California)

haafii.org

Healthy African American Families (HAAF) began in October 1992 in order to gather information and ideas about the social, cultural, health and political currently is a nonprofit, community serving agency with a goal of improving the health outcomes of the African American, Latino and Korean communities in Los Angeles County by enhancing factors that affect pregnancy outcomes for African American women in Los Angeles. HAAF the quality of care and advancing social progress through education, training, and collaborative partnering with community, academia, researchers and government. Areas of focus include prevention of preterm delivery; addressing health disparities in asthma, diabetes and kidney disease; dissemination of the 100 Intentional Acts of Kindness Toward a Pregnant Woman (more information below); and male involvement.

Healthy Births Learning Collaborative – LA Best Babies Network (California)

labestbabies.org/healthy-births-collaboratives

The Healthy Births Collaborative consist of agencies, organizations and associations that implement the Healthy Births Initiative Core Approaches to improve birth and pregnancy outcomes, strengthen community support for pregnant women and families, and increase their ability to care for newborns. Core Approaches include policy and advocacy, community building, health education and messaging, social support, prenatal care and quality improvement, interconception care, outreach, and case management. Agencies involved in the Healthy Birth Collaborative work together with others, understanding that no one agency, organization or individual can single handedly undertake the comprehensive, integrated, multi-level approach required to improve pregnancy and birth outcomes in a community.

Honoring Our Children with a Healthy Start (Wisconsin)

glitc.org/web-content/HOC/index.html

The Honoring Our Children Project is a partnership of eight tribes in Wisconsin through the Great Lakes Inter-Tribal Council. The goal of this Healthy Start initiative is to reduce American Indian infant morbidity and mortality and to improve the health and well-being of Native American children, families, and communities. The project promotes the health of infants, women, and families through outreach, education, care coordination, depressions screening and referral, interconception care and consortia building. The project activities teach families about health and safety and help them have healthier pregnancies. Project staff offer support for healthy living by encouraging families to become smoke-

free households, to breastfeed, to get their children vaccinated and to follow-up with a physician's care. The Honoring Our Children Project receives Title V MCH Block Grant funds from the Wisconsin Division of Public Health to enhance the activities funded by the federal Healthy Start Program. In 2012, MCH funded activities include an assessment and plan to support a system of care for developmental screening of infants and children up to 24 months of age at 10 tribal sites.

Illinois Council on Responsible Fatherhood

responsiblefatherhood.com

The Illinois Council on Responsible Fatherhood is a state commission established by the Illinois State Legislature to promote the positive involvement of both parents in the lives of their children. The mission of the Illinois Council on Responsible Fatherhood is to significantly increase the number of children in Illinois that grow up with a responsible father in their lives. The council seeks to do this through raising public awareness of the impact of father absence on children; assisting state agencies and other service providers with the resources they need to promote responsible fatherhood; reforming perceptions within state agencies and other service providers regarding the role of fathers as parents; and advocating for programs, policies and legislation that will encourage the positive involvement of fathers.

Northern Manhattan Perinatal Partnership

sisterlink.com

The Northern Manhattan Perinatal Partnership (NMPP) and its Central Harlem Healthy Start Program consists of clinical and group education interventions, as well as initiatives to address structural reforms in the built environment in order to reduce infant mortality. Through NMPP more than 9,500 women and their children have been linked and maintained in care. The program addresses sustained economic and physical well-being through a job readiness program that has placed more than 890 women in full- and part-time employment. At the policy level, NMPP supports the empowerment-zone legislation, which infused Harlem with up to $300 million in block grants for community revitalization and job-creation projects and actively advocated for reforms in urban services, such as reducing the number of bus depots to improve air quality and supporting the building of supermarkets that provide healthier food. Since the inception of the program in 1990 when the infant mortality rate was 27.7 infant deaths per 1,000 live births, the infant mortality rate in Central Harlem has plummeted to 5.2 in 2004.

Seven Principles Project (California)

cdc.gov/nccdphp/dach/chhep/pdf/voices_101007.pdf

Coordinated by the San Francisco Department of Public Health, the Seven Principles Project implemented three interventions that show promise in reducing disparities and improving infant survival rates among African Americans in San Francisco. The first intervention is community awareness campaigns that address the lack of knowledge among African Americans about their community health and the disparities in infant death rates. The second is activities designed to improve community health by addressing social factors that have been linked to high infant death rates. These include violence, substance abuse, crime, poor nutrition, food insecurity, and lack of community unity and leadership. The third is skills training and workshops for health care providers to improve patient-provider interactions, promote mutual respect, and examine the impact of race and racism on health disparities and health outcomes. The project has shown increases in knowledge and awareness of the racial disparity in infant death rates in their community, as well as correct sleep positions for infants, which help reduce deaths. The project also developed a cultural competency training class for health care providers and organized community-action teams to implement actions to address social factors in their neighborhoods.

Toolkit for Health and Resilience in Vulnerable Environments

thrive.preventioninstitute.org/thrive.html

The Toolkit for Health & Resilience In Vulnerable Environments (THRIVE) is a community resilience assessment toolkit, developed by the Prevention Institute. The goal of this project was to develop a tool to assess community-level resilience factors that serve as benchmarks for the *Leading Health Indicators of Healthy People 2010*. The tool, which is informed by research, included an environmental scan and piloting in Del Paso Heights, California; Hidalgo County, New Mexico; and East Harlem, Central Brooklyn and the South Bronx in New York, New York. A diverse, national expert panel provided guidance throughout the process. THRIVE helps communities bolster factors that will improve health outcomes and reduce disparities experienced by racial and ethnic minorities. It provides a framework for community members, coalitions, public health practitioners and local decision-makers to identify factors associated with poor health outcomes in communities of color, engage relevant stakeholders and take action to remedy the disparities. The pilot process confirmed the tools utility in rural and urban settings and for community members, as well as practitioners and local policymakers. It includes collateral materials, such as training materials and preliminary guidelines to translate the THRIVE results into concrete changes in local policies, programs and priorities.

Case Studies

The following set of case studies is provided to highlight seven states that are making progress in improving birth outcomes and reducing infant mortality by implementing a comprehensive approach.

California

Recently, the California Department of Public Health (CDPH) reported that the California infant mortality rate (IMR) has reached a record low. In 2009, the most recent year data are available, the rate was 4.9 infant deaths per 1,000 live births. The IMR has fluctuated over the past 20 years, from a high of 7.5 per 1,000 in 1991, to the previous low of 5.0 infant deaths per 1,000 live births in 2006. In 2007, California had the lowest IMR among the 10 states with the highest number of births. African Americans in California experienced the largest decline in infant mortality, from 12.1 infant deaths per 1,000 live births in 2008 to 10.6 in 2009. However, racial/ethnic disparities in infant mortality persist. Because rates may fluctuate from year to year, future data will be needed to assess whether the recent decrease in the California IMR is part of a long-term trend.

The reduction in infant mortality is attributed to many ongoing programs and initiatives in CDPH at the state and local level. Working in partnership with various stakeholders including the March of Dimes and the University of California, the Maternal, Child and Adolescent Health (MCAH) Division works to reduce the IMR through:

- Direct services for at-risk populations (Black Infant Health Program, Adolescent Family Life Program, California Diabetes and Pregnancy Program, Comprehensive Perinatal Services Program)
- Public health approaches to support improvements in nutrition, physical activity, breastfeeding and preconception health status
- Quality improvement strategies for neonatal and maternity care practices (Regional Perinatal Programs of California, California Perinatal Quality Care Collaborative, California Maternal Quality Care Collaborative)
- Mortality reviews (Fetal Infant Mortality Review, Sudden Infant Death Syndrome reviews, Pregnancy-Associated Mortality Review) and birth defects surveillance (California Birth Defects Monitoring Program)
- Provision of funding and technical assistance to local health jurisdictions (LHJs) to support the work of improving the health of mothers and infants in their communities

Targeting At-Risk Populations

Several MCAH programs target specific populations at risk for adverse pregnancy outcomes. An example is the Black Infant Health (BIH) Program, which serves pregnant and parenting African-American women through a group intervention, as well as complementary case management to improve the health and social conditions for these women and their families. The BIH group intervention is a 20-session intervention (10 sessions prenatally and 10 postpartum) designed to empower and support African-American women by providing information and skills in a culturally relevant and affirming manner, and ultimately improve women's health across the lifecourse. Research has shown that promoting capacity for social support influences birth outcomes by buffering the adverse effects of chronic stress. The BIH program is located in 15 LHJs where more than 75 percent of California African-American live births occur. Direct services for at-risk populations are also provided through programs that promote not only perinatal health but also women's health, thus influencing the infant outcomes of subsequent births.

Funding information for California initiatives to improve birth outcomes:

- The majority of MCAH efforts addressing infant mortality are funded through the Title V MCH Services Block Grant
- Certain initiatives are supported with grants in partnership with academia, community organizations, such as the March of Dimes and local county funding sources

Promoting Health through Public Health Strategies

Healthy eating, physical activity and breastfeeding promotion are integrated and coordinated within MCAH and its LHJs to promote healthy lifestyles and improve birth outcomes. The MCAH Preconception Health and Health Care Initiative promotes preconception health messages to women of reproductive age, integrates preconception care into public health practice, monitors preconception health indicators, and evaluates preconception health programs and interventions to guide policy strategies. LHJs conduct educational programs on preconception health for women of reproductive age and providers, addressing health behaviors and conditions that cause poor pregnancy outcomes. Resources, tools and best practices for professionals, as well as information and preconception health factsheets for the general public are available through the initiative website. With funding from the Health Resources and Services Administration, three social media campaigns were developed to target African American women, Latina women and youth of color with culturally appropriate and tailored preconception health messages.

Supporting Improvement in the Quality of Care for Mothers and Children

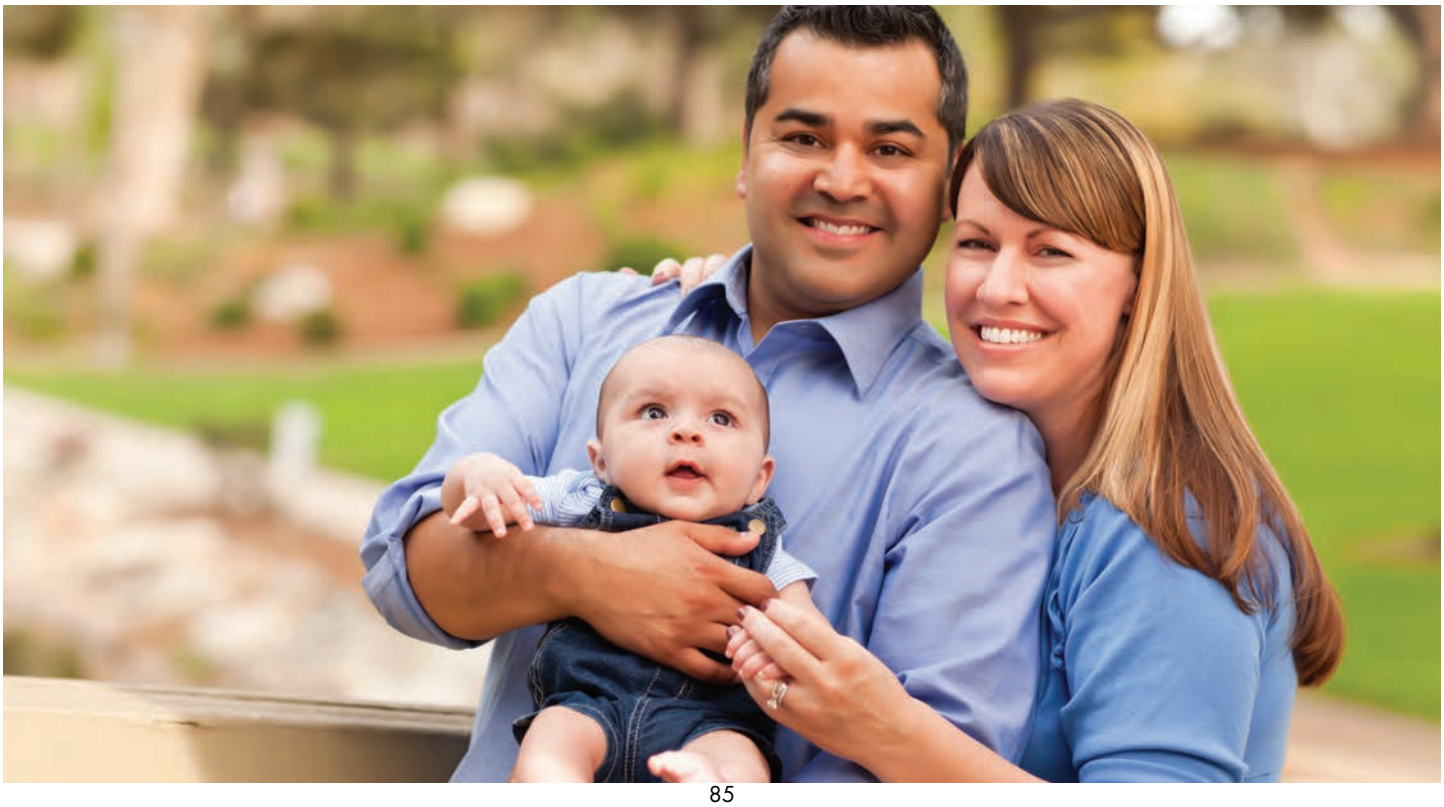
MCAH implemented quality improvement (QI) strategies to ensure a high level of care, particularly for neonatal and maternity care practices through the California Perinatal Quality Care Collaborative and California Maternal Quality Care Collaborative. QI toolkits covering a variety of clinical topics available on the websites for these collaboratives have been used by institutions across the state and the nation. The Regional Perinatal Programs of California promote access to risk-appropriate perinatal care for pregnant women and their infants through regional QI activities, including assisting hospitals with data-collection protocols; developing quality assurance policies and procedures; and providing resource directories, referral services, hospital linkages and ongoing technical assistance. The Birth and Beyond California Project utilizes QI methods and training to implement evidence-based policies and practices that support breastfeeding within the maternity care setting.

Using Data to Drive Interventions

Examining data from mortality case reviews and birth defects surveillance guides MCAH in program planning and priority goal setting. MCAH administers the Maternal Infant Health Assessment, an annual survey of California women who recently gave birth to a live infant. This survey, which is modeled after the CDC Pregnancy Risk Assessment Monitoring System survey, collects population-based information about maternal health status, health behavior, knowledge, and experiences before, during and shortly after pregnancy. These data are used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress toward the goal of improving the health of mothers and infants. MCAH also uses data sources such as the California Women's Health Survey to examine the evidence for public health practice.

Partnering with other Programs in CDPH

- WIC provides nutrition education and support for mothers, infants, and children (under five years of age) and integrated preconception health into the WIC setting to address the prevention of poor birth outcomes. In partnership with the March of Dimes, WIC Offers Wellness project helps high-risk mothers maximize their chances for healthy, full-term pregnancies by providing health assessments, referrals to family planning, psychosocial intervention services and overall care coordination.
- The Genetic Disease Screening Program screens newborns and pregnant women for genetic and congenital disorders. More than 99 percent of newborn babies are screened in California. By providing testing, follow-up and early diagnosis of these disorders, clinical effects are minimized and adverse outcomes are prevented. In August 2010, screening for Severe Combined Immunodeficiency (SCID) began as part of a



pilot program. During the first year of the pilot, 17 cases of SCID, SCID variant and other t-cell immune deficiencies were detected and referred to specialists for treatment. Seven bone marrow transplants have been performed to date and the earliest of this group is already cured and off all medication.

- Nearly half of pregnancies in California are unplanned, with women frequently conceiving in less than optimal health or while engaging in behaviors that can harm a pregnancy and lead to adverse outcomes. The Office of Family Planning (OFP) works on the reduction of unintended pregnancy through the Family Planning, Access, Care and Treatment (Family PACT) Program, which provides comprehensive family planning services to eligible low income men and women, including teens. Children of teen mothers are more likely to be born prematurely and at low birth weight, raising the probability of infant death and disability. The Teen Pregnancy Prevention Program utilizes a variety of approaches and strategies to reduce teenage pregnancy and absentee fatherhood, promote responsible parenting, and assist adolescents in accessing clinical services.
- The Immunization Branch implements the Vaccines for Children (VFC) Program, which provides vaccines at no cost for eligible children through VFC-enrolled doctors, thus helping to improve the overall immunization rate of children in the last 15 years. The Immunization Branch and local health departments promote immunizations, which protect infants against potentially deadly vaccine-preventable diseases, such as invasive pneumococcal disease, pertussis (whooping cough) and *Haemophilus influenzae,* type b (Hib).
- In addition, advances in the provision of neonatal intensive care have contributed to the reduction of infant mortality over the past 20 years. Since the 1970s, the California Children's Services Program (the California Title V Children with Special Health Care Needs program) has developed and applied standards of care for services provided in California neonatal intensive care units that serve 90 percent of the most vulnerable infants.

Legislative actions that may have contributed to the reduction in infant mortality include:

- **Safely Surrendered Baby Law (SB 1368, Chapter 824, 2000)** – Voluntary surrender of an infant 72 hours old or younger to an employee on duty at a public or private hospital emergency room, designated fire station, or any safe surrender site designated by the local board of supervisors is legal and anonymous.
- **Infant Crib Safety Act (AB 3760, Chapter 1176, 1994)** – Commercial users are prohibited from remanufacturing, selling, leasing or placing in the stream of commerce, a full-size or non-full-size crib, as defined, that is unsafe for any infant using the crib. Informational materials regarding crib safety should be made available to consumers through the Department of Consumer Affairs.
- **Shaken Baby Syndrome Act (AB 3760, Chapter 1176, 1994)** – Health facilities and midwives are required to provide information and instructional materials relating to shaken baby syndrome, if available, free of charge to parents or guardians of newborns. The State Department of Social Services is required to provide information and instructional materials, if available, free of charge to child care providers upon licensure and at the time of a site visit.
- **Swimming Pool Safety Act (AB 3305, Chapter 925, 1996)** – Certain safety standards are required for swimming pools, including pool enclosures, safety pool covers, or exit alarms, as defined, or certain other means of protection, beginning on or after Jan. 1, 1998.
- **Child Passenger Restraint Requirements (AB 1697, Chapter 524, 2003)** – Certain infant and child passenger restraint standards are required, depending on the age and weight of the child.
- **Sudden Infant Death Syndrome (SIDS) Bills** – In 1990, four bills were passed to address the need for public awareness and to provide services to parents who lost infants to SIDS. The laws require the following: mandated training for police, firefighters and paramedics on the dynamics of SIDS deaths; requirements for local county coroners to use a standardized autopsy and death scene protocol to determine diagnosis of sudden unexplained infant deaths; and establishment of the SIDS Advisory Council to provide guidance to CDPH on meeting the needs of the SIDS community.
- **Educational and Child Care Facility Immunization Requirements (California Health and Safety Code Sections 120325-120380)** – Specified immunizations are required prior to admission to schools and child care facilities.
- **Newborn Screening (California Health and Safety Code Section 124975)** – State regulations specify reporting requirements for both licensed perinatal health facilities and county registrars to ensure testing. All newborns must be tested; the only legal ground for refusal is a conflict with beliefs and practices.

More information is available on the CDPH Maternal, Child and Adolescent Health Program website: cdph.ca.gov/programs/MCAH/Pages/default.aspx.

Delaware

Delaware experienced steadily increasing rates of infant mortality from the mid-1990s through 2005, with a peak rate of 9.3 deaths for every 1,000 live births in the 2000-2004 reporting period. This rate gave Delaware the sixth worst infant mortality rate in the nation and was the worst rate among the contiguous states in the northeastern region. In response, Delaware implemented an infant mortality initiative in 2004 to understand the drivers of infant mortality and develop initiatives to address factors that contribute to the high rates. Recent data from the Delaware Division of Public Health show that state initiatives are proving successful. The state infant mortality rate decreased for the fourth consecutive reporting period, dropping by 10 percent to 8.3 deaths for every 1,000 live births in 2005-2009.

Infant Mortality Task Force

In 2004, the governor appointed an Infant Mortality Task Force (IMTF) to investigate the reasons that Delaware had a high infant mortality rate. In 2005, the IMTF delivered a full report, including recommendations outlining a course of action to reduce the high infant mortality rate. Among these recommendations was the establishment of the Delaware Healthy Mother and Infant Consortium (DHMIC) to oversee implementation of the recommendations of the IMTF. The DHMIC is established in Delaware Code. The membership is jointly appointed by the governor and the legislature and reports to the governor. Annual reports document the progress of the consortium. The overall target of the consortium is 4.5 deaths per 1,000 births and elimination of the racial disparity in birth outcomes.

Translating Research to Practice

The Delaware Division of Public Health (DPH) staff used vital statistics data to produce a statewide research agenda that included reviewing vital record reporting procedures, highlighting infant mortality disparities by birth weight and race, studying the effect of demographic factors on infant deaths and using data to inform proposed projects.

In 2004, Delaware joined a multistate, State Infant Mortality Collaborative (SIMC), led by CDC, AMCHP and the March of Dimes, to better understand the risks and causes of infant mortality in their state. Analyses completed during and as a result of the SIMC helped DPH staff better understand the infant mortality problem in Delaware. Findings provided the basis for more in-depth study of specific subgroups of women and infants, and were used to establish new surveillance systems and modify existing MCH programs. For example, Delaware was able to highlight a need for specific data collection and surveillance, and successfully piloted PRAMS and FIMR programs, both of which are now currently implemented in the state.

Funding information for Delaware initiatives to improve birth outcomes:

- The Healthy Women Healthy Babies program is funded directly from the state budget
- The program is complemented by services provided through grants, such the Title V MCH Services Block Grant and Title X

Additionally, the value of the initial analyses in 2005 led DPH to establish a research center with the goal of providing state surveillance data to programs for use as the foundation in decision making and modifying services. The Center for Family Health Research and Epidemiology (CFHRE) was established in 2006 so data findings could

be better translated to other public health program staff, and center staff could better communicate the importance of evidence-based science. The CFHRE also collaborated with local hospitals and universities to increase the number of interagency projects and provide training to public health professionals. The joint data and analysis efforts led to new interventions in preconception, prenatal, and postpartum health and health care; statewide education campaigns; and revision of some state standards.

Expanding Preconception and Interconception Care: Healthy Women, Healthy Babies

The Delaware Healthy Mother and Infant Consortium supports many key programs across the state. For example, in 2009, at the direction of the DHMIC, DPH staff developed and introduced a preconception/interconception-focused program: Healthy Women, Healthy Babies (HWHB). The HWHB program is a systematic initiative that targets high-risk women by expanding health care services to include a focus on preconception/interconception health. A key goal of HWHB is to help women reach optimal health prior to pregnancy so they have a higher likelihood of delivering a healthy baby.

Through community partnership with seven health care organizations and private practitioners, HWHB widens the scope of health care services offered to women before or during pregnancy to include a broad set of American College of Obstetricians and Gynecologists, CDC, U.S. Preventative Services Task Force-recommended preconception health services at participating clinic sites located throughout the state of Delaware. The Delaware DPH reimburses the sites based on four bundles of services available to women in the program. The program specifically targets African-American women, as well as women whose most recent pregnancy resulted in a poor birth outcome. In March 2010, the DHMIC reported the HWHB program served 9,118 women. Of the 2,264 women who took part in the prenatal aspects of the program, 94 percent did not experience pregnancy complications.

One of the noteworthy features of the design of the HWHB program is its alignment with the life course approach, a model that conceptualizes birth outcomes as the end product of the entire life course of the mother leading up to the pregnancy and not only the nine months of pregnancy. The preconception program gives enrolled women the tools to maintain a healthy weight, eat a nutritious diet, include adequate amounts of folic acid daily, manage chronic disease, understand and mitigate environmental risk factors around them, and work toward achieving or maintaining a tobacco- and substance-free lifestyle. Through these highly vetted and comprehensive efforts, the HWHB program helps enrolled women meet both the objectives of their respective reproductive plans and personal health goals.

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- Infant Mortality Task Force full report: dhss.delaware.gov/dph/files/infantmortalityreport.pdf
- Delaware Healthy Mother and Infant Consortium: dhmic.healthywomende.com/

Kentucky

In Kentucky, the percent of preterm live births consistently increased from 11.3 percent in 1993 to 15.2 percent in 2007. Similarly, the percent of low birth weight live births increased from 7.1 percent in 1993 to 9 percent in 2007. Kentucky identified that late preterm infants comprised 72 percent of all premature births in Kentucky and were driving the increase in the rates of prematurity. This was consistent with the national data. These infants who are just a few weeks early (34 thru 36 weeks gestation), are three times more likely to die in the first year of life than full-term infants and six times more likely to die in the first week of life. Because of the rapid rise in preterm births and high prevalence of modifiable risk factors, Kentucky was selected by Johnson&Johnson Pediatric Institute and the March of Dimes to partner on developing an initiative to prevent "preventable" preterm births, called Healthy Babies are Worth the Wait (HBWW). During the project period, the initiative intervention sites showed a reduction in preterm births while the comparison sites showed increases in their rates. Kentucky overall saw a drop in preterm singleton births of 9.4 percent and a drop in late preterm singleton births of 10.1 percent during the initiative.

Implementing Multifaceted, Multilevel Interventions

HBWW takes a multidimensional, community-based approach to reducing the known risk factors for preterm birth during prenatal care and between pregnancies. Within the program, multiple interventions are deployed to promote systemic, synergistic change. Intervention groups include providers, patients and the wider public. There are five core components of the HBWW model, known as the "5 Ps": partnerships and collaboration, provider initiatives, patient support, public (community engagement), and progress measurement.

The objectives for each intervention group were unique, but all combined for a comprehensive approach:

- **Patient Objectives:** Improve access to clinical and support services. Create positive changes in knowledge, attitudes and behavior regarding preterm birth circumstances and modifiable risk factors, with a focus on late preterm birth.
- **Provider Objectives:** Bring the latest research to everyday practice, particularly regarding late preterm infants; create positive changes in knowledge, attitudes and behaviors regarding adherence to professional guidelines on preterm birth prevention (especially late preterm birth) and elective inductions and cesareans.
- **Public (Community) Objectives:** Increase awareness of the importance of preventing preterm birth to the community and the risks associated with late preterm birth.

Funding information for Kentucky initiatives to improve birth outcomes:

- The Healthy Babies are Worth the Wait initiative was funded by Johnson&Johnson Pediatric Institute and March of Dimes
- Community agencies provided in-kind support by building activities into ongoing operations

During the three-year pilot program, HBWW Kentucky was implemented in three communities with an overall goal of a 15 percent reduction of preterm birth in the aggregated intervention sites. Each 'community' consisted of a hospital and a local health department. The executive leadership team included national partners, state health department staff and the March of Dimes Kentucky Chapter. The executive leadership team worked with the staff of the pilot communities on multiple, bundled interventions. Each set of interventions was carefully selected to address the most significant issues of each community and based on the likelihood of success within the three-year time frame. The initiative was funded by Johnson&Johnson Pediatric Institute and March of Dimes. Community agencies built these activities into ongoing operations, thus providing in-kind support.

Examples of clinical interventions include:

- Preconception and interconception care
- Folic acid consumption
- Improve access to prenatal care
- Psychosocial screening and referral
- Infection diagnosis and treatment
- Periodontal disease treatment
- Progesterone for prevention of preterm birth

These teams worked together on local systems of care to provide consistent messaging and increase referrals to support programs, such as smoking cessation, home visiting, group prenatal care (CenteringPregnancy), substance abuse, domestic violence, stress management, nutrition and healthy weight, and other services. They also brought the most recent research on prematurity prevention to providers, which included the increased risks of late preterm infants. The late preterm brain development became a primary message for providers, patients and the public. This informed reducing elective deliveries less than 39 weeks, and the public engagement was important in reducing the pressure on obstetricians to schedule early elective deliveries.

Over the pilot program period, these three sites were compared to similar communities in Kentucky that did not receive the intervention. A year after the HBWW implementation, Kentucky had the largest drop in preterm birth rates of any of its contiguous states. In the HBWW intervention sites, the rate of preterm births was reduced by 15.6 percent. In addition, HBWW built successful relationships and partnerships that resulted in enhancement of services and patient care.

In 2010, the program sustained HBWW activities in the three intervention sites and expanded programmatic activities at four additional sites. In 2011, HBWW was launched at one more site in Kentucky. Due to the success of the model in Kentucky, March of Dimes is adapting and piloting it in New Jersey and Texas and is planning to disseminate HBWW in additional locations.

Contact Information:

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Resources, including a detailed toolkit on specific implementation steps for the HBWW model are available on the March of Dimes website: marchofdimes.com/professionals/medicalresources_hbww.html

Kentucky Department of Public Health:

chfs.ky.gov/dph/

Maryland

To address stalled progress and the racial and ethnic disparities in infant mortality in Maryland, Governor O'Malley made reducing infant mortality, and the racial disparity in infant mortality, one of the 15 strategic goals tracked by the Governor's Delivery Unit. The Governor's goal was to reduce the infant mortality rate by 10 percent by 2012. This goal was met in 2009, and in 2010 the infant mortality rate for African Americans decreased for the first time since 2008. This success is due in part to efforts spearheaded by the Maryland Department of Health and Mental Hygiene's Center for Maternal and Child Health (CMCH) with many public and private sector partners at the state and local level.

Focusing on Geographic Areas of Need and Systems Improvements

Maryland efforts to reduce infant mortality, under its Babies Born Healthy (BBH) initiative, are outlined in the Plan for Reducing Infant Mortality in Maryland and are coordinated with the State Health Improvement Process. BBH is a collaborative, interagency program that focuses proven interventions at different points across the life span – before pregnancy to ensure healthier women at the time of conception; during pregnancy to ensure early entry into prenatal care; and after delivery, to ensure comprehensive, high quality follow-up care. Key partners have been the DHMH Office of Minority Health and Health Disparities, the Governor's Office for Children, the Maryland Department of Human Resources, the Community Health Resources Commission, the Maryland Patient Safety Center and Carefirst. Efforts are targeted to jurisdictions where infant mortality and racial disparities in pregnancy outcomes are highest.

DHMH also partners with local jurisdictions and academic medical centers to implement systems changes to enhance access to health services for women, improve the quality of care and disseminate health promotion messages throughout the community. Examples include:

- Establishing a Perinatal Collaborative with the Maryland Patient Safety Center, which brings Maryland birthing hospitals together to share best practices and quality improvement strategies. (For example, an effort to reduce early elective deliveries achieved a dramatic decrease between 2009 and 2011 among participating Maryland birthing hospitals.)
- Providing high-risk pregnancy consultation, made available to local OB providers around the state under a partnership between the University of Maryland and Johns Hopkins University Schools of Medicine
- Updating the voluntary standards for perinatal care in Maryland hospitals in collaboration with the Maryland Institute for Emergency Medical Services Systems (MIEMSS)
- Implementing a new state-of-the-art, Web-based electronic birth certificate developed by Vital Statistics, to improve the quality and timeliness of data reporting
- Launching new programs to organize community coalitions and deploy perinatal navigators to assist pregnant women, from the Office for Minority Health and Health Disparities
- Providing hospital-specific very low birth weight outcomes to hospitals annually
- Developing a hospital breastfeeding policy for Maryland hospitals to use as a model
- Soliciting public comment and convening advisory committee to review data on benefits and risks of crib bumpers; proposed ban on sale of traditional crib bumpers starting in 2013

Funding information for Maryland initiatives to improve birth outcomes:

- The majority of state initiatives described in this case study were funded by State General Funds, with significant support through the Title V MCH Services Block Grant.

The Maryland Community Health Resources Commission (CHRC) joined as a partner, setting aside a portion of commission funding for projects to improve access to prenatal care in medically underserved areas. The innovative Tapestry Project in Prince George's County is one example of the projects supported by the CHRC. The Tapestry Project enrolls high-risk pregnant women into early prenatal care at the Prince George's health department and utilizes "high-touch" services provided by nurse-midwives through the Prince George's Hospital Center and the University of Maryland, and "high-tech" consultation from the University of Maryland School of Medicine when needed. Pregnant women also receive further support from Perinatal Navigators.

Under the Affordable Care Act, DHMH is also working with the Governor's Office for Children and several other agencies and partner organizations to expand and implement evidence-based home visiting programs in at-risk communities across Maryland. These programs serve expectant parents, young children, and their families and caregivers to strengthen attachment, enhance parenting, provide optimal development, promote safety and health, and reduce the potential for child maltreatment.

Before Pregnancy – Expand Access to Comprehensive Women's Health Services

A new, evidence-based Comprehensive Women's Health model expanded family planning services to include risk assessment, screening and referral for chronic diseases, substance abuse, mental health, domestic violence, smoking cessation, and Medicaid and WIC eligibility. Further, Maryland has expanded Medicaid Family Planning benefits to women ages 51 and younger with incomes at or below 200 percent of the federal poverty level, and no longer limits these benefits to postpartum women (representing an estimated 31,191 newly eligible women). Maryland has also required admission within one business day of the request for all pregnant women that present themselves to a behavioral health or disabilities program.

During Pregnancy – Earlier Entry into Prenatal Care

Through close partnership with Medicaid, a new Accelerated Certification of Eligibility (ACE) process ensures that Medicaid-eligible women access prenatal care as early as possible. A Quickstart prenatal care visit, which includes initial screening, counseling, and referral services and assistance in accessing ongoing prenatal care, is offered at health departments in the target jurisdictions. A letter was sent to all prenatal providers encouraging uninsured pregnant women to apply for Medicaid. Additionally, Perinatal Navigators assist at-risk women in navigating through the prenatal and perinatal care systems to ensure infant and maternal health.

After Pregnancy – More Comprehensive Follow-Up Care

DHMH is also working with the Maryland Patient Safety Center, birthing hospitals and local health departments to ensure that high-risk babies and mothers receive postpartum follow-up through development of a statewide standardized postpartum discharge referral process. A postpartum Infant and Maternal Referral Form has already been implemented statewide.

Messaging for Healthy Babies

Promoting messages on healthy pregnancy and "Safe Sleep" has also been an integral component of the program. Maryland has been active in the text4baby campaign, using text message technology to send mothers and couples accurate, text-length health information and resources. In addition, safe sleep has been identified as a priority area for education. Unsafe sleep and Sudden Infant Death Syndrome (SIDS) is among the top risk factors for infant death in Maryland. A safe sleep video developed by the B'More for Healthy Babies program in Baltimore City has been distributed widely around the state. Maryland also promotes and supports tobacco cessation through its Maryland Quitline (1-800-QUIT NOW) for consumers, and MDQuit.org for providers.

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North Carolina

In 1988, North Carolina had the second highest infant mortality rate in the country with 12.5 deaths per 1,000 live births. Over the last 24 years, there has been a steady downward trend. In 2010 the infant mortality rate was seven per 1,000 live births, a 44 percent reduction since 1988. The past success and continued efforts on improving birth outcomes in North Carolina are driven by partnerships across multiple sectors. Through a collaborative method, North Carolina developed a multidimensional approach to improving birth outcomes that addresses the broad areas of clinical quality improvement, community-based programs, public awareness campaigns and policy change. Specific examples are highlighted below.

Funding information for the North Carolina initiatives to improve birth outcomes:

- As noted in the text, funding for the variety of initiatives and programs comes from North Carolina General Assembly (state funds), federal funding (including MCHB) and limited other sources
- The Folic Acid Campaign also received an infusion of funds from the Vitagrant Settlement

Changing the Clinical Context

One of the overarching strategies in North Carolina is to implement clinical improvements to reduce infant mortality. Areas of focus include the use of 17P, enhancing smoking cessation counseling and education, building partnerships through the Perinatal Quality Collaborative of North Carolina, and promoting the pregnancy medical home.

Since 2006, a statewide initiative strove to increase the appropriate use of 17P and ensure that all women in North Carolina who meet the clinical criteria for 17P have access to the intervention to reduce their risk of a recurring preterm birth. The campaign provided education to public health leaders, clinicians and women about the intervention, as well as addressed systems and access barriers. The North Carolina General Assembly provided funding to the campaign and health care systems and providers within the state partnered with the department throughout implementation. The North Carolina Division of Medical Assistance or Medicaid reimbursed providers for 17P since 2007. Educational materials, tools for incorporating 17P into practice and other resources about reducing the risk of recurring preterm birth with 17P are online.

North Carolina focused on tobacco cessation for many years and is currently reducing smoking among pregnant women through multiple avenues. Since 2008, the state partnered with the former Health & Wellness Trust Fund (Master Settlement Fund) on the 'You Quit Two Quit' campaign to reduce smoking among women of reproductive age. The goal of this project is to ensure that there is a comprehensive system in place to screen and treat tobacco use in women, including pregnant and postpartum mothers. The many activities of the project include operating quality improvement initiatives focused on tobacco cessation screening and counseling and distributing patient education materials statewide. In 2011, smoking cessation efforts received funding from the federal Office of Women's Health for a project directed specifically at women of childbearing age who have low incomes. The project focuses on provider screening practices within the Community Care North Carolina Network and offers training to all practices and chronic disease and pregnancy care managers within the network. The North Carolina work is done in partnership with the Women and Tobacco Coalition for Health (WATCH) and the Tobacco Prevention and Control Branch.

The Perinatal Quality Collaborative of North Carolina (PQCNC) is a group of hospitals, community organizations and individuals committed to making North Carolina the 'best place to be born.' The overall goal is to promote high value perinatal care through spreading evidenced practice and reducing the variation among practice of perinatal care, partnering with families and patients and optimizing resources across the state. The PQCNC initiatives throughout North Carolina encourage hospitals to eliminate elective deliveries before 39 weeks, reduce catheter associated blood stream infections by 75 percent in participating centers, increase exclusive human milk in both mother-baby settings and the neonatal intensive care unit, and support intended vaginal birth.

Promoting a pregnancy medical home is another avenue that is being used to improve birth outcomes specifically within the North Carolina Medicaid population. The pregnancy medical home provides evidence-based, high-quality maternity care to Medicaid patients and focuses care management resources on those women at the highest risk. In the medical home model, quality improvement goals are aligned with cost savings goals, keeping more babies out of the neonatal intensive care unit and avoiding associated expenses. Pregnancy care management is the key intervention of the medical home model. Pregnancy care managers, trained social workers and nurses, provide care management services for pregnant and postpartum women with specific risk criteria. The services are provided based on need and risk stratification. The pregnancy medical home incentives to include increased rate of reimbursement for the global fee for vaginal deliveries to equal that of a c-section

global fee, incentive payment for risk screening, incentive payment for a postpartum visit, and no prior authorization required for OB ultrasounds.This new model is based on the Community Care of North Carolina system of regional networks of providers, clinics and partners across the state.

Working with Families in Community-Based Programs

In order to explicitly address health disparities, North Carolina has multiple community-based initiatives designed to reach families of color. The Healthy Beginnings program operates out of the North Carolina Division of Public Health. Healthy Beginnings serves 12 communities across the state with paraprofessionals providing outreach, care coordination and education to families. The program served 900 women in 2010; program participants experienced no infant deaths. Healthy Beginnings focuses on breastfeeding promotion, folic acid, safe sleep, environmental tobacco reduction/ elimination, healthy weight and reproductive life planning.

In addition, North Carolina has four federally funded Healthy Start Programs that operate in 15 communities across North Carolina. Healthy Start focuses services primarily on the African-American and American-Indian populations, including health education, case management, depression screening, interconception care and community engagement. Each healthy start site (Healthy Start Corps, Eastern Baby Love Plus, Northeastern Baby Love Plus and Triad Baby Love Plus) also are lead by a regional consortia inclusive of consumers, community leaders and providers.

The ACA also enhanced home visiting in North Carolina. The state receives $3.2 million annually to support evidence-based home visiting programs. Program models include the Nurse-Family Partnership, Healthy Families America, Parents as Teachers and the Early Head Start/Home Based Option. Implementation of these home visiting programs began in December 2011 at seven sites.

Raising Public and Provider Awareness

The North Carolina Preconception Health Campaign grew out of a focused campaign on folic acid. The current campaign is run by the March of Dimes local chapter with funding from state and federal contracts. The overall campaign focuses on educating the public and health care providers about the importance of being healthy prior to pregnancy. Current campaign topics include folic acid, reproductive life planning, healthy weight and tobacco cessation. The North Carolina Preconception Health Coalition is coordinated by

the Division of Public Health Title V Program and partners closely with the campaign. North Carolina developed a five-year preconception health strategic plan in 2009 that has been used by coalition members and partners across the state. The state has been fortunate to secure First Time Motherhood New Parent and Pregnancy Assistance federal funds to support preconception social marketing, outreach and education in various communities across the state.

North Carolina is also part of the National Preconception Peer Educators Program. This program focuses on reaching college-age populations with targeted health messages that emphasize preconception health and health care. Eleven universities across the state participate in the peer educator program.

North Carolina also has a comprehensive shaken baby prevention program, the Period of PURPLE Crying, that focuses on hospital education of parents of newborns, community reinforcements through prenatal visits and well-child visits at primary care provider offices and a mass media campaign including radio/TV, print and social media.

Changing Policy to Support Infant Health

North Carolina has also seen policy change that supports healthy infants. This is particularly evident is in the area of breastfeeding promotion. In addition to the ACA efforts to promote breastfeeding among hourly workers, the North Carolina Office of State Personnel adopted a lactation policy covering all state employees with paid break time and space. State regulation for child care centers also requires onsite spaces for mothers to pump or feed their children. In addition to these policies, breastfeeding is being promoted across the state through a Breastfeeding Peer Counselor Program covering 86 counties. The North Carolina Breastfeeding Coalition has a strategic plan that includes a number of future policy goals, including Medicaid reimbursement for lactation specialists and break time and space for salaried employees.

Policy change has also led to progress in safe sleep. In 1994, North Carolina started the 'Back to Sleep' campaign, now called the NC Infant Safe Sleep Campaign. In 2003, the North Carolina legislature passed the NC Prevents SIDS Law (GS 110-91-15). The law requires child-care providers to put babies on their back when placing them to sleep in child-care settings.

Federal policy opportunities have also streamlined ability to provide family planning waivers through a Medicaid State Plan. Based on federal health care reform legislation, states now have the option to provide family planning services through a Medicaid State Plan amendment without the formal process of routinely needing to seek federal approval for a waiver. The North Carolina Division of Medical Assistance has submitted a state plan amendment (SPA) to the Centers for Medicare and Medicaid services seeking to provide family planning services to persons at or below 185 percent of the federal poverty level. In addition to providing services currently covered under the waiver, the state is proposing screening and treatment for STIs, which will be covered for any or all of the six periodic visits allowed under the new SPA program. In addition, under the SPA, there will no longer be restrictions for eligibility based age to receive family planning services.

Finally, for more than two decades the North Carolina Child Fatality Task Force studied issues related to child deaths and worked with partners to improve outcomes through a variety of mechanisms, including policy changes. Members of the Task Force are appointed and include legislators and other key leaders. The task force also receives recommendations from the local child fatality prevention teams that are located in each county and review local deaths. To ensure a sustained focus on healthy birth outcomes, the task force created a Perinatal Health Committee.

Additional Information and Resources:

ncpublichealth.com

everywomannc.com

nchealthystart.org/backtosleep/index.htm

mombaby.org (click on 17P or health equity)

PURPLEcryingnc.info

YouQuitTwoQuit.com

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Ohio

The Ohio infant mortality rate has not substantially changed in more than a decade. Furthermore, in Ohio African-American infants die at more than twice the rate of white infants. In 2009, the infant mortality rate for white Ohioans was 6.4 deaths per 1,000 live births, while it was 14.2 deaths per 1,000 live births among African Americans in the state. The lack of sustained progress in reducing infant death and the marked differences in birth outcomes when comparing different racial, ethnic and geographic subpopulations throughout led to the establishment of an Infant Mortality Task Force in 2009 at the request of then Governor Strickland. Additionally, concurrent efforts in the state have led to quality improvement in perinatal care and better birth outcomes.

Building a Collaborative Effort to End Infant Mortality

The Infant Mortality Task Force was charged with making short- and long-term recommendations to address the overall infant mortality rate and increasing disparities among different populations in Ohio. The task force was made up of more than 70 individuals, cochaired by the Ohio Department of Health (ODH) director and the CEO of a regional health care system. Membership on the task force included public and private health care providers, businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state.

In late 2009, the task force completed its recommendations for preventing infant mortality, including rationale and strategies for implementing each recommendation. In 2010, the Ohio Collaborative to Prevent Infant Mortality was formed as a successor to the task force to continue its work and ensure oversight and accountability for the implementation of the recommendations. The collaborative currently has five workgroups addressing the following areas: coordinated health care, disparities and racism, data/metrics/quality improvement, education/outreach, and public policy.

Expanding Access to Care

The collaborative was successful in pushing forward recommendations related to expanded access to care. In September 2010, the collaborative urged rapid implementation of an amendment to the Ohio Medicaid State Plan to provide family planning services for persons otherwise not eligible for Medicaid. The approved amendment allows men and women with incomes up to 200 percent of the federal poverty level to become eligible for family planning services, effective Jan. 1, 2012. In addition, the collaborative issued an opinion on the availability of 17P urging all physicians in Ohio to obtain the compounded version of 17P and all payers to continue to cover the compound to help reduce the risk of preterm birth in high-risk women.

Funding information for Ohio initiatives to improve birth outcomes:

- The majority of state initiatives described in this case study were funded through the Title V MCH Services Block Grant

Targeting Racial Disparities

In addition to working with partners to collaboratively address infant mortality, the ODH Child and Family Health Services program is administering the Ohio Infant Mortality Reduction Initiative (OIMRI) in 14 counties with high infant mortality. OIMRI is funded through the Title V MCH Services Block Grant and addresses the financial, geographic, cultural, and structural barriers that African American women and children experience and improves their access to and utilization of health care. The OIMRI programs provide community-based outreach and care coordination, employing individuals from the community as trained advocates who empower pregnant women to access resources. These advocates, professional community health workers, provide a cultural link to the community and to community resources. The work of the advocates includes:

- Case finding
- Home visits on a regular basis during pregnancy and through the baby's second year of life
- Identifying and reinforcing risk-reduction behaviors
- Appropriate education and support for behavior change
- Working with the strengths of the client
- Appropriate referrals to ensure positive birth outcomes

Using Quality Improvement for Better Birth Outcomes

Ohio engaged in initiatives to improve birth outcomes overall, with a particular focus on prematurity. Since 2007, the Ohio Perinatal Quality Collaborative (OPQC) used quality improvement methods to reduce preterm births and improve outcomes of preterm newborns as quickly as possible. Using the Institute for Healthcare Improvement Breakthrough Series, OPQC worked with 20 maternity hospitals, which represents 47 percent of all births in the state, through a collaborative focused on several obstetric improvement projects. Efforts included documenting the method of pregnancy dating, documenting reasons for scheduled delivery before 39 weeks, educating patients about risks of delivery before

39 weeks, implementing a scheduled delivery form, establishing direct communication with pediatricians, promoting early ultrasound and conducting ongoing monitoring of clinical data using the Ohio birth certificate. Since initiating this project, more than 18,000 births have moved from occurring prior to the due date to full term (39 to 41 weeks). Approximately 500 NICU admissions and some infant deaths have been avoided. OPQC estimates saving approximately $11 million annually in Ohio health care costs.

The CDC State-Based Perinatal Quality Collaboratives grant program provided funding to Ohio, California and New York for the purpose of enhancing existing state-based quality improvement collaboratives by collecting accurate and timely data and that providing feedback to help improve perinatal care.This funding will expand current projects to include a broader range of neonatal and maternal health issues.

Contact Information:

Ohio Collaborative to Prevent Infant Mortality:
odh.ohio.gov/odhPrograms/cfhs/OCTPIM/infantmortality.aspx

Ohio Infant Mortality Task Force full report:
odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/infant%20mortality%20task%20force/imtfreport2009-rev12-02final.ashx

Ohio Perinatal Quality Collaborative:
opqc.net

Ohio Infant Mortality Reduction Initiative: odh.ohio.gov/
odhprograms/cfhs/comcar/precare1.aspx

Texas

Preterm birth is a major cause of infant mortality in Texas, as well as the United States. The percent of infants born preterm in Texas increased from 12.6 percent in 2000 to 13.0 percent in 2009, with an increase in late preterm births from 8.9 percent in 2000 to 9.4 percent in 2009. Induction rates increased by 39 percent in Texas from 2000 to 2009, compared to a national increase of only 15 percent. In 2009, 25.6 percent of deliveries were induced in Texas. In 2007, approximately 70 percent of Medicaid costs for hospitalized newborns in Texas can be attributed to the billing codes for prematurity and extreme immaturity. To address these concerns, Texas developed a statewide initiative to decrease preterm births by 8 percent over two years. The initiative is expected to save the state approximately $7.2 million in state and federal Medicaid costs, improve birth outcomes and save lives.

Funding information for Texas initiatives to improve birth outcomes:

- The Healthy Texas Babies initiative was funded by a $4.1 million dollar investment, over two years, by the Texas Legislature
- Efforts were complimented by collaborations with key partners to maximize impact across the state

Healthy Texas Babies Initiative

The Texas Legislature invested $4.1 million dollars over two years to fund the Healthy Texas Babies initiative. More than half of the funding has been distributed to 10 local coalitions to implement evidence-based interventions in their communities. The 10 coalitions were selected based on their response to a competitive opportunity for funding. Twenty-three counties in the state with the highest number of Medicaid births, large African American population, highest rates of prematurity and more than 1000 deliveries per year were eligible for funding. Each was provided with a county PPOR analysis of their leading causes of infant mortality, as well as a list of PPOR-appropriate and evidence-based interventions. Each coalition received $200,000 for a 21-month funding period and technical assistance from the Texas Department of State Health Services (DSHS).

The remainder of the legislative funds will be used to support coordinated statewide educational efforts for providers and a public education campaign to convey key messages to patients, providers and the public. The Healthy Texas Babies initiative is a comprehensive approach characterized by evidence-based action at both the state and community levels. Collaborations with key partners maximize the impact of the initiative across the state.

Using Evidence to Guide Action

In January 2011, DSHS, the Texas Health and Human Services Commission (HHSC) and the March of Dimes convened a Healthy Texas Babies Expert Panel of approximately 45 stakeholders in maternal and infant health to provide input on a plan to implement the initiative. During the Spring of 2011, three subgroups of providers, payers and community members worked to develop deliverables, which each included a literature review, a measurable, evidence-based intervention, and a plan for scalability and sustainability. Each workgroup presented the deliverables to the entire expert panel in July 2011 and the proposed deliverables were approved. The expert panel continues to meet every six months and is available for consultation to the state health commissioner on issues pertaining to perinatal outcomes. The expert panel has recently been expanded to include members of the faith community, academic community, and others who work with diverse racial and ethnic populations in the state.

Activities are coordinated by the lead partners of the initiative, DSHS, HHSC and March of Dimes. For example, a Neonatal Intensive Care Unit and Obstetrical Services (NICU/OB) survey to determine the locations of NICUs and their levels of care was disseminated to hospitals that deliver babies across the state. DSHS and HHSC collaborated develop and analyze the results of this survey so it can inform a legislatively-mandated NICU council coordinated by HHSC. This council is charged to develop standards of care and a plan for improved service delivery to high-risk mothers and babies.

Using Legislative and Policy Actions to Promote Healthy Births

During the most recent state legislative session, HHSC was directed to develop quality initiatives and implement cost-cutting measures designed to reduce the number of nonmedically indicated deliveries. House Bill 1983, 82nd Regular Session, supports a reduction in elective deliveries by induction or c-section through provider education and training. In response to the legislation, beginning Oct. 1, 2011, providers billing Medicaid for labor and delivery were required to include a modifier on claims to indicate whether deliveries were nonmedically indicated and less than 39 weeks, medically indicated and less than 39 weeks, or greater than 39 weeks.

Those without a modifier and those indicating they are not medically indicated will be denied payment. Those indicating medically indicated and less than 39 weeks will be subject to audit by the Texas Office of the Inspector General. In addition, HB 2636 creates a council to study NICUs to develop standards and recommendations for Medicaid reimbursement. Through HB 824, the Office of the Attorney General and the WIC program are directed to share responsibility for an outreach campaign to promote the involvement of fathers with their children before birth.

Educating the Public and Providers

To improve public understanding of the importance of a full-term delivery, the March of Dimes donated 2,000 English and Spanish posters to local WIC clinics across the state and provided training for local WIC staff on use of the materials. Additionally, DSHS distributed 250,000 English and Spanish brochures on "Why the Last Weeks of Pregnancy Count." A Web-based well-woman curriculum for WIC participants is also being developed with input from the March of Dimes.

Efforts to increase public awareness of and education about the issue are currently being delivered through the DSHS Healthy Texas Babies website and through promotion of theText4baby program. Provider education has been delivered through community health worker/ *promotora* trainings and an ongoing series of DSHS Grand Rounds continuing education webcasts. To provide online continuing education to Medicaid doctors, nurses and other professionals, a Texas Health Steps online provider education module is being developed. In addition, an in-person learning series for social worker, nurses, hospital administrators and clinicians also is in development, focusing on the importance of a full pregnancy and involvement of a woman's partner in her preconception, prenatal and intrapartum care.

Working with Partners to Maximize Impact

Healthy Texas Babies is implemented in strong partnership with the March of Dimes. Learning from the success of the Kentucky *Healthy Babies are Worth the Wait* (HBWW) initiative, March of Dimes has implemented HBWW at three sites in urban centers of Houston. Each site includes a hospital and a clinic that collaborate on initiatives to promote early entry into prenatal care, provider education to improve birth outcomes and reduce elective cesarean sections. In addition, through the Healthy Texas Babies Local Coalition funding opportunity, Waco-McLennan County will implement HBWW at two sites in a more rural area of the state. Thus, by the end of 2012, Texas will have five HBWW sites in operation, contributing to the evidence of the efficacy of this model in different settings.

The Texas chapter of the March of Dimes also implements quality improvement initiatives across the state. These initiatives include the "Think 39" campaign aimed at provider education on the benefits of eliminating elective deliveries before 39 weeks' gestation. Texas also participates in the national March of Dimes Big 5 Prematurity Collaborative to improve adoption of data systems to track changes in specific perinatal issues and indicators.

The Texas chapter of the March of Dimes is working directly with communities to promote supportive environments for healthy pregnancies. March of Dimes implements programs such as Honey Child, *Comenzando bien* and Centering Pregnancy. Honey Child delivers prenatal support to African-American families in a faith-based setting. *Comenzando bien* is a bilingual prenatal education program that is culturally and linguistically appropriate for Hispanic women and is designed for implementation in a variety of settings, including work sites, houses of worship, health departments, Hispanic community-based organizations and neighborhood centers. Centering Pregnancy offers prenatal care in a group setting at sites across Texas, including city/county health clinics, military bases, hospitals and academic institutions. A new Centering Pregnancy site is being introduced in Longview, Texas through the Healthy Texas Babies Local Coalitions funding opportunity.

Centralizing Communications on the Healthy Texas Babies Website

Communication is core to the Healthy Texas Babies Initiative. The Healthy Texas Babies website (healthytexasbabies.org) provides a communications portal to share information on the initiative and receive feedback. The website offers specific information for parents, the public and providers. The site also offers resources for the expert panel and community coalitions. In addition, healthytexasbabies.org provides a platform to share up-to-date statewide data on infant and maternal health.

A statewide public education and communications campaign will be developed based on formative research presently being conducted on appropriate media with which to target at-risk populations in Texas. The campaign will use multiple media to reach target populations with key messages in a delivery model that is most effective and long lasting. The goal of the campaign is to deliver clear messages that are evidence-based, memorable, and easily reinforced by providers, friends, and family of men and women in their childbearing years.

Next Steps

In the coming year, Healthy Texas Babies will continue to focus on reduction of preventable infant morbidity and mortality. The initiative will develop and offer continuing education for providers at all levels. DSHS will continue to support the activities of the 10 local coalitions across the state. DSHS and HHSC will work together to develop of programming based on the NICU/OB Survey results and recommendations by the NICU council. DSHS will work with partners to develop additional programming related to fatherhood and will conduct a preconception peer educator training in coordination with the National Office of Minority Health and Historically Black Colleges and Universities in the state. Healthy Texas Babies will work with the expert panel to plan for the future of the initiative and ensure its sustainability.

For more information:

Visit the Healthy Texas Babies website **healthytexasbabies.org**. For questions, please contact the Texas Office of Title V and Family Health at TitleV@dshs.state.tx.us.

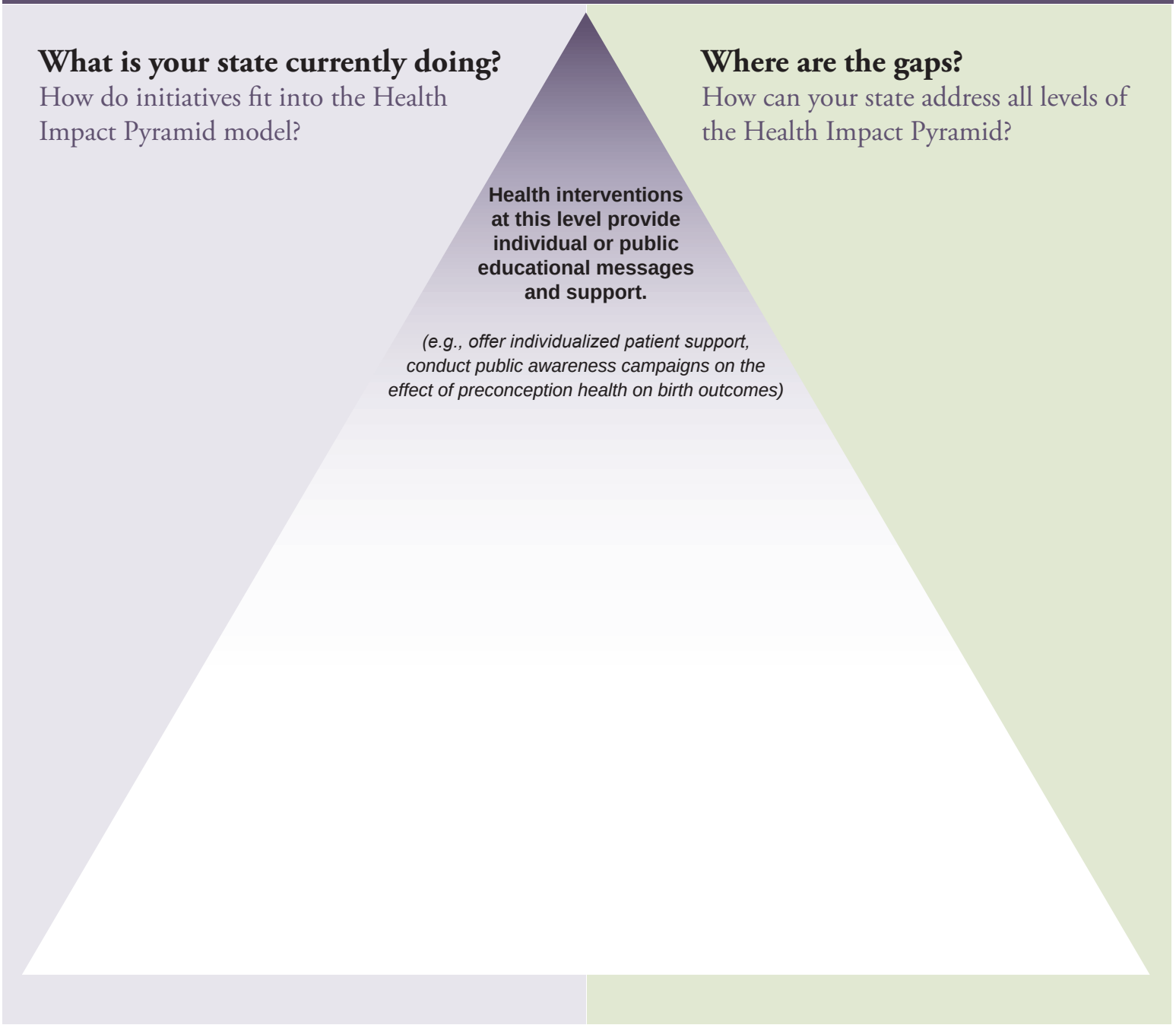
Appendices

APPENDIX A –
Build Your Own Health Impact Pyramid Worksheet

TIER 5: EDUCATION AND COUNSELING

What is your state currently doing?
How do initiatives fit into the Health Impact Pyramid model?

Where are the gaps?
How can your state address all levels of the Health Impact Pyramid?



APPENDIX A –
Build Your Own Health Impact Pyramid Worksheet *continued*

TIER 4: ONGOING CLINICAL INTERVENTIONS

What is your state currently doing?
How do initiatives fit into the Health Impact Pyramid model?

Where are the gaps?
How can your state address all levels of the Health Impact Pyramid?

Health interventions at this level implement evidence-based practices within clinical settings

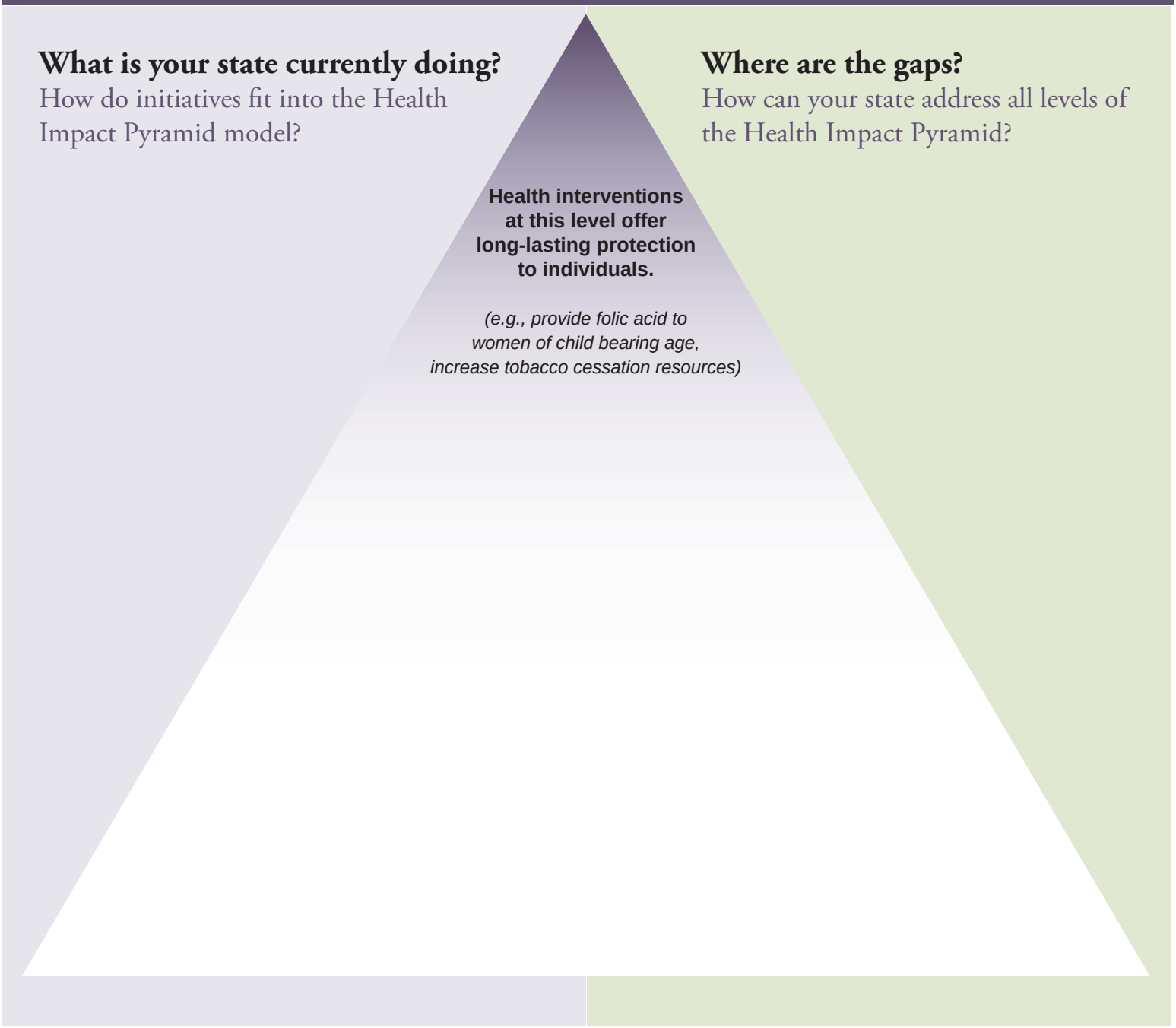
(e.g., improve management of chronic diseases among pregnant women, implement holistic family-practice team models of care)

APPENDIX A –
Build Your Own Health Impact Pyramid Worksheet *continued*

TIER 3: PROTECTIVE, LONG-LASTING

What is your state currently doing?
How do initiatives fit into the Health Impact Pyramid model?

Where are the gaps?
How can your state address all levels of the Health Impact Pyramid?



APPENDIX A –
Build Your Own Health Impact Pyramid Worksheet *continued*

TIER 2: CHANGING THE CONTEXT

What is your state currently doing?
How do initiatives fit into the Health Impact Pyramid model?

Where are the gaps?
How can your state address all levels of the Health Impact Pyramid?

Health interventions at this level change the environmental context to making the healthy choice the easy choice.

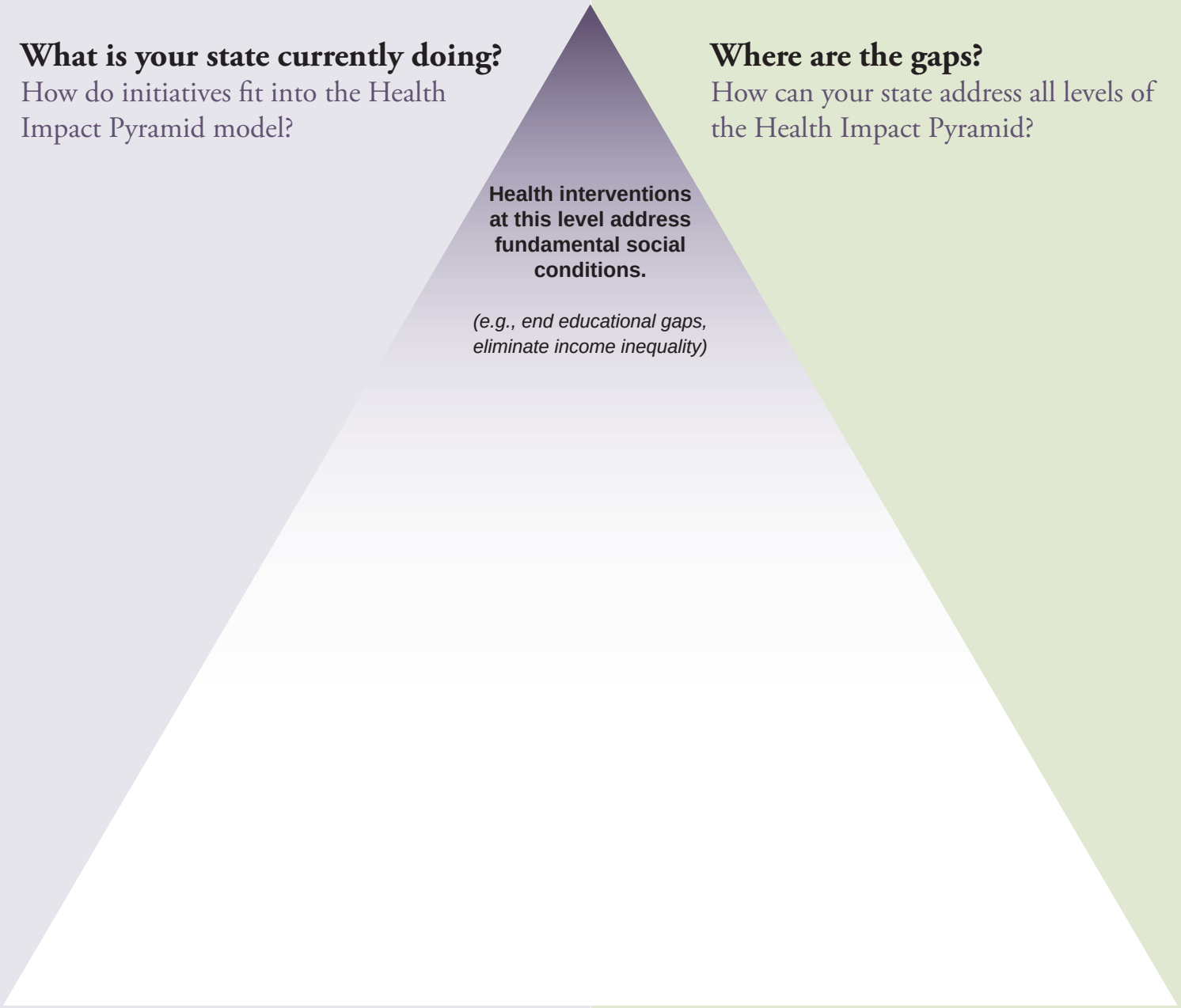
(e.g., remove barriers to accessing prenatal care, improve public health infrastructure)

APPENDIX A –
Build Your Own Health Impact Pyramid Worksheet *continued*

TIER 1: ADDRESSING SOCIOECONOMIC FACTORS

What is your state currently doing?
How do initiatives fit into the Health Impact Pyramid model?

Where are the gaps?
How can your state address all levels of the Health Impact Pyramid?



APPENDIX B – Source Documents

A total of seven national reports, which included 60 separate recommendations, and eight state reports, which included 62 recommendations were reviewed.

National Sources (60 recommendations)

- AMCHP (4): *Creating a National Initiative to Reduce Premature Births, Infant Mortality and Related Disparities*
- ASTHO (7): *State Policy Options to Improve Birth Outcomes*
- Childbirth Connection, The Reforming States Group, Milbank Memorial Fund (4): *Evidence-Based Maternity Care: What it is and What it can achieve*
- Healthy People 2020 (24): Healthy People 2020 evidence-based recommendations related to maternal, infant, and child health
- March of Dimes (5): *Healthy Babies are Worth the Wait*
- Michael Lu, Neal Halfon, et al (12): *Closing the Black-White Gap in Birth Outcomes: A Life Course Approach*
- National Prevention Council (4): *The National Prevention Strategy, Section on Reproductive and Sexual Health*

States (62 recommendations)

- Delaware (20): *Reducing Infant Mortality in Delaware: Task Force Report*
- Louisiana (4): Louisiana Birth Outcomes Initiative-June 2011 PCH Summit Presentation
- Maryland (5): *Plan for Reducing Infant Mortality in Maryland*
- Michigan Infant Mortality Task Force Report
- Minnesota (4): Maternal and Child Health Advisory Task Force Infant Mortality Work Group
- Mississippi (5): *2007 Mississippi Infant Mortality Report*
- Ohio (10): *Ohio Infant Mortality Task Force Report*
- Texas (6): *Healthy Babies are Worth the Wait* Purpose-to-Interventions Schema
- Wisconsin (8): *Elimination of Racial and Ethnic Disparities in Birth Outcomes in Wisconsin*

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Birth Outcomes: A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans. Center for Health Care Strategies, Inc.

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APPENDIX B – Source Documents *continued*

Maryland Department of Health and Mental Hygiene. Maryland Infant Mortality Epidemiology Workgroup. (2011). Maryland Infant Mortality Epidemiology Work Group Findings from Data Analysis and Overall Recommendations. Maryland.

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APPENDIX C – Matrix Mapping of Strategies to the Health Impact Pyramid

Health Impact Tier & Description	Broad Recommendation	Sub-Recommendation *(see full compendium for specific actions for each sub-recommendation)*
Tier 5: Counseling and Health Education Summary: Tier 5 is the top of the pyramid and represents individual public health education. When applied consistently and repeatedly these interventions can have large impacts. These interventions require the highest amount of individual effort as they involve individual choices to change behavior. Furthermore, a population-level impact from counseling and health education may take longer to reach and be harder to measure. The impact of individualized messages and relationships on individual health choices, however, cannot be underestimated. (Examples: peer education about reducing HIV risk, personalized smoking cessation advice.)	**Implement Health Promotion Efforts**	Develop messages about preconception and interconception health to promote women's health before and after pregnancy. Incorporate messages on healthy pregnancies and healthy infant care into social marketing and education campaigns. Expand preconception and interconception health planning among women and providers. Promote daily folic acid for women of childbearing age. Reduce the use of and exposure to harmful substances among all women. Promote safe sleep campaigns. Promote healthy weight among women of childbearing age. Chronic disease and obesity prevention programs may be partners who are particularly engaged in healthy weight policy and program development. Increase awareness among pregnant women, families and providers on the importance of carrying an infant full term. Improve public and professional awareness of benefits and risks of newly developed and available contraceptive technologies – keeping in mind the wants and desires of the woman and her family/partner (including cultural considerations). Educate communities and service providers on the issues and impact of infant mortality within your community in order to develop additional champions for improving birth outcomes. Reduce unintentional injuries to women and infants in the home and child care settings. Injury prevention messages and services can be delivered through multiple programs and partners serving pregnant women and families. Reduce injuries and death related to motor vehicle crashes. Promote oral health, particularly the prevention and treatment of periodontal disease, as a component of comprehensive perinatal health programs. Support breastfeeding promotion for all mothers. Educate expectant parents about newborn screening as a life-saving intervention for infants.

APPENDIX C – Matrix Mapping of Strategies to the Health Impact Pyramid *continued*

Health Impact Tier & Description	Broad Recommendation	Sub-Recommendation *(see full compendium for specific actions for each sub-recommendation)*
Tier 4: Clinical Interventions Summary: Tier 4 interventions are individual and require an ongoing clinical component (low population impact and high requirement of individual effort). There are many evidence-based clinical interventions that are proven to have a large health impact on the individual level, but non-adherence can be problematic so rigorous oversight and accountability are required to make sure interventions are implemented as intended. (Examples: medications for treating hypertension, hyperlipidemia and diabetes.)	**Ensure Quality of Health Care for All Women and Infants**	Create or partner with a statewide perinatal quality collaborative to study and address perinatal outcomes across the state. Understand and share perinatal health data. Ensure the best available evidence guides maternity care decisions and that the family partners with their health care providers to make decisions about their care. Implement policies to decrease rates of elective deliveries prior to 39 weeks in all birthing hospitals. Create or strengthen a perinatal regionalized system of care to ensure ongoing review of the appropriateness of deliveries and level of care for newborns based on maternity licensure levels of care. Ensure access to appropriate consultation and referral for pregnant women to a higher level of care when indicated. Pursue telemedicine and other mechanisms to connect women with specialists as indicated for women in rural or underserved areas to increase access to risk-appropriate care. Implement neonatal quality improvement initiatives to improve care for infants in the NICU and reduce variation in NICU outcomes. Implement uniform postpartum discharge programs and ensure access to comprehensive postdelivery follow up care. Offer postdelivery services to all women, not just those with poor birth outcomes. Support expansion of Mother and Baby Friendly Hospital programs to promote immediate and sustained breastfeeding. Implement electronic medical records for women and infants to allow easily access to reproductive health data for health care providers, which may increase the safety and quality of care for pregnant women and infants. Study, disseminate and increase the adoption of innovative, evidence-informed prenatal-care models (e.g. home visiting, community health workers, group pregnancy care, use of doulas) in obstetric practices, including certified nurse midwifery settings and community health centers, that provide prenatal care in a group setting. Implement group parenting classes to promote parenting skills, infant health and wellness, injury prevention, and create a network for new parents.

APPENDIX C – Matrix Mapping of Strategies to the Health Impact Pyramid *continued*

Health Impact Tier & Description	Broad Recommendation	Sub-Recommendation *(see full compendium for specific actions for each sub-recommendation)*
Tier 3: Long-Lasting Protective Interventions Summary: Tier 3 interventions have broad population impact, but require outreach to individuals. Interventions at this level are not clinical, they do not require ongoing relationships between an individual and the health care system, but they may involve a singular clinical intervention that makes a permanent change. (Examples: immunization, smoking cessation.)	**Improve Maternal Risk Screening for All Women of Reproductive Age**	Increase the number of women who are screened and monitored for chronic disease, infections and other high-risk conditions that may impact pregnancy or birth outcomes, including hypertension, obesity, gestational diabetes, HIV, STIs, previous poor birth outcomes or preterm birth, unsafe medication use during pregnancy, violence and depression. Ensure that women who are at-risk or screen positive are linked to programs and services.
Tier 2: Changing the Context to Make Individuals' Default Decisions Healthy Summary: Tier 2 represents interventions that change the environmental context – so making the healthy choice becomes the easy choice. These interventions have high population impact and still require little individual effort. (Examples: clean environments (water, air, food), eliminating toxic exposures in building materials, improving public health infrastructure, developing the public health workforce.)	**Enhance Service Integration for Women and Infants**	Ensure access to a medical home for all women and infants that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. Create health services that provide comprehensive care, connecting medical and social services with the goal of improving perinatal outcomes. Implement innovative models for comprehensive, coordinated prenatal and interconception care. Supporting a continuum of early childhood services to address family needs.
	Improve Access to Health Care for Women Before, During and After Pregnancy	Expand coverage of comprehensive reproductive health services, including family planning and other health services, for all uninsured and underinsured populations. Ensure prenatal, family planning and other health services are accessible to all women, particularly women living in underserved areas. Support mechanisms to facilitate easy enrollment into Medicaid so providers can directly enroll eligible clients, based on declaration of income and family size. Strengthen the workforce to ensure access to providers for all women of reproductive age. Promote comprehensive oral health care, particularly the prevention and treatment of periodontal disease, as a component of perinatal health programs. Increase access to interconception care for women with prior adverse pregnancy outcomes. Core services include family planning, screening for maternal depression and intimate partner violence, assessing social support for the pregnant woman, smoking cessation and substance treatment programs, physical activity and nutritional education and intervention, management of chronic diseases, and education on back-to-sleep and parenting skills.

APPENDIX C – Matrix Mapping of Strategies to the Health Impact Pyramid *continued*

Health Impact Tier & Description	Broad Recommendation	Sub-Recommendation *(see full compendium for specific actions for each sub-recommendation)*
Tier 2: Changing the Context to Make Individuals' Default Decisions Healthy *continued*	**Develop Data Systems to Understand and Inform Efforts**	Conduct a thorough assessment of existing data systems to determine what currently exists and what data systems may need to be developed. Strengthen epidemiology capacity focused specifically on maternal and child health. Create formal data-sharing partnerships to facilitate timely and ongoing data sharing. Create a linked database system or conduct strategic data linkages to enhance birth and death certificate information and facilitate identification of additional risk and protective factors for infant mortality and other poor birth outcomes. Key datasets include vital records, hospital discharges, newborn screening (blood spot and hearing), the immunization registry and the birth defects registry. In addition, Medicaid and other insurer data, program data and surveys, such as PRAMS, can provide a wealth of information on the health of women and infants. Use effective methods to understand infant mortality in your state and communities. Using analytic methods will assist in identifying root causes of poor birth outcomes and infant mortality and clarify underlying issues in geographic areas of high infant mortality to help in targeting interventions and setting a baseline for improvement. Examine environmental influences on birth outcomes and infant mortality. Conduct a comprehensive review of all fetal, infant and child deaths. Expand information collected through birth and fetal death certificates. Conduct a comprehensive review of all maternal and pregnancy-related deaths. Establish a PRAMS survey. Establish or expand birth defect registry surveillance. Establish or expand collection of qualitative data to help enhance surveillance data with information on the lived experience of women and communities. Measure women's reproductive health status. Evaluate all programs aimed at reducing infant mortality. Publish birth outcomes data annually to stakeholders, including through accessible reports for consumers.

APPENDIX C –
Matrix Mapping of Strategies to the Health Impact Pyramid *continued*

Health Impact Tier & Description	Broad Recommendation	Sub-Recommendation *(see full compendium for specific actions for each sub-recommendation)*
Tier 1: The Socioeconomic Factors Summary: Tier 1 represents the bottom of the pyramid, which means interventions have the largest population impact and require the smallest individual effort. Health interventions at this level include fundamental social restructuring. (Examples: ending educational gaps, eliminating racism.)	**Promote Social Equity**	Support working mothers and families. Raise awareness on the effects of racism. Racism is multidimensional: intrapersonal, interpersonal and institutional. The public health community must raise awareness of and actively address racism in all its forms. Invest in community rebuilding and urban renewal. Ensure health care services are provided in a manner compatible with the cultural beliefs, practices and preferred language of the consumer. Create reproductive social capital actively supporting and celebrating pregnant women and promoting reproductive health within a community as a whole. Develop, recruit and train a diverse network of culturally competent health professionals statewide.

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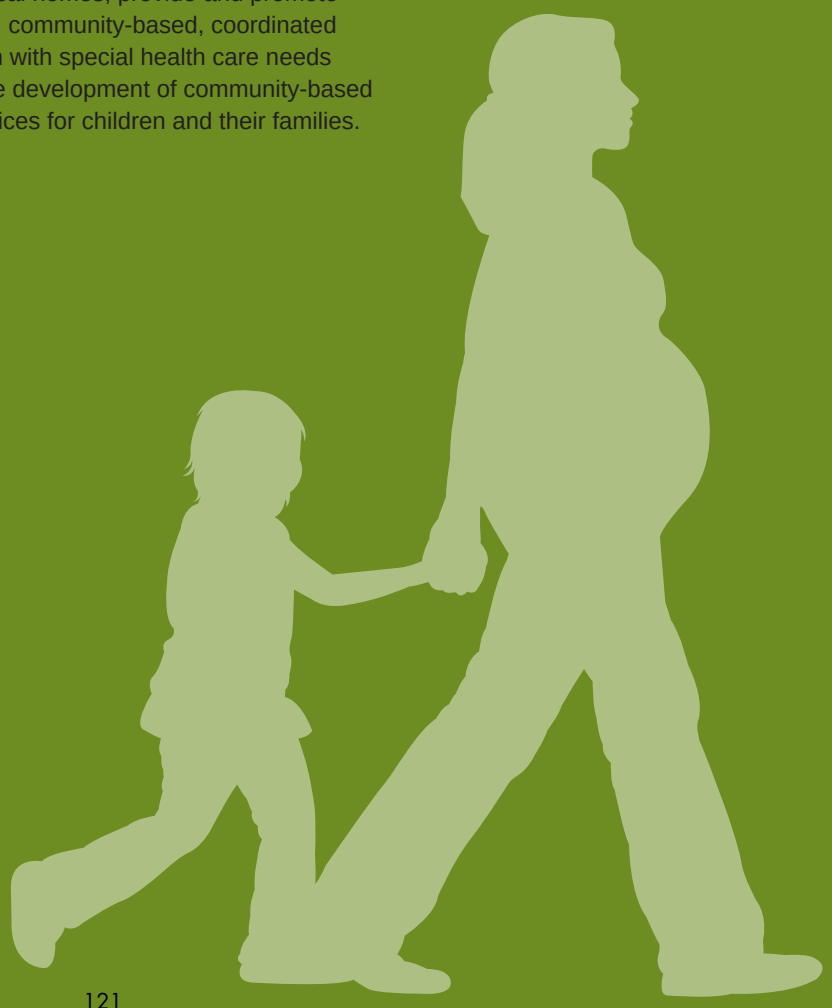
Notes

ABOUT AMCHP

The Association of Maternal & Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.

AMCHP supports state maternal and child health (MCH) programs and provides national leadership on issues affecting women and children. We work with partners at the national, state and local levels to expand medical homes, provide and promote family-centered, community-based, coordinated care for children with special health care needs and facilitate the development of community-based systems of services for children and their families.

amchp.org



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Comparison Table of Regional Meetings Themes

Domains ↓	South central Region	Southwest Region	Northwest Region	North central Region	Northeast Region
Woman/Maternal Health					
Breastfeeding Support			X	X	X
Quality of Care	X	X			X
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X	X	X	X	X
Healthier eating options (cross cutting)	X		X	X	X
Children					
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X		X	X	X (just children identified)
Healthier eating options (cross cutting)	X		X	X	X
Access to mental health services				X	
Access to oral healthcare					X
Perinatal/Infant					
Quality of care		X		X	
Access to care	X				X
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X		X		X
Healthier eating options (cross cutting)	X		X	X	X
Immunizations					X
Access to developmental screenings			X		X
Adolescents					
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X		X	X	X
Healthier eating options (cross cutting)	X		X	X	X
Mentoring programs					X
Adolescent education				X	
CYSHCN					
Mental health stigma (cross cutting)		X			
Continuity of care (cross cutting)	X	X	X	X	X
Healthier eating options (cross cutting)	X		X	X	X

ADDRESSING THE HEALTH NEEDS OF KANSAS COMMUNITIES THROUGH PARTNERSHIPS, TARGETED EFFORTS AND INTERVENTIONS

Date: Thursday, November 13, 2014
Time: 9:30 a.m. – 4:00 p.m.

Location: Garden City Community College
Beth Tedrow Student Center 1109
801 Campus Drive, Garden City

Meeting Goals:

1. Expand the partner base and network for referral across counties to increase and improve maternal and child health services in the Southwest Public Health Region.
2. Collectively commit to transforming the model of service delivery in the Southwest Public Health Region* by aligning services and programs and identifying existing and potential partnerships to improve birth outcomes in the region.
3. Demonstrate a process for assessing and mapping activities within a Public Health region to build our statewide capacity to address and improve community health priorities: sustainable collaborative partnerships, targeted interventions, and services.

Meeting Objectives:

1. Assess the mother/infant/family supports, services and programs in the Southwest public health region to reveal collective strengths as well as potential service gaps.
2. Identify opportunities for engaging new partners and approaching our work differently as a result of this process.
3. Recommend actions to transform region-wide collaborations based on aligning activities with the Health Impact Pyramid to address individual and population health needs.
4. Obtain stakeholder input to inform the Kansas Title V Maternal & Child Health (MCH) priorities for the period 2016-2020.

Learning Objectives: *Participants will leave this meeting with…*

1. A clear understanding of the purpose of the efforts of the Kansas Department of Health and Environment to assess activities to improve birth outcomes as well as the role each sector plays in forging a statewide initiative.
2. A clear understanding of the MCH programs and services in the Southwest Public health Region, the Health Impact Pyramid, the domains of the AMCHP Birth Outcomes Compendium, and the Title V Needs Assessment.
3. A clear understanding of the March of Dimes *Healthy Babies are Worth the Wait* model/*Becoming A Mom* program and implementation in communities across Kansas.
4. At least one new potential partner relationship established to support achieving the mission of their programs.
5. Ability to identify how their activities and role contribute to a comprehensive shared agenda to improve birth outcomes in Kansas.

Pre-work for Participants:

- Review the AMCHP Birth Outcomes Compendium, including the Health Impact Pyramid within, and come prepared to discuss recommendations/actions to be considered for your community.
- Review the Stanford Social Innovation Review on Collective Impact.
- Review the Kansas MCH Block Grant Website.
- *Optional:* Utilize *Kansas Health Matters* to review local level data and/or identify gaps in service, health disparities, or other priority issues.

AGENDA

9:00 – 9:30	Arrival and Registration
9:30 – 9:45	Welcome, Introductions, Icebreaker
9:45 – 10:15	Setting the Stage and Context *Describe the motivation to assess statewide initiatives to reveal collective strengths as well as potential service gaps related to improving maternal and infant health outcomes. Orient Participants to the Association of Maternal & Child Health Programs (AMCHP) Birth Outcomes Compendium.*
10:15 – 10:45	Southwest Public Health Region Inventory Findings (Ex. 1) *Summarize and interpret basic findings from the inventory of the Public Health Region, while aligning individual programs and services on a larger scale within the region.*
10:45 – 11:00	BREAK
11:00 – 11:30	Southwest Public Health Region Inventory Findings (Continued) (Ex. 2)
11:30 – 12:00	Collective Impact
12:00 – 12:45	WORKING LUNCH – SPECIAL PRESENTATION *Healthy Babies are Worth the Wait: Kansas Community Collaborative Model* **Presenter:** *Diane Daldrup*, State Director, Programs & Government Affairs, March of Dimes, Greater Kansas Chapter
12:45 – 1:00	BREAK / TRANSITION
1:00 – 1:45	Leveraging Programs/Services in the Southwest Region (Continued) (Ex. 3) *Align inventory findings with domains from the AMCHP Compendium and Health Impact Pyramid. How do programs and services in the Region align with the level of impact we want to achieve?*
1:45 – 2:30	South Central Region Reflection, Roles, and Partnerships *Organize around findings from the inventory—interpretation and application. Bring roles and relationships together.*
2:30 – 2:45	BREAK
2:45 – 3:45	Community Action: Reflections, Opportunities, and Strategies (Ex. 4)
3:45 – 4:00	Group Commitment and Concluding Remarks

Group Exercise 1
10:15 – 10:45 am

Purpose: The purpose of this exercise is to summarize and interpret basic findings from the inventory of the Public Health Region, while aligning individual programs and services with the bigger picture in the region.

Instructions: Your group for the exercise is your assigned table. You have a facilitator assigned to your group. Please do the following:

1. Assign a note taker. This person will be responsible for reporting out your responses to the questions to the larger group.

2. Find the pages of the handout your group is responsible for summarizing:

Table 1: Pages 3-6	Table 4: Pages 7-9
Table 2: Pages 3-6	Table 5: Pages 10 & 11
Table 3: Pages 7-9	Table 6: Pages 10 & 11

3. REVIEW (briefly) all of the graphs and charts within this handout. This will help you to acquaint yourself to the information and context for your assigned pages.

4. DISCUSS the questions for your assigned pages/charts. Your facilitator will keep time; you will have approximately 15 minutes. Note that ALL tables should consider the following questions, in addition to the assigned questions.

   - Does the information accurately reflect the services you're familiar with/aware of?
   - What are the key take-aways?
   - What surprises you?
   - Where is the need?
   - Are there priorities in the region that services aren't supporting?

5. SUMMARIZE your discussion for a 1-2 minute presentation to the group.

Group Discussion: Use this space to record answers to the questions

Table	Questions	Responses
All	Does the information accurately reflect the services you're familiar with/aware of? What are the key take-aways? What surprises you? Where is the need? Are there priorities in the region that services aren't supporting?	
1 & 2	Who is investing in improving birth outcomes? Is this about right? Are we all working together to identify shared strategies, align services, and leverage what's in place? If no, why? Is there duplication? Who do we serve? Who aren't we reaching? How do we address that? How are you linking essential services with high-need populations? What's working?	
3 & 4	How do the services represented as well as your own align with the state priorities and Title V MCH performance measures? What might the distribution of activities across the Healthy Kansans measures say about our priorities?	
5 & 6	If data is not utilized, why? What data sources do you use that others might not? What data sources do you want to learn more about? How and why are Community Health Assessments important to work at the community, county, and regional levels?	

SUMMARY SOUTHWEST INVENTORY FINDINGS

29 Programs Responded (detailed list by program on page 12)
Main Locations by County: Finney, Seward, Gray, Kearny, Ford, Hodgeman, Meade, Morton, Shawnee, Stanton, Stevens

Primary Funding Source

Inventory Question #11. *Select primary funding sources for the specific program identified at the beginning of the survey*.

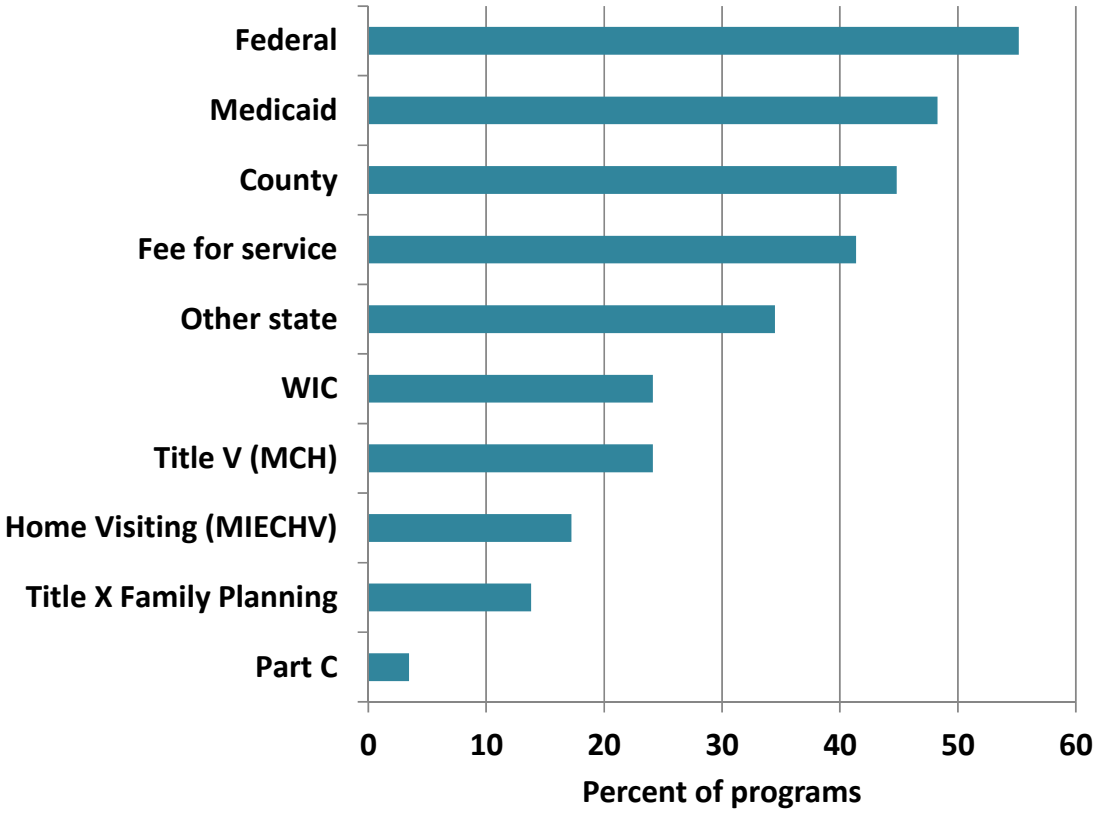
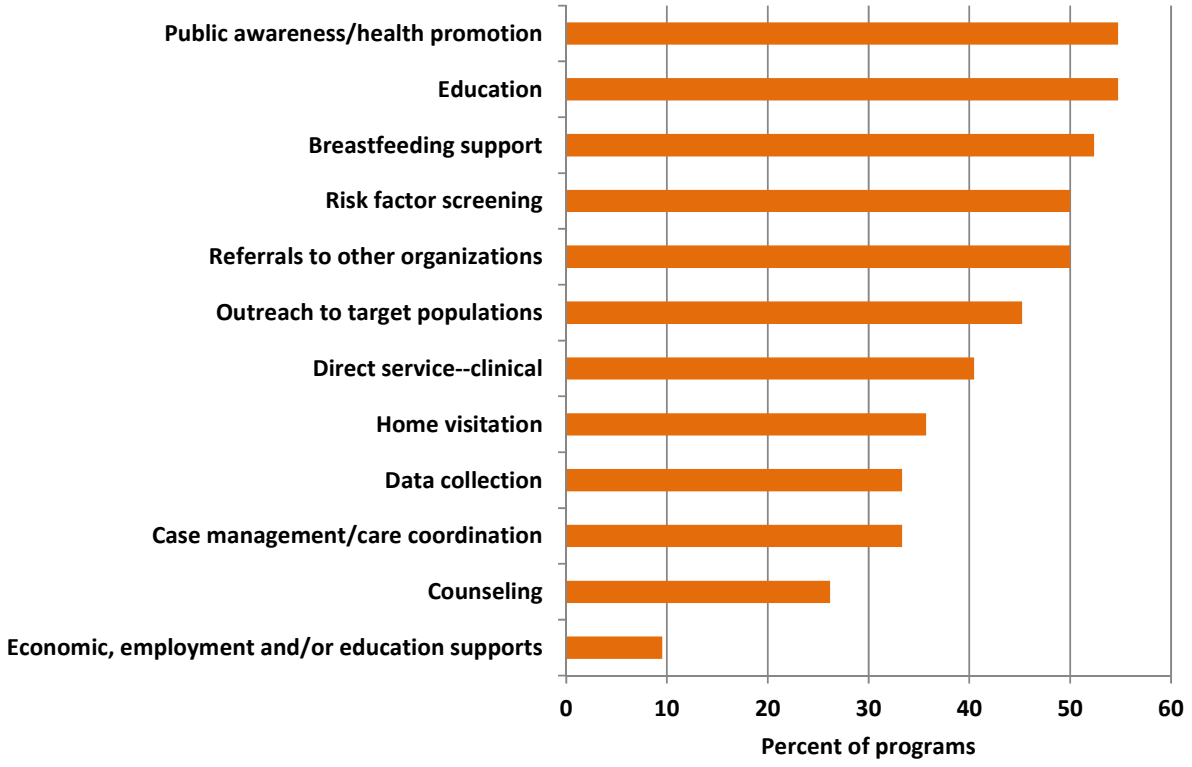


Table 1 & 2 (pp. 3-4):

Who is investing in improving birth outcomes?
Is this about right? Are we all working together to identify shared strategies, align services, and leverage what's in place? If no, why? Is there duplication?

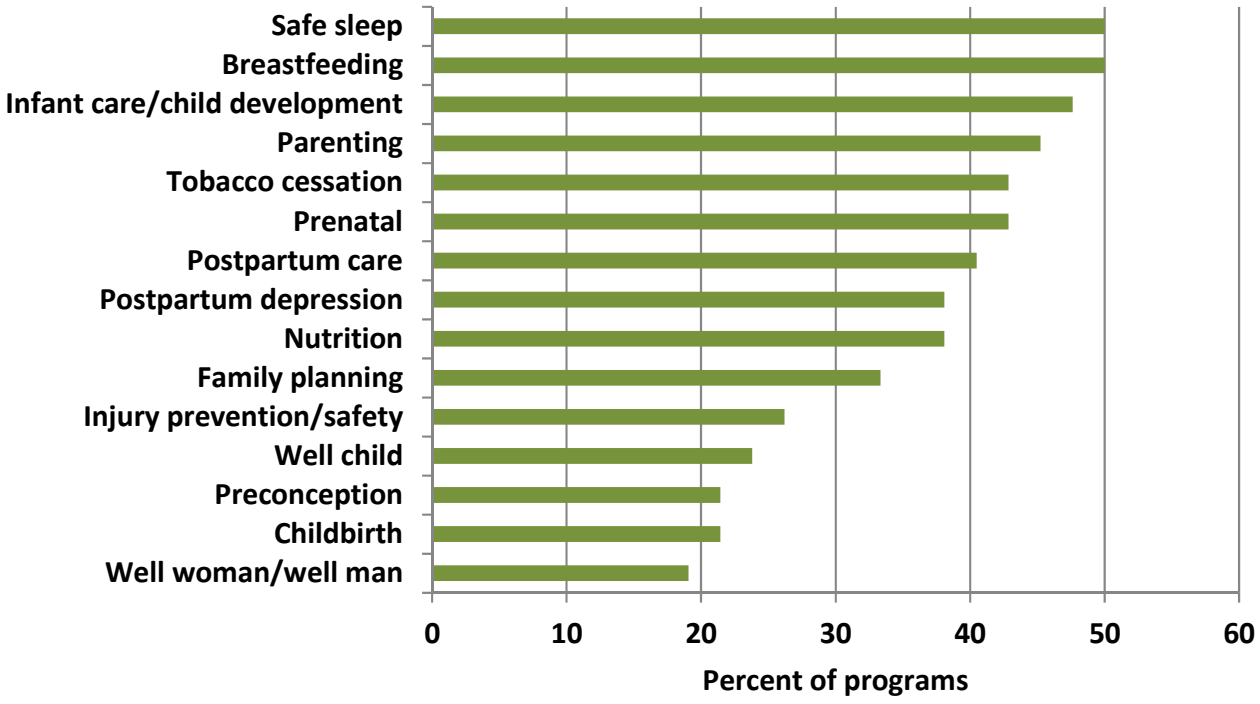
Main Services Provided

Inventory Question #12. *Select the main services provided through the program.*



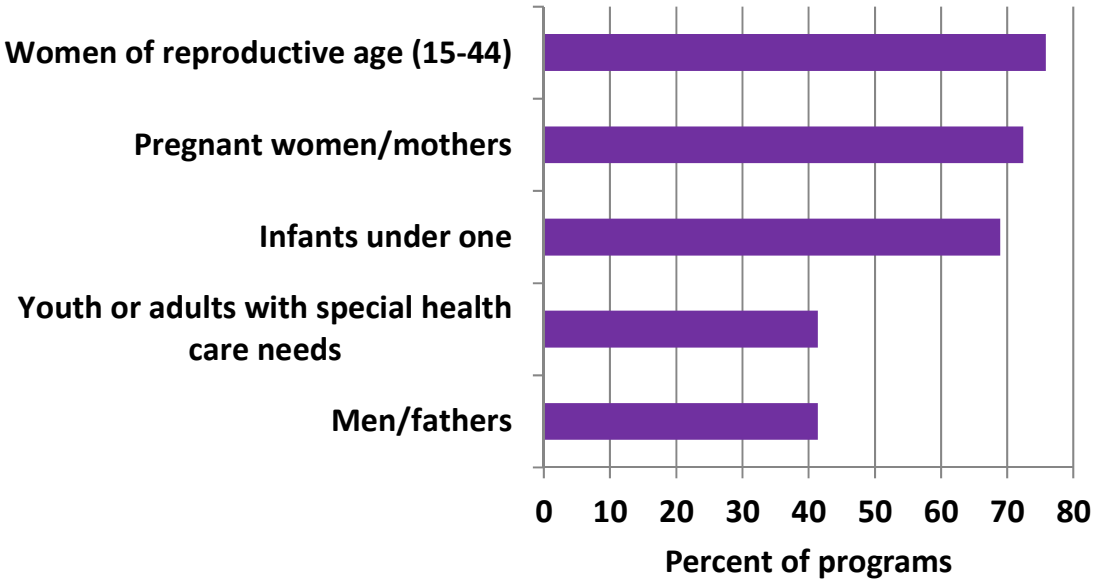
Type of Education Provided *(if selected as a main service reflected above)*

Inventory Question #13. *If you provide education as part of this program, specify types.*



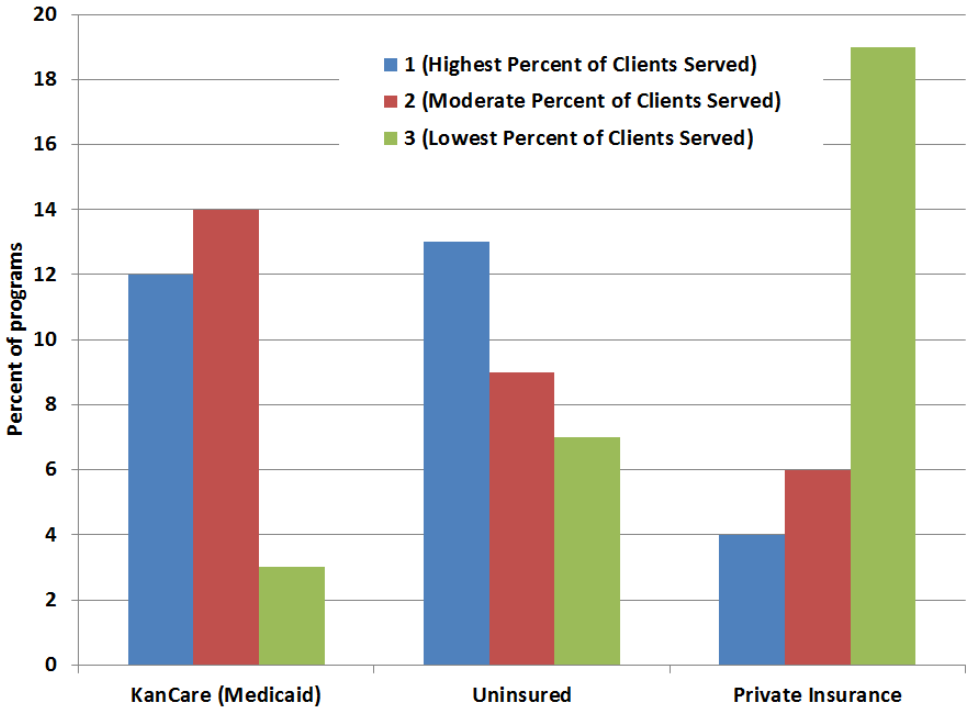
Populations Served

Inventory Question #15. *Which populations do you serve?*



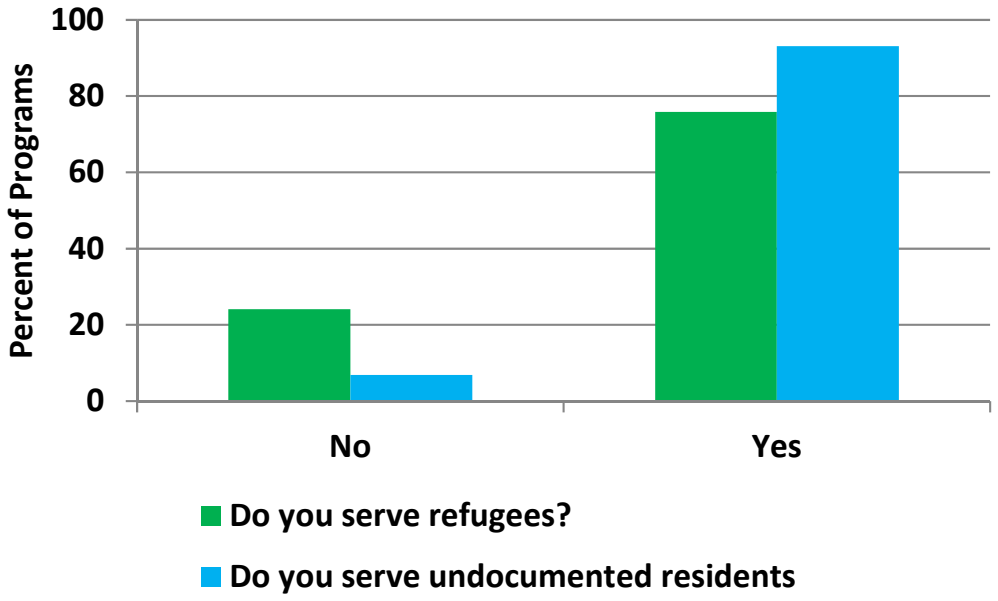
Insurance Status

Inventory Question #16. *Rank the insurance status of the populations you serve.*



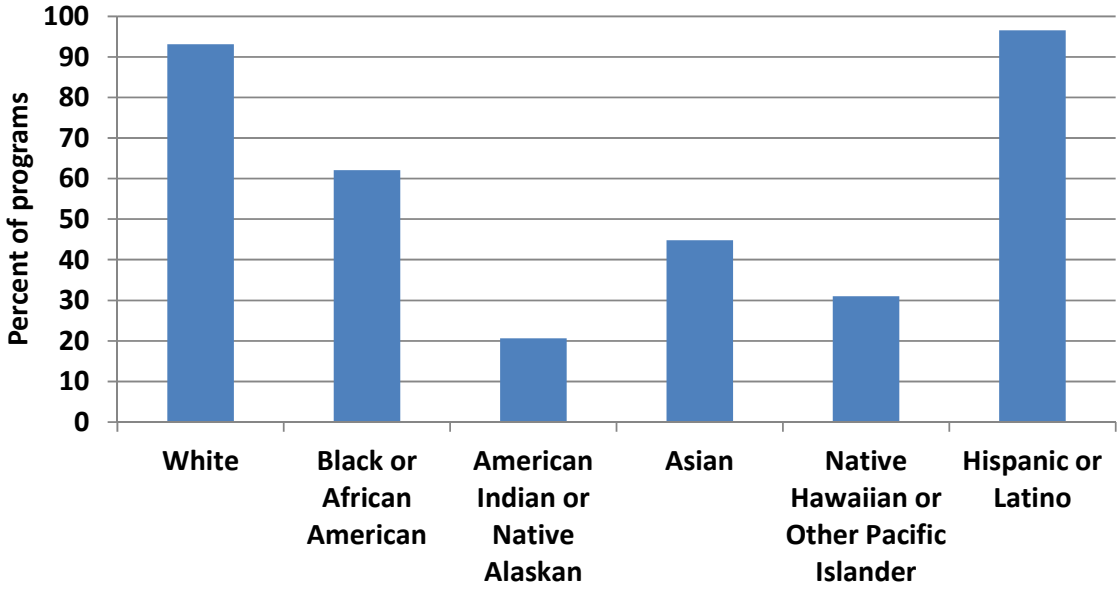
Refugees and Undocumented Residents

Inventory Questions #17-18. *Do you serve refugees? Do you serve undocumented residents?*



Race/Ethnicity of Clients:

Inventory Question #19. *Select the primary races/ethnicities of those you serve.*

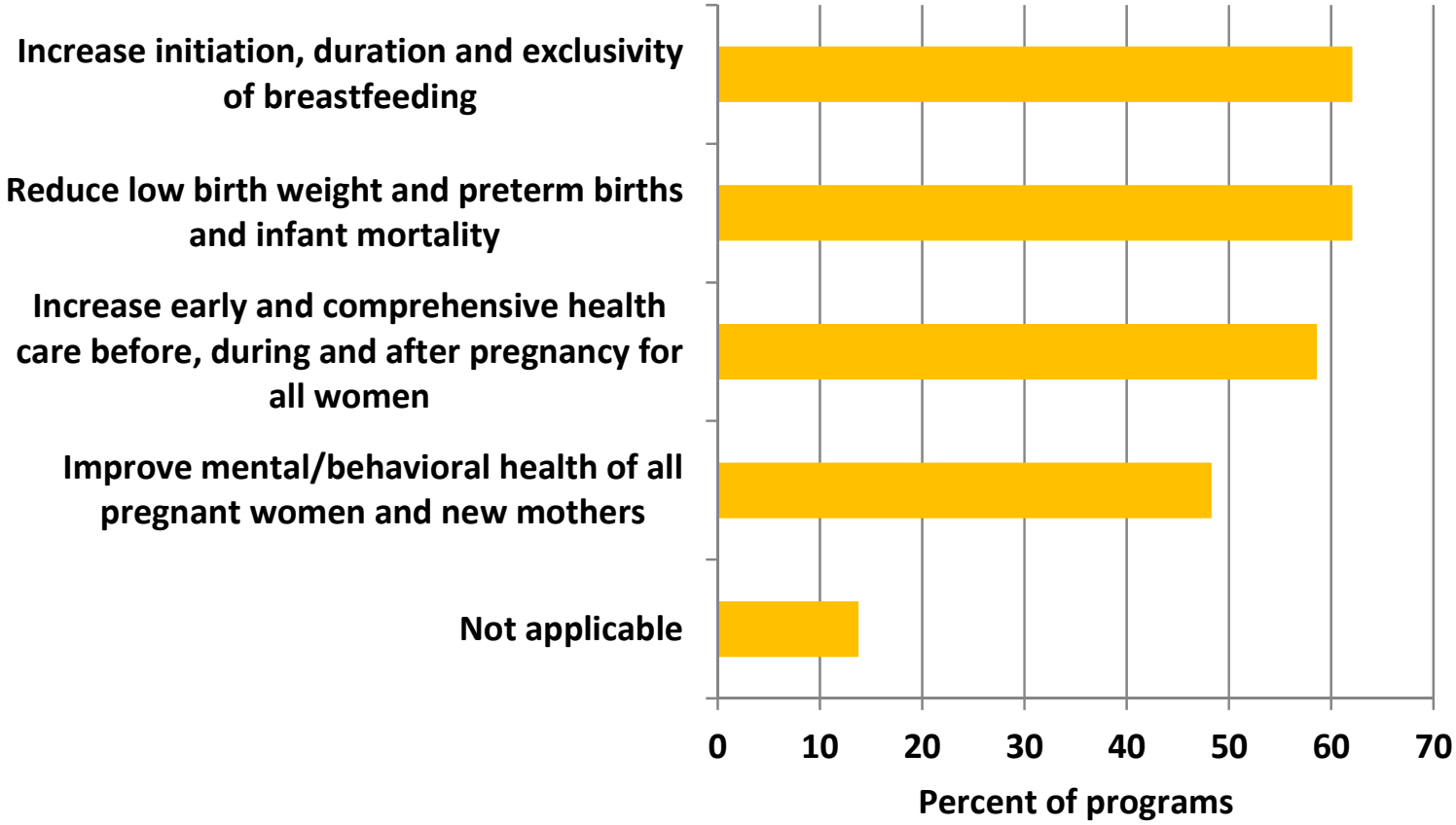


Tables 1 & 2 (pp. 5-6):

Who do we serve? Who aren't we reaching?
How do we address that?
Uninsured/Undocumented/Refugees: How are you linking essential services with high-need populations? What's working? Barriers?

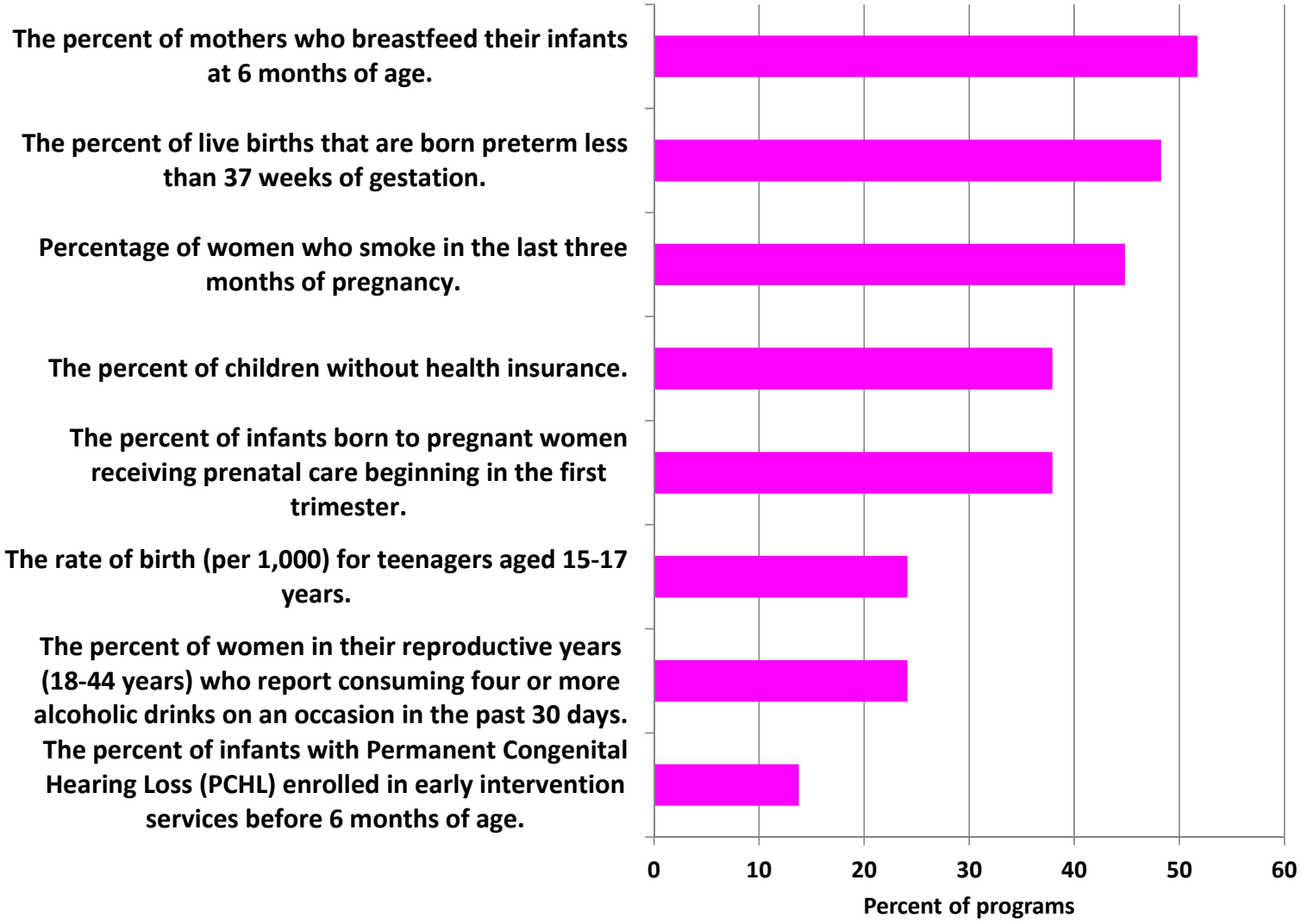
MCH State Priority Needs

Inventory Question #20. *Select the MCH State Priority need(s) with which your program most directly aligns.*



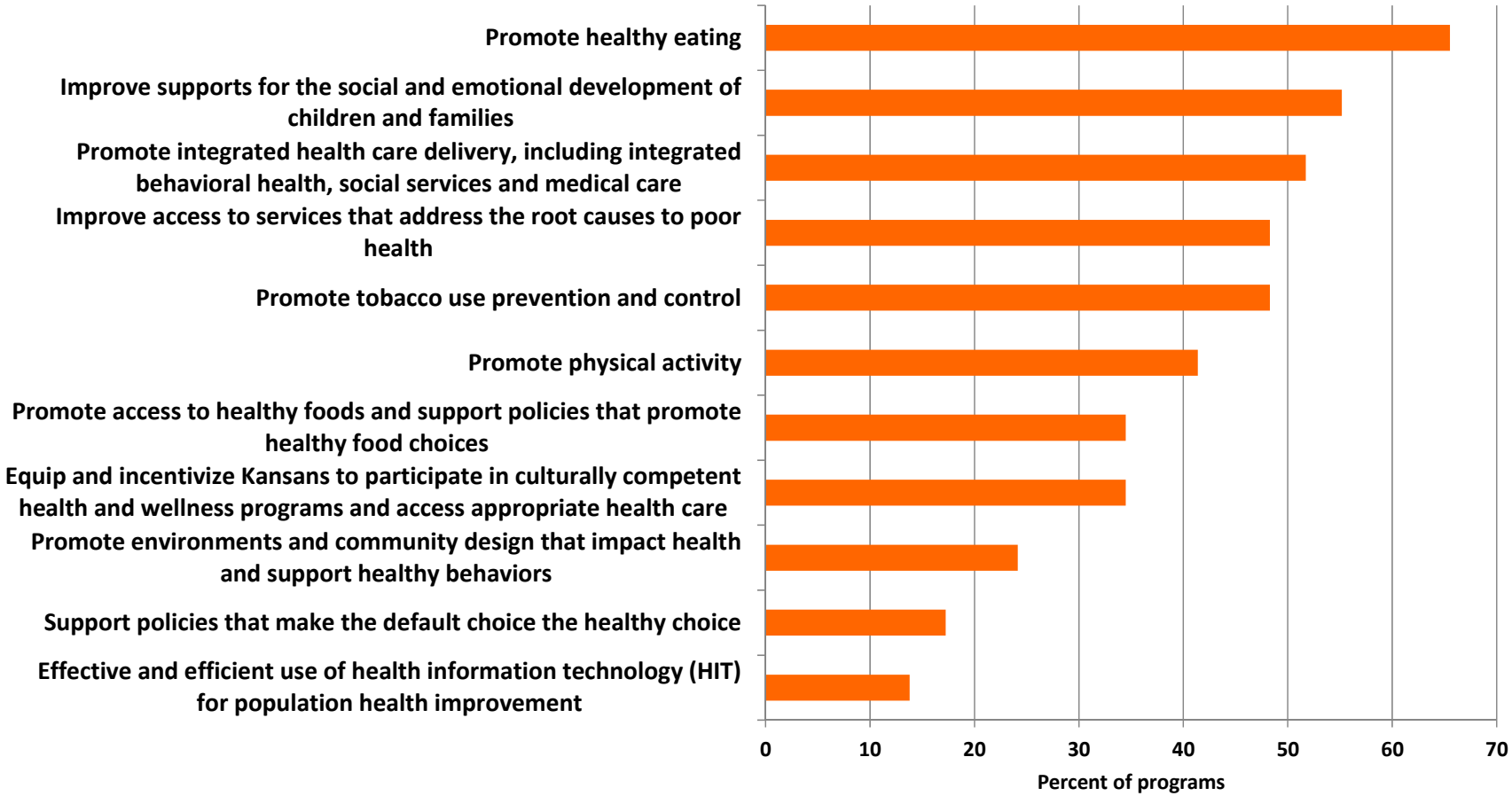
Title V Performance Measures

Inventory Question #21. *Indicate which Title V MCH measures related to your program goals/work*.



Healthy Kansans 2020

Inventory Question #22. *Indicate which Healthy Kansans 2020 priorities your program is working to improve*.

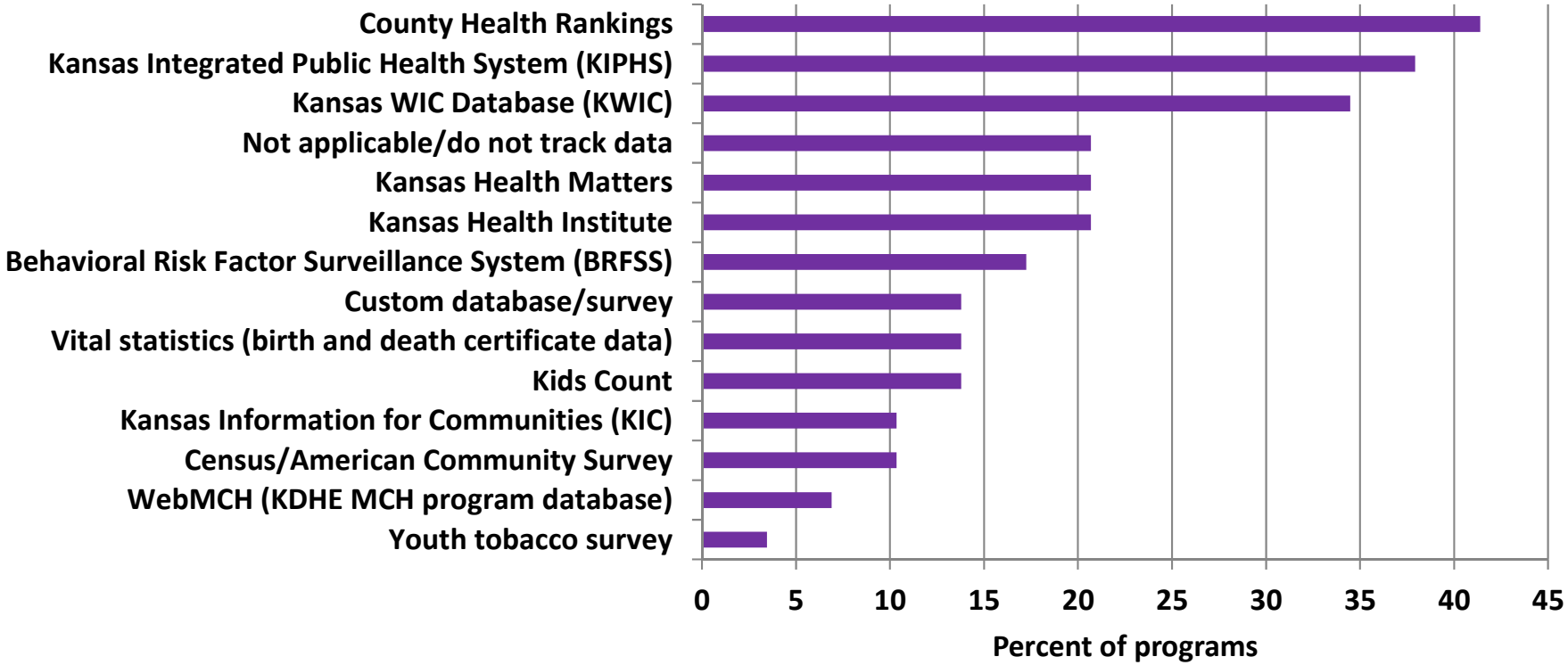


Tables 3 & 4 (pp. 7-9)

How do the services represented as well as your own align with the state priorities and Title V MCH performance measures?

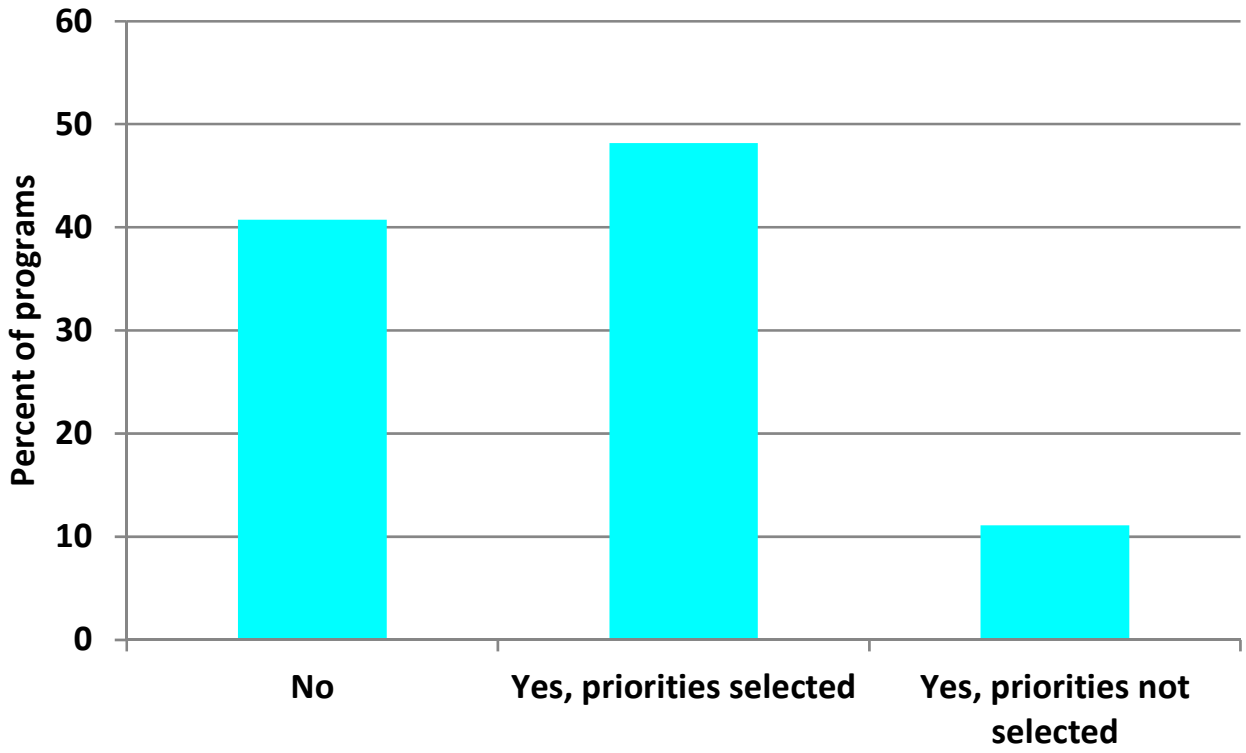
What might the distribution of activities across the Healthy Kansans measures say about our priorities?

Inventory Question #23. *Select primary data sources for the indicators used to assess, measure performance and evaluate your program/service.*



Participation in a Community Health Assessment

Inventory Question #26. *Has your organization participated in a community health assessment?*



Tables 5 & 6 (pp. 10-11)

Discuss the importance of data and how you're using it. If data is not utilized/important, why not?
What data sources do you use that others might not?
What data sources do you want to learn more about?
How and why are Community Health Assessments important to work at the community, county, and regional levels?

SUMMARY SOUTHWEST INVENTORY FINDINGS

29 Program Responses

Name of program:	Local organization/provider name:	County
Building Blocks Early Childhood Block Grants	Russell Child Development Center	Finney
Compass Behavioral Health	Compass Behavioral Health	Finney
Family Literacy	Finney County Community Health coalition	Finney
Finney County Health Department M&I Program	Finney County Health Department	Finney
Kansas Children Service League Head Start	KS Children's Service League	Finney
Project LAUNCH	Finney County Community Health Coalition	Finney
Siena Medical Clinic Pediatrics	Siena Medical Clinic Pediatrics	Finney
Tiny-K Early Intervention Program	Russell Child Development Center	Finney
Dodge City Community College Nursing Program	Dodge City Community College	Ford
Family Planning	Gray County Health Department	Gray
Maternal and Infant Program	Gray County Health Department	Gray
Well Child Services/WIC/Maternal & Infant Program	Gray County Health Department	Gray
MCH, Home Visiting, WIC	Hodgeman County Health Department	Hodgeman
Healthy Start	Kearny County Health Department	Kearny
Kearny County Hospital	Kearny County Hospital	Kearny
Meade County Health Department	Meade County Health Department	Meade
Healthy Start Home Visitor	Morton County Health Department	Morton
County WIC Program	Seward County WIC Program	Seward
Family Planning Program	Seward County Health Department	Seward
Healthy Start Home Visitor	Seward County Health Department	Seward
M&I/WIC/Teen Pregnancy/Immunizations /Family Planning	Seward County Health Department	Seward
Maternal & Infant Program	Seward County health Department	Seward
Maternal & Infant Program	Seward County Health Department	Seward
Seward County Community College Nursing Program	Seward County Community College	Seward
KanCare Family Medical	Heart of Kansas Health Care	Shawnee
Healthy Start	Health Office	Stanton
Stevens County Health Department	Stevens County Health Department	Stevens

Group Exercise 2
11:00 am - 11:30 pm

Purpose: The purpose of this exercise is to consider existing partnerships and collaborations that are essential to completing our work. This is the first of many times we will discuss partnerships throughout the day.

Instructions: Your group for the exercise is your assigned table. You have a facilitator assigned to your group. Please do the following:

1. Assign a note taker (different from the individual who served in this role for Exercise 1). This person will be responsible for reporting out your responses to the questions to the larger group.

2. All groups will be responding to the same questions.

3. DISCUSS the following questions after reviewing pages 3-4. Your facilitator will keep time; you will have approximately 15 minutes.

    - Do the critical partners indicated align with your own?
    - When you identify a partner as "critical", what does that working relationship involve?
    - What roles do critical partners have, beyond referral?
    - Does this represent the comprehensive/collective impact approach? Why/Why Not?
    - Does any organization or partner listed surprise you? Why/Why not?
    - Who is missing based on the need? Why might that be?
    - What is the role of the missing organization or partner?
    - What action should we take around partnerships to establish new/needed and increase collaboration with existing?

4. SUMMARIZE your discussion for a 1-2 minute presentation to the group.

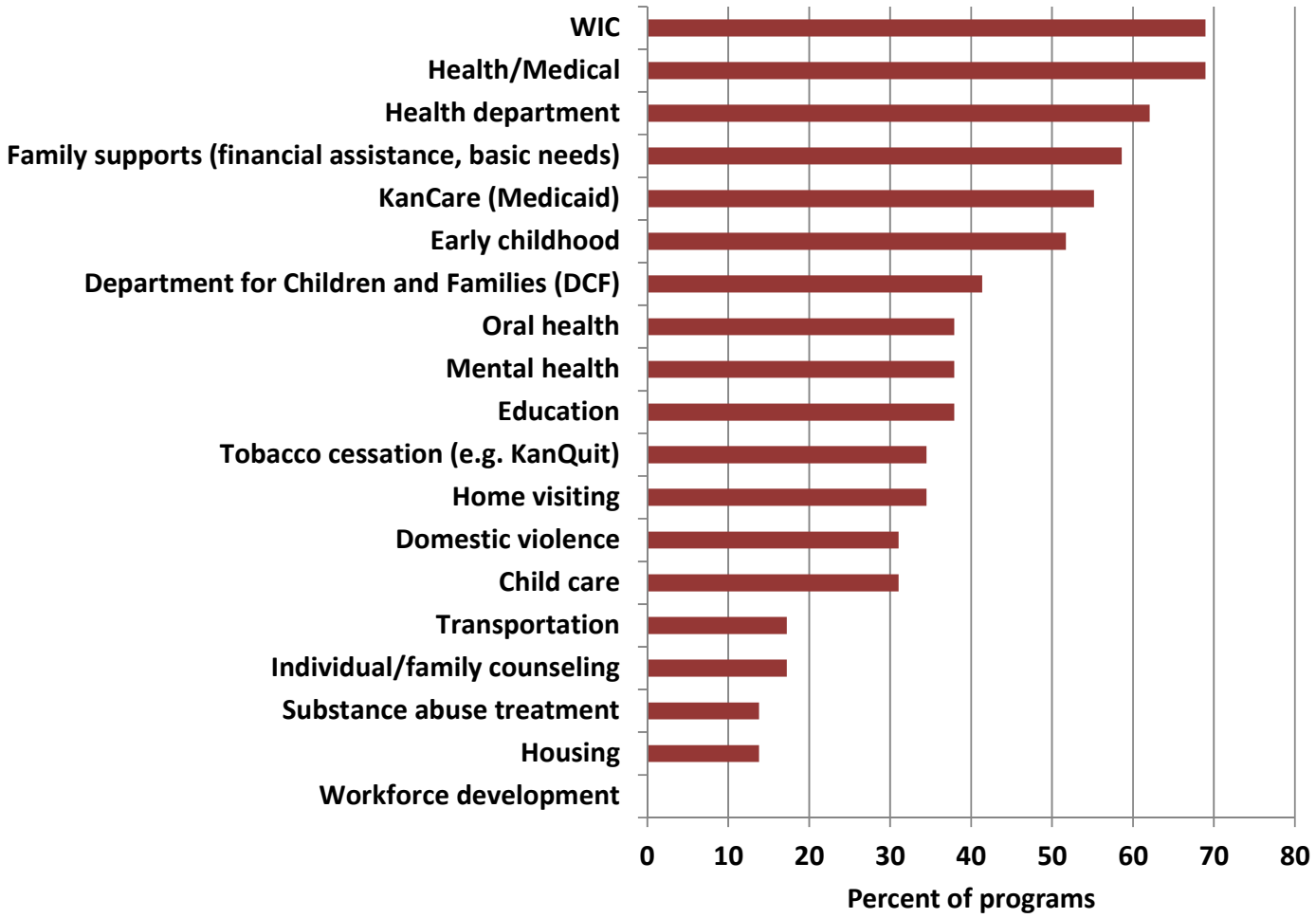
Group Discussion: Use this space to record answers to the questions

Questions	Responses
After review of the partners identified, consider: Do the critical partners indicated align with your own? When you identify a partner as "critical", what does that working relationship involve? What role do critical partners have, beyond referral? Why are those roles important?	
Does this partner list represent the comprehensive/collective impact approach? Why/Why not?	
Does any organization or partner listed surprise you? Why/Why not? Who is missing/underutilized based on the need? Why might that be? What is the role of the missing organization or partner?	
What action should we take around partnerships to establish new/needed and increase collaboration with existing?	

Referral Organizations

Inventory Question #14. *If you refer to other organizations, to which types do you most commonly refer?*

29 Program Responses (Finney, Seward, Gray, Kearny, Ford, Hodgeman, Meade, Morton, Shawnee, Stanton, Stevens)



Critical Partners – By Type/Frequency

Partner/Organization	% Selected	Count
Local health department	63.3%	19
School district(s)	50.0%	15
WIC	50.0%	15
Private practice physicians	43.3%	13
Hospital(s)	40.0%	12
Community mental health center(s)	36.7%	11
Home visiting programs	33.3%	10
Local government	33.3%	10
Department for Children and Families (DCF)	30.0%	9
Primary care clinics	23.3%	7
Domestic violence program	16.7%	5
Local non-profit organization(s)	16.7%	5
College/university	13.3%	4
Managed care organizations	13.3%	4
Law enforcement	10.0%	3
Faith communities	6.7%	2
Local foundation(s)	6.7%	2
Private business(es)	6.7%	2
Faith based organizations	3.3%	1
Local elected officials	3.3%	1
Media	3.3%	1
Substance abuse prevention	3.3%	1
Substance abuse treatment	3.3%	1
Workforce development organization	3.3%	1
Other (please specify)		0

Group Exercise 3
1:00 - 1:45 pm

Purpose: The purpose of this exercise is to align the findings of the inventory (and our discussions thus far) with the domains of the Compendium and the Health Impact Pyramid. We are 'zooming out' and considering the complete picture of how the programs and services in the Public Health Region align with the level of impact we want to achieve.

Instructions: Your group for the exercise is your assigned table. You have a facilitator assigned to your group. Please do the following:

1. Assign a note taker (different from the individual who served in this role for Exercises 1 & 2). This person will be responsible for reporting out your responses to the questions to the larger group. All groups will be responding to the same questions.

2. DISCUSS the following questions after reviewing pages 3-7. Your facilitator will keep time; you will have approximately 30 minutes.

    - What domains for improving birth outcomes are of highest priority?
    - How does activity within domains differ by funding?
    - How are the domains distributed across the services provided?
    - How are programs in the Region distributed across the levels of the Health Impact Pyramid and the domains for improving birth outcomes?

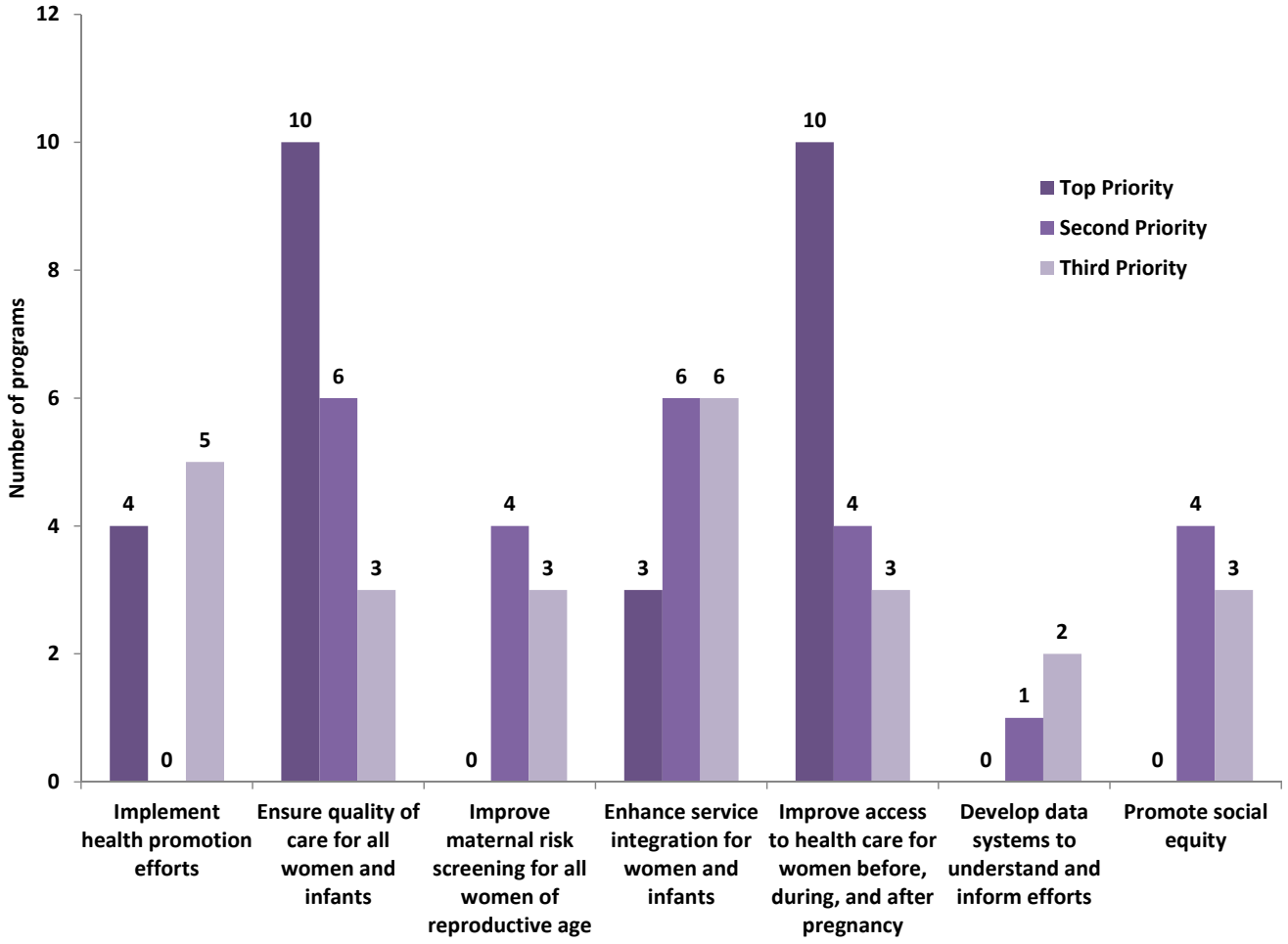
3. SUMMARIZE your discussion for a 3-4 minute presentation to the larger group. For your presentation, you may wish to focus on the responses to questions that elicited the most interest or discussion among your group (you don't need to report out on all of them).

Group Discussion: Use this space to record answers to the questions

Questions	Responses
What domains for improving birth outcomes are of highest priority? • What programs are 'strong' in each domain? • Within each domain, what activities are happening? • Are you a part of this work? If not, do you need to get connected?	
How does activity within domains differ by funding? • What could that mean? • What other existing funding/resources can be leveraged to support and/or expand needed services?	
How are the domains distributed across the services provided?	
How are programs distributed across the levels of the Health Impact Pyramid and the domains for improving birth outcomes? • How true or real does the image on page 7 feel? • What does it mean for the region to leverage some domains more than others, and the particular domains being leveraged? • What are you doing to contribute to this work?	

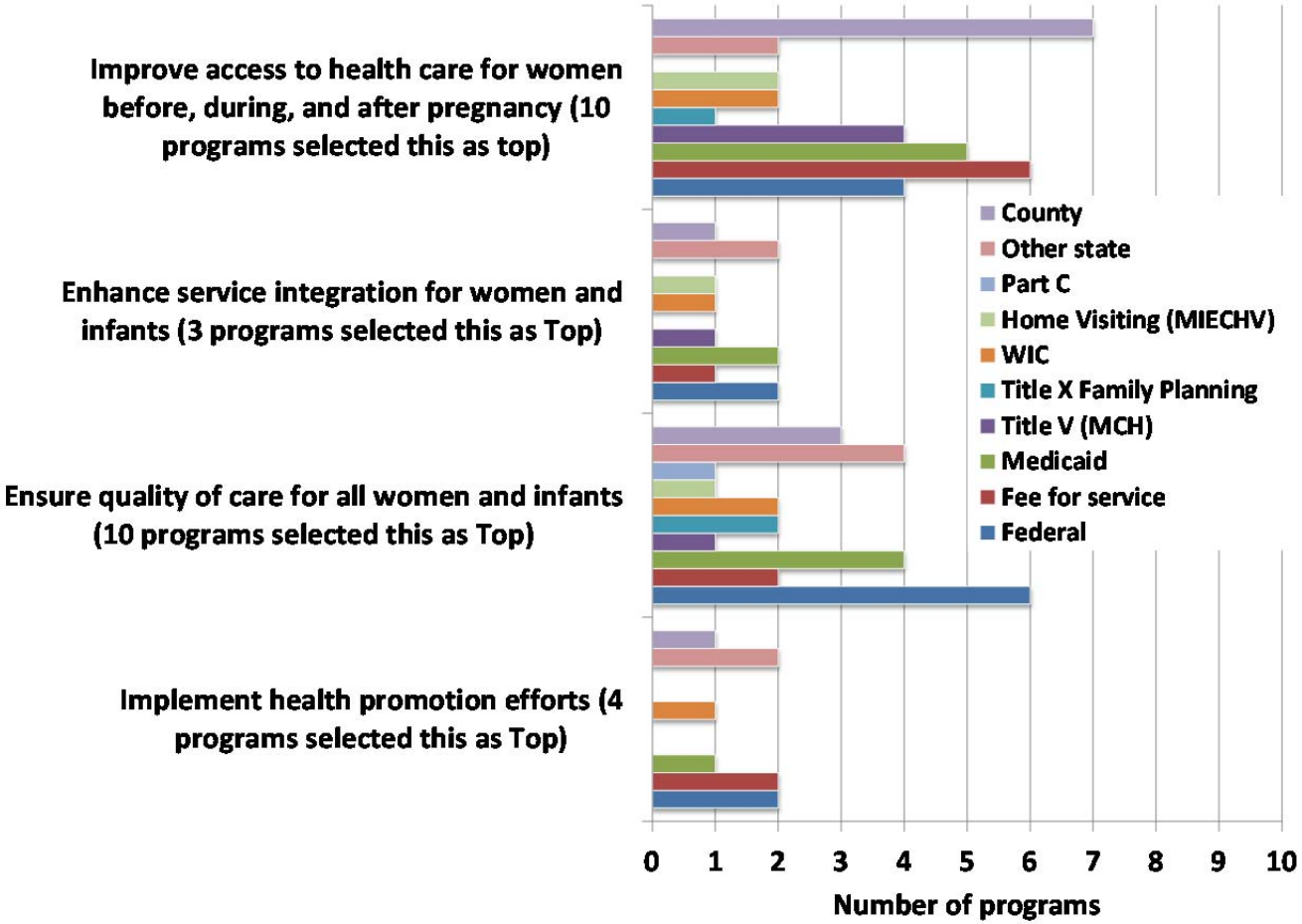
Priorities by Compendium Recommendation

Inventory Question #24. *Identify the top 3 most important areas of focus to improve birth outcomes in your region*



What domains for improving birth outcomes are of highest priority?
What programs are 'strong' in each domain?
Within each domain, what activities are happening?
Are you a part of this work? If not, do you need to get connected?

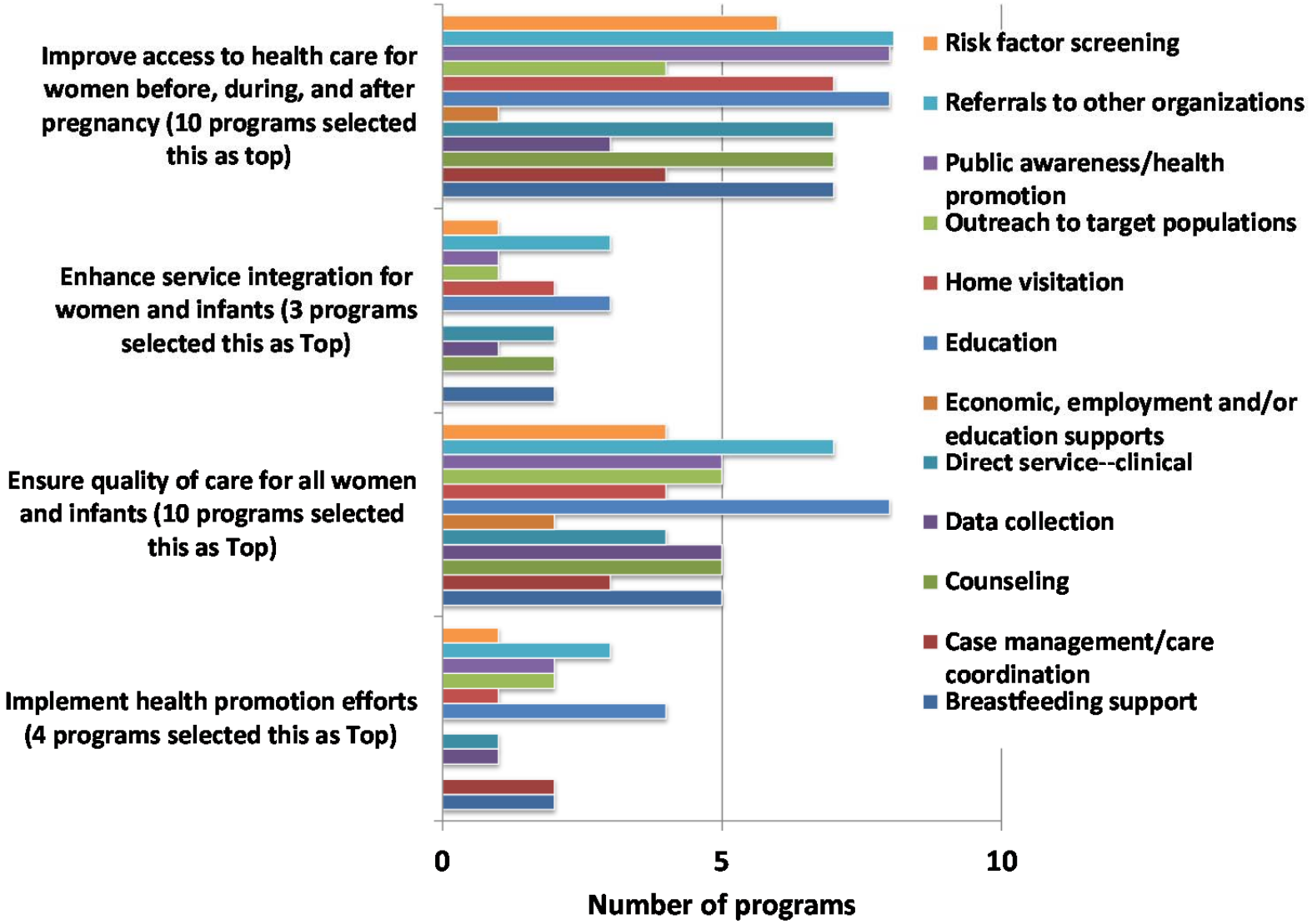
Top 3 most important areas of focus to improve birth outcomes in your region, by primary funding



How does activity within domains differ by funding?

What could that mean?

What other existing funding/resources can be leveraged to support and/or expand needed services?



How are the domains distributed across the services provided?

Health Impact Pyramid	Recommendations for Improving Birth Outcomes
Tier 5: Education and Counseling *Individual or public educational messages and support.*	1. Implement Health Promotion Efforts
Tier 4: Ongoing Clinical Interventions *Evidence-based practices within clinical settings.*	2. Ensure Quality of Care for All Women and Infants
Tier 3: Protective, Long-lasting *Offer long-lasting protection to individuals.*	3. Implement Maternal Risk Screening for All Women of Reproductive Age
Tier 2: Changing the Context *Change the environmental context to making the healthy choice becomes the easy choice.*	4. Enhance Service Integration for All Women and Infants 5. Improve Access to Health Care for Women Before, During and After Pregnancy 6. Develop Data Systems to Understand and Inform Efforts (i.e. infrastructure development)
Tier 1: Addressing Socioeconomic Factors *Address fundamental social conditions.*	7. Promote Social Equity

Health Impact Pyramid	Recommendations for Improving Birth Outcomes	SW Region Programs
Tier 5: Education and Counseling Individual or public educational messages and support.	1. Implement Health Promotion Efforts	4
Tier 4: Ongoing Clinical Interventions Evidence-based practices within clinical settings.	2. Ensure Quality of Care for All Women and Infants	10
Tier 3: Protective, Long-lasting Offer long-lasting protection to individuals.	3. Implement Maternal Risk Screening for All Women of Reproductive Age	0
Tier 2: Changing the Context Change the environmental context to making the healthy choice becomes the easy choice.	4. Enhance Service Integration for All Women and Infants 5. Improve Access to Health Care for Women Before, During and After Pregnancy 6. Develop Data Systems to Understand and Inform Efforts (i.e. infrastructure development)	13
Tier 1: Addressing Socioeconomic Factors Address fundamental social conditions.	7. Promote Social Equity	0

How are programs distributed across the levels of the Health Impact Pyramid and the domains for improving birth outcomes?
How true or real does the image feel?
What does it mean for the region to leverage some domains more than others, and the particular domains being leveraged?
What are you doing to contribute to this work?

Reflection, Roles, and Partnerships (Discussion)
1:45 – 2:30 pm

Red/Blue/Yellow Groups

Optional: Collapse the tables into three groups (red, blue, yellow), based on the color noted on the participant's name tag. This allows for expanded networking.

Each table/group needs:

- Flip chart/markers
- Recorder
- Reporter

The questions will be displayed on the main screen. The group facilitators assigned will assist the group by getting them started on the first question.

Spend 10-15 minutes as a group discussing the questions.

Record highlights of the discussion on the flip chart – no need to cover every bulleted question…just document main ideas and thoughts that would be helpful for the larger group discussion.

Be prepared to report out to the larger group. The large group facilitator will request a summary from each group.

- What has stood out for you thus far today? Major takeaways?
- What excites you? What confuses you? What makes you feel anxious?
- What opportunities are we seeing?
- What are the anticipated challenges of seizing these opportunities?
- Are there organizations, partners, or stakeholders that might help us to seize these opportunities? What strengths do they bring to the table?
- Who has unique access to these partners or the resources we need?
- What are your own strengths that you can offer?
- In what ways will you approach/conduct your work differently?
- How do we feel about the distribution of the domains across the Region? Do you concur? What are we missing?
- How useful is the compendium and aligning our strengths/programs?
- How might you use the compendium in your work? Will you share it?

Group Exercise #4
2:45 - 3:45 pm

Purpose: The purpose of the large group discussion is for members representing different organizations/programs and counties to determine where areas of improved/increased coordination and communication could greatly impact health outcomes in the region.

Instructions: Please do the following; prepare to share in 30 minutes. Spend at least 10 minutes to silently reflect as individuals/document actions. Share within the team for about 10 minutes and then identify a few examples to share with the larger group.

1. REFLECT on information provided throughout the day related to state programming, services, and inventory findings for the Public Health Region. Review the action steps documented throughout the day.

    - *What do I have to offer?*
    - *How can I continue working with new/existing partners on shared goals?*

2. CONSIDER your work in relation to programs/services and identify the "strongest" connections and/or greatest potential for impact (think within your city/county as well as across the region).

3. IDENTIFY 3 actions (more if time allows) you will commit to as they relate to new partnerships, increasing coordination and/or collaboration with local programs/partners. DOCUMENT your 3 coordination actions/commitments.

    - *How might we do our work differently as a result of this process?*
    - *How will you reach out to new partners or change your relationships with existing partners?*
    - *What will you do more of to build upon the strengths/bright spots?*

4. SHARE what you liked as well as what you would change about the process/meeting.

    - *Is there anything you would change for the inventory?*
    - *How will the region collectively move this work forward?*
    - *What do you see as the State's role in supporting efforts?*
    - *What questions do you have?*

5. CONSIDER how the work today can move forward (individual and group) and be prepared to share an example or two from your team with the larger group.

    - *Who can be the champion to initiate the next step(s)?*
    - *How will the strategies/actions come together as a community action plan for collective impact?*

COMMITMENT TO COMMUNITY ACTION
WHAT: WHO: WHEN:
WHAT: WHO: WHEN:
WHAT: WHO: WHEN:

Group Activity

Johnny Applestack

Goal	In under a minute, participants will stack 5 apples to make a tower.
Equipment Needed	Apples and a table
Time Needed	5-7 minutes so that you can explain (but not too much!), do the activity, and discuss.
Logistics	This is dependent on the size of your group. Ideally a table will have 5-6 participants for each stacking activity. For example, in a group of 40, you hope your room will have 8 tables and you will need 40-50 apples.
Rules/Instructions	The apples must be placed on top of one another and cannot be manipulated in any way (such as taking a bite out of one, or anchoring the apples with a pen, toothpick etc).
CPPR Goals/Message	Official rules state that once stacked, the apples must be free-standing for at least three consecutive seconds, but our idea is to bring people together for the shared collaboration during the process. To bounce ideas and suggestions off each other towards the common goal.

How Comfortable are you with looking at data?	**North Central**	**North East**	**South Central**	**Southwest**
Really comfortable-I love it!	**32%**	**32%**	**n/a**	**41%**
Somewhat comfortable-it's ok	**64%**	**59%**	**n/a**	**50%**
Not comfortable at all-I break out in hives	**4%**	**8%**	**n/a**	**9%**
What is your reaction to the findings?	**North Central**	**North East**	**South Central**	**Southwest**
What I expected	**20%**	**33%**	**n/a**	**25%**
Some surprises	**76%**	**54%**	**n/a**	**60%**
Had no idea	**4%**	**10%**	**n/a**	**15%**
Missed conversation	**0%**	**3%**	**n/a**	**0%**
What is most important to collaboration?	**North Central**	**North East**	**South Central**	**Southwest**
Time	**0%**	**3%**	**6%**	**16%**
Money	**4%**	**0%**	**0%**	**5%**
Trust	**8%**	**8%**	**n/a**	**5%**
Common Goal	**54%**	**49%**	**26%**	**16%**
Relationships	**35%**	**41%**	**68%**	**58%**
How would you describe your current collaboration?	**North Central**	**North East**	**South Central**	**Southwest**
Great	**20%**	**12%**	**n/a**	**18%**
Pretty good	**20%**	**29%**	**n/a**	**41%**
Need Some Work	**20%**	**50%**	**n/a**	**36%**
Not happening	**20%**	**6%**	**n/a**	**5%**
Other	**20%**	**3%**	**n/a**	**0%**

Statewide Assessment Results: Comparison by Region

Largest to Smallest Change

Question	SE	SC	SW	NC	NE	Avg
	Increase					
I feel knowledgeable about statewide priorities to improve birth outcomes.	0.91	0.82	1.17	0.99	0.96	0.97
I understand where my program and activities fit within the Health Impact Pyramid.	0.80	0.80	0.80	1.18	0.94	0.90
I feel a part of a shared, region-and state-wide agenda to improve birth outcomes	1.01	0.80	0.73	0.81	0.75	0.82
I know how to identify new partners or stakeholders to help me in achieving my program goals to improve birth outcomes.	0.82	0.59	0.84	0.7	0.57	0.70
The partnerships I have today are adequate to achieve my desired impact.	0.69	0.77	0.89	0.67	0.33	0.67
I am aware of the range of services provided and activities happening in my region to improve birth outcomes	0.77	0.61	0.64	0.65	0.49	0.63
I feel comfortable describing the strengths of my program to other organizations I may not work with frequently.	0.72	0.65	0.39	0.61	0.29	0.53
I am aware of partners in my region that are also serving the population(s) I serve in my work to improve birth outcomes.	0.52	0.59	0.45	0.59	0.26	0.48
I know the strengths of my program that uniquely contribute to improving birth outcomes in the region.	0.51	0.38	0.45	0.59	0.34	0.45
I know the opportunities and challenges my organization faces in its work to improve birth outcomes.	0.50	0.44	0.61	0.34	0.27	0.43
I feel valued by organizations and partners in the region I work.	0.56	0.50	0.33	0.38	0.26	0.41
I have strong relationships with organizations and programs serving the maternal and child health population in my region.	0.46	0.56	0.39	0.24	0.24	0.38
I feel valued by my community and the population I serve.	0.39	0.36	0.60	0.41	0.12	0.38

Answer Options: 5 Strongly Agree 4 Agree 3 Neither Agree or Disagree 2 Disagree 1 Strongly Disagree

APPENDIX C

Adolescent Health Report Executive Summary (Including Focus Group Summary & Data)

K·STATE Research and Extension

Executive Summary

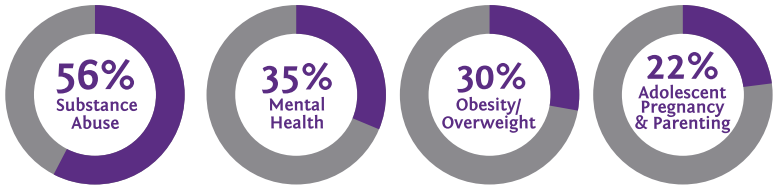
Guiding Principles of Positive Youth Development

Adolescence is an important developmental stage filled with health opportunities, as well as health risks. During this stage, health behaviors are established that pave the way for adult health, productivity and longevity. Adolescents who thrive have access to caring adults that foster healthy development, and are offered meaningful opportunities to belong and build their competencies and abilities (Lerner, 2009). Instead of being problems to be managed, adolescents are assets to their communities. Consequently, Kansas chose a postive youth development approach for its five-year needs assessment for the 2016-2020 Title V Maternal and Child Health Services Block Grant for the Bureau of Family Health, Kansas Department of Health and Environment. The assement was conducted by Kansas State University's Kansas Adolescent Health Project, consisted of: a) a review of existing health data, b) an online community input survey, c) community focus groups, and d) interviews with key individuals and leaders.

Identifying Needs and Issues among Kansas Adolescents

More than 850 respondents* of an online survey, which was open from August to September, 2014, resulted in the following findings:

Top health issues affecting adolescents in their area were:



Top barriers that youth faced to accessing health services were:

(= 854 respondents were 86.4% female; average age of 49; 60% rural and small town; 22.7% upper middle income; 85 counties represented. A Spanish version of survey was offered, but no Spanish version surveys were received.)*

More than 400 Kansans** shared their perspectives through 26 focus groups conducted in Chanute, Dodge City, Great Bend, Hoisington, and Kansas City. Many commonalities exist between youth and adult focus group participants:

*(** = 324 of the 401 participants were high school students; 60% female, 63% white, 17% Latino/Hispanic, 7% African American; 2% mixed race, <1% Asian, American Indian, etc. Focus groups were conducted with high school FCS/advising/study hall classes, local coalitions, Kansas Partnerships for Health conferees, health departments, Young Women on the Move afterschool members, 4-H councils, ESL mothers group, Wyandotte High Health Science III class members.)*

The focus group data resulted in the following findings relating to issues, barriers and challenges expressed by youth and by adults (in order of prominence of youth focus group data):

Top health issues included:

- School lunch (portions too small or distasteful food)
- Substance abuse
- Sexuality and reproductive health
- Mental health (including depression and self-injury)
- Obesity
- Overall stress
- Bullying
- Boredom leading to the use of technology
- Wanting real services and information
- Wanting to confide in adults and mentors.

Top barriers and challenges included:

- Lack of information
- Access to services
- Costs too high
- Lack of parental support/skills and awareness
- Embarrassment/shame
- Lack of mentors.

Recommendations and Strategies to Address Adolescent Health

The overall goal is to enhance the health of adolescents and young adults (ages 12 to 22) across the lifespan.

RECOMMENDATION 1: *Address the highest priority adolescent health issues.* Thus, some of these recommendations are redundant by intent. Each of these health issues is related and should be addressed as such. Mental health was shown to be linked to each of the health issues affecting adolescents, and as a result was ranked as the number one priority to address.

Mental Health

Recommended Strategies/Planned Activities:

- Provide school-based access to confidential mental health screening, referral, and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances, and seeking treatment.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

Substance Abuse

Recommended Strategies/Planned Activities:

- Increase access to substance abuse screening, treatment, and prevention services through co-locating screening, treatment, and prevention services in schools and/or facilities easily accessible to adolescents in out-of-school time.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.
- Provide opportunities for adolescents to occupy their out-of-school time in pro-social activities, establish pro-social relationships, and gain meaningful skills and competencies.

Sexual and Reproductive Health

Recommended Strategies/Planned Activities:

- Make accurate information on responsible sexual behavior, including the benefits of abstinence, more easily available to youth and their families.
- Support youth development behavioral interventions (for example, social, emotional, or cognitive competence training that promotes pro-social norms, improved decision making, improved communication skills, positive bonding experiences between youth, their peers, or non-parental role models) coordinated with community services to reduce sexual risk behaviors.
- Provide confidential, youth-friendly reproductive health services.
- Encourage communication between adolescents and their parents about reproductive health issues.
- Encourage all providers who serve adolescents to screen sexually active females for chlamydia.

Nutrition and Physical Activity

Recommended Strategies/Planned Activities:

- Increase the availability of healthy food and beverages in sufficient supply in schools.
- Increase opportunities for students to participate in regular physical activity both in and out-of-school (e.g., non-competitive sports leagues, intramural sports).
- Improve adolescents' awareness of good nutrition and physical fitness through relevant and technologically current education during the school day and out-of-school.

- Implement an awareness/information campaign to reduce sedentary recreational screen time among adolescents.

Injury Prevention

Recommended Strategies/Planned Activities:

- Encourage the implementation of policies, procedures, and the evaluation of programs in health-care settings to assess for and intervene with adolescents at risk for suicide.
- Support public awareness campaigns to prevent adolescent self-injury.
- Develop policies and establish prevention activities that work to reduce motor vehicle crash injuries and deaths to adolescents due to distracted driving and/or use of substances.
- Continue to enforce existing laws regarding adolescent drivers, such as mandatory seat belt use and zero tolerance for alcohol use.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

RECOMMENDATION 2: *Help families support the health and well-being of their adolescents.*

Recommended Strategies/Planned Activities:

- Increase the availability of information to parents and family members about normative adolescent development, and risk and protective factors for youth.
- Provide support to parents who experience problems, such as relationship, violence, substance abuse and mental health issues, to enable enhanced relationships with their adolescents.
- Provide support to parents who experience problems — such as relationship, violence, substance abuse, and mental health issues — to enable enhanced relationships with their adolescents.
- Using the "Parents as Teachers©" model, provide parenting resources and mentors for parents of adolescents.
- Encourage communication between adolescents and their parents about any health issue.
- Provide opportunities for parents to improve their skills in seeking out quality health-related information and services.

RECOMMENDATION 3: *Provide educational environments that prepare youth for healthy adulthood.*

Recommended Strategies/Planned Activities:

- Emphasize social emotional as well as academic competence in the school setting.
- Increase the availability of skill-based health information for youth.
- Support schools to establish and sustain health access points and health services on-site during the school day.
- Increase connections among schools, families, communities, and health providers through programs such as Communities in Schools (CIS)©, and KU Medical Center's "Bull Dog/Bull Doc Clinic" at Wyandotte High School.
- Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances, and seeking treatment.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

RECOMMENDATION 4: *Encourage collaborations and increase community support for those working for and with youth.*

Recommended Strategies/Planned Activities:

- Co-locate services for youth to ease access and decrease embarrassment.

- Support effective afterschool and out-of-school programs.
- Provide assistance to help community programs integrate positive youth development approaches and principles into their service framework.
- Increase youth-related continuing education opportunities for professionals and para-professionals.
- Catalogue agencies, organizations, and programs serving youth, and identify their missions and goals.
- Encourage interdisciplinary teams to provide comprehensive and coordinated services for youth.
- Institute regular interdisciplinary conferences and workshops to encourage development of shared knowledge, language, and goals among networks and communities.
- Include youth in decisions about service integration.
- Expand on the successful "Parents as Teachers" model that provide parenting resources to help parents of adolescents understand the critical importance of their child's adolescent years.

RECOMMENDATION 5: *Improve the responsiveness, availability, and access of health care to youth*

Recommended Strategies/Planned Activities:

- Use education and outreach to inform youth and parents about health-care options and providers who specialize in serving adolescents.
- Increase training about adolescent health care for providers to ensure youth-friendly, culturally competent health services.
- Create avenues for youth to be involved in discovering and utilizing health-care systems that meet their needs.
- Work with health insurers to widen the concept of well-child visits through adolescence (up to age 24).
- Improve access to comprehensive care including dental, eye/vision, and mental health services.

(Details are included in the full Kansas State Adolescent Health Report, which is available at http://www.he.k-state.edu/fshs/extension/)

For more information, contact:

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APPENDIX D

Communities for Kids Meeting Example

Facilitator Agenda – February Communities for Kids Meetings

Concordia - January 12th, 2015

- Welcome/Intro/Ice Breaker (15 minutes)
  - Have you ever, or has someone you know…
    - received services from the infant toddler program/early intervention services?
    - had a baby in Kansas who received a genetic or hearing screening?
    - ever been served by the special health care needs program?
    - ever utilized MCH home visiting services?
    - ever utilized WIC services, including breastfeeding or nutrition consultation?
    - utilized a licensed child care provider/facility?
    - ever been in the foster care system?
- Title V Needs Assessment Overview (15 minutes)
- Facilitated Discussion: Behavioral Health (30 minutes)
  In 3 domain groups (if enough people and facilitators) – Early Childhood (0-5) / Child (6-11) / Adolescent (12+) – If not enough people, do as large group discussion
  - What agencies or organizations do behavioral health screening in your community?
  - What are the biggest challenges your community faces related to behavioral health?
  - What resources do you have in your community related to behavioral health? (People, providers, coalitions, agencies, funding, etc.)
  - What promising strategies are already in place to improve behavioral health for the following populations? Young Children (1-5); Children (6-11); Youth and Adolescents (12 – 18); Children with SHCN (0-11); Youth with SHCN (12-26); Adult services?
  - What are your views on how mental health services are being delivered – or how they SHOULD be delivered?
  - How can we best support behavioral health needs in our state for the following populations? Young Children (1-5); Children (6-11); Youth and Adolescents (12 – 18); Children with SHCN (0-11); Youth with SHCN (12-26); Adults?
  - What are some ideas that can help strengthen behavioral health services and supports in your community?
- Open Forum (30 minutes)
  - Questions from Public Input Survey
    - Major Health Concerns for Newborn and Infants; Young Children (1-5); Children (6-11); Youth and Adolescents (12 – 18); Children with SHCN (0-11); Youth with SHCN (12-26)
    - Most important unmet health needs for same populations
    - What specific recommendation do you have for improving the health of infants, children, and adolescents, including those with special health care needs and/or disabilities, and their families in the state?
    - Are there any specific populations in this community that need additional supports? Indicate who or where and what types of supports are needed.
    - What specific programs or services do you have experience with that you feel are working well? Please be specific.
- Wrap Up and Next Steps (10 minutes)

Regional Input Comparison Table; KDHE CYSHCN Commuities for Kids Meetings

	NE		NC		NW	SW	SC	SE
Community →	Roeland Park	Topeka	Concordia	Junction City	Great Bend	Garden City	Wichita	Parsons
Health Insurance	X	X			X			
Access to healthcare	X							
Funding	X							
Transportation	X			X			X	X
Awareness of services	X							
Home Based Services	X		X	X		X		X
Access to mental health services					X		X	
Supportive family services			X		X			
Access to developmental screenings			X		X	X	X	
Evidence-based programs					X			X
Collaboration/Continuity of care					X	X	X	
Accessible childcare			X					
Access to healthy, nutritious food			X	X				
Adolescent education			X					
Access to healthcare			X					
Parent Education			X	X		X		
Access to oral healthcare		X				X		
Navigating healthcare system						X		
Access to well-child checks						X		
Injury prevention		X						
Lack of providers		X						
Access to after hour clinics		X						
Centralized service agency		X						
Safe recreation areas				X				
Quality childcare				X				
Early Intervention services								X

APPENDIX E

Children and Youth with Special Health Care Needs Strategic Planning

Special Health Care Needs Strategic Planning Phase 3
Develop Long-Term Objectives
September 23rd, 2014 Agenda

Department of Children and Families (DCF) Learning Center
2600 SW East Circle Drive South, Topeka, KS – Meeting Room A

10:00 **Welcome and Introductions** ..... Heather Smith

10:15 **Overview of Progress** ..... Heather Smith

11:00 **Review Objective-Setting Process** ..... Connie Satzler

11:15 **Discussion Round 1** ..... Group Facilitators

Noon **Working Lunch and Finish Drafting Round 1 Objectives**

12:50 *Break, move to Round 2 table*

1:00 **Discussion Round 2** ..... Group Facilitators

1:40 *Break, move to next group*

1:50 **Discussion Round 3** ..... Group Facilitators

2:20 *Break, Facilitators Prepare to Report*

2:30 **Report Out and Large-Group Feedback by Priority Area** ..... Connie Satzler/Group Facilitators

- *2:30* Care Coordination
- *2:40* Family Caregiver Health
- *2:50* Behavioral Health
- *3:00* Training and Education
- *3:10* Direct Health Services

3:20 **Next Steps** ..... Heather Smith

3:30 **Adjourn**

***Kansas SHCN Program Mission**: To promote the functional skills of persons of young persons in Kansas who have or are at risk for a disability or chronic disease.*

Introduction

The Kansas Special Health Care Needs (SHCN) Program promotes the functional skills of persons, who have or are at risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction. SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions. Additionally, the program provides services to persons of all ages with metabolic or genetic conditions screened through the Newborn Screening. Services may include diagnostic evaluations, treatment services or care coordination.

KDHE SHCN director, Heather Smith continued a very unique approach to the needs assessment by traveling to nine (9) communities across Kansas where a total of seventeen (17) meetings were held.

Community for Kids Meeting Process

Keeping in mind children with special health care needs are children first and foremost, KDHE SHCN was able to intimately and in detail capture the needs of all children as well as their parents and caregivers. This was an opportunity to learn from families, community and health providers, school professionals, and any member of the community interested in the health of Kansas children to voice the most prevalent maternal and child needs are within these communities. The communities visited are listed below:

Roeland Park	December 10
Great Bend	December 16
Concordia	January 12
Garden City	January 14
Topeka	January 21
Junction City	February 10
Wichita	February 19
Parsons	February 26

Each meeting consisted of a presentation on the state of CYSHC in Kansas as well as the programs goals and philosophy of children first and the Title V needs assessment overview. The community meetings were essentially open forum and group process and comments were recorded by staff. Meeting participants actively engaged in discussing what they believed to be were needs or service gaps relating to each of the five domains.

An overwhelmingly number of the meetings engaged participants at the community level and included parents as well as extended family, providers, and educators including home visitors.

Meeting Notes

Roeland Park – December 10

Participants within this community stated that they need greater access to health insurance coverage and treating chronic conditions.

Factors that contribute to services being unmet are lack of funding, transportation issues, and lack of knowledge that the services exist.

Supports needed by parents and families include home based services, including faith-based services, and telemedicine.

Great Bend – December 16

Needs identified within this community include gaining proper healthcare coverage, and support revolving around mental health and families that feel isolated. Specifically it was noted that young parents don't have the necessary support and end up developing mental health issues. To help support the family it was identified that evidence-based programs were needed as well as developmental screenings.

Collaboration and coordination of care was identified as a strong need within the community amongst providers.

Concordia – December 17

Participants within this community felt isolated as it was reported that children and parents were left home all day together and need an opportunity to expand social outlets. Particularly home visiting services were reported to be needed for children and youth with special needs. Access to screenings was also identified.

Mentors for families was also voiced as a need as well as availability of childcare, health and nutrition information, relationships skills and sex education for adolescents, and telemedicine.

Parent education around adolescent issues such as birth control, suicide, and sexual identity was also stated as a need.

Garden City – January 14

This community voiced the need for medical homes that incorporate all objectives, a dental home, and navigation of the health care system. It was identified that in order to make this work, collaboration would be needed amongst providers.

Other needs included behavior and mental health screening for children in all age ranges, well-child checks, improving ways to address and increase awareness of toxic stress, as well as a readiness to learn from providers and parents were identified.

Topeka, KS – January 21

Major themes within this community were access to dental providers. Providers that will accept the medical card and pregnant women were specifically needing to be serviced as well as dental care for children and youth with special needs.

Other areas of need were injury prevention, lack of available providers and transportation, as well as working families having trouble maintaining appointments due to their schedules.

Another suggestion included having one centralized area where families can access a variety of services including dental and mental health and maternal and child infant care.

Living in poverty was a central issue that participants voiced as well.

Junction City – February 10

Participants in this community felt that parent education surrounding parenting skills was needed more, as well as home visiting program. Additionally, it was voiced that daycare providers are not trained to have kids with mental health issues. Other areas in which participants felt there was a need was in transportation, access to healthy food, and safe recreation areas.

Reoccurring themes included the need for more providers, accessing services more efficiently and an increase in collaboration amongst providers.

Wichita – February 18

Participants within this area felt that there needed to be increased availability for screenings, transportation, mental health services for mothers and childcare providers that are trained in social/emotional support for children

Parsons, Kansas – February 26

Participants in this region voiced several needs that are not being met within their community. Home visiting services were lacking. Home visiting was identified as a need due to the inaccessibly of transportation within the community. Early intervention services were not being met as the county data represented a high number for infant hospitalization.

Lack of providers was also an ongoing theme as well as the need for interdisciplinary education for teachers. Participants voiced that support for evidence-based trainings would help to facilitate quality professionals relating to health care and the school system.

Regarding a positive aspect, it was reported that counties are doing good coalition work where various providers from different backgrounds come to meet and discuss what is going on in the community and how to best service the community's needs.

Summation

The Regional and Community for Kids meetings served as an instrumental means to hear the voices within the community. The maternal and child needs of each community that were stated were of significant importance to discovering themes across regions of the state of Kansas. The most prevalent need expressed by participants was the necessity for continuity of care amongst service providers. This entails providers working in collaboration with one another rather than in silo environments only focusing on that agencies particular realm of focus.

Other areas in which participants expressed needs for across the regions were access to healthier eating options, improved access to transportation and the need for developmental screenings. It's important to note that many of these needs are cross cutting, meaning that they affect each of the domains. When each of the domains are affected, this impacts the entire family unit, impacting the community as a whole. While many communities voiced their concerns for improvement in these areas within their communities, they realize this will take a team effort from not only families but providers across the state to address the needs.

APPENDIX F

Maternal and Child Health Council

Kansas Maternal Child Health Council

12:30 – 4:30 p.m. | Hotel at Old Town, 830 East 1st Street
September 10, 2014 | Wichita, Kansas

Welcome and Introductions .....Dennis Cooley, MD

Old Business .....Dennis Cooley, MD

Approval of Minutes (6/25/14)

Review of Action Items

KMCHC Planning Session

Review of MCH 2015 Priorities and Action Steps: Discussion

Challenges/Opportunities

Recommendations for Next Five Year Period (2016-2020)

Priorities Moving Forward: Women & Infants, Children & Adolescents, Children & Youth with Special Health Care Needs

Review of Related Groups, Councils, and Advisory Committees

Review Updated Table

Review Action Plans and Priorities: Linkages/Alignment with MCH?

Possibilities to Improve Connections and Collaborative Opportunities?

New Business *(handouts)*

MCH 3.0 Title V Transformation .....Rachel Sisson/Heather Smith

Infant Mortality CoIIN / Kansas DRAFT *Blueprint for Change* .....Dennis Cooley, MD

Healthy Start Grant (Geary County): Eliminating Disparities in Perinatal Health ..... Joe Kotsch

SHCN Strategic Planning Meeting on Sept 23rd ..... Heather Smith

FAC Recruitment ..... Heather Smith

Next Steps, Additional Information Needed

Adjourn

Next Meeting
Wednesday, December 3, 2014
10:00 am – 2:00 pm
Note Room Change! Marvin Auditorium 101B
Topeka and Shawnee County Public Library
1515 SW 10th Avenue
Topeka, KS 66604

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
***Women & Infants Priority Objective 1:* All women receive early and comprehensive health care before, during, and after pregnancy.** Performance Measures: National Performance Measures 8, 15, 18; National Outcome Measures 1, 2, 3; State Performance Measure 3				
1.1. Educate women and the public about reproductive health decisions that lead to a healthy pregnancy.				
1.1.1. Plan, implement and evaluate public health messages through advanced technology media (billboards, text4baby, Facebook, twitter, Op-Ed pieces, Dr. Jason's Blog).	Text4Baby consistent messaging tool that has moved forward. Other items are one-time or limited in scope. Center for Health Equity funding went away, so some of other items went away. Still a priority and continues to grow. Healthy Babies are Worth the Wait billboard campaign in 2013-2014. Text4Baby works, billboards have been effective. Facebook, Baby Buffer – emails to those who sign up – for new moms. This is like Text4Baby but emails. Age-appropriate info. Link to science behind it, etc. Media blitz on Safe Haven for newborns (maybe move to another action step).	How do we consistently send messages? What is the evidence that these messages are working? What is the content of the messages? Concerned on starting with assumption that they just need more knowledge – what really changes behavior?		
1.1.2. Modify MCH Aid-to-Local contract language to incorporate a requirement of information/education to public/families about the importance of early and comprehensive health care before, during and after pregnancy.	It has become clearer on annual application instructions – response required. LHD or other health agencies that apply have to address this specific objective. Moving in the direction of specific reporting requirements. Don't have uniformity in this, reporting is getting there. Still some variations. Still more to go, but moving in this direction for reporting, tracking.	Opportunity to measure this in MCH site visit evaluation tool as this tool is further developed.		
Comment: Have this as part of Title X assessment requirements. Do we capture it, or have actual data? It is a data point that is expected to be included in 2017 version of FP report. Have questions in guidance and manual.				
Opportunity: Real need for curriculum development around the pre-conception, life cycle. Then, locals can utilize this information.				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
1.2. Utilize community partners to disseminate information about healthy pregnancies, all phases.				
1.2.1. Educate women and their male partners to understand and participate in reproductive health decisions that lead to healthy pregnancies through the Fatherhood Coalition efforts.	Fatherhood Coalition has lost funding. Moved to Kansas Children's Service League (KCSL). Not really active with male partner initiatives. Focusing on healthy family relationships. Teen pregnancy and targeted case management: work with pregnant mothers and their partners. Loosely use Becoming a Mother program.			
1.2.2 Maintain and enhance partnerships with professional health care provider groups (AAP, family practice, OB-GYN, nursing groups, others) to promote quality and comprehensive prenatal care.	KMCHC helps do this. American Congress of Obstetrics and Gynecologists (ACOG) and Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) still not at the table. Managed Care Organizations (MCOs) are trying strengthen their educational components and messaging.			

Comment: Education materials going out through MCOs, not the state program directly, though the state program has to approve what goes out.

Other comment on challenges/opportunities. Challenge in Garden City related to community partnerships: This is a difficult issue. One of clinics does not want to refer to health department for M&I programs. Only two clinics that are delivering doctors. Struggling with the education piece. Sexual and domestic violence screening is not getting done. A lot are teen pregnancies.
Issues include disconnect with health department and clinics (including FQHCs), other cultural, community-specific, rural, and education issues. Not always good partnerships among health department and other clinics. This is happening all over the state. Consider convening all these? Can MCOs help facilitate this conversation? One of the roles of the state health agency is to convene group and have conversation. Challenges include local politics and local finances. But these are also opportunities.

MIECHV Program home visiting model sites address this issue. Data are collected on the following Benchmark constructs:

- Prenatal care (mean number of recommended prenatal visits pregnant women attend after program enrollment)
- Parental use of alcohol, tobacco, or illicit drugs (percent of pregnant women and mothers screened using standardized tool)
- Preconception/Interconception Care (percent of non-pregnant enrolled mothers who receive one or more routine primary care visits after birth of index child and before a subsequent pregnancy)
- Inter-birth Intervals (percent of mothers who receive information on the benefits of inter-birth spacing). More targeted resource materials and training need to be developed and provided to the home visiting programs regarding interconception care and inter-birth intervals
- Screening for maternal depressive symptoms (percent of enrolled pregnant women and mothers who are screened for depression using standardized tool)
- Screening for Domestic Violence (percent of enrolled pregnant women and mothers who are screened for domestic violence using standardized tool)

Referrals are also a major element. Additionally, the coordinated outreach and referral (central intake) systems, make contact with the target population (pregnant women and families with children under age 5), assess needs and make referrals to the home visiting programs as well as an array of other community health and social services.

MCH Programs in local health departments provide education on healthy pregnancies utilizing information from recommended national resources (e.g., March of Dimes, SAMHSA FASD Center for Excellence, CDC Office of Women's Health and others). There is room for discussion and further development of moving toward a more standardized set of educational materials to promote healthier pregnancies and the benefits of the development of local/regional perinatal collaboratives using a standard curriculum (namely, Becoming A Mom/Comenzando Bien). The obvious need would be for additional funding to support this larger work, although the efforts by the MCH Program at KDHE in convening regions to look at resources and partnerships and the possibility of leveraging partner resources (AMCHP Project), have begun to initiate some activity in this area.

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
1.3. Assure evidence-based home visiting services for high risk pregnant women.				
1.3.1. Apply for Federal funding to conduct an evidence-based home visiting program project.	Maternal, Infant, and Early Childhood Home Visiting (MIECHV): Funding received and continuing. Received 5 years of annual formula funding plus a 2 year development grant. Federal reauthorization for at least 1 more year (FFY'15), hopefully will be extended further. Sites: Wyandotte County, SE KS (Montgomery, Labette, Cherokee) Evidence-based models involved are Early Head Start, Healthy Families America, and Parents as Teachers; Promising approach is TIES (Team for Infants Endangered by Substance use)	Competitive Expansion Grant opportunity is anticipated in Fall 2014.	Continue	
1.3.2. Review of evidence base for services provided by Healthy Families grantees and modify as needed.	Need to do more investigation. Wyandotte – verified, using evidence-based HV (Healthy Families America). Need to do more review of Geary.			
Other comment on challenges/opportunities moving forward: Home Visiting State Strategic Plan finalized in 2014. Depending on funding and Home Visiting State Strategic Plan, looking at opportunities for further expansion. Trying to build quality and availability, accessibility of evidence-based home visiting (HV) programs. The MIECHV Program has addressed system coordination and improvements in targeted communities. A cross-site data collection system is in place, and evaluation and CQI projects undertaken. Have data to show this directly impacts outcomes. Becoming a Mom is a great vehicle to get moms in program connected with whoever their home visitor will be. Want to get more connected there. State will have more data to share. Also need to coordinate better with HV program – some moms don't get any visits by HV programs, others get several contacts – there's duplication that needs to be avoided. One mom on the 4th visit said, that's enough. For rural areas, we have needs in that area. Rural moms don't get several visits!				
***Women & Infants Priority Objective 2:* Improve mental health and behavioral health of pregnant women and new mothers.** **Performance Measures: National Performance Measures 8, 15, 18; National Outcome Measures 1, 2, 3**				
2.1. Inform and Educate public and families about mental health and behavioral health issues surrounding pregnancy.				
2.1.1. Plan, Implement and evaluate public health messages through advanced technology media (billboards, text4baby, Facebook, twitter, Op-Ed pieces, Dr. Jason's Blog).	Text4Baby, billboards – breadth of messaging. Healthy Babies – ComCare they do messaging. Beating the Blues is an online module/self-help tool. Advanced technology media not really happening; don't have resources locally to develop. Sometimes agency/organizational policies are barriers to social media use. Baby Buffer. Becoming a Mom is trying to determine how to share centralized social media info. Create a one-stop portal.	1. What is effective? 2. How are you going to fund it? Collectively build this information As a role, Title V can help with this, share; has to be a process for this. Recommendation: create a one-stop portal.		

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
	What are the websites? What are the Facebook pages? How do we not duplicate info? Portal something for the public! What about expanding the KidLink website? Great site!			
2.1.2. Obtain resources to address public information/education regarding pre and postnatal depression.	ComCare message This hasn't really been addressed. Was put on the table because it should be addressed, but hasn't yet been addressed with a concerted effort. Need to replicate good practices. ComCare – dealing with mild depression – could be pre or post-partum Becoming a Mom Collaboratives – put into place screening during certain sessions	How do we roll some of this out in internship programs, like in Smoky Hills residency?		
Other activity/challenges/opportunities: MIECHV Program home visiting model sites discuss, observe, and provide information to enrolled women, and screen and refer. Data are collected on the following Benchmark construct: Screening for maternal depressive symptoms (percent of enrolled pregnant women and mothers who are screened for depression using standardized tool).				
2.2. Assess/monitor mental and behavioral health status of KS women.				
2.2.1 Conduct maternal health surveillance to assess/monitor mental and behavioral health status of KS women.	BRFSS. Not sure about relation to maternal health, but certainly looking at mental/behavioral health of Kansas women. Jamie has looked at this BRFSS data, and the pregnant woman part is difficult to pull out. It is due to the sample size being too small. PRAMS pilot in the three Sedgwick County Healthy Start zip codes (67213, 67214, 67218): includes mental/behavioral health. FIMR also does surveillance, including mental health indicators, very prevalent among women. Places locally are identifying what a need it is. Not a lot of providers address maternal severe and persistent mental illness (SPMI). Have surveillance from PRAMS and FIMR that maternal SPMI is an issue, but there are limited providers to address. MCOs are identifying through Health Homes project.	Limited providers to address SPMI. For women that don't qualify for Medicaid, there is nothing. This is a gap. Also nothing for undocumented women. PRAMS – it is a funding issue. We need statewide PRAMS. Currently funding a pilot with Title V funds and doing it internally. Trying to position KS for next round of PRAMS. Demonstrating we can follow protocol.	Apply for future CDC PRAMS funding.	High
Other comments/activity/challenges/opportunities:				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
2.3. Educate public health/private provider work force about behavioral and mental health issues during pregnancy.				
2.3.1. Educate public health/private provider work force about behavioral and mental health issues during pregnancy in partnership with mental health and substance abuse professionals.	*Have included providers in conferences, sessions. *KAAP – KidLink – Social Emotional: Go to provider offices and educate them on the difference between baby blues and depression. Preface is you are seeing that mom with the new baby, maybe do screening at 1 month. *MIECHV – has been a focus area in terms of specific training related to multiple evidence-based models, all are now commonly conducting screens for depression, substance abuse, and domestic violence using standard tools with moms, prenatally and postnatally. MIECHV programs have been provided additional training on various mental/behavioral health subjects and on Motivational Interviewing. *Evidence-based model, Moving Beyond Depression In-Home Cognitive Behavioral Therapy, has been implemented for MIECHV enrolled moms in WY Co.. *SW region of KS in Dodge. Screening Brief Intervention Referral to Treatment (SBIRT). Huge push from CDC coming soon. Substance abuse. It is a Medicaid-covered service now. *Family planning history has brief questions for both males and females; this provides screening for depression and substance abuse. *LHDs do this at different levels. *Neonatal Abstinence Syndrome (NAS) - Moms that are taking medications (Schedule 3 and 4 narcotics) while pregnant. New ASTHO challenge on this emerging issue. ASTHO has resources to address this.	In general, this continues to be a need. Cultural competency – screening – is an issue – is available in other languages. Do talk about this in training. Moving Beyond Depression is limited to English. Being also thoughtful about other cultures – how men and grandparents play a role. PHQ-9 model – can be used with men, too. Addressing NAS, an emerging issue. There is a new toolkit but no best practices to draw on. What is Kansas doing to combat this? MIECHV Competitive Expansion Grant opportunity is anticipated in Fall 2014 that could continue/expand practices, including adding a bilingual MBD therapist. While some MCH local grantees/health depts. routinely conduct screens, this is not a uniform or systematic practice statewide. More specific guidance, policies, training, etc. could be developed and implemented.		Addressing the emerging issue of NAS is a high priority.
Other comments/activity/challenges/opportunities:				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
***Women & Infants Priority Objective 3*: Reduce preterm and low birth weight births, and infant mortality.** **Performance Measures: National Performance Measures 8, 15, 18; National Outcome Measures 1, 2, 3; State Performance Measures 1, 2, 3, 8, 9**				
3.1. Inform and educate the public about contributing factors leading to preterm birth.				
3.1.1. Inform and educate the public about factors contributing to preterm/LBW/IMR through advanced technology media (billboards, text4baby, Facebook, twitter, Op-ed pieces, Dr. Jason's Blog)	Text4Baby, billboards			
3.1.2. Partner with MOD to reduce preterm births on National Prematurity Campaign.	ASHTO challenge Becoming a Mom AMCHP			
Other comments/activity/challenges/opportunities:				
3.2. Assure public health workforce capacity to address prematurity.				
3.2.1. Educate the public health workforce on best practice to reduce prematurity.	KPHA includes this in their annual conference. Perinatal conference each November focuses on this, Geary's perinatal conference, Delivering Change, Heartbreak and Hope Fair amount going on with consistent messaging to public health and clinical professionals. Smoky Hill residency is promoting TTT module for health care professionals Becoming a Mom training Smoking cessation also promotes and prioritizes pregnant women if they call the hotline			
Other comments/activity/challenges/opportunities:				
3.3. Support local projects that address health disparities among pregnant women including evaluation.				
3.3.1. Support evidence-based local projects that address health disparities among pregnant women including evaluation.	Becoming a Mom Safe Sleep campaign MEICHV FIMR – more intentional? Blue Ribbon Panel on Infant Mortality	MIECHV – see comments with Obj. 1 above. MIECHV local teams have also been working to improve outreach and engagement of underserved populations, diverse cultures and languages, etc.		
Other comments/activity/challenges/opportunities:				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
Women & Infants Priority Objective 4: **Increase initiation, duration and exclusivity of breastfeeding.** **Performance Measures: National Performance Measures 11, 15; National Outcome Measures 1, 2, 3; State Performance Measures 3, 5**				
4.1. Educate Kansans on the benefits of breastfeeding infants exclusively for the first six months.				
4.1.1. Educate Kansans on the benefits of breastfeeding infants exclusively for the first six months (breastfeeding peer counselor program).	Kansas Breastfeeding Coalition, Inc. has 6 programs currently working to promote and support breastfeeding. Breastfeeding peer counselors Becoming a Mom WIC - Breastfeeding education and support and Kansas Baby Behavior Campaign Kansas Perinatal Quality Collaborative (KPQC) High 5 for Mom and Baby			
Other comments/activity/challenges/opportunities:				
4.2. Collaborate with hospitals and employers to adapt policies to support initiation and continuation of breastfeeding infants.				
4.2.1. Expansion of The Business Case for Breastfeeding Program to employers.	1305 grant United Methodist Health Ministries grant Kansas Breastfeeding Coalition, Inc. Child care provider training – providing a place for breastfeeding – it's a partnership between employer and child care provider			
4.2.2. Expansion of The Business Case for Breastfeeding Program to hospitals.	KPQC High 5 for Mom and Baby Kansas Breastfeeding Coalition, Inc.			
Other comments/activity/challenges/opportunities:				
4.3. Provide education and training of health care providers and public health workforce in comprehensive lactation support services.				
4.3.1. Implement Loving Support Breastfeeding training.	WIC – New employee breastfeeding training Kansas WIC Baby Behavior Campaign Business Case for Breastfeeding.			
Other comments/activity/challenges/opportunities: MIECHV - More consistent training and resource materials on this subject may be needed for evidence-based home visiting programs While some MCH local grantees/health depts. routinely address this issue, practices/approaches are not uniform or systematic statewide. More specific guidance, policies, training, etc. could be developed and implemented (including HSHV)				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
***Children & Adolescents Priority Objective 1*: All children and youth receive health care through medical homes.** **Performance Measures: National; Performance Measures 7, 13, 14; National Outcome Measures 1, 2; State Performance Measure 3**				
1.1. Educate families on the importance of preventive healthcare with a primary provider in a medical home.				
1.1.1. Disseminate "What To Do When Your Child Gets Sick" through MCH local agencies to improve health literacy of parents.	This is happening. Secured funding through BCBS of Kansas and Healthcare Foundation of Greater Kansas City. Have conducted 40 trainings throughout state – home visitors, nurses, anyone who is interacting with parents. SHCN has supported health literacy trainings through Families Together and plans to provide more of these trainings in the future targeting families in vulnerable communities and populations across the state.	Opportunity: MCH and SHCN to coordinate more on this activity.		
1.1.2. Develop and disseminate additional materials that educate parents about medical home and how to navigate the health care system.	Special Health Services (SHS) worked with community partners to have medical home presentation, medical home focus with previous grant, also building into new D70 grant. This will be a main target. KAFP has materials. Locally, there is some activity. Most of medical home and care coordination activity is in the SHS program. CMS has developed materials on navigating healthcare system. Some info out there is very basic, like making sure you get to your appointment on time.	Health Home program is being confused with medical home concept, in some ways. Most of these are opportunities vs. what is actively being done (other than SHS) Define this for our state – develop a consistent and comprehensive definition. There is a statutory definition of a medical home, but it is a minimal definition.		
1.1.3. Provision of information and education to public health and health care providers through articles in newsletters and other publications.	Programmatically, have promoted different articles to partners in newsletters Public Health newsletter– Connections	LHDs can lose funding if patients are referred to medical home instead of HD for certain services (e.g., immunizations). What role will LHD play and how do we replace lost funding? Opportunity: LHDs are invited to participate in the KanCare Health Homes effort for reimbursement for related services.		

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Other comments/activity/challenges/opportunities: Federal guidance for MIECHV FY'14 formula funds stated that "MIECHV programs should play a role in implementing the ACA by assisting participants in enrolling in expanded health insurance coverage beginning in 2014, using clinical preventive services and accessing primary health care, and understanding the ACA consumer protections. Working closely with Title V MCH Directors and State Medicaid Directors, MIECHV State Project Directors will ensure that Home Visitors have the state-specific information necessary to connect individuals with Navigators (Federally-facilitated Marketplace) or Non-Navigator Assistance Personnel (State based or Partnership Marketplace) and Certified Application Counselors." Further training and resources need to be developed and provided to the local programs for this purpose. MIECHV Program home visiting model sites address and collect data on the following related Benchmark constructs: • Percent of index children who attend at least 85% of well-child visits according to AAP recommendations while enrolled in the program. • Percent of enrolled mothers and index children who are covered by health insurance. • Mean number of visits to the emergency department from all causes for enrolled index children.				
1.2. Enlist the assistance of community partners to increase Medicaid/HealthWave enrollment for eligible children.				
1.2.1. Establish a schedule of regular meetings with Medicaid staff to define how the MCH public health system can assure community outreach and enrollment of eligible children.	Medicaid rep on KMCHC. Not having regular meetings (per se) in agency at this time, but have regular conversations, share data, participating in COIIN. Working with outstation eligibility. Delivered training and shared data on prematurity, connected them with Becoming a Mom (BAM) sites. Outstation workers coming to community baby showers and helping them get signed up and choose MCO.	Eligibility system. (KEES) There is room for additional partnerships with MCOs value-added services. Matching those with what the community needs.		
1.2.2. Enlist the assistance of school nurses to outreach and enroll eligible school children through education at school nurse conferences.	Medicaid representatives had booths at school nurse conferences, nurses were invited to promote KanCare at the school roundups and registration. Nurses were asked to invite MCO or Medicaid representative to talk with parents at parents nights and different events where parents were present. Several schools have done this – invited Medicaid and have several providers in booths at conferences. USD 259 has outstation worker in school system.	Opportunity: stronger collaboration on health outcomes between schools and insurance through engaging MCOs in the IHP process, if appropriate. School nurses are not trained in assisting parents to complete a KanCare application, which is what is needed in some cases. Simply handing them the form does not mean they have the literacy level to complete the form.	Work with KSDE, school counselors, to get health insurance for the students.	High

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1.2.3. Enlist the assistance of day care providers to outreach and enroll eligible children through MCH local agencies' grant/contract requirements.	*MCH has a manual on their web site with many resources that was updated last in January 2012. *Monthly MCH agencies are given current resources in zips newsletter	Time to review 148 page manual Child care licensing grantees could deliver this information. Child care aware – another potential link?	Update after finish new State Health Plan	Medium
1.2.4. Enlist the assistance of faith-based and other community organizations to identify and refer for enrollment eligible children - through MCH local agencies grant/contract requirements.	*This has been done on zips and with sessions from KAAP representatives at MCH and SN conferences.	Getting information to appropriate program leaders to share the information.	Solicit daycare and private health care providers from other members on KMCHC board.	Medium
Need to know: Where are we with # of eligible vs. enrolled Medicaid and HealthWave children. Does KHI have this? Medicaid: enrollment has increased. **Other comments/activity/challenges/opportunities:** MIECHV – same comments as 1.1 above.				
1.3. Assure the local health departments have community/regional health services and information available to the public including medical, mental health and dental health.				
1.3.1. Assure that local MCH agencies comply with MCH guidelines for referral resources to medical, mental health and dental services for children.	MCH staff provide routine technical assistance during site visits, e-mail and telephone interactions with MCH grantees on the importance of providing targeted referrals to the spectrum of community services of which families and children are in need. It is emphasized programs assess families for services that would most benefit them reflecting individual and culturally relevant needs.			
1.3.2. Publicize availability of on-line directory of children's mental health services (ABCD+) focusing on schools, public health, day care, and private health care providers.	Apparent need to develop this activity step further in terms of outreach better utilizing web resources, e-mail blasts, etc. with help from partners in these sectors.	Coordination of efforts with partners hopefully will become more and more integrated with program activities (e.g., AMCHP Project) in terms of outreach and support.		
Other comments/activity/challenges/opportunities:				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, etc.)	Priority Moving Forward? (High/Med/ Low)
***Children & Adolescents Priority Objective 2*: Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs.** **Performance Measures: National Performance Measures 10, 16; National Outcome Measure 6; State Performance Measure 4**				
2.1. Develop a statewide strategic plan for adolescent health.				
2.1.1. Develop a State Plan for Adolescent Health including recommended action steps tied to evidence-informed practices and evaluation strategies; identify and convene stakeholders; enlist technical assistance from CDC-DASH; search and apply for grant funding to support and sustain strategic plan.	In 2014, KDHE/BFH/MCH contracted with Kansas State University to conduct state Adolescent Health Needs Assessment and develop State Adolescent Health Plan. There are three phases to the plan and phase one and two are almost complete. This involves getting input from community member and key stake holders at the State level.	Development of a state plan that can be feasibly implemented.	Continue with progress of developing State Plan for Adolescent Health. Integrate the State Plan into the five years needs assessment.	High
Other comments/activity/challenges/opportunities:				
***Children & Adolescents Priority Objective 3*: All children and youth achieve and maintain healthy weight.** **Performance Measures: National Performance Measures 11, 14; State Performance Measure 5**				
3.1. Provider education on AAP healthy weight guidelines.				
3.1.1. Assure education for MCH grantees and private providers on AAP's Healthy Habits accessible free through KS-TRAIN.	This information was published in ZIPS newsletter. More than 40 people have reviewed the four modules with Obesity module having the most positive comments.	Getting local MCH providers to take the modules on line.	Continue to encourage MCH grantees to take courses.	Medium
Other comments/activity/challenges/opportunities:				
3.2. Conduct a social marketing campaign about healthy weight for young Kansas children.				
3.2.1. Conduct a social marketing campaign about healthy weight for young Kansas children.	This is being address in the schools through a grant housed in BHP in the schools called K-FIT funded by Ks Health Foundation. The goal is to enhance the understanding of the relationships between various fitness components and individual academic performances.	Link MCH and KSDE to work together to promote healthy weight	Develop opportunity for the MCH and community organizations to link with the schools.	High
Other comments/activity/challenges/opportunities:				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
***Special Health Care Needs Priority Objective 1:* All CYSHCN receive coordinated, comprehensive care within a medical home.** Performance Measures: National Performance Measure 3; State Performance Measure 3, 6				
1.1. Inform, educate, and involve families and providers about medical home components and initiatives to promote effective and successful systems change.				
1.1.1. Identify and assess available information, including best practices, programs in other states, national medical home initiatives, etc.	This was a component of the D-70 grant and has been completed. Extensive research on best practices, activities from other states, and reference materials was completed and utilized in grant activities.	None identified.		
1.1.2. CYSHCN program promotes the adoption of a medical home through education and self-advocacy training: Provide trainings to educate families and providers regarding the medical home concepts and how to build a medical home.	Ongoing. Have sub-contracted work to educate providers and families about the medical home concept. Continuation of a partnership with Families Together, Inc. to provide information about medical home, assist families in developing partnerships with providers to support the medical home approach, and make available trainings or educational information through conferences and other activities.	Biggest challenge at this point is helping families understand the difference between the medical home and the new KanCare health homes approach.		
1.1.3 CYSHCN program promotes the adoption of a medical home through education and self-advocacy training: Provide workshops to practice self-advocacy and share information with peers on the positive impact of medical home concept for both families and providers.	This was a component of the D-70 grant and was completed during that grant cycle. The workshops discussed in 1.1.2 above integrate self-advocacy in the trainings to families and help to educate about positive partnerships within the medical home.	Same as 1.1.3		
Other comments/activity/challenges/opportunities: A recent grant application was submitted to expand on these efforts from the previous D-70 grant. Unfortunately KS was not issued one of these grant awards, however some of the activities will be integrated into the SHCN Care Coordination initiative and it is anticipated that KS will submit for this grant again in the next cycle (anticipated state date of September 2015, application due in June 2015 – pending HRSA funding).				
1.2. Mobilize community partnerships (between policy makers, health care providers, families, and the public) by coordinating services for eligible CYSHCN and linking children and families to providers and community services/resources.				
1.2.1. Sponsor and coordinate conferences, meetings, and other networking opportunities: (1) Multi-state collaborative conference on medical home (2) Serve on stakeholder groups	A multi-state collaborative conference was not held due to a change in focus for the MO partners we had anticipated for this activity. HOWEVER, through sub-contracts with Families Together, Health TEC conferences were started to assure this information was provided to families across the state. Additionally,	The question has arisen if the current system of services surrounding the SHCN multi-disciplinary clinics is a sustainable model in the current health care environment.		

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
(3) Coordination/facilitation of Advisory Councils (4) Support of multidisciplinary, special needs clinics (5) Sponsorship of learning collaborative KRG utilized to help improve linkages and collaboration	support was provided to the Patient-Centered Medical Home Initiative through KAFP. SHCN staff participated on multiple stakeholder groups related to medical home, both state and national. D-70 grant stakeholder council dissolved in 2012, however the SHCN Family Advisory Council has continued to focus on medical home efforts. SHCN continues to support the multi-disciplinary clinics in Wichita and Kansas City and outreach across the state. Medical home pilot projects were completed through the D-70 grant, however a formal learning collaborative was not conducted.	The benefit to the family is high, however the cost-effectiveness of the current payment structure is not sustainable.		
Other comments/activity/challenges/opportunities: Regarding the clinics, the inconsistencies and poor billing practices of providers causes budget challenges. An ongoing clinic review, restructuring of billing practices, development of billing protocols, and a ROI/Cost-Analysis is ongoing for these clinics. A new funding request process was implemented in FY2015 and will continue in the future. Additionally, clinics who are already set up to bill private and public insurance have been transitioned to fee for service model for all clinical services, in addition to non-reimbursable clinic support. Those without the capabilities or system to bill are expected to have this in place prior to July 1, 2015.				
Special Health Care Needs Priority Objective 2: **CYSHCN receive early transition planning and services necessary to achieve maximum potential in all aspects of adult life, including health care, work and independence.** **Performance Measures: National Performance Measures 2-6; State Performance Measure 3, 6**				
2.1. Enhance community partnerships by identifying community resources, integrating service delivery systems, and streamlining the transition process for children and youth.				
2.1.1. Identify available local, regional, state, and national resources: (1) Develop and disseminate a regional and state-wide resource tool kit and navigational guide. Provide maintenance and updates as necessary. (2) KRG utilized to help improve linkages and collaboration with regard to transition services.	The state-wide resource guide, Kansas Resource Guide (KRG), was launched in 2011. The navigational guide is in development and the first phase is expected to be complete in early 2015. As a focus of the D-70 grant, transition resources, materials, and documents were developed and are available for dissemination. An online transition curricula was developed, however delays in implementation have been widespread. Resolution is being sought and the curricula/site is near recovery.	Challenge: recruitment of providers into the KRG has been slower than anticipated, coupled with a 9 month vacancy in the KRG admin position, delaying the navigational tool kit.		

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
2.1.2. Participate in and sponsor conferences, meetings, and other networking opportunities related to the transition process: (1) Coordinate multi-state collaborative conference on health care transition. (2) Serve on stakeholder groups (3) Expand program advisory councils as appropriate to promote further integration and collaboration. (4) Participate and support other transition-related events and activities.	A multi-state collaborative conference was not held due to a change in focus for the MO partners we had anticipated for this activity. HOWEVER, through sub-contracts with Families Together, Health TEC conferences were started to assure this information was provided to families across the state. SHCN staff participated on multiple stakeholder groups related to transition, both state and national. D-70 grant stakeholder council dissolved in 2012, however the SHCN Family Advisory Council has continued to focus on transition efforts.	Largest challenge faced regarding transition continues to be societal biases and disconnect about what transition really means for youth with disabilities. A common misconception we hear from health providers and families is that youth with significant delays or disabilities cannot participate in their transition. This continues to be a barrier to integration of effective transition programs into the health community.		
Other comments/activity/challenges/opportunities: Transition activities will be integrated into the new SHCN Care Coordination program.				
2.2. Inform and educate children, youth, and families about available transition services and where/how to access these services.				
2.2.1. Identify available local, regional, state, and national resources: (1) Develop and disseminate a regional and state-wide resource tool kit and navigational guide. Provide maintenance and updates as necessary. (2) KRG utilized to help improve linkages and collaboration with regard to transition services.	See response in 2.1.1	See response in 2.1.1		

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
2.2.2. Promote successful transition through educational opportunities and self-advocacy training: (1) Recruit and maintain a Youth Advisory Council and provide opportunities to enhance leadership and self-advocacy skills. (2) Provide learning opportunities for families, youth, and partners on all aspects of transition.	KDHE coordinated, in partnership with the KS Youth Empowerment Academy (KYEA), a Youth Advisory Council (YAC) from 2010 through 2012. After multiple transitions within the YAC, including a name change to re-focus efforts and a high turnover rate within KYEA support for YAC, the group dissolved. KDHE continues to support each year components of the Youth Leadership Forum (YLF) to provide opportunities for youth to build self-advocacy and leadership skills.	A challenge with youth councils is high turnover in membership and the nature of adolescents and the transition period present multiple barriers to constant participation from youth. There is a potential youth leadership program being developed with KYEA to build strong youth leaders, taking leadership beyond YLF.		
2.2.3. Identify, assess, and disseminate local, regional, state, and national transition initiatives: (1) Transition initiatives and supporting information disseminated through CYSHCN and partner publications. (2) Develop or adopt transition materials to disseminate to providers, families, and partners.	CYSHCN developed two "magazines" that shared transition resources and continue to disseminate information through partner list servs and email groups. The magazines have not continued due to funding and reduced staffing. The SHCN Family Advisory Council developed a three-part series of transition booklets, ages 0-6, 7-13, and 14 and up. These are widely disseminated across the state and appear to be widely utilized. The youth transition curricula developed through the D-70 grant is being updated and is anticipated for dissemination in the coming year.	Opportunities exist to work with partners to continue to disseminate these resources and integrate these efforts into activities within the SHCN program as well as working with partners to integrate into their work.		

Other comments/activity/challenges/opportunities:

Transition activities will be integrated into the new SHCN Care Coordination program.

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
Special Health Care Needs Priority Objective 3: **Link families to providers who are contracted with or referred by CYSHCN and accept negotiated reimbursement rates.** **Performance Measures: National Performance Measures 2-6; State Performance Measure 3**				
3.1. Link families to providers who are contracted with or referred by CYSHCN and accept negotiated reimbursement rates.				
3.1.1. Monitor, assess, and evaluate federal and state policies as they relate to health coverage and services: (1) Information and updates are disseminated on websites, in newsletters, and other publications. (2) Regular updates are provided at internal and community meetings identifying anticipated impact on coverage and services. (3) Workshop(s), training(s), and materials are offered informing partners in how to advocate and change policy. (4) Kansas services and coverage's are benchmarked in relation to other states and peer groups.	These activities are ongoing as part of the work of the SHCN program. Partnerships with Families Together allow additional opportunities for workshops and training for families to understand how to advocate for their services. Ongoing efforts to align SHCN reimbursement rates with competing payment structures. Review of the clinic payment and billing processes continues to identify ways to better support families.	Reduced funding, increasing health care costs, etc. are continued challenges, however given the recent changes to the health care system nationwide, there is hope that families will receive more comprehensive services, thus reducing the need for some to the SHCN gap-filling services. Program staff are monitoring these activities and implementing changes as appropriate.		
3.1.2. Provider outreach and education: (1) See 3.1.1 above, as applicable (2) CYSHCN program collects and provides Kansas-specific information on barriers and challenges to state and national professional and stakeholder organizations. (3) The impact of national and state professional organization recommendations on Kansas is assessed; appropriate information is disseminated to providers.	The SHCN Strategic Planning process has been the largest activity related to this. Participation in state, regional, and national work groups and meetings allow the program to keep up to date on efforts impacting this work. Provider outreach and education is conducted through the Family-to-Family Health Information Center (i.e.: Families Together) for medical providers. Additionally, ongoing provider outreach and education occurs with KRG to increase the number of community providers in the directory and with SHCN to increase the number of medical specialty providers who will agree to accept our reimbursement rates.	None		

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
3.1.3. Staff and Consumer education (See also 3.1.1).	Continued focus within the SHS section on workforce development, specifically with regard to the MCH population. The FAC and sub-contract with Families Together support the consumer education component of this activity.	None		
3.1.4. Educate and mobilize Families Together, Family Advisory Council, and other partners and stakeholder groups (See also 3.1.1).	The FAC has been co-coordinated by SHCN and Families Together since 2010. Recent changes to the council, including an expansion of scope from SHCN to SHS programming and the desire for stronger recruitment efforts, has resulted in a shift in coordination to KDHE with participation only from Families Together. Expansive growth among the current FAC members has been noted and the group continues to build in self-advocacy skills, leadership, and a stronger interest in systems change and building capacity.	Challenge: need help with recruiting families, we have had a consistent group, however we want 15-17 members with recent changes and usually fluctuate around 9-10.		
Other comments/activity/challenges/opportunities:				
3.2. Ensure CYSHCN Clinic/Field staff assist families in applying for and maximizing benefit of funding sources and family supports.				
3.2.1. Staff education: (1) Regular updates are provided at internal meetings identifying anticipated impact of health reform on coverage and services. (2) Staff monitors listservs, KS-Train, national resources to stay current. (3) Staff receives training and information on cultural competency/preferences.	Ongoing – always looking for ways to share information and build workforce capacity/knowledge related to these issues.	None		
3.2.2. Identify, assess, and monitor resources at the state and local level: Regular, ongoing communication regarding resources takes place among staff.	Ongoing	None		
Other comments/activity/challenges/opportunities: A lot of this work is being embedded into the SHCN Care Coordination program initiative, as well as within quarterly regional office conference calls/meetings.				

Priority Objective/Activity/Action Step	Where are we now? (activities, accomplishments)	Challenges or Opportunities?	Recommendations? (e.g., completed, no longer applicable, seek new partner, address challenges, continue for next 5 years, modify focus)	Priority Moving Forward? (High/Med/ Low)
3.3. Support expansion of primary and specialty care services to minimize travel time and missed work/school days.				
3.3.1. Needs assessment of primary and specialty care services, current utilization, and gaps to service delivery: (1) Explore service expansion options, including alternative and innovative solutions. (2) Regional specialty clinic implementation plan developed.	The SHCN Strategic Planning process is ongoing and will build towards MCH2020 Needs Assessment. Additionally, sub-contracts are being developed for an extensive service/condition revision by a medical provider. A cross-walk of services for each condition has been developed and will be utilized in planning for future expansion efforts. A new focus in telemedicine has begun for clinics and outreach seating clinics started in 2013.	None		
Other comments/activity/challenges/opportunities: Clinic and service review is ongoing and will lead toward changes to be implemented over the next few years, beginning with launching a new care coordination program in 2015, continued changes to clinic billing protocols, and focus of outreach and telemedicine for specialty clinic delivery.				

KMCHC Meeting

Minutes

September 10, 2014 (Wednesday)

12:30pm – 4:30pm

Hotel at Old Town – Wichita, KS

Attendees:		**Absent:**	**Visitors:**
Katrina Benyshek, RN	Christy Schunn, LSCSW	Lori Haskett	Barbara Kramer, KDHE
Kayzy Bigler	Fran Seymour-Hunter	Wes Jones, PhD	Connie Satzler, facilitator
F.E. Bustillo, MD	Pam Shaw, MD, FAAP	Jamie Kim, MPH	Nicole Fox Phillips, Sedgwick County HD
Dennis Cooley, MD, FAAP	Heather Smith, MPH	Jamie Klenklen, BPA	Rebecca Gillam, KU-Lawrence
Diane Daldrup	Michele Spainhower	Patty McNamar, DNP, ARNP	Tracy Vanvlack, KU-Lawrence
Hank Guerrero, LBSW	Jane Stueve, RN, MHCL, BSN	Gianfranco Pezzino, MD, MPH	
Joe Kotsch, RN, MS	Ruth Werner, ARNP, MN	Debbie Richardson, PhD	
Traci Reed, LMSW	Stephanie Wolf, RN, BSN	Rachel Sisson, MS	
Cherie Sage		David Thomason, MPA	
		Erick Vaughn, LMSW	
		Donna Yadrich	

Staff:
Chris Steege, Executive Director

Minutes	**Issues Discussed/Actions Completed**	**Action Item / Completed by Whom**
Welcome & Introductions	Introductions were completed.	
Old Business – Approval of Minutes (6/25/2014) – Review of Action Items	**Motion**: It was moved by Dr. Shaw and seconded by Ms. Daldrup to approve the 6/25/14 minutes. All approved. Dr. Cooley stated that all the Action Items from the 6/25/14 meeting are still in process. The outstanding Action Items are listed to the right. Outstanding Action Items, continued.	**Pending**: Dr. Jones has contacted Kyle Kessler, executive director - Governor's Task Force Children Subcommittee on Mental Health, several times about participating in the KMCHC. Wes will let Chris know if he is interested in being a member of the KMCHC.

		Pending: Ms. Daldrup will invite Dr. Jeff Kuhlmann (FP), Wichita to participate in the KMCHC. **Pending**: Ms. Daldrup will contact Terrah Stroda about participating in the KMCHC. **Pending**: Ms. Daldrup will contact the Director of Shawnee Mission Medical Center to ask about a neonatologist name. She will contact that neonatologist about participating in the KMCHC. **Pending**: Ms. Sisson will talk with Dr. Robert Moser about approaching Dr. Long to invite to KMCHC.
KMCHC Planning Session	Connie Satzler, facilitator, led the group in the continued 2nd Planning Session. Discussion items included: The following items were discussed by the KMCHC members: Review of MCH 2015 Priorities and Action Steps: Challenges/Opportunities • Recommendations for Next Five Year Period (2016-2020) • Priorities Moving Forward: Women & Infants, Children & Adolescents, Children & Youth with Special Health Care Needs Review of Related Groups, Councils, and Advisory Committees • Review Updated Table • Review Action Plans and Priorities: Linkages/Alignment with MCH? • Possibilities to Improve Connections and Collaborative Opportunities?	

New Business - MCH 3.0 Title V Transformation - SHCN Strategic Planning Meeting on Sept 23rd - FAC Recruitment - Infant Mortality CoIIN / Kansas DRAFT *Blueprint for Change* - Healthy Start Grant (Geary County): Eliminating Disparities in Perinatal Health	Heather Smith reported on MCH 3.0 Title V Transformation, the SHCN Planning Meeting, and the FAC Recruitment. Dr. Cooley gave an update on the Infant Mortality CoIIN Joe Kotsch gave an update on the Healthy Start Grant in Geary County.	
Future Meeting Dates	<u>December 3, 2014</u> 10:00am – 2:00pm (lunch provided) Topeka and Shawnee County Library Room: Marvin Auditorium 101B 1515 SW 10th Avenue Topeka KS 66604-1374 (785-580-4495)	

Table Discussion/Priority Setting Process
Overview and Discussion Guide - Facilitators

1. Facilitators are assigned to MCH population health domains as follows:

    - Women's/Maternal/Infant Health: *Rachel Sisson & Jamie Kim*
    - Child Health: *Debbie Richardson & Barbara Kramer*
    - Adolescent Health: *Jane Stueve & Traci Reed*
    - Children & Youth with Special Health Care Needs: *Heather Smith & Kayzy Bigler*

2. Review the participant instructions and guiding documents. Note the one-page MCH population health domain profiles/snapshots provide the emerging themes and health priorities identified to date; the group may quickly reach consensus on the priorities by selecting one or more from the profile OR identify a new priority/need for the domain.

3. Before you begin, determine if the number of participants at each table is reasonably balanced and a variety of perspectives are represented for each population health domain.

4. Pass around the sign-up sheet for each round to keep a record of participants.

5. Consider discussion questions for Round 1 on the participant instructions (#4). The intent is not for the participants to document answers to these questions—questions are provided to frame the discussion and engage the participants. Keep discussion focused on themes/priorities and long-term objectives that are relevant and will make a difference.

6. Emerging themes and priorities are most important, so the group should come to consensus on priorities before moving on to objectives. **Priorities documented should not simply be "Behavioral Health" for example, but *what about behavioral health***. If time allows, move the group into discussing objectives. If the group reaches consensus on objectives, optional questions tied to the objectives can be discussed (in order of importance on the participant instructions and on the "Objective-Setting Process Optional Worksheet"). For example, the national performance measure (NPM) question is most important—refer participants to the Measures table OR domain profile.

7. Groups for each round may build from the previous work or start fresh. During each round, the groups should work toward consensus on themes/priorities, objectives, and strategies.

8. You may wish to use one flip chart to capture discussion bullets or brainstorming ideas and the other flip chart to capture the recommendations each round.

9. After each round, record themes/priorities, objectives, and strategies on the worksheet provided.

10. During the large group report, briefly share the summary results for your assigned MCH population health domain and allow all participants to ask questions and offer suggestions.

Planning Process

Domain:_____

Round 1 Participants	

Round 2 Participants	

Round 3 Participants	

Planning Process Results

Round 1, Domain:_____

Round 1 Priorities	
#1	
#2	
#3	

Round 1 Objectives	
#1	
#2	
#3	

Round 1 Key Strategies	
#1	
#2	
#3	

Notes:

Planning Process Results

Round 2, Domain:_____

Round 2 Priorities	
#1	
#2	
#3	

Round 2 Objectives	
#1	
#2	
#3	

Round 2 Key Strategies	
#1	
#2	
#3	

Notes:

Planning Process Results

Round 3, Domain:_____

Round 3 Priorities	
#1	
#2	
#3	

Round 3 Objectives	
#1	
#2	
#3	

Round 3 Key Strategies	
#1	
#2	
#3	

Notes:

Objective-Setting Process Optional Worksheet

Round 1, Domain:_____

Objective	Improve national performance measure(s)? (List)	Current work/ successes?	Key partners or stakeholders?	Immediate next step?	Resources available?	Barriers or challenges?

Objective-Setting Process Optional Worksheet

Round 2, Domain:_____

Objective	Improve national performance measure(s)? (List)	Current work/ successes?	Key partners or stakeholders?	Immediate next step?	Resources available?	Barriers or challenges?

Objective-Setting Process Optional Worksheet

Round 3, Domain:_____

Objective	Improve national performance measure(s)? (List)	Current work/ successes?	Key partners or stakeholders?	Immediate next step?	Resources available?	Barriers or challenges?

Title V Maternal & Child Health Needs Assessment Planning Session
Overview of Process & Preliminary Findings/Priorities
December 3, 2014

MCH Council Meeting - Topeka & Shawnee County Library, Marvin Auditorium 101B

Agenda

9:45 **Title V Needs Assessment Approach & Framework**.....Rebecca Gillam & Tracy VanVlack

10:00 **Methodology for Collection of Input & Preliminary Findings** (by 6 MCH population domains)

Women/Maternal, Infant, & Child Health.....Rebecca Gillam & Tracy VanVlack
Adolescent Health.....Elaine Johannes
Children & Youth with Special Health Care Needs ..... Heather Smith
Cross-Cutting or Life Course .....Rebecca Gillam & Tracy VanVlack

11:30 **Lunch Break**

12:00 **Review Table Discussion/Priority Setting Process** ..... Connie Satzler

12:10 **Discussion Round 1** .....Group Facilitators

12:40 *Break, move to Round 2 table*

12:45 **Discussion Round 2** .....Group Facilitators

1:15 *Break, move to Round 3 table*

1:20 **Discussion Round 3** .....Group Facilitators

1:50 *Break, Groups & Facilitators Prepare to Report*

1:55 **Report Out and Large-Group Feedback by Domain** .....Connie Satzler/Group Facilitators

Women/Maternal/Infant Health
Child Health
Adolescent Health
Children & Youth with Special Health Care Needs

2:15 **Next Steps**

Title V 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.*

Table Discussion/Priority Setting Process
Overview and Discussion Guide - Participants

1. All participants are asked to provide input during the three table discussion rounds, sitting at a table for a different MCH population health domain each round. All members are assigned to the Special Health Care Needs domain for at least 1 of the 3 rounds; participants should self-select 2 of the remaining 3 domains for the other rounds. (You must move to a different table each round.)

2. A diverse set of perspectives is needed for each health domain. In order to achieve this, a balance of expertise, diversity of perspectives, and number of participants is needed at each table for each round. **To ensure adequate numbers and expertise at each table, it is possible some of you may be asked to switch tables during this process.** We ask for your cooperation and flexibility.

3. Facilitators and recorders will be assigned to each health domain/table.
   - **Women's/Maternal/Infant Health**
   - **Child Health**
   - **Adolescent Health**
   - **Children & Youth with Special Health Care Needs**

4. For Round 1, consider these questions (simply meant to engage participants and guide the discussion; groups do not need to answer the questions) :
   - What themes, trends, or health needs (priorities) are emerging for the population?
   - If we focus on those themes/health needs, what do we hope will happen?
   - In 5-10 years, we hope to see … [fill in the blank].

   Note: Do not limit your proposed priorities and objectives based on current barriers and challenges. Think about what the ultimate goal(s) should be. (Feasibility will be addressed later by the program.)

   At the end of Round 1, the group should come to a consensus on the top 1 to 3 themes/priorities, objectives, and/or strategies for the population health domain, depending status of planning for that particular domain. Consider the broadest context and sense about long-term vs. short-term improvement.

   If your group comes to quick consensus on themes/priorities, move on to discussing objectives. If draft objectives are identified, begin discussing questions on the objectives table:
   - What, if any, national performance measure(s) align with the objective?
   - Current work/successes related to each
   - Key partners or stakeholders for each
   - Immediate, concrete next step for each
   - Resources available to help achieve each
   - Barriers or challenges related to each

5. For Rounds 2 and 3, review the results from the previous group(s)/round(s). You may use some or all of the previous work, or you may start fresh.

6. During the final large group session, table facilitators will present their results.

Table Discussion/Priority Setting Process
Participant Worksheet

MCH Population Health Domain: *Women, Maternal, & Infant Health*	
PRIORITY *Where do we want to focus programmatic efforts and resources?*	
#1	
#2	
#3	

OBJECTIVE *What do we want to accomplish (and measure to determine if we have been successful)?*	
#1	
#2	
#3	

KEY STRATEGY *What actions/program activities are needed to achieve the objectives?*	
#1	
#2	
#3	

Table Discussion/Priority Setting Process
Participant Worksheet

MCH Population Health Domain: *Child Health*

PRIORITY *Where do we want to focus programmatic efforts and resources?*	
#1	
#2	
#3	

OBJECTIVE *What do we want to accomplish (and measure to determine if we have been successful)?*	
#1	
#2	
#3	

KEY STRATEGY *What actions/program activities are needed to achieve the objectives?*	
#1	
#2	
#3	

Table Discussion/Priority Setting Process
Participant Worksheet

MCH Population Health Domain: *Adolescent Health*	
PRIORITY *Where do we want to focus programmatic efforts and resources?*	
#1	
#2	
#3	

OBJECTIVE *What do we want to accomplish (and measure to determine if we have been successful)?*	
#1	
#2	
#3	

KEY STRATEGY *What actions/program activities are needed to achieve the objectives?*	
#1	
#2	
#3	

Table Discussion/Objective Setting Process
Participant Worksheet

MCH Population Health Domain: *Children & Youth with Special Health Care Needs*	
Priority #1: Care Coordination	
DRAFT OBJECTIVE *What do we want to accomplish (and measure to determine if we have been successful)?*	
#1	Assist and empower individuals and families to navigate systems for optimal health outcomes throughout the life course.
#2	Improve communication and outreach among services providers, individuals, and families to help with coordination of care.
#3	Increase collaboration between the SHCN program and other systems of care to support change.
KEY STRATEGY *What actions/program activities are needed to achieve the objectives?*	
#1	
#2	
#3	
Priority #2: Family Caregiver Health	
DRAFT OBJECTIVE *What do we want to accomplish (and measure to determine if we have been successful)?*	
#1	Support activities and initiatives to educate family caregivers on the importance of taking care of their own health needs and the impact of their health on those they care for.
#2	Engage and support collaboration among systems for the provision of respite services for SHCN family caregivers in order to proactively address their health care needs, including physical, emotional, and dental health.
#3	Provide training and education opportunities to support informed, engaged, and empowered family caregivers and providers.
KEY STRATEGY *What actions/program activities are needed to achieve the objectives?*	
#1	
#2	
#3	

Priority #3: Behavioral Health	
DRAFT* OBJECTIVE** ***What do we want to accomplish (and measure to determine if we have been successful)?	
#1	Collaborate with other agencies serving individuals with behavioral health needs to support an integrated continuum of care.
#2	Educate families about behavioral health issues and provide referrals and resources of available services and peer supports.
#3	All SHCN families will have a behavioral health assessment and be supported in obtaining necessary services.
#4	Improve the mental health and wellbeing of children with SHCN by ensuring access to timely and quality mental health services. (Healthy People 2020)
KEY STRATEGY ***What actions/program activities are needed to achieve the objectives?***	
#1	
#2	
#3	

Priority #4: Training & Education	
DRAFT* OBJECTIVE** ***What do we want to accomplish (and measure to determine if we have been successful)?	
#1	Training and education will support an empowered society that is culturally sensitive, well-informed, and respectful of all people with disabilities.
#2	Empower children, youth, and families to advocate for needed services, supports, and family/professional partnerships.
#3	Provide training and education for providers to promote diversity, inclusion, and integrated supports in the provision of services for the SHCN population.
KEY STRATEGY ***What actions/program activities are needed to achieve the objectives?***	
#1	
#2	
#3	

Priority #5: Direct Health Services	
DRAFT* OBJECTIVE** ***What do we want to accomplish (and measure to determine if we have been successful)?	
#1	Collaborate with agencies and providers in the oral health system to support increased access to, and payment of, oral health services for SHCN.
#2	Partner with public and private insurance companies to enhance coverage of services for individuals with special health care needs for primary and specialty care.
#3	Increase support for outreach clinics & utilization of telemedicine for the SHCN population.
KEY STRATEGY ***What actions/program activities are needed to achieve the objectives?***	
#1	
#2	
#3	

Table Discussion/Priority Setting Process: Objectives

Round 1, Domain:_____

Objective	Improve national performance measure(s)? (List)	Current work/ successes?	Key partners or stakeholders?	Immediate next step?	Resources available?	Barriers or challenges?

Objective-Setting Process Optional Worksheet

Round 2, Domain:_____

Objective	Improve national performance measure(s)? (List)	Current work/ successes?	Key partners or stakeholders?	Immediate next step?	Resources available?	Barriers or challenges?

Objective-Setting Process Optional Worksheet

Round 3, Domain:_____

Objective	Improve national performance measure(s)? (List)	Current work/ successes?	Key partners or stakeholders?	Immediate next step?	Resources available?	Barriers or challenges?

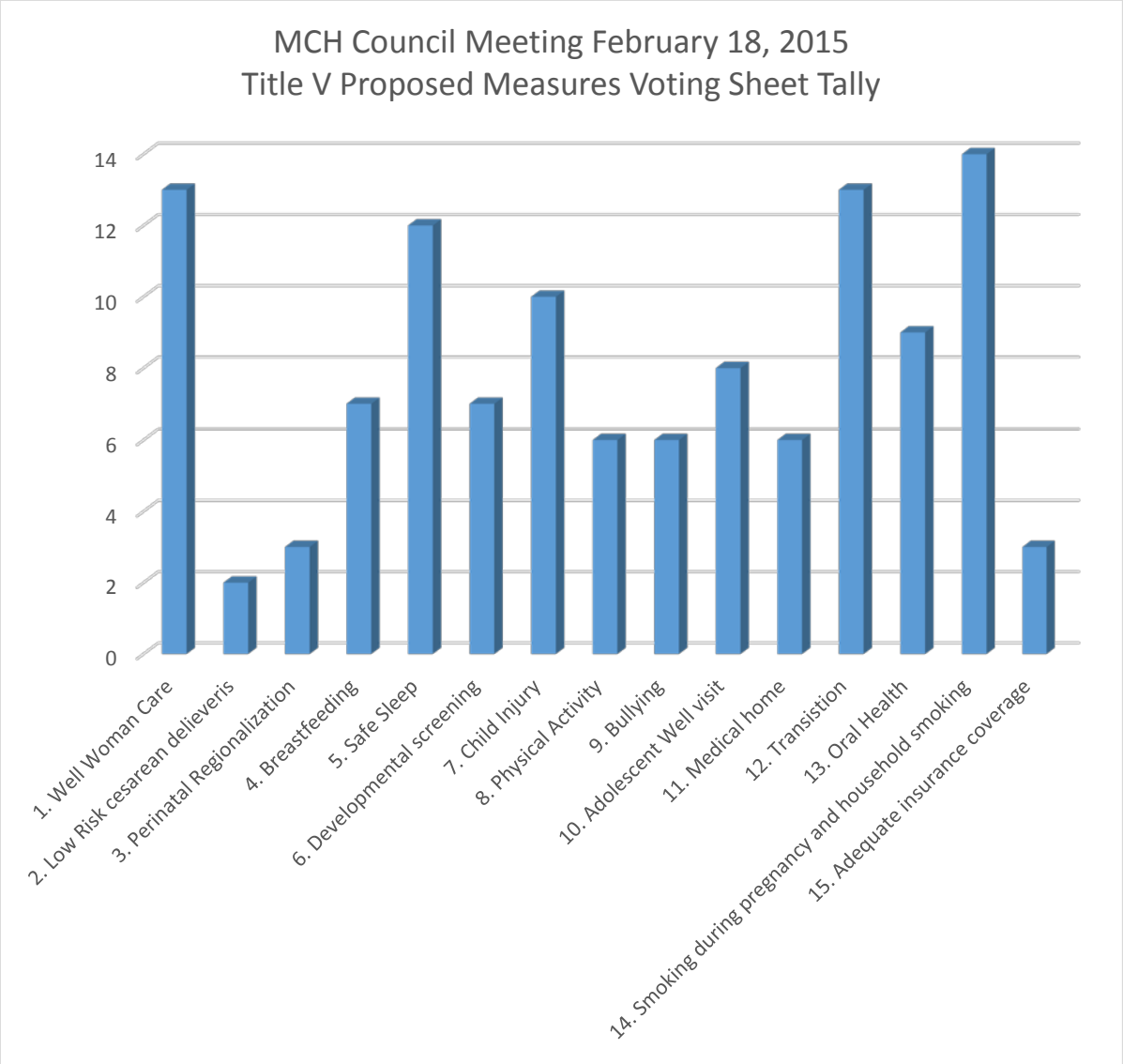
KMCHC Meeting

Agenda

February 18, 2015 (Wednesday)
10:00am – 2:00pm (lunch provided)
Topeka and Shawnee County Library – Room: Marvin Auditorium 101A
1515 SW 10th Avenue
Topeka, KS 66604-1374

Agenda Items	Issues Discussed/Actions Completed	Action Item / Completed by Whom
10:00 Introductions – Dennis Cooley, MD		
10:10 Old Business – Dennis Cooley, MD - Approval of Minutes (12/03/2014) - Review of Action Items	*(attachment)* Four Uncompleted Items: **Pending**: Dr. Jones has contacted Kyle Kessler, executive director - Governor's Task Force Children Subcommittee on Mental Health, several times about participating in the KMCHC. Wes will let Chris know if he is interested in being a member of the KMCHC. **Pending**: Ms. Daldrup will invite Dr. Jeff Kuhlmann (FP), Wichita to participate in the KMCHC. **Pending**: Ms. Daldrup will contact Terrah Stroda about participating in the KMCHC. **Pending**: Ms. Daldrup will contact the Director of Shawnee Mission Medical Center to ask about a neonatologist name. She will contact that neonatologist about participating in the KMCHC.	
10:15 KDHE Update – Rachel Sisson, MS - Title V MCH Needs Assessment: Emerging Issues, Priorities, Measures *Continued from December 3* - MCH Aid to Local Grant Applications		

- Organizational Update		
11:30 Lunch		
12:00 New Business – Dennis Cooley, MD - Kan Be Healthy Form (EPSDT) - Vaccine Payment issue - FYI - MOC-4 Safe Sleep Opportunity to KAAP members - Infant Mortality CoIIN	 *(attachment)* OPR and Shawnee Mission Medical Center are part of the large health network known as Adventist Health System, which calls itself a church. It is a large network, and it is outside the regulations. They do offer plans that include WCC and immunizations, known at tier 1 plans which are more expensive. But they do not have to offer anything in compliance with health care regulations because they say they are a church. *(attachment)*	
Miscellaneous - KMCHC Member Updates - KSHSAA has made changes to forms - Other items		
Future Meeting Dates	April 23, 2015 9:00am – 1:00pm (lunch provided) Hampton Inn & Suites (Country Club Plaza) Kansas City, MO June or July Meeting (TBD) Topeka, KS September 30, 2015 12:20am – 4:30pm (lunch provided) Hotel at Old Town Wichita, KS	


MCH Council Meeting February 18, 2015
Title V Proposed Measures Voting Sheet Tally
14
12
10
8
6
4
2
0
1. Well Woman Care
2. Low Risk cesarean delieveris
3. Perinatal Regionalization
4. Breastfeeding
5. Safe Sleep
6. Developmental screening
7. Child Injury
8. Physical Activity
9. Bullying
10. Adolescent Well visit
11. Medical home
12. Transistion
13. Oral Health
14. Smoking during pregnancy and household smoking
15. Adequate insurance coverage

MCH Council Meeting Februaury 18, 2015 Clicker Results

Maternal/Woman	***Percentage***
Women in Kansas have access to comprehensive, coordinated care	**53%**
Women in Kansas have access to mental health services and education	**12%**
Women in Kansas receive support toward positive family functioning and healthy relationships	**24%**
Women in Kansas have appropriate support to develop positive parenting techniques	**12%**
Infant/Perinatal	***Percentage***
Infants regularly receive preventive care that is coordinated among providers	**47%**
Infants grow and thrive in safe environments through supported parenting practices	**41%**
Infants receive the nutrition that they need for healthy development	**12%**
Children	***Percentage***
Children in Kansas regularly receive preventive care that is coordinated among providers	**29%**
All children have the tools they need to be socially and emotionally healthy	**71%**
Children receive adequate nutrition to support healthy growth and development	**0%**
Adolescents	***Percentage***
All adolescents regularly engage in self-care/preventive care that is coordinated among providers	**6%**
Adolescents' mental health and emotional well-being is addressed proactively	**59%**
Adolescents develop the life skills they to thrive	**35%**
Adolescents receive adequate nutrition to support healthy growth and development	**0%**
There are qualified, trained adults available to work with adolescents	**0%**

KMCHC Meeting

Minutes

February 18, 2015 (Wednesday) 10:00am – 2:00pm
Topeka and Shawnee County Library, Topeka, KS

Attendees:		**Absent:**	**Visitors:**
Carrie Akin Katrina Benyshek, RN Kayzy Bigler Dennis Cooley, MD, FAAP Lori Haskett Wes Jones, PhD Barbara Kramer Traci Reed	Debbie Richardson, PhD Cherie Sage Christy Schunn, LSCSW Fran Seymour-Hunter Heather Smith, MPH David Thomason, MPA Stephanie Wolf, RN, BSN Donna Yadrich Gianfranco Pezzino, MD, MPH	Diane Daldrup Hank Guerrero, LBSW Jamie Kim, MPH Patricia McNamar, DNP, ARNP, NP-C Pam Shaw, MD, FAAP Rachel Sisson, MS Michele Spainhower Susan Mosier, MD Erick Vaughn, LMSW	Tracy Vanviack

Staff:
Melissa Hudelson, KAAP Associate Director

Minutes	**Issues Discussed/Actions Completed**	**Action Item / Completed by Whom**
Welcome	Dr. Cooley welcomed KMCHC members	
Old Business – Dennis Cooley, MD - Approval of Minutes (12/03/2014) - Review of Action Items - KSHSAA has made changes to forms	**Motion:** it was moved by Dr. Jones and seconded by Lori Haskett to approve the 12/03/2014 minutes. All approved. The committee will continue to research new members.	**Pending**: Ms. Daldrup will invite Dr. Jeff Kuhlmann (FP), Wichita to participate in the KMCHC. **Pending**: Ms. Daldrup will contact Terrah Stroda about participating in the KMCHC. **Pending**: Ms. Daldrup will contact the Director of Shawnee Mission Medical Center to ask about a neonatologist name. She will contact that neonatologist about participating in the KMCHC.

10:15 KDHE Update – Rachel Sisson, MS - Title V MCH Needs Assessment: Emerging Issues, Priorities, Measures *Continued from December 3* - MCH Aid to Local Grant Applications - Organizational Update	Tracy and Lori discussed the Title V MCH Needs Assessment that will need to be narrowed down from 15 proposed measures to 8. Tracy showed the data from survey. The timeline shows finalizing state priorities in April. Surveys were given to KMCHC members so that they can pick their top 8, one in each of the 6 population category, then 2 additional measures. Group discussion for all 15 measures: <u>Women/Maternal Health</u> Measure 1. Well woman care - majority of family care givers are women, and it's important that they take care of themselves. This could be an opportunity for other screening (alcohol, drugs, etc.). Measure 2. Low risk cesarean delivery – when you get women in for preventative care, you can educate on low risk cesarean. Numbers are already dropping on this. <u>Perinatal/Infant Health</u> Measure 3. Perinatal Regionalization –in KS we have very good scores of VLBW infants that were born in a hospital with a Level III NICU (80% from 2012 data). This is an area that we could improve, but we are doing fairly well. Measure 4. Breastfeeding – Not sure if there is an accurate data source for 6 month breastfeeding rates. Measure 5. Safe Sleep – how would we measure since we don't have PRAMS? Since they are only measuring sleeping on the back, this measure really only addresses a small part of safe sleep. Another data source wouldn't be very accurate. <u>Child Health</u> Measure 6. Developmental Screening	

	Child Health and/or Adolescent Health Measure 7. Child Injury – tremendous cost benefit to injury prevention, those cost savings are available broken down by categories like bike helmets, smoke detectors, etc. There is a network already in place. Injury is the leading cause of death for people 1-19. Accurate data is available. A way to reach different populations with violence prevention too. This covers unintentional and intentional injuries, so it addresses a big group. Measure 8. Physical Activity – discussion on how to get accurate data. Adolescent Health Measure 9. Bullying – this does capture both the bully and the victim. There are a few programs that are addressing the issue, and schools have to develop a bully policy. Possible stakeholders – Dept of Education, KS children's league, YMCA, after school programs, boy/girl scouts. Measure 10. Adolescent well visit – what do they consider a well visit? Does a sports physical with a chiropractor could count? This is an area that could use improvement if the well visit is with a primary care provider. Children w/ Special Health Care Needs Measure 11. Medical Home – children with and without special needs. This might work well with Measure 10, but maybe Transition would be more important, because if we address preventative care, then medical home is already addressed. This has already been chosen the last 10 years. Measure 12. Transition – This might hit something that is not addressed through other measures. Could be a problem that it looks at both with and without special needs. Hopefully we can keep the data separate so numbers don't get skewed. Cross Cutting/Life Course Measure 13. Oral Health – Could get data from Becoming a Mom. We could just do B since we don't have PRAMS data, but it was discussed that we should do A and B.	

	Measure 14. Smoking during pregnancy and household smoking – we have some of the highest rates in the country for pregnant women smoking, and SIDS rates are high for smoking in the home. Measure 15. Adequate insurance coverage – having insurance and having access are two different things particularly now that Medicaid reimbursements have been cut. Traci Reed looking for help with MCH Aid grant applications. Contact her if you can help. Awards will be made April 15th. Organizational Update: Healthy Homes and Lead Hazard programs were added to Bureau of Family Health. Governor's reorganization order moves foster care to DCFS.	
11:30 Lunch		
12:00 New Business – Dennis Cooley, MD - Kan Be Healthy Form (EPSDT) - Vaccine Payment issue - FYI - MOC-4 Safe Sleep Opportunity to KAAP members - Infant Mortality CoIIN	Notes: Kan Be Healthy Form – there will be an audit tool to make sure that the components of the Kan Be Healthy form are addressed in an EMR so that they don't also have to fill out the form. Vaccine rates have gone down again – into the 40's of the 50 states. Kansas Immunization Coalition has been developed focused on improving vaccine rates in children and adolescent vaccine rates – HPV is a focus. **MOC-4 Safe Sleep for KAAP** – through Ohio, a screening tool, sleep sacks are components. **Infant Mortality CoIIN** – Launched June 2014, 5 strategy topics: - Safe Sleep	

	- Smoking cessation - Preconception/Interconception Health - Social Determinants of Health - Prevention of preterm and early term births **Legislative Update**: Midlevel Dental practitioner bills have not moved forward. HB2099 – school surveys would be "opt out" instead of being "opt in" as they are now, being heard now. HB2149 – donor breast milk paid for by Medicaid, it's very expensive and now hospitals cover the cost. Hearing today. HB2239 – CCHD screening, secretary can include in the newborn screening. SB123 – psychotropic drugs – prior authorization SB129 – abuse reporting –Law enforcement has to report to DCF. Abuse doesn't get reported many times to the correct department.	
Miscellaneous - KMCHC Member Updates - KSHSAA made changes to forms - Other items	WIC – stakeholder meeting on Tuesday, February 24th 10:00am – 2:00pm KIDS – Safe Sleep Safe Kids task force. Hospital survey going out. Working on a statewide campaign with a single, clear message. We will have more safe sleep trainers across the state, regional "champions". Creating safe sleep training. Looking for more "champions" to do the safe sleep training throughout the state, let Christy know if you know someone. Safe Kids – 4 priority injury prevention areas each have coalitions working on those. State needs assessment will be completed by the end of 2015. Creating resources for coalitions and partners to make it easy to get the message out to the public.	

	KDHE Injury Prevention - Updating strategic plan, all are invited to attend. Lori sent out information. EMSC – Emergency Medical Services for Children – had a pediatric specific training for EMS in Wichita, planning to have these in other regions. Great attendance and speakers. There will be several more this year. School Nurses – conference July 14-17, 2015 Developmental Screening - Train the trainer session from the publisher of ASQ. Dr. Shaw will be doing more trainings. Becoming a Mom – integration of WIC, safe sleep, mental health screening into the program as it spreads across the state. Growing quickly across the state and building collaboratives, not just targeting one issue or group. Discussed creating a youth MCH ambassadors program in the future to relay a message of different health issues to their peers in schools.	
Future Meeting Dates	April 23, 2015 9:00am – 1:00pm (lunch provided) Hampton Inn & Suites (Country Club Plaza) Kansas City, MO June or July Meeting (TBD) Topeka, KS September 30, 2015 12:30am – 4:30pm (lunch provided) Hotel at Old Town Wichita, KS	

APPENDIX G

Maternal and Child Health Input Survey

Kansas Title V
Maternal and Child Health Services
Block Grant
2014 Application / 2012 Annual Report

Executive Summary of Public Input

July 2013

Bureau of Family Health
Kansas Department of Health and Environment

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Phone: 785.291.3368
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Kansas Title V Maternal and Child Health Services Block Grant
2014 Application/2012 Annual Report
Executive Summary of Public Input

This executive summary summarizes the public input received by the Kansas Title V Maternal and Child Health (MCH) - Bureau of Family Health (BFH), Kansas Department of Health and Environment (KDHE) during the development of the 2014 Application/2012 Annual Report of the federal Title V Maternal and Child Health Services Block Grant.

Public Input

Public input is a required component of the annual MCH Block Grant application process. In 2013, the Kansas Title V Maternal and Child Health - Bureau of Family Health (BFH) initiated several new strategies (adapting Wisconsin and Tennessee's resources) to solicit public input for the 2014 Application/2012 Annual Report. MCH staff developed resources to increase knowledge and understanding about the Kansas Title V MCH federal-state partnership, services, Block Grant, and 2011-2015 state priority issues including an Executive Summary, Public Input Survey, Quick Reference Guide, and MCH federally reported indicators and progress. Additionally, on the BFH homepage, a separate Title V information page with these resources was posted at: http://www.kdheks.gov/c-f/mch.htm.

Public Input period

May 2, 2013 - June 1, 2013

Methods

The following email was sent by the Title V Director to Kansas MCH partners (a complete list is included as Appendix A).

"Dear Kansas Maternal and Child Health Partner:

As Director of the Kansas Title V Program, it is my pleasure to request your input related to Kansas Title V Maternal and Child Health (MCH) Services, a federal-state partnership/block grant administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health. Whether you are a parent, government official, advocate, or member of the general public, the MCH Block Grant likely touches your life. Its success lies in the strength of partnerships and collaborations to maximize reach and promote efficiency. Please complete this short survey related to statewide MCH programs and services: http://www.surveymonkey.com/s/XD6ZQSM. In order to ensure that your comments are reviewed and incorporated into the 2014 Application/2012 Annual Report, we ask that you complete the survey by **June 1.** Your input is needed to assure the MCH Program is guided by the needs of Kansas families and MCH priority populations: women of reproductive age,

pregnant women, mothers, infants, children, adolescents, and individuals with special health care needs. Please feel free to forward this message and survey link. Questions should be directed to Jamie Kim at jkim@kdheks.gov.

Resources to increase your knowledge about the Kansas Title V MCH Block Grant and state's priority issues for 2011-2015 are provided below. Included in the list is an Executive Summary which orients the reader to the Block Grant, highlights key programmatic themes and data points, provides specific examples of MCH program activities, and encourages comment concerning the document itself.

- Executive Summary (2013 Block Grant): http://www.kdheks.gov/c-f/downloads/Executive_Summary_KS_MCH_BG_2013_App_2011_Report.pdf
- Health Status Indicator Progress Report (2013 Block Grant): http://www.kdheks.gov/c-f/downloads/Indicator_Progress_KS_MCHBG_2013_App_2011_Report.pdf
- MCH Block Grant (full length 2013 Application/2011 Annual Report): http://www.kdheks.gov/cyshcn/download/FY2013_KS_MCH_Block_Grant_For_Public_Comment.pdf
- Quick Reference Guide for Block Grant: http://www.kdheks.gov/c-f/downloads/MCH_Quick_Reference_Guide.pdf
- MCH 5-Year Statewide Needs Assessment (*MCH 2015*): http://www.datacounts.net/mch2015/documents/MCH2015_Report.pdf
- MCH 2012 Biennial Summary: http://www.kdheks.gov/bfh/download/MCH_2012_Biennial_Summary.pdf
- KDHE Bureau of Family Health website: www.kdheks.gov/bfh (direct link to MCH Block Grant website: http://www.kdheks.gov/c-f/mch.htm)

Thank you for your dedication and commitment to working together for a healthier Kansas."

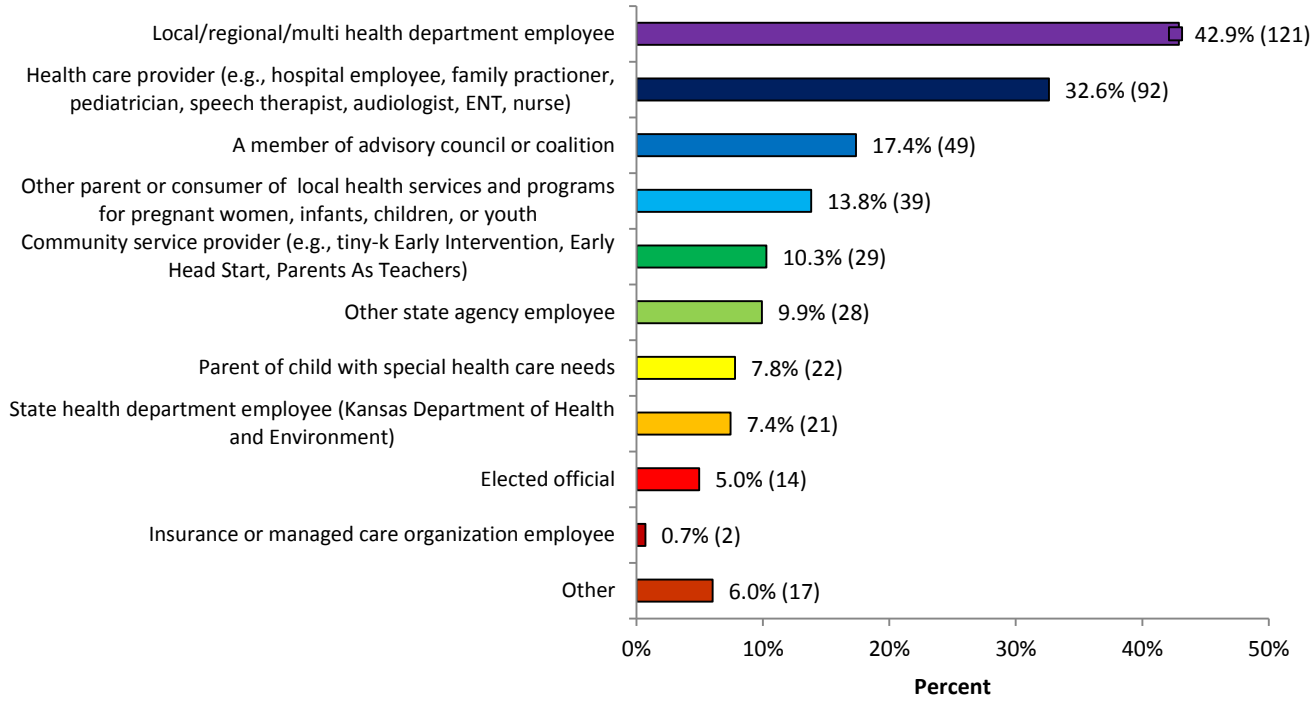
The public input was gathered via an on-line survey tool (Survey Monkey). The survey was structured to focus on major and emerging health concerns and unmet needs for the target populations served by the block grant. In addition, the survey asked for input on the service delivery system for these populations to include what is and is not working well.

Results

Characteristic of Respondents

A total of 292 responses were received. Participants were asked to best describe their role (selecting multiple categories, if appropriate). Figure 1 shows the categories of respondents. The majority of respondents were local/regional/multi health department employees (42.9%), followed by health care providers (32.6%).

Figure 1. Respondents to Public Input Survey



Total = 282 Responses

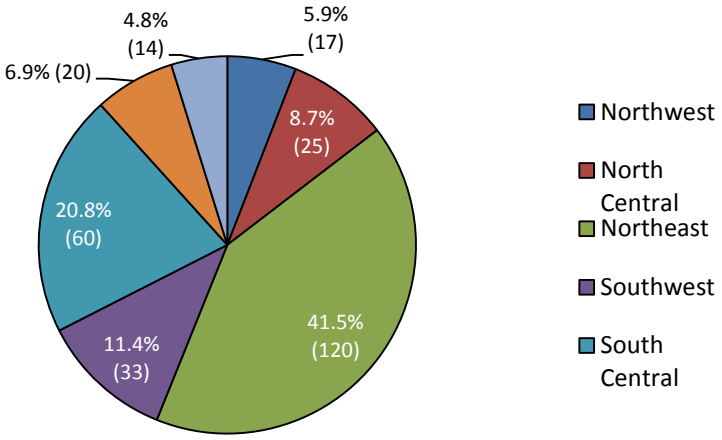
Other respondents included:

- Abortion provider, small
- Advocate
- Consultant working with many of the above groups
- Data Analyst- Stroudwater Associates
- Emergency Aid Agency
- Former school social worker
- Foundation officer
- Health philanthropy leader
- Healthy Start Home Visitor
- Law Enforcement
- Non-profit Executive Director
- Non-profit organization volunteer
- School nurse
- Staff of Community Mental Health Center
- Technical Advisor to KDHE
- Volunteer mother-to-mother breastfeeding counselor (La Leche League)
- Work in health care- Medical records Director of a hospital

Geographic Distribution of Respondents

In order to better understand whether the public inputs were representative of the population, respondents were asked to indicate the area of the state in which they work or live. Figure 2 shows the geographic distribution of respondents. As expected, the majority of respondents indicated Northeast (41.5%), followed by South Central (20.8%).

Figure 2. Geographic Distribution of Respondents

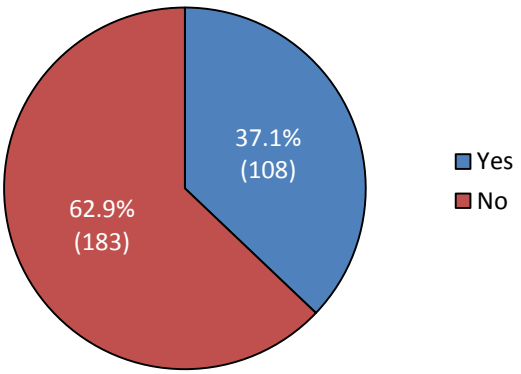


Total = 289 Responses

MCH Block Grant Review Status

Respondents were asked whether they had ever read the Kansas MCH Block Grant. Figure 3 shows the MCH Block Grant Review Status. Only one-third of respondents had read the grant.

Figure 3. MCH Block Grant Review Status



Total = 291 Responses

Key Findings

Kansas Title V MCH Program serves specific maternal and child populations.

They are:

- Reproductive age women (15-44 years of age)
- Pregnant adolescents and women, newborn and infants (birth to 1 year of age)
- Young children (1-5 years of age)
- School age children (6-12 years of age)
- Youth and adolescents (13-18 years of age)
- Children with special Health care needs (birth to 12 years of age)
- Youth with special health care needs (13-26 years of age).

All respondents expressed overall support for prevention-related services.

The following common/overarching/recurring issues were identified in the comments of the target populations served:

- Adequate and appropriate nutrition/obesity prevention including childhood obesity
- Assistance to families with newborns
- Breastfeeding education and support
- Developmental screening and early identification services
- Immunization education and support
- Mental health screening and services
- Oral health
- Parenting education and support services
- Strong adolescent health education and services
- Support for access to and utilization of reproductive health services
- Support infrastructure for health care system
- Supports for families who have a child or youth with special health care needs

It was suggested the MCH programs continue to find ways to make greater use of technology to provide:

- Health education and support services
- Improve access to and utilization of health care system in rural areas
- Improve health literacy of families
- Encourage public/private partnerships between existing programs and services
- Support advocacy for policies to improve public health

Detailed survey responses are included as Appendix B.

Future Plan

The BFH plans to use the input and comments to inform state direction and Title V MCH activities such as providing a foundation for the statewide needs assessment, bringing together all system providers to support movement toward integrated services and comprehensive approach to care. Internally, regular MCH coordination/working meetings will be held beginning September 2013 to ensure all program and epidemiologist staff have the forum to communicate updates, develop plans/activities, and monitor progress related to Title V, especially the Block Grant measures/indicators and needs assessment priorities. New activities, collaboratives, councils, coordination, and communication are the keys to success with reaching goals and creating movement toward collectively improving outcomes. Potential agenda items include:

- MCH Epidemiology projects
- Coordination with other bureaus in the Division of Public Health and the Division of Health Care Finance (Medicaid)
- Continuous improvement of public comment and input
- Increasing and improving communication with local health departments and other MCH partners

For next year's application, MCH plans to post the final version of the 2014 application and 2012 annual report on the Title V MCH website following a federal agency review in August, 2013. The MCH programs will monitor for public comment and inquiry throughout the year. MCH staff will review on a routine basis and incorporate into the next year's application.

Appendix A: Kansas Maternal and Child Health Partners

- Birth Centers
- Cerebral Palsy Research Foundation
- Children's Alliance
- Families Together
- Family Advisory Council
- High 5 for Mom and Baby
- Kansas Action for Children
- Kansas Breastfeeding Coalition
- Kansas Chapter of American Academy of Pediatrics
- Kansas Chapter of Family Physicians
- Kansas Children's Service League
- Kansas Department for Children and Families
- Kansas Foundation for Medical Care
- Kansas Health Foundation
- Kansas Maternal & Child Health Council members
- Kansas Perinatal Quality Collaborative members
- Kansas Public Health Leadership Institute and Core Public Health Programs
- Kansas University Medical Center/Kansas University
- KDHE Department of Public Health Directors/staff
- KIDS Network
- Local Health Department Administrators
- Managed care organizations
- March of Dimes
- MCH grantees/representatives
- Mother & Child Health Coalition of Greater Kansas City
- Newborn Hearing Advisory
- Newborn Screening Advisory
- Nutrition Physical Activity Collaborative
- School nurses
- State Children's Institutions
- Sunflower Foundation
- Teen Pregnancy Targeted Case Management and Pregnancy Maintenance Initiative grantees
- The Blue Ribbon Panel on Infant Mortality
- United Methodist Health Ministry Fund
- WIC Advisory Committee
- WIC grantees/representatives
- Youth Advisory Council

Appendix B: Detailed Survey Responses

1. What is your role? Please check ALL that apply.

Response	Percent	Count
Parent of child with special health care needs	7.8%	22
Other parent or consumer of local health services and programs for pregnant women, infants, children, or youth	13.8%	39
A member of advisory council or coalition	17.4%	49
Local/regional/multi health department employee	42.9%	121
State health department employee (Kansas Department of Health and Environment)	7.4%	21
Other state agency employee	9.9%	28
Health care provider (e.g., hospital employee, family practitioner, pediatrician, speech therapist, audiologist, ENT, nurse)	32.6%	92
Community service provider (e.g., tiny-k Early Intervention, Early Head Start, Parents As Teachers)	9.9%	28
Insurance or managed care organization employee	0.7%	2
Elected official	5.0%	14
Other (please specify) Volunteer mother-to-mother breastfeeding counselor (La Leche League) PTI/F2F Law Enforcement Foundation officer abortion provider, small non-profit organization volunteer Non-profit Executive Director Technical Advisor to KDHE Emergency Aid Agency former school social worker Consultant working with many of the above groups Healthy Start Home Visitor Advocate Staff of Community Mental Health Center Data Analyst- Stroudwater Associates Work in health care- Medical records Director of a hospital School nurse Health philanthropy leader	6.0%	17
answered question		**282**
skipped question		**10**

2. In which region of the state do you work or live?

Response	Percent	Count
Northwest	5.9%	17
North Central	8.7%	25
Northeast	41.5%	120
Southwest	11.4%	33
South Central	20.8%	60
Southeast	6.9%	20
Central	4.8%	14
answered question		**289**
skipped question		**3**

3. The 2013 Application/2011 Annual Report can be found at: http://www.kdheks.gov/bfh/index.html. Have you ever read the Kansas MCH block grant?

Response	Percent	Count
Yes	37.1%	108
No	62.9%	183
answered question		**291**
skipped question		**1**

Major and Emerging Health Concerns and Unmet Needs

The Kansas Title V Maternal and Child Health (MCH) Program serves specific maternal and child populations. For each of the following populations for which you have experience, what do you think are: a) the major or emerging health concerns; b) the essential (or primary) health needs that are not being met

4. Reproductive Age Women (15 - 44 years of age)

Response	Count
	142
answered question	**142**
skipped question	**150**

Response Text
getting the care that they need to prevent pregnancy, and then once pregnant, getting care
Access to health care for women in rural areas Knowledge about services available
reproductive health needs
a) development, supportive parenting practices b) maternal depression, domestic violence, other social determinants that contribute to poor health outcomes for

children and families
a) Obesity; Use of drugs, tobacco, and alcohol; Domestic Violence; mental health issues; STDs; risky behaviors including use of cell phones/texting and driving. b) Oral Health; Smoking Cessation; and mental health services. In addition Housing, Child Care, and Transportation needs are critical to address.
Access to care. (lack of transportation)
A. STIs, knowledge of birth control & effective use
An essential element missing that directly impacts health is education on parenting and nutrition. Women (and men) need education on properly nourishing a child and how those needs change as they grow. They need to know how to soothe a screaming baby while keeping themselves cool headed. There are too many deaths of babies and young children because their care-giver did not know how to properly handle the stressors of parenting.
Need for good maternal health/preconception health. Many in child bearing years do not access adequate health care for lack of insurance, high cost of health care, high cost of healthy foods, vitamins, etc. Unhealthy women lead to unhealthy/premature babies.
Visible community support for breastfeeding to normalize breastfeeding. Women of childbearing age need to have discussions about breastfeeding during their regular health care provider appointments. In addition, workplace lactation support programs need to be communicated to all employees so women know prior to conception that breastfeeding and returning to work is supported.
a) Not taking precautions for STD & having sex with multiple partners, obesity, hygiene & lack of dental care. b) Lack of responsibility for ones actions and their effects on individual health.
Easy access to health care for the uninsured.
nutrition, and lack of education on child development and parenting skills
Family prevention focus, for ALL families through HEALTH/MENTAL HEALTH.
a. Health Concerns: The unknown with the Affordable Care Act. If the State doesn't expand Medicaid there may be some that fall through the cracks of the system. b. Unmet health needs. Affordable dental care for adults.
I didn’t have any trouble getting my health care needs met.
Major or emerging health concerns = African American premature birth rate Additional education on prevention
Access to care no insurance or underinsured cultural competence lack of life course perspective contraception
Poor health and nutrition; obesity!
a) STDs and transmission of those b) treatments for people needing colposcopy
1. Women aren't getting Annual Health Screenings (Paps, STI testing for those at risk, Mammograms, etc.) 2. Obesity 3. Large population of smokers 4. Large population of illicit drug use and abuse of prescription drug usage. Needs: Patients to realize the importance of screenings, good health, etc.
The lack of preconception education
failure to use reliable contraception, exposure to STI's
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
The numbers of premature/ preterm babies being born, The accessibility to good, affordable health care to low income. (afterhours) Not meaning going to the ER for services. The lack of information to mothers about how important, nurturing, efficient and cost effective breast feeding is.
Lower income clients needing care Health departments need assistance with providing a wider range of birth control options.

All areas have adequate resources for this group. It appears that it is choice whether to utilize. Some agencies need to be more involved and not depend on this group always coming to the agency and not going out amongst the population.
Establishing a medical home Uninsured
Prenatal Care, Breastfeeding Support, Food Security, Birth Control
GED programs job skill so they can get a better job affordable dental care
Access to dental care/dental insurance.
for women in that group I think it is lack of health insurance
Having family planning methods available. education of the risk of having closely spaced pregnancies Important of Folic acid supplements
a. obesity b. lack of insurance causes an absence of primary care services
Obesity Dental Health Mental Health Drug/alcohol/smoking abuse
No low cost services in a reasonable travel area for conditions that require additional screening or treatment for follow-up from Family Planning exams - colposcopy, mammograms, etc.
a. Gaps between private health insurance that parents hold and can afford (typically they pay a percentage of the total premium and they may not be able to afford to put their children on) and what Medicaid covers with the children when private insurance does not cover their children. b. Better school and Daycare services that will inhibit disease spreading. It is well known that schools and Daycares spread influenza, lice, chicken pox, et cetera, and that then parents will get sick from their kids. When parents have to take time off for sickness, either to take their kids to doctors, or time off for themselves, is a financial blow. For example, ways to auto-clean schools and Daycare might be some kind of hospital-like UV lights at nights, less humidity to dry out wet bacteria snot wipes, low level ozone (but that aggravates asthma), UV lights in air conditioning, electrostatic air filters, hand cleaning stations (wipes, sanitizer foams), required antibacterial rug/floor cleaners. A snotty nose is known to culture viruses and bacterial. Teach children and parents to clean their noses by snuffing water or other solutions to clear mucus. Maybe have LPN associated with a Daycare or School so they can easily get their lice treatment, or antibiotic, antiviral meds, or immunizations at low cost.
I feel that we need more education on sexual health. We also have a large population of teen pregnancies and these children have very little support at home. I find we need things like mother to mother ministries, child care due to most teens in our program feel they have to drop out of school because no one can babysit. Need more support with breastfeeding moms have very few programs or support groups that will support breastfeeding mom's in our community.
Affordable services such as community health clinics that have a sliding scale fee and that offer services the local health department does not offer.
access to health care across the whole community Screening women for STDs
obesity, drug and alcohol usage, chronic disease (e.g. diabetes) limited number of providers accepting Medicaid; large number of women still uninsured integrated care -- women connected to dental and mental health services -- care still very much in silos acceptance of teenage pregnancy as the norm easy access to family planning
Access to care (Some services are available here in our county, but women don't either know about services or have skewed perceptions of the services available). Also, our childbearing women have to go out of the county at least 30 miles to the nearest provider qualified to deliver babies.
obesity, physical inactivity
a) Obesity a) Lack of exercise a) Tobacco use b) Dental Health

b) Folic Acid supplementation
Taking Prenatal Vitamins Obesity
access to birth control that is affordable, parenting education, breastfeeding education, emergency birth control, domestic violence, unstable home life, access to dental care
Increased awareness of why the PAP is so important
a. STD's and unplanned pregnancy b. family planning
STI's, effective birth control that will be used correctly HPV vaccination
a. Obesity/poor nutritional status, poor dental hygiene/health, unplanned pregnancies b. Lack of dentists who will accept payment from KanCare. Lack of planning for healthy pregnancies. Need more widespread information about the importance good health status before pregnancy--Most women are not taking vitamins/folic acid before becoming pregnant
dental services; mental health services; lack of insurance and/or Medicaid providers; obesity and diabetes
Dental (no Medicaid dentists in the county) Mental (limited resources in our area) Sexual health education & Delay of sexual activity education Education on how the body works (menstrual cycle etc.)
Access to affordable, quality health care, including physical, dental and mental health. There exists both a shortage of providers willing/able to take Medicaid and a shortage of providers in certain, primarily rural areas of the state. Mental health care concerns are of particular importance to this population and without quality health insurance, recognizing the need for MI/MH services and finding quality providers is difficult.
safe access to information regarding reproductive health including contraception
Mentoring to women who are raising their children there is not enough resources offered. Some of the issues are Discipline, setting boundaries, family unit not stable, mothering skills, nutrition and health lack of knowledge and motivation. Mothers do not know how to interact with their children. Leaving their children in car seats and not holding or nurturing child.
Sexually transmitted disease, unplanned pregnancies, obesity (growing problem), Healthy relationships (not being in)
a) The major or emerging health concerns Mental health support and access to care. b) The essential (or primary) health needs that are not being met Accident prevention and preventative care. Education to families supporting these children.
Unprotected sexual activity among teens. Sexual solicitation among teens.
Reproductive health needs, e.g.: birth control, pregnancy prevention, prenatal care, nourishment and health care during and after pregnancy. Education about the effects of substances on the developing fetus, and the importance of adequate nutrition during pregnancy and breastfeeding.
Obesity, STD's, Teen pregnancy, alcohol/drug use during pregnancy
induction of labor & prenatal care
a. Repeat teen pregnancy and STD contacts. b. Money for health care in order to get screenings like Paps or mammograms. Close availability for no insurance individuals needing specialized testing.
a. preconception care b. comprehensive reproductive health
Family Planning is essential. The county is contemplating stopping this program due to the cost to the county.
a) preconceptual health including preconceptual genetic testing. b) Kansas has less than 10 genetic professionals statewide and only three that practice in prenatal/women's care. Physicians cannot keep pace with the changes in genetic testing available to assist individuals and couples in making reproductive choices.
a) pre/post natal care b) Preventative health maintenance

Information and counseling for pre-menopausal women, this topic is very rarely touched on. With so many women going through early menopause, by either surgical or hormone changes. More opportunities and funding for long term reversible birth control options. With the limited funding offered thru Title X programs, there are only a few options available
Availability of birth control and reproductive freedom. Without these, we will be back in the early 60s where young women resorted to methods that could be life threatening.
Availability and access to contraception Brain Health resources
Prenatal care among Hispanic women
wellness checks- not getting and keeping up with health concerns
Major health concerns at this age would be a lot of them do not have health insurance. HPV is common in this age group. A lot of individuals that we see at this age group do not have a primary physician and do not follow up when advised.
teen pregnancy, obesity, drug use, STDs, mental health Education on self-care; importance of preventative health, risk behavior
Domestic Violence Under Reporting and related physical and psychological trauma Contraceptive use and options Alternatives to abortions such as adoption
Helping them understand what their screening needs are birth control for adolescents STI prevention
No major health concerns observed for this age group.
a) Access to affordable care for those who are uninsured, specifically immigrant women (documented and undocumented); refugee women, and homeless women (including victims of domestic violence and human trafficking). b) pre-natal care for pregnant women, while for immigrant and homeless women basic preventive health care, including mental health and dental care
Prenatal care for uninsured or non-English speaking women. Easy access to birth control.
A) Obesity B) Obesity
Lack of health care.
Accurate information about, and assistance with, breastfeeding to be sure that each woman can achieve her breastfeeding goals. Reproductive options -- access to midwifery care, delivery options in birth center, hospital or home. Family planning -- choice of methods, including emergency contraception and, as a last resort, safe abortion. Nutrition education -- all ages.
Lack of available and affordable family planning services in Miami, Linn and other eastern Kansas rural counties. Lack of support or assistance/ direction for health departments to help them maintain services in this current political and economic climate.
Accessible, affordable yearly exams and birth control.
Alternative women's clinics-outside of OBGYN.
Preconception health and natural family planning options are rarely discussed
Access to quality primary care.
Access to care Nutritional services Toxic stress
We are not teaching how to be good parents, especially about bonding, attachment, and responsiveness to babies as the foundations of personality, motivation, mental health, and learning; Nor are we teaching about the developmental origins of health and disease.
Access to health care--this age group is often under or not insured; Education and screening for abuse; STDs and prevention Pregnancy education and prevention is needed Blood pressure screening; depression screening

Clients' knowledge of ACA Coverage for undocumented a Number of pregnant women showing up in local hospitals with late or no prenatal care. Lack of awareness of local medical providers of all of the above issues.
No stability at home Not being parented
infant mortality
a) no health insurance b) preventive care
Adequate Health care for infant delivery in rural areas
a) Access to care; protection against VPD (vaccine preventable diseases); b) STD concerns
a) Fibroids b) Reproductive life planning
affordable healthcare for women who do not qualify for the medical card and cannot afford health insurance, if not covered under an employer policy
a) The major or emerging health concerns 1. Unintended pregnancy/access to contraception 2. Sexually transmitted disease, including HPV b) the essential (or primary) health needs that are not being met 1. Universal access to contraception and family planning services 2. under-immunized with HPV vaccine
Access to regular healthcare, including preventive well-women care and affordable birth control options.
access to birth control
Unintended pregnancies Human trafficking Lack of knowledge about reproductive health
More opportunities and options for birth control programs in the rural setting. mental health screening
a) Obesity is a well-known problem I find that in our area many of the women who are obese do not find concern in this and unfortunately do not want to change lifestyle. b) Unplanned Pregnancy- So often in our area we have women who come to our office already pregnant yet totally unprepared. Often they are not using any form of birth control (not because it isn't available, but because they only had access to unreliable methods. We are only able to provide pills, dpma, condoms, and occasionally the patch or ring. I advocate for my patients to use LARC's, but my advocacy and their wishes for that type of contraception does not mean that they will get it. Many of the ob/gyn's in this area are VERY far behind the curve and choose not to follow the newer less restrictive guidelines with regard to use of LARC's like Mirena or Nexplanon. This is not a matter of cost, I see the same practice with patients regardless of payer source. c) Many of these women choose to "not use anything" and if they get pregnant that is fine. The problem is that they are completely out of touch with the responsibilities that are ahead once they have a child. Sometimes they are blind to the complications that arise when having children with multiple men. We feel that so much of this behavior is related to low levels of self-respect and low levels or poor education regarding a reproductive plan. I also see HUGE amounts of misinformation regarding reproductive/contraception practices. This ranges from plan b or IUD's being abortion to what ovulation is. I think EDUCATION, EDUCATION, EDUCATION is the key for these individuals. d) Education and access to better/more progressive reproductive care practices.
A shortage of doctors and services in rural areas. More and more places are having the doctors leave providing no services for those clients.
a) tobacco use (smokeless/new products), obesity, oral diseases, mental health, prescription drug abuse b) access to care, integrated health care delivery systems (patient centered health homes), mental health services, chronic disease screening (heart disease, stroke, cancers, diabetes), mental health, diabetes prevention
Unplanned/unwanted pregnancy Depression, postpartum depression Lack of knowledge re: child development
well woman and preventive care access to needed care and interventions

a) Access to well women checkups for those without insurance, access to prenatal care for those with disabilities and no health insurance b) access to doctors who will take Medicaid patients
Obesity and it's impact on fertility and pregnancy outcomes Alcohol and tobacco usage in reproductive aged women who might become pregnant - many say they will stop "once" pregnant, but this leads to early pregnancy exposures
Financial ability to pay or insurance coverage available for immigrants. OBGYN timely services available for immigrants or uninsured clients. Variety of Medical services needed that contract with state MCO's in southwest Kansas.
a and b) HIV and other STD's - education and TESTING!
STD education pre-natal checks Pregnancy prevention for teens
Major health concerns would be obesity that may affect a women's ability to have children as well as many other health concerns. Needs not being met would be some do not see doctors early in pregnancy and they are not preparing their bodies a head of time to become pregnant.
Teen Pregnancy Dental Care
Lack of services for problem youth (adolescents) leading to increased juvenile offences.
Cost of health care for self Consistent access to physicians
a. meeting their birth control needs affordably b. ?
Access to primary and specialty care
a) smoking b) reproductive care
Education for women.
There are not many OBGYNs in McPherson County to meet the needs of this population. Many go to Salina or Newton to receive care.
Cost of Health care for all categories listed and covered benefits
Access to care, especially prenatal care during first trimester Pre-conception health Reduction of smoking Reduction of obesity
Although family planning services and contraceptives are available, teens and women of reproductive age do not use the services available to them. Of mothers who use our facility's other services, 71% have had their children out of wedlock. mental health
a- smoking and obesity b- pre-conceptual counseling including genetic
postpartum depression screening
Breastfeeding initiation and duration Post- partum depression Adequate prenatal care
a) Birth control, obesity, smoking/drug use, preventive healthcare, chronic diseases b) Education with understanding on reproductive health; options, nutrition; healthy foods and proper preparation for best method to gain most benefit, effects of drug use to individual and family members, routine checkups of total health system to identify and treat chronic problems. Homelessness Jobs
family planning
a) affordability of health care if not pregnant b) basic well woman care
Those without insurance or the ability to obtain insurance do not get the medical care they need.
teen pregnancy patients/families living in poverty

a) STDs b) Basic education about reproductive health.
a) Hygiene basic care, dental care & healthy diet b) same as above
Quality Providers/Doctors to evaluate, assess, monitor and prescribe wellness and medical concerns/issues of women. Essential health needs not being met: Birth control Education on women's issue from a trusted provider Access to affordable and quality preventative treatment
a health insurance coverage b primary care access
Receiving information against all hormonal contraceptives from some church related teachers
Access to preventative well women services
We work hard to educate our females, the cost to the county makes it hard to maintain title X

5. Pregnant Adolescents and Women

Response	Count
	145
answered question	**145**
skipped question	**147**

Response Text
getting adequate medical care, insurance issues
Prenatal care access
pregnancy prevention sexual disease prevention
a) & b) access to affordable pre-natal care resources, high-quality childcare options
a) Lack of early prenatal care; obesity and poor nutrition. b) Awareness about available resources; greater awareness about impact of planned early deliveries.
Education on health care. Accessing health appropriately
A. Same as above. Increasing knowledge of breastfeeding. B. Hospitals need to work toward becoming baby-friendly.
Parenting education, as mentioned in #4.
Access to adequate health care at reasonable cost. Healthcare data needs to be collected across state and
Access to quality prenatal breastfeeding education that is evidence based and presented in an adult-learning style that allows for discussion, practice and integration of new skills.
a) Pregnancy outside of marriage without financial resources to care for self & infant/children. Smoking during pregnancy. b) Limited prenatal care due to Ellsworth does not offer prenatal care (one OB Gyn does have a satellite office in Ellsworth). Ellsworth county falls outside of the boundary for services from Salina Family Healthcare Center.
Same as above
education in child care and poor prenatal care local child birth classes and parenting classes
Access and services for pregnant moms and continuing after birth of their child to focus on whole person- including mental health and prevention.
a. Health Concerns. Not receiving prenatal soon enough or consistently. b. Unmet Health Needs. Transportation. Not exactly a health need but the lack of transportation in some areas of our county means missed doctor visits.
More discussion on prevention
Access to prevention methods

prenatal care access to care first trimester prenatal care lack of life course perspective interconception care prenatal education cultural competence no insurance/underinsured genetic testing/counseling
single moms mental health and drug issues again poor nutrition and health, stress
a) number of teens getting pregnant and also prenatal care for women with diabetes or other high risk conditions b) appropriate follow up and education for women who get gestational diabetes
1. Not getting adequate prenatal care: Either no prenatal care prior to delivery or only a few appointments prior to delivery (especially those that are low income/Medicaid) 2. Illicit drug and prescription drug usage in pregnancy is 3. Obesity 4. Smoking Needs: Mental health resources for inpatient and outpatient drug rehab. There are none in this area. Most would have to go an hour away in Missouri or 2 hours to Wichita. Most of our patients that need rehab don't have the resources (vehicle, money, etc.) to get to rehab and therefore don't go.
Wraparound services such as state and federal Healthy Start
closely spaced repeat pregnancies
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
Same as above. Free breast cancer screenings for all women
Lower income clients needing care Education in the homes. The need for better funding to allow RNs to go into the home.
School settings are preferred. Again agencies depend too much on the client coming to them. Flyers being mailed or send home in backpacks are a joke to the funding and non-effective.
Access to Prenatal Care without having up front money or insurance
Prenatal Care, Breastfeeding Support, Food Security
We don't have lamaze classes that are close need parenting classes women need to be empowered to make better choices about being PG without a partner to help them need to know how to cook how to budget their money dental care
Prenatal care for those who do not have insurance. Lack of public transportation to get to prenatal appointments. In the MCH program there is lack of incentives to get clients to come to appointments. We also struggle with getting clients to allow our HSHVs into their homes.
Dental care should be expanded
More support for breastfeeding--in the way of breastfeeding clinics in health depts
Accessing health care - especially of no health insurance Preparing woman for what to expect with breastfeeding
a. Access to early prenatal care is difficult in uninsured pregnant women who do not qualify for Medicaid.

Obesity Dental Health Mental Health Access to low cost prenatal care Domestic Violence drugs/alcohol/smoking abuse
We do not have OB/GYN services in our community -neither of the local hospitals are birthing hospitals. This sometimes delays prenatal care and follow-up care.
a. Access to better birth control, and IUD's since abortion is being taken away in Kansas. b. Better sex education, and better self-esteem in school curriculum. No, you don't have to get pregnant to be a real woman. Same with guys.
Mental health concerns for new mom's. Same issues as above more education on breastfeeding as well as support in our communities.
Lack of child birth classes that are affordable and lack of parenting classes. Health care providers that do not support a breastfeeding friendly hospital and/or give out misinformation about breastfeeding. Lack of health care providers that will see a pregnant woman prior to receiving her KanCare insurance approval and not charge $500 up front.
proper nutrition access to care education on parenting and ADL
lack of coordinated care; greater need for REAL case management lack of culturally competent care for target population limited resources for a high-need population; Medicaid system too confusing lack of basic needs being met; increased homelessness low education levels; lack of understanding of importance of prenatal care limited access to WIC services; many going without
Same as above.
Major problem we see here is PG adolescent women.
obesity, excessive weight gain during pregnancy, tobacco use
a) Amount of appropriate weight gain based on pre-pregnancy weight is not known by women
No Prenatal Care Tobacco Use
education (parenting, prenatal and breastfeeding)
Better birth control information on viable options
a. poor prenatal care b. prenatal education
prenatal education, from WIC to provider's office
a. Teenage pregnancies are becoming more "acceptable" in the eyes of their peers. Need more ways of reaching this population with information that is on "their level" Facebook, etc. See above b. KDHE and local HD's would benefit from a more comprehensive partnership with the Kansas Board of Education and local USD's. (to be able to make a collaborative effort to reach more children/teens BEFORE they make the decision to have sexual encounters)
Lack of health literacy - understanding what the doctor tells them during the visit. Dental Care - Dental Hygiene
Same as above; extended mental health services; lack of services/coverage for postpartum depression
Access to early prenatal care. Some physicians will not take an OB until they have a medical card. Limited funds to support breastfeeding and duration of breastfeeding Limited funds to support home visitors (only works 1 day week)
Not sure. I see the primary health needs of this population as being more fully addressed than other populations.
safe, affordable access to the full range of care needed including safe access to abortion for medical issues
Teens need self-confidence and self-esteem, need help with spacing second child, have goals, need to have someone care about them instead of just their body. Changes in own life style that are positive so they can raise their children in a positive way. Mental health interventions due to their own neglect from their parents. Teens are seeking love from the

child.
early prenatal care, getting medical cards quickly for pregnant women who qualify, more access to follow up care for low income women that need further follow-up after abnormal pap smears.
a) the major or emerging health concerns Obesity, risk behaviors, and access to care b) the essential (or primary) health needs that are not being met Preventative care access, primary care access, and QUALITY care provider systems for these moms.
Inadequate diet, lack of healthy food education. Healthcare needs not always being met.
education about reproductive health needs, e.g.: birth control, pregnancy prevention, prenatal care, nourishment and health care during and after pregnancy. Education about the effects of substances on the developing fetus, and the importance of adequate nutrition during pregnancy and breastfeeding.
Teen pregnancy, Alcohol/drug use during pregnancy
a. Limited resources for healthcare providers. b. prenatal education
a. early prenatal care b. comprehensive reproductive health
I have seen a woman with a positive pregnancy and trouble with a previous pregnancy get denied health coverage because she and her boyfriend "make too much money" . She has no coverage otherwise. So she could not get prenatal care with the previous pregnancy and eventually lost her twins at 23 weeks. Then I have seen perfectly healthy people, not pregnant, get a card just because they could not find work!
Adequate education on prenatal care, access to the vitamin supplements needed if they can't afford them, education on proper nutrition, smoking cessation, alcohol cessation.
a) Again, prenatal testing for birth defects is emerging as one of the fastest growing areas of prenatal care. b) without professionals in this area, women are receiving varied, limited and often misconstrued information regarding this testing.
a) Healthy pregnancy b) Preparing for healthy pregnancy
a) mental health issues b) Access to dental care and mental health treatment
Support groups teaching parenting skills and basic newborn & infant care, in the rural areas, where there is a much higher need
Availability of early pre-natal care. Availability of healthy foods, especially fruits and vegetables.
Access to prenatal care Brain health resources
access to WIC services for pregnant high school students Fatherhood education for adolescent dads
Regular physician visits for healthcare needs due to insurance, feeling as if they do not need any healthcare and that they handle concerns on their own.
Smoking or chewing tobacco is a health concern at this age. Late prenatal care and unplanned pregnancies.
lack of care for the body; smoking/drug use; nutrition; Importance of prenatal care for woman and baby; diet and exercise benefits; effects of drugs/medications on baby/woman
Nutritional and healthcare concerns during pregnancy
undocumented immigrants who are pregnant working poor who are pregnant high teen pregnancy 18-20 year olds
No major concerns
a) access to affordable pre-natal care specifically for immigrant, refugee and homeless teens and women; along with post-delivery care for these women, infants and children (although the child may be covered under the Medicaid program, women in these categories are reluctant to visit a physician or clinic until the child is ready to enter school and must have mandatory immunizations). b) mental health services, dental care and preventive health care (e.g. annual Pap, well-woman exams)
Pre-natal care at the earliest possible phase and continuing through delivery.
Postpartum depression counseling and support groups

A) Plan B over the counter- How safe is that? Who's to say that someone younger than 15 years old will purchase it? B) STI prevention
lack of prenatal education
Unnecessary Inductions and C-sections Lack of Adequate Breastfeeding Support Too Many Interventions Used in Labor Lack of Information and Education on All of the Unnecessary Interventions Used in Labor Lack of Information on Alternatives to Laboring and Birth in Hospitals Lack of Information on the Positives of Breastfeeding Past One Year
Accurate information about, and assistance with, breastfeeding to be sure that each woman can achieve her breastfeeding goals. Reproductive options -- access to midwifery care, delivery options in birth center, hospital or home. Family planning -- choice of methods, including emergency contraception and, as a last resort, safe abortion. Nutrition education -- all ages.
Difficulty in access to care Providers for pregnancy and birth in Miami, Linn, and Anderson. Counties. There is no where to have a baby in those three counties. There is one healthcare provider in Miami County that attends births 30 miles away in Olathe.
lack of support. postpartum issues(anxiety, depression) undiagnosed. education for options for delivery and education regarding birth and being an active participant.
Not enough natural childbirth options
Access to quality prenatal care. Women who are pregnant do NOT have access to low intervention care...rather they are subjected to HIGH RISK COSTLY Care--esp. the urban core where preterm birth and low infant babies are born. KANCARE does not reimburse well therefore they are few providers.
Early prenatal care Nutrition Education on healthy life styles
Pediatricians and OGBYN providers do not interview or teach prospective or new parents about bonding, attachment, or the new endocrine risks of hormone-like substances in the environment that can shape the developing architecture of various bodily systems in fetuses, infants, and toddlers. They should be using their expertise to help get these parents and children started, and screening parents for depression and other impairments that put their children's development at risk. In addition, the health records of these providers have to be integrated into a longitudinal record of individuals that can follow each one's developmental course from before birth through high school. These longitudinal data bases will help us identify the sources of developmental illnesses like autism and can be used to test much more cost effective preventive interventions rather than the less-effective and expensive remedial approaches we are stuck with now.
Access to adequate prenatal care, especially in rural areas. Many providers in rural areas have stopped providing prenatal/delivery care. Women must then choose to travel for care/delivery. This becomes a hardship for women-due to time/distance and the expense of travel. Access combined with under/not insured often lead to late or no prenatal care and sometimes emergent delivery in rural settings under-prepared for deliveries, especially complicated deliveries.
Bias of local boards of health of above issues
Having the belief that the government will take care of both of them for the rest of their lives
prenatal care and education -
a) no health insurance b) preventive care
Adequate Health care for infant delivery in rural areas
Access to care and medical coverage for needed services
a) Environmental exposures b) Options for terminations of pregnancies
affordable healthcare for women who do not qualify for the medical card and cannot afford health insurance, if not covered under an employer policy
a) the major or emerging health concerns 1. premature delivery 2, prenatal tobacco and alcohol exposure b) the essential (or primary) health needs that are not being met 1. access to prenatal care 2. education (particularly to adolescents) on positive parenting practices

learn how to use birth control to prevent unwanted pregnancies
Lack of knowledge about nutrition in pregnancy Lack of knowledge about the effects of tobacco, drugs, and alcohol in pregnancy
Smaller Health Department are not able to offer the programming and services that a larger Health Department can with more employees. Can we get help through webinars and other IT programs to help educate pregnant adolescents and women. More mental health services are needed in the rural area as well.
All of the above in #4 as well as: Adolescents- Education and more education. In our area many people think that education regarding contraception is equal to promotion of sex. More education is need regarding not only contraception, but also the way the body works. It is insane to me that people of reproductive age are unable to explain to me how ovulation occurs, what is in ejaculate, or how a contraceptive method works. As educators, health care providers, and parents the is a MAJOR failure happening. Bible belt or not the best way to stop abortion and welfare is to prevent unplanned or unprepared pregnancy. Pregnant Women- In our area I feel that pregnant women need better/more breastfeeding information. Our regional hospital is very bad as far as promoting breastfeeding is concerned. Many moms go to the hospital with plans to breastfeed, but once the baby is delivered they are unsure of what to do and rather than provide them with education or assistance the hospital staff will offer bottles of pacifiers. It is my understanding that they are in the process of making improvements which hopefully will remedy this. The mothers also need to understand that they must be an advocate for themselves and their babies.
Support group for the pregnant adolescents is missing. That age group is shunned or so it seems if they turn up pregnant and not given the support they need. Also the shortages in doctors that handle OB/GYN because of malpractice suits in the rural areas.
Essentially same as above, including need for early prenatal care.
My concern about pregnant adolescents and young adults is: It is evident that unplanned pregnancies continue to occur, and now, I believe that I read, that 1 out of 2 births are to single parents (those without a partner, and/or those in an adversarial relationship with the other parent). Single parenting should be rare. It is very unfair to the health and well being of the child. We (public health) have done a very poor job of educating re the effects of single parenting on children. It is a difficult topic to address without being perceived as a judgmental moralist. Sensitive topic or not, we (public health) now have the equivalent of an epidemic on our hands. I would prefer we educate PRIOR to pregnancy in a more effective way. We need to share the FACTS that research has uncovered and get a grass roots discussion going. If it is not up to the schools and the majority of parents are uninformed about the facts and or feel incompetent to address it with their own children, I feel that it is the job of public health.
Education, access to early care
Those with disabilities having access to doctors who will take Medicaid patients
Programs for healthy pregnancy behaviors
Education and marketing of health services available locally. Community trust in medical confidentiality in rural areas.
a and b) HIV and STD's - TESTING and education
Some do not see doctors early in pregnancy and they are not preparing their bodies a head of time to become pregnant.
Increase in teen pregnancy in our county Distance to prenatal care uninvolvement of the fathers to their girlfriends and then the infants after birth
Diet, continue WIC, provide educational opportunities at the local community level.
Assistance for adolescents and how to continue education
a. meeting their birth control needs affordably
Smoking Cessation Access to primary and specialty care
a) smoking and poor diet b) prenatal care
Resources and education made available.
There are not many OBGYNs in McPherson County to meet the needs of this population. Many go to Salina or Newton to receive care.

Access to care during first trimester Focus on preconception health Reduction of smoking Reduction of obesity
Premature deliveries
a- drugs of abuse especially narcotic use, overuse of antidepressants instead of counseling b- genetic testing and counseling, behavioral health evaluation and treatment
Rising healthcare costs
parenting support
Same as above
a) smoking/drug use, STDs, proper nutrition, exercise b) proper birth control, STDs transmission to baby at birth
education on pregnancy and care of infants/children
a) if don't qualify for Medicaid or have private insurance being able to afford health care b) prenatal care if doesn't qualify for the above
No insurance, not able to get on state insurance, availability of local physicians for prenatal care. In rural areas driving over 30 miles to get prenatal care.
same as above
a) Undocumented and uninsured women are a great concern in our area. b) These women need basic prenatal care.
a) Importance of eating a healthy diet; no tobacco or alcohol b) same as above same a #4 also
A place in the area that can safely care for high risk pregnancies. (adolescents and older women) The people in this age group have to drive many miles to have adequate care.
a prenatal care b prenatal care
possible shortage of doctors delivering babies in our area
Access to prenatal care
state and federal putting unfunded mandates on local HD we need to help the persons working to better themselves and not keep them off of state insurance if needed

6. Newborns and Infants (Birth to 1 year of age)

Response	Count
	131
answered question	**131**
skipped question	**161**

Response Text
-Newborn screening
getting adequate care, issuance issues
Coordination of care
Early id and intervention
typical development immunizations
a) toxic stress b) affordable health care
a) vaccine preventable diseases (Pertussis); low-birth weight; b) greater public awareness about safe sleep; immunizations; all babies should have breast milk;
Immunization and Nutrition

A. Overcoming misinformation about vaccines, teaching parents about infant cues rather than assuming that because the baby is crying he/she is hungry and plop a bottle in his/her mouth.
Support for exclusive breastfeeding through: improved maternity care while in the hospital; knowledgeable health care provider support; access to peer support; access to breast pumps and other breastfeeding aids; support from employers for mothers returning to work; improved child card support for the breastfed infant; improved community support for public breastfeeding. There are many gaps across the state in these areas.
a) Initiation & continuation of breast feeding for 6 months falls below desired goals. b)Nutritional needs not being met.
Parents who refuse vaccines - need more statewide public education - TV radio - positive reasons why to vaccinate!
babies born to single mom's with lack of support from two parents support groups for multiples
a. Health Concerns. Parents not having the education or skills sets to provide the best environment and foundation for good outcomes. Perhaps I am somewhat jaded but we often encounter parents who don't want to change for the better of the child. When the baby and clothing smells of cigarette smoke when they are in our office I assume their home environment isn't great. The parents addiction to smoking seems priority to the needs of the infant.
Breast feeding support
safe sleep low birth weight prematurity infection
I believe needs for this age range is being met.
a) need to increase numbers of infants who are breastfed b) more Baby Friendly hospitals in Kansas to help women initiate breastfeeding in the hospital and affordable support for those mothers once they leave the hospital.
1. Parents smoking around children and children experiencing the side effects (increased respiratory issues, asthma, etc.)
Lack of providers Providers need to understand where the families are at and how their recommendation affect the family Health literacy of the parent Better patient/provider communication
Wraparound services such as state and federal Healthy Start
Lack of breastfeeding
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
Breastfeeding issues More IBCLC services.
Peer connection and support groups would be helpful. Instead of trying to force an textbook approach to finding a solution, actually going out to the masses seems to be a more practical solution. Save Postage and paper.
Preterm infants Uneducated Parents
Breastfeeding Support. Parent understanding of baby behavior.
parenting classes good day care for moms who work
Lack of parenting skills for new moms. Breastfeeding education. We have a high no show rate for our M&I appointments. It's a struggle to get clients to allow our HSHVs into their homes.
community based centers for helping children with special needs, and good quality childcare at an affordable price
Good support for breastfeeding dyads
b. Delayed or absent immunizations. Parents lack the knowledge of the importance of timely immunizations.
No specialized pediatric care available in the community.
Have no contact.
We need Pedestrian's or family practice that will take infants. Pedestrians are overwhelmed and over crowed parents can't find a doctor to see child when sick. So they use our ER system for Doctor's office.

Unsafe sleeping environments Falls
Providers that lack an understanding of breastfeeding and tell new moms to give formula. Lack of parenting classes on how to care for your newborn.
nutrient Home visits from community health screening for growth and development
basic needs not being met parenting skills limited; existing programs piecemeal and lots of duplication, redundancy increasing number of single parent homes; inconsistent and unstable environments limited access to WIC services; no coordination with medical home
We don't have pediatricians in our county, especially those with special needs, like ADHD, etc. There are providers available to deal with the children with serious mental issues, but really no medical provider with specialty in this area.
breastfeeding duration
a) Breast pump use; especially since pumps are available in the affordable care act...women need to know how to use them appropriately so as to not diminish their milk supply - just not be handed a pump. Safety comes into play here also - that they fit appropriately.
Few Babies being Breastfed
help with childcare, breastfeeding, parenting
Importance of Breast Milk and more employers making space for this to happen at work so breastfeeding is supported
a. safety and nutrition b. safety education
normal infant hunger cues, benefits of breastfeeding for babies and mothers
a. Early introduction of foods for infants--local MD's still recommending infant cereal at 4 months. Parents of infants delaying/separating or refusing immunizations Poor breastfeeding rates b. information and support given to parents are incomplete or incorrect. Need to have all health care professionals giving same information.
Understanding the importance of KBH and immunization.
immunizations for those uninsured; well child checkups
Early childhood education
Not sure.
well child support - education to parents - safe and adequate care
Car seat babies, no tummy time, lack of affect, lack of nurturing, fed well and appropriately Propping the bottle, well child checks, distracted parents on cell phone , immunizations not given, educated parents getting misleading vaccination information from the internet and not appropriately vaccinating children.
Addressing immunizations with parents and the importance of maintaining the current schedule, reasons for vaccinations more in the media--the anti-vaccine movement is doing a better job with media and advertising, newborn check ups.
a) the major or emerging health concerns Safety for newborns in their home, access to support. b) the essential (or primary) health needs that are not being met Primary care access, education to families caring for these newborns.
Healthcare need not always being available. Improper child restraints in vehicles.
perinatal screening for metabolic disorders, hearing, vision, and developmental delays, if risk factors for possible delays are present. Adequate nutrition and parent/ caregiver support, to get the infant off to the most positive start possible. Support and guidance about typical child development for new parents, so they know what to look for in their child's development. Adequate financial support for early intervention programs and services, so that developmental support is available for children and families who need it.
Post-Partum depression, maternal/paternal attachment and bonding
a. breastfeeding benefits, no continuation of long term breastfeeding. b. immunizations
a. complications from mother not seeking early prenatal care. b. maternal education
a) Newborn screening for genetic disorders. b)currently Kansas has no dedicated pediatric geneticist to care for these

children or any children with genetic disorders.
a) Premature birth b) preventing premature birth and early intervention for developmental delays
Safe Sleep
Better incentives for breastfed infants and families. WIC "rewards" with "Free Formula" - need to make less formula available and ONLY the generic brands. People who do not qualify for WIC, do not purchase the expensive formulas and we ALL know that all formulas are the same. do not allow artificial baby milk companies to get the bid. Many WIC clients continue to BF, but report to WIC agencies that they are full formula. The formula is then sold on various websites. When Local staff report this activity, WIC replies with "we are not a policing agency" Make parents who want their baby on the VERY EXPENSIVE special formulas, see a TRUE pediatric specialist, NOT a quack who puts all infants on Alimentum
Support for families around Brain health
Under vaccination or no vaccination
immunizations and regular physician or healthcare visits.
Have a few newborns that have had SIDS in our area. We've stressed SIDS education to all of our mothers. Parents or caretakers that don't believe in immunizations. Caretakers that prop bottles.
proper physical/mental development healthy diets with proper proportions; activity/stimulation
Domestic violence and infant abuse. Maternal neglect Nutritional and healthcare concerns for the mother and newborn.
low birth weight infant mortality
None
In Wichita, the presence of three FQHCs have improved access to health care for children (and adults)
Newborn through 1 year well baby clinic
Education for first time moms prior to discharge on feeding requirements and needs of newborns. Education on emotional needs as well as physical.
A) Nutrition B) Safety
parent support groups
Negative Side Effects Associated with the Lack of Support for Moms with Breastfeeding Up to and Past One Year
Breastfeeding Parental care, which means paid parental leave. Day care is not an adequate substitute for a loving parent.
Heart defect screenings. Heart defect screenings. Heart defect screenings.
support for lactation. cutting funding to breastfeeding educators and lactation consultants.
Breastfeeding needs
Nutrition Safe Sleep information Toxic stress Early brain development
Make sure that all parents have an understanding of the key importance of appropriate responsiveness and language during this age.
primary
Access to care Education and follow up with well-child visits/immunizations. In rural areas, many providers have found it cost effective to have local health departments be the sole providers of immunizations. The local health departments may only provide well-child visits if the parent asks or there is a problem identified--this is due to staffing and other projects taking priority. Rural clinics provide well-child visits, but these are not seen as a priority by parents--unless they have concerns. If parents have to choose, often immunizations are chosen rather than well-child visits--especially if time must be taken from work. Once again--time, distance and expense of travel must figure into the picture in rural areas.
Lack of consistency between local hospitals to assure adequate follow up of uninsured new mothers and their infants (Hep B vaccine, home visits in postpartum period)
No parenting skills

infant mortality
a) parents who are not immunizing their children b) children's diet
infant immunizations
access to care
Affordable health insurance, and the cost of immunizations, for those who don't qualify under the medical card, and cost of insurance is too much for parent to take out family insurance on infant/child
a) the major or emerging health concerns 1. lack of investment in teaching positive parenting leading to "toxic stress" and limitations on health, mental health, and physical development 2. safety (bedding, SIDS prevention) b) the essential (or primary) health needs that are not being met 1. access to good parenting education classes - particularly for those parents in poverty or at high risk for other reasons. 2. broader efforts at education on safety issues (such as bedding and infant death, SIDS, quality childcare)
Access to affordable health insurance, and the provider network for low-income populations.
high infant mortality rate
Lack of knowledge about development Lack of knowledge about nutrition and breastfeeding benefits.
Breastfeeding and Immunizations
a) Unprepared mothers This covers a wide array of issues, from low breastfeeding numbers, to poor feeding practices, to unstable home life. Many times I see mothers who make multiple doctor appointments and stop breastfeeding or switch formula multiple times simply because they are not familiar with how a baby acts. I feel like the new WIC campaign regarding baby behaviors will actually help some of this. Cigarette Smoke Exposure - Parents voice the understanding of the dangers of smoking around their infants/children yet they continue to smoke around them (or allow others to smoke around them).
a) injury, nutrition, access to care b) breastfeeding, healthy environment (free from exposure to second hand smoke, violence, safe sleep, safe transportation),
Bonding and attachment problems due to lack of knowledge, single parenting, postpartum depression.
Immediate access to care Education for parents Access to great child care
a and b) HIV and STD's - TESTING and education for families
Premature babies so that they get the care they need and just education to parents on different mile stones and how and when to introduce different things during that first year of life. There seems to be a lot of various opinions out there and it is hard for parents to know what is best for their child.
Lack of attention need to the infants and children of teen and young parents. Lack of parenting skills. Did not have it when they grew up and now they have no idea how to parent and care for a child. Neglect of a child health care needs esp. dental
Infants at risk should receive the Denver Developmental screen to identify needed services earlier.
Cost of health care for newborns and children Assistance in getting essentials, such as car seats
Safe Sleep practices
a) low birth weight b) immunizations
Adequate testing at birth.
In McPherson County there is only one program providing free home visitation services for infants. McPherson Family Life Center's Parent Link program. It is only available for first time parents. Since Parents As Teachers is not active anymore, there is definitely a gap in services for that age group. There is a great need for quality child care for infants.
Improved immunization rates Improved community education about Safe Sleep and measures to lower SIDS
Not enough are being breastfed.

a- variation in quality of NICU services across the state b- breastfeeding support for women in the first week after dismissal
The visibility of the importance of newborn screening
Breastfeeding
education of mothers regarding health care of infants
a) breastfeeding issues/formula cost
No insurance, not able to get on state insurance, availability of local physicians for pediatric care. In rural areas driving over 30 miles to get prenatal care.
improving vaccination rates education to public about importance of primary care medical homes
a) Lack of maternal support
a) Caregivers giving a bottle every time an infant cries; not realizing that might just need loved, diaper changed etc. b) same as above
Quality or specialized doctors that can evaluate and care for newborn/infants. Newborn/infants are not just "little people" we are in need of GOOD pediatric care out in this area.
a parental (Mom AND Dad) involvement/engagement b nutritional needs
shortage of pediatricians taking new patients and Kancare patients in our area
Parents resistance to all needed immunizations

7. Young Children (1 - 5 years of age)

Response	Count
	127
answered question	**127**
skipped question	**165**

Response Text
-ABA services for young children with autism spectrum disorders
Insurance doesn't want to cover the necessary treatment for many disorders and it will impact these children's lives forever.
*Education on the prevention of toxic stress through the use of positive parenting skills * Recognition of atypical development and red flags for autism
Seamless service from infant toddler services to services for 3 and older
Early identification of disabilities, particularly autism spectrum disorder the use of evidence based practices
As above
typical development dental health
a) increased autism spectrum disorders, social/emotional mental health concerns, obesity b) developmental surveillance and routine screening, affordable health care
a) poverty and housing issues; limited affordable quality child care options available; b) Good oral health and access to dental services for all children.
Nutrition and Obesity
A. Physical activity to prevent obesity, information about not giving sugar-laden drinks to young kids.
Continued breastfeeding support and information. Breastfeeding need not stop at one year of age. The World Health Organization recommends breastfeeding until two years of age and beyond if possible.
a) Parents not displaying healthy role models. b) Essential health needs not being met.

Sad to see lead abatement funds stopped and pushed on locals we have no time or funds to be become experts! One expert in the state can do so much for less cost! Poor funding of child care licensing with many new mandates so loss of local participation in LHD!
more children living in poverty and lack of nutrition
Limited access for early childhood mental health - prevention services for birth to age five...which MUST include parents of these children. there is no state agency with this sole responsibility so this is often overlooked since it is mental health. Mental health is a part of the HEALTH profile and the whole child. There are limited and fragmented services that try to address this area, but it for birth to three or school aged and does not address the child and family. Mental health for children is not always addressed with our mental health provides, nor with our health providers. Home visiting services would be the most likely, but many times families do not receive these services unless they meet some other program requirement such as at risk or poverty. This is a prevention area and needs more STATE focus for our youngest. This cannot be handled by smaller entities that do not have accountability and oversight. Thank you
a. Health Concerns. Good Nutrition, Dental Care, and lack of exercise. b. Unmet needs. Dental care providers who accept Medicaid
They need to make it a more efficient process to get out of state care for children who can't get the care they need in their state. It has taken us 5 months to get as far as we've gotten and we aren't there yet. We have been fold the process is almost complete.
Early education
poor nutrition and obesity starting mental health issues due to single parent homes and drug/ETOH abuse in the parents.
a) childhood obesity b) affordable family centered support for those children that are obese
Same as above
Wraparound services such as state and federal Healthy Start
poor dental hygiene passed from parent to child
Feed oral health care and education to help prevent dental caries Better access to healthy food sources.
Head lice
Again, sending flyers home in backpacks is a foolish waste of tax payer funds. The enabling attitude of agencies needs to change with more interpersonal relationships. Parents need to be held accountable to provide adequate healthcare. More needs to done to improve parenting skills and real life skills. So many of the programs are silly and not practical. Some agencies spend funding on things many impractical and self-serving. Entirely too much spent on administration staff.
Dental visits and fluoride varnish or fluoridated water Access to Preschool for children that have working parents of medium income - resources for low income but none for in-between incomes that both parents are working and paying daycare already.
Dental care, health care
parenting classes
Lack of pediatric dentists. Lack of parenting skills.
good quality pre-school and childcare at an affordable price, with people with training in early childhood, more resources for families that do not qualify for food stamps, and other programs but are just getting by, services that do not discriminate against married parents
safety Normal eating habits and growth patterns
b. Delayed or absent immunizations. Parents lack the knowledge of the importance of timely immunizations.
No specialized pediatric care available in the community.
Have no contact.
Day Care issues we do not have enough licensed day care in our area so it is hard for parents to find day care when they need to work. They also need more children's activities for this age. Most activities in our area are for children that are at school age. As well as need for doctor's for children this age. With the changes in our Medicaid system some of our Doctors have decided not to take Medicaid so this has really limited what our pediatrician can do. No dentist in the area take Medicaid and allot of our clients don't have the means to travel to another town. I am seeing lots of children of this age with dental decay and no one to see them. Immunizations are also a problem because so many doctors' offices are starting to refuse to do VFC because of the extended amount of paper work for very low pay.

Unintentional poisoning Falls Motor Vehicle Child Occupant protection Drowning
Lack of outdoor and/or physical activity
nutrition early childhood education immunizations screening for disabilities
increased number in foster care; typical custody arrangements foster instability and inconsistency in care with children going between multiple homes immunizations lacking, staggered; limited access (and or unaffordable) in some communities unsafe housing conditions; increased homelessness care coordination poor for special needs/chronically ill children; increasing numbers of special needs children with limited resources ER highly used for care that should be provided in medical homes
Vaccination issues; some parents are now apprehensive in vaccinating their children due to misconceptions or negative experiences of others.
obesity, physical inactivity
a) Overweight and Obesity
Obesity
obesity, dental care, childcare
Importance of nutrition to developing immune and brain functioning
a. safety and nutrition b. safety education
healthy habits start early
a. Children with incomplete immunizations, poor dental health-(using cups/bottles as a comfort measure), obesity/poor nutritional health, lack of physical activities b. Need collaborative effort among health care professional to promote healthy eating and activities.
WE need DENTAL SERVICES - dentist do not get reimbursed for Medicaid in a timely manner so they do not accept children on Medicaid..... Many children with asthma and allergies.
Dental, eating right
immunizations for those uninsured; well child checkups dental
Dental Mental health
Dental Services and Mental Health Services
safe and adequate care - access to medical
Well child checks, immunizations , early childhood interventions, too much TV screen time, beef up daycare. physical activity, safe, supervised, outdoors. Lack of positive discipline, parental stress, consistency. Too much convenience store fast food. Parents do not know how to cook, not enough time, lack of knowledge of foods and cooking. Lack of dental and mental health services, knowledge
Need for exercise, healthy foods and habits, regular physicals
a) the major or emerging health concerns Accident prevention and nutrition support. b) the essential (or primary) health needs that are not being met Preventative and primary care access. Accident prevention. Family education.
Healthcare needs not always being met. Improper child restraints in vehicles
Adequate nutrition for developing minds and bodies. Appropriate developmental screenings to catch developmental delays as early as possible. Support and guidance about typical child development for new parents, so they know what to look for in their child's development. Adequate financial support for early intervention programs and services, so that developmental support is available for children and families who need it.
Social Emotional skill development

a. dental health b. adequate dental care provided to them due to young ages.
a. & b. appropriate screening for developmental delays
a) Safety b) Parenting of this age group
Unintentional Injury Prevention
a) behavioral concerns and social-emotional disorders b) mental health intervention
Do not allow the use of special formulas on children over the age of 12 months unless they have seen a REAL gastroenterologist. The formula companies have convinced a few Drs that ALL babies need to be on Alimentum up to the age of 15 - 18 months. These parents will not even try other types of milk
Brain health and supports to families of young children
Under Immunization or no immunization
immunizations
Parents or caretakers that don't believe in immunizations. Children that don't pass hearing tests due to ear infections.
chronic diseases; obesity; physical/mental/social development with readiness for school entry screenings for chronic disease/condition; mental development testing; physical fitness time; social interaction with other children
Domestic violence and child abuse Speech and language development (identification and treatment of delays and abnormalities)
health insurance navigation immunizations basic health services
Dental Care is a big issue. We have one dentist in the area.
In Wichita, the presence of three FQHCs have improved access to health care for children (and adults)
parental guidance programs that enhance the parent child relationship.
A) Nutrition B) Safety
Unhealthy Family Eating Habits
Breastfeeding Parental care, which means paid parental leave. Day care is not an adequate substitute for a loving parent. Safe child care provided by affectionate caregivers. Good nutrition. Emphasis on free play and hands-on learning opportunities.
Access to acceptable outdoor play areas (playgrounds) as well as neighborhoods with sidewalks to allow more outdoor play.
primarily being raised in day cares as the US does not offer paid maternity leave.
Food Allergies and intolerances on the rise
Early brain development Toxic stress Nutrition Access to care
We are not providing consistently high-quality early education and child care to parents so that they can work efficiently, and where ever employers and the economy need them and best reward them. As a country, we should put much more emphasis on investments in this age--something like provided in the Abcedarian Project--for all children, than say, investments in high salaries for medical and educational administrators, or beautiful buildings on college campuses.
See above... Also, this age group needs early identification of developmental issues--again through appropriate screenings at well-child visits--with early referral and intervention. There is a stress on the special education in the school system, possibly related to the late identification of developmental issues.
Immunizations, establishing a medical home, WIC eligibility
No parenting skills
accidents

a) parents who are not immunizing their children b) children's diet, lack of exercise
Services that address special needs
Affordable health insurance, and the cost of immunizations, for those who don't qualify under the medical card, and cost of insurance is too much for parent to take out family insurance on infant/child
a) the major or emerging health concerns 1. recognition of and management for children with developmental delays or behavioral problems. 2. overweight/obesity b) the essential (or primary) health needs that are not being met 1. lack of early recognition of developmental delays/autism spectrum disorders and lack of appropriate intensity of early intervention 2. lack of resources/payment mechanisms for young children with behavior problems/emerging mental health problems. 3. prevention of obesity in young children with appropriate nutrition and physical exercise.
Access to affordable health insurance, and an adequate provider network for low-income populations. Of particular concern is access to dental care for young children, especially those that are insured by Medicaid. There are not enough providers in Kansas to meet this need.
pre-school education
Lack of knowledge about development and stimulation of learning Safety in childhood.
Nutrition and Immunizations
more in-depth screenings through clinics with up-to-date equipment
a) I feel that major emerging health concerns are obesity and for our area access to untreated/preserved fresh foods. We are seeing large increases in food allergies in the child population. Many of these kids are unable to consume preservatives of many types. Our local stores do not provide selection, and we do not currently have a farmers market. Many in our community are voicing concern r/t food supply/production and it's safety. As a society we spend tremendous amounts of time quelling the active play of youngsters. It definitely starts with this age group. They are pushed away from active and imaginative play and push them toward adult structure. Even child care facilities are being forced to do away with free time and made to have lesson plans. Many studies clearly show that this type of behavior is not in the best interest of our children.
a) injury, obesity, asthma (increasing in prevalence and severity), nutrition b) healthy food environments, protection from secondhand smoke, safe environment (free of exposure to violence, safe transportation, etc.), active play, decreased exposure to unhealthy food advertising
Their parents' lack of knowledge re child development
Access to great child care Education for parents nutrition
See some obesity but also some kids who have a failure to thrive type situation. Also see some kids that have behavior issues and need help when they start school with these social/emotional behaviors when it may have helped to find them earlier.
Same as above
Increased level of poverty among young families requires additional assistance to provide child locks, smoke alarms, any materials to improve the safety of the home. Some of the "affordable housing" used by young families with children ages 5 and under should be condemned.
Vaccinations
Early childhood education Immunizations Access to Care
a) obesity b) mental health and dental
Immunizations education and availability.
In McPherson County there is no program providing home visitation type services for 1 year +. Since Parents As Teachers is not active anymore, there is definitely a gap in services for that age group. There is also a need for quality child care.
Improved immunization rates Adequate food

Immunizations
a- neurodevelopment delay and autism b- availability and reimbursement for autism/developmental evaluations and intervention
Social and emotional screenings and appropriate interventions Healthy nutrition and adequate physical activity
education of mother regarding nutrition and care
Those without insurance or the ability to obtain insurance do not get the medical care they need. Parents keeping up on required or recommended physicals and immunizations.
same as above
a)Immunizations
a) Teaching caregiver that she's the one that supposed to be in control - not the child. Positive discipline b) same as above same as # 4
We are need of good pediatric care in this area. We have to drive at least 2 hours for a pediatrician on staff. Some do come in on a monthly basis but it is hard to get an appointment.
a parental (Mom AND Dad) involvement/engagement b nutritional needs
same as #6 answer
Special need services

8. School Age Children (6 - 12 years of age)

Response	Count
	116
answered question	**116**
skipped question	**176**

Response Text
Same as 7
Addressing participation in school activities Inclusive care Consistent services for rural areas Evidence based practice service provision
the use of evidence based practices in therapies
dental health
a) increased autism spectrum disorders, social/emotional mental health concerns, obesity, food deprived homes, bullying b) developmental surveillance and routine screening, affordable health care
a) poverty and housing issues; lack of after school programs and summer camps; b) Good oral health and access to dental services for all children.
Nutrition and Obesity. Risk behaviors. Sex and reproductive education.
A. Bullying, increased physical activity for kids who do not participate in team sports or organized athletics.
Breastfeeding information integrated into their school curriculum, as part of for normal infant nutrition and care.
a) Parents not displaying healthy role models. b) Essential health needs not being met.
Health promotion - exercise and healthy eating - obesity issues.
a. Health Concerns. Obesity, Nutrition - limited fresh fruits/vegetables. b. Unmet needs. Education of the parents and child on good nutrition, food preparation and importance of exercise. Also needing to address the age group about sex, drugs, alcohol and bad behaviors.
mental health issue and obesity ; poor nutrition
a) poor foods offered in the lunch room and in vending machines b) policies for schools on foods that are offered in the vending machines or through the snack bar

Need: Mental Health resources for any mental health issues in this age group.
Same as above access to mental health Better medical coverage of mental health
Wraparound services such as state and federal Healthy Start
lack of physical activity and poor diet
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
same as above
Head lice Need for nutrition education in school. Similar to Home Economics in High School.
This is the age in which we lose children and this is a prime time for mentoring programs.
Dental Health Issues Obesity
parenting classes
Need more nutritious food in schools.
safe, high- quality after and before school care
safety self esteem
a. asthma
Nutrition related concerns - adequate low-income dental and medical care. Mental health services limited and expensive.
Have no contact.
I think the next problem we will see in school age children is more obesity. Times that are available for health care are limited most Doctors offices in our area close by 12 noon on Friday including Health Department, closed at noon hours, and close office by 5pm that gives school age children only 1-2 hours daily for appointments also because so many children cannot get dental care in our town they have to travel to another town. Most do not have financial means or parents cannot take off without risking their jobs because Dr. and dentist appointments take at least 1/2 a day even if they are in our town.
Falls Motor Vehicle Occupant Protection
Children being overweight and lack of outdoor and/or physical activity.
nutrition immunizations after school activities in the arts counseling
little preventative care; most care episodic high absenteeism rate due to chronic illness; limited care management obesity/poor nutrition dated medical practices among some providers; limited access to mental health services
Bullying
obesity, physical inactivity
a) Overweight and Obesity
Obesity; Lack of Physical Activity
obesity, safe childcare after school and in summer
Increased awareness and access to nutritious foods
a. obesity b. diet and exercise
Healthy eating and activity, appropriate immunizations

a. Poor nutrition and lack of physical activities. Becoming acceptable to drink "adult" drinks such as power drinks and coffee. Increase in sexual experimenting in the older preteens. Increase in preteen pregnancies and STD's b. Lack of information to the elementary school children about the importance of delaying physical (sexual) activities
dental, eating right
immunizations for those uninsured; well child checkups dental; lack of mental health providers; obesity and diabetes
Dental Physical activity opportunities Education for parents on good food choices/meal planning/
Not sure.
safe and adequate care - access to medical
Lack of physical activity, dental and mental health services. Flossing and brushing teeth for length of time needed. Screen time and TV time. Marketing to children, size of candy bars and portions of food at restaurants. Kids meals need altered to healthier choices. Unsupervised time and children have opportunity to do what they want and eat what they want, encourages unhealthy activities.
Need for exercise and activity, limiting computer, TV and gaming time. Getting outside and playing and the benefits of doing so,
a) the major or emerging health concerns Accident prevention and nutrition support. Obesity b) the essential (or primary) health needs that are not being met Preventative and primary care access. Accident prevention. Family education.
Healthcare needs not always being met. Improper child restraints in vehicles
Adequate nourishment for young and growing minds and bodies. Accurate, timely information about developmental delays and developmental milestones for children of different ages. Adequate parent/ caregiver support and guidance, so the caregiver can support the child.
Social Emotional skill use
a. childhood obesity b. adequate physical activities in the school, limited gym time and intermural sporting activities.
a. & b. prevention/education of risky behaviors
a) Safety b) Continued immunizations and health maintenance
Unintentional Injury Prevention
not sure
regular healthcare checks
Notional or weight problems Missing immunizations
diabetes; obesity; heart disease; mental skills; homelessness; drug addiction of adult(s) in home; Physical assessments; nutrition with portion control, variety, good food choices; personal hygiene; dental care
Targeted educational plans for each child Domestic violence and child abuse
health insurance navigation immunizations basic health services
Dental Care is limited. Lack of behavioral support.
In Wichita, the presence of three FQHCs have improved access to health care for children (and adults)
Just say no - learning to read - self-esteem programs Excellence in school
Afterschool programs.
A) Nutrition B) Safety
Unhealthy Family Eating Habits Lack of Nutritious and Desirable Food at School Lack of Exercise and Activity
Good nutrition, safe school environment, WELL-PAID teachers who love what they do. Literacy, grammar, writing and

reading skills are absolutely essential and are not getting the attention they deserve.
Same as young children. Playgrounds and sidewalks.
exposure to marketing, media, violence, and lack of exposure to nature.
Food Allergies and intolerances
Nutrition including hunger and obesity Toxic stress Access to care
Use developmental knowledge to reduce the damaging over-emphasis on test scores to provide the right developmental challenges and environments for the right ages. For example, for this age, children need fantasy play and group play that improves their social skills and ability to work with others.
Access to care Obesity/healthy eating Well-child visits Abuse identification/education This is a good age to educate regarding: nicotine use; alcohol use; drug abuse
Above as we'll as oral health needs
No parenting skills
chronic illness and oral health
a) parents who are not immunizing their children b) children's diet, lack of exercise
Emotional health needs
Affordable health insurance, and the cost of immunizations, for those who don't qualify under the medical card, and cost of insurance is too much for parent to take out family insurance on infant/child
a) the major or emerging health concerns 1. mental health problems 2. learning disabilities 3. obesity 4. safety (accidents) b) the essential (or primary) health needs that are not being met 1. adequate resources for treatment of mental health problems 2. intensive support for reading for children with reading disability 3. education on nutrition and exercise for school age children 4. parent education on car safety, gun safety
Access to affordable health insurance, and an adequate provider network for low-income populations. Of particular concern is access to dental care for children, especially those that are insured by Medicaid. There are not enough providers in Kansas to meet this need.
exercise and proper nutrition
Lack knowledge of effects of use of drugs, alcohol, and tobacco Obesity Lack of knowledge of oral care Lack of knowledge of nutrition and exercise
Nutrition and Immunizations
Make sure all counties have school nurses
a) Obesity & Use of healthy foods Children are not active enough and they eat badly, period. As a society we have moved away from looking out for our children's developmental and health needs and moved way to far towards academic standards. Children are under active and families choose to not eat healthy even when healthy foods are accessible. Although I do believe that access to fresh fruits and vegetables is a big problem we are also seeing very poor choices related to the foods that are available.
a) obesity, tobacco use (new products), prescription drug abuse, mental health, oral health, food insecurity b) access to services, healthy school environments, physical activity opportunities, healthy food environments
physical and nutritional health
strong school attendance education on healthy habits
Don't see many of these kids. Obesity would probably be the big one that comes to mind.

Same as above Nutritional needs. High fat fast food. Anything easy to fix.
Continue meal program for poverty level and after school program so that parents can work.
a) behavioral health issues b) mental health and dental
Special need education in schools.
There is a need for more afterschool child care options and summer child care programs.
Improved immunization rates Mental health services
obesity
a- ADHD overtreatment with medications, obesity and poor nutrition b- behavioral health, obesity prevention, healthy active lifestyle training
Healthy nutrition Physical activity
nutrition and exercise education
a) some insurances not covering immunizations recommended for this age group
Those without insurance or the ability to obtain insurance do not get the medical care they need. Parents keeping up on required or recommended physicals and immunizations.
childhood obesity increase in number of children with special health care needs - dx of autism
a) Immunizations
The same as # 7 & # 4
a parental (Mom AND Dad) involvement/engagement b adoption of healthy habits i.e. physical activity
same as #6 answer

9. Youth and Adolescents (13 - 18 years of age)

Response	Count
	116
answered question	**116**
skipped question	**176**

Response Text
same as 7
Birth control information Access to vocational training in each community
pregnancy prevention sexual disease prevention substance abuse prevention mental health
a) depression, suicide, bullying, obesity b) mental health supports
a) Obesity; Use of drugs, tobacco, and alcohol; mental health issues; STDs; risky behaviors including unprotected sex; visiting certain Internet sites; use of cell phones/texting and driving. b) Oral Health; Smoking Cessation and prevention; and mental health services.
Nutrition and Obesity, Risk behaviors. Sex and reproductive education.
A. Same as above.
Parenting education, as mentioned in #4.
Breastfeeding information integrated into their school curriculum, as part of for normal infant nutrition and care.

a) Parents not displaying healthy role models. Adolescents making bad choices in regards to sex, alcohol, drugs & tobacco. b) Essential health needs not being met.
Same as young children Also smoke tobacco issues in rural schools especially.
a. Health Concerns. Obesity/poor nutrition. Drug\alcohol abuse. Sexual activities. b. Unmet needs. Parental involvement and education on the above topics as well as understanding social media and teenagers. Engaging teenagers in positive ways. Unfortunately this age group suffers from stereotyping.
obesity, pregnancy and drug/alcohol exposure.
1. Increase in STI's 2. Increase in Teen Pregnancy 3. Increase in prescription drug abuse Needs: Better education on STI's and pregnancy.
Same as above Improve transition skills
Wraparound services such as state and federal Healthy Start
need for more education regarding sexuality
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
Same as above plus mental health services
STDs Need for more education on STD, pregnancy prevention and sex education in the schools.
Real life skills and pre-employment training. Preparation for community college or technical training.
Obesity Physical Activity - life long process
education to build confidence a place where they could get help with abuse issues
Sex education.
programs to develop fitness and self-esteem and resist peer pressure
self esteem
obesity dental health mental health preconception counseling drug/alcohol/smoking abuse
Nutrition related concerns - adequate low-income dental and medical care. Mental health services limited and expensive. High incidence of underage drinking, drug use.
Similar to Pregnant Adolescents. Better sex education and self-esteem in school curriculum.
Sexual health is needed since our area still is one of the top 10 in the state for teen pregnancy and STD's in teens.
In 2011, 235 Kansans died by unintentional poisoning in 15-24 age group.
lack of outdoor/physical activity
education on healthy life styles access to health care screening for STD/HIV
limited access to family planning; attitudes conservative limited access to mental health services; almost no preventative/routine care (medical or dental) drug/alcohol usage teen pregnancy acceptable
Tobacco use seems to be more prevalent in this age group.
obesity, physical inactivity
Drug and Alcohol Use Obesity

access to birth control
Suicide prevention awareness increased and birth control options (including how to say 'no')
a. sex education b. sex education
HPV and all other appropriate immunizations, continue to encourage healthy lifestyles
a. Teen pregnancies are more "acceptable". Increase in sexual activities with multiple partners, unknown partners, etc. Poor decisions that are affecting their health. Lack of good nutrition, poor physical activities, use of illegal drugs b. Increase in STD's. Increase in obesity. Lack of providers/people of influence who will talk with the teens about the risk of the above, or have a community effort to provide a program to address this issue
Dental, eating right.
immunizations for those uninsured; well child checkups dental; lack of mental health providers; lack of school therapists (speech pathologists, occupational therapists, physical therapists, supportive services); obesity and diabetes
see #9 Sexual activity delay/delay of pregnancy Information for both boys and girls on STDs
Not sure.
education for reproductive health - nutrition support
Promiscuous sexual activities, human trafficking, STIs, drug use, smoking, alcohol use, lack of physical activity, parental supervision. Parental example of immoral activities, lack of modeling of moral activities, violence on TV and video games. sexual attire, lack of clothing that is wholesome Lack of male influence, Marketing to teens food and items. Peer pressure, wanting to be like everyone else and fit in. Lack of self-esteem and worth. Processed foods, muffin tops.
Healthy relationships, STD talks, immunizations, sexual risk reduction, activity vs. computer/gaming time, texting, sexting
a) the major or emerging health concerns Accident prevention, risk behavior attention, and mental health support. b) the essential (or primary) health needs that are not being met Preventative and primary care access. Accident prevention. Family education. Mental health support.
Improper child restraints in vehicles
Information about reproductive health and pregnancy prevention. Adequate adult guidance with addressing developmental concerns of adolescence.
Drug/Alcohol use, Teen pregnancy
a. pregnancy prevention b. lack of acceptance for recommended vaccinations
a. & b. comprehensive sex education
Improved education on avoidance of smoking, alcohol, drinking and driving, sexual promiscuity.
a) Sexual health, transfer of health-care responsibility from parent to child b) Preventative health
Unintentional Injury and Suicide Prevention
same
STDs Alcohol and Drugs Driving and Texting Not wearing seatbelts.
drugs; pregnancy; obesity; mental health issues; homelessness; personal care of mind and body; dangers of drug use; development of chronic health issues related to poor habits already formed
health insurance navigation immunizations basic health services
Dental Care is limited. Lack of behavioral support.
In Wichita, the presence of three FQHCs have improved access to health care for children (and adults)

Drug & alcohol awareness and peer pressure Excellence in school
Easy access to sex education and birth control.
A) STI B) Birth Control
Unhealthy Family Eating Habits Lack of Nutritious and Desirable Food at School Lack of Exercise and Activity
Good nutrition, safe school environment, WELL-PAID teachers who love what they do.
Access to Family Planning services in Miami County is now limited, since the loss of our county's Family Planning Grant. Fewer terns are coming now to the new clinic, probably due to cost.
Education regarding sexual health and protection.
different definitions as to what is acceptable with sexual experimentation. shaming girls and bullying.
Education healthy life styles Nutrition Obesity Low Immunization rates
Improve social integration, involvement and bonding with the school tribe, and niche groups in the school, and cultivate emotional intelligence.
Continues well-child visits with recommended education done with youth/adolescents and parents
STD and contraception knowledge
No parenting skills
sexual health/education -family planning
a) STD's, unplanned pregnancies b) lack of parental supervision, alcohol, tobacco and other drug use
adequate care for sexually active teens
Access to emotional health services
Affordable health insurance, and the cost of immunizations, for those who don't qualify under the medical card, and cost of insurance is too much for parent to take out family insurance on infant/child
a) the major or emerging health concerns 1. mental health problems/suicide prevention 2. substance abuse 3. obesity 4. safety b) the essential (or primary) health needs that are not being met 1. adequate resources for treatment (both providers/payment) for mental health problems. 2. more widespread education on issues like texting while driving, gun safety
Access to affordable health insurance, and an adequate provider network for low-income populations. Of particular concern is access to dental care for children, especially those that are insured by Medicaid. There are not enough providers in Kansas to meet this need.
drug use, alcohol use, unprotected sex
Same as above. Lack of use of skills in problem solving.
Nutrition and Physical Activity
More mental health services are needed and to education medical providers of how to screen for mental health at each appointment.
Many the same as #8 as well as poor education regarding self-worth and body changes/function (primarily reproductive). This group is also in need of continued education regarding substance abuse. We have stopped communication with parents by telling this age group that they can make sexual/reproductive decisions without parental consent. Many of these kids seem to be shutting them- selves into a box and looking for attention in all of the wrong ways.
a) obesity, tobacco use (new products), prescription drug abuse, sexually transmitted diseases, mental health, b) healthy environments, access to services, education,
Lack of knowledge re: personal responsibility, goal setting, postponing parenthood, early child development

Strong adults in addition to family members (excellent teachers) Strong alternatives to drugs in order to fit in and succeed School retention strategies
Need increased immunization percentages for this age group.
a and b) HIV and STD's - TESTING and education
Obesity comes to mind. Also wanting to fit in with peers. Education needs on nutrition and continued education on reproductive systems.
Same as above. Not enough adult supervision to prevent teen pregnancy.
Continue drug education, safe sex education
Education on birth control
a) Tobacco, alcohol and drugs b) Mental health needs
Education on making the right choices.
Mental health services Smoking cessation education Alcohol awareness education Safe driving practices Suicide prevention
lack of healthy living knowledge, STD's, use of legal or illegal drugs
a- same as school age adding smoking b- Pregnancy and STD prevention, behavioral health including in patient psych treatment
Tobacco use Pregnancy prevention
birth control, drug and alcohol education, STD education
a) some insurances not covering immunizations recommended for this age group
Seeking out birth control
obesity lack of mental health services for teens
a)Immunizations
a) Basic training of how to survive & make a living b) same as above Same as # 4 & # 7
a parental (Mom AND Dad) involvement/engagement b adoption of healthy habits i.e. physical activity
same as # 6 answer

10. Children with Special Health Care Needs (Birth to 12 years of age)

Response	Count
	101
answered question	**101**
skipped question	**191**

Response Text
If problems occur, insurance enters into it, and these babies can't get the proper medications, specialized care, and families are at a loss as to what to do
Inclusion in school programs
Appropriate eval and intervention. Access to services outside of school based
developmental therapies

a) complex chronic conditions that require specialist care for effective management, decreased understanding and involvement of the person with the SHCN, obesity b) Comprehensive Medical Home care, affordable and accessible specialists, communication and collaboration among systems of care and education that serves the individual, limited development of physical exercise and leisure interests for life long health, life satisfaction and well-being
Affordable, appropriately care provided locally.
Breastfeeding support is critical for this population and is often overlooked. Families with children with special health care needs should be referred to International Board Certified Lactation Consultants (IBCLC) who can work together with their health care provider to maintain the breastfeeding relationship. Kansas currently has over 160 IBCLCs.
a) A family has to stay within financial restraints to receive help. b) Availability of resources to families who fall out of financial guidelines, yet are unable to afford resources as out of pocket expense.
I don't know these issues Limited access to support in rural settings New man are issues
people with more needs as times gets harder and lack of funding for some or the delay of funding for some.
Just being able to get in to see doctor. Kancare is very unorganized just getting medicine takes several hours with several different departments and they don't know what the other departments are doing. It SHOULD NOT take 13 days to get a prescription approved.
Having services readily available when needed.
Health Concerns. Getting the correct diagnosis and then having the needed services available within the community. Having insurance coverage to help cover the cost of care. Unmet Needs. Having enough assistance available when needed for both the child and parents.
It is so hard to get to a doctor in another state.
Continued decreases is available funding for medical supplies and durable medical equipment.
I think their needs get met in our county
Same as above
Wraparound services such as state and federal Healthy Start
more support, interaction with others
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
Respite care for parents and caregivers and same as above
Funding will never be enough. The function of teaching parents about their children special needs child has never been accomplished and parents are not really encouraged to be part of the solution. Many parent feel inadequate because the agencies make them feel that way then then disengage. Still specialized care is something on the eastern part of the state or exhausted by chosen families playing the system.
Services are limited
Parents accessing free screening so special needs can be addressed
community based centers for parent to bring their children to that have special equipment for PT and OT, staffed by professionals
support for parents
Limited specialized services available in the community.
Have no contact.
Motor Vehicle Child Occupant Protection
unsure
parental support cover medication costs coverage for hospitalizations transportation
uncoordinated and limited resources backward attitudes including teachers, caregivers lack of health professionals truly knowledgeable in identification and treatment lack of specialists to provide services requiring travel for those who can afford it

In-county providers skilled in certain areas of need
Limited resources in Northwest Kansas for assistance with special healthcare needs
Early intervention to make their lives as productive and healthy as possible
I believe the McPherson Area has a good program in place to address the early children and then the schools are in place. We do not see too many special health care need children
immunizations for those uninsured; well child checkups dental; lack of mental health providers; lack of school therapists (speech pathologists, occupational therapists, physical therapists, supportive services); obesity and diabetes
All kinds of services that are not readily available in our area. Development, cognitive, social, etc. We have an agency in Great Bend that provides services to Stafford County
Not sure.
care to meet their needs
Medical care, respite care, lack of parental follow through, sexuality. Cost of medical care, going to other areas for special care, lack of prenatal care , medical providers who are not able to determine ethical decisions regarding very early and interventions. Durable medical equipment, dental care and providers, early intervention services, funding for school services. Services for transition and lack of care.
a) the major or emerging health concerns Chronic health management in tandem with parental support b) the essential (or primary) health needs that are not being met Accident prevention. Family education. Access to services. Equipment rental support is minimal due to lack of reimbursement.
Improper child restraints in vehicles
a. inadequate care for the young child with needs. b. lack of skilled care providers to assist families with the care of every day needs.
a. & b. family coping methods
Improved assistance in the school system.
a) There are many new treatments for children with genetic disorders b) No geneticist to treat these children within our state.
a) Illness prevention. Finding healthcare resources. b) Team approach to health care and other needs. Providers do not work together to treat the whole.
funding for services.
same
chronic conditions associated with disability; nutrition; dental, mental/physical issues, housing skin conditions, mobility assistance devices availability/use; dependency on caregivers
health insurance navigation immunizations basic health services developmental services
Lack of services to support those with mental and behavioral support.
Proper care and education
A) Safety B) Dev. Learning
The concept of mainstreaming every child, regardless of the severity of their conditions, is not in the best interest (in terms of meeting the learning needs) of other children in the class. There are too many situations in which the "normal" children do not get the attention they need and cannot progress as they should because the teachers are required to deal with special needs children. Some of the children put in regular classrooms cannot benefit academically; I'm aware of situations in which those children just spent the day screaming or moaning, while the rest of the students tried to hear and focus on their studies despite the distractions.
No experience to comment.
lack of support in smaller towns, inner city school districts etc.
Simplification for obtaining services Availability of services especially specialists

See comments above in box 4: we need to create individual, integrated longitudinal data systems the unify medical and social service and educational data over time, then use these databases to discover the specific origins of poor child and adult outcomes, and then test preventive interventions to lower the incidence of these impairments. In addition, we need to tax commercial enterprises that prey upon this age group, foisting bad food, and socially and mentally damaging activities on them. This is the only way we will succeed in gradually improving population health.
access to care and adequate services--especially in rural areas
Lack of resources and respite care for parents
Severe lack of affordable services for kids who have private insurance. Many day care/summer program providers and therapy options are only for kids who are on a medical card. Those providers are punishing parents who choose to care for their kids outside the "system." Many service care providers (Class LTD in our area) charge outrageous prices to Medicaid, and therefore try to do the same to parents with private insurance or who self-pay. Day/summer care and specified therapies are non-existent for kids who are not on state aid. A great many kids go without adequate care services simply because the state pays better than the parent can.
No parenting skills
access to care and RX
specialized care for individual needs in rural area
Access to care
health care costs
a) the major or emerging health concerns 1. co-occurring mental health problems. 2. obesity in some CSHN population) 3. lack of collaboration/communication between the primary care medical home and subspecialists b) the essential (or primary) health needs that are not being met 1. experienced mental health providers (especially in rural communities) to manage this complex population. 2. inadequate payment mechanisms to really support the comprehensive primary care medical home
Access to affordable health insurance, and an adequate provider network for low-income populations. Of particular concern is access to dental care for children, especially those that are insured by Medicaid. There are not enough providers in Kansas to meet this need.
access to affordable & appropriate health care
Lack of access to adequate day care and parent respite. Increase expense of health care. Poorly trained caregivers.
More grant notices on how to apply for special needs equipment for families
I am not real familiar with specific challenges that this group faces, although I do know of several families in this area who have to travel great miles in order to have their child's needs met. This of course is burdensome, but I know that it is not feasible to have specialized services in remote areas.
Services that are needed for these special needs children. Parents have to drive quite a distance to have any help for their child.
a) diseases or conditions of genetic origin, obesity, mental health b) healthy and safe environments, access to services, health insurance coverage, physical activity opportunities, healthy food environments (quality and adequacy)
Support systems
Early identification
Finding doctors who will take Medicaid patients
Area services being reduced due to budget concerns.
Difficulty in access due to distance to care.
Optimize individualized accommodations as needed.
Where and how to get help in rural areas
Resources available.
Outside of MCKIDS offered through the Infant Toddler Center, I do not know of another program in McPherson County addressing this population.

Better support for home equipment in medically fragile children, it's cheaper than being in the hospital Better home nursing for medically fragile children Respite care for medically fragile children, to ease the care taking burden on the parents Financial support for medically fragile children Improved access and financial support for Early Intervention for infants with special needs and those at risk
a- transportation, organization of providers and navigation through the new health care law b- preparation for transition to adolescence
Rising health care costs Access to specialized care and health care professionals
Access to dental care
access to needs which are not covered by healthcare directly. re: dme or education of family members
Availability in rural areas to assist those with special needs
access to services - sometimes is a problem. Patients may need more services (OT, PT, SLP services) than they get. We need to look at the model - and shift the public's perception that the services provided are there to "teach" them as primary caregivers what to do in the home, not to improve function, just with therapies provided.
a)Lack of health care services.
a) Care giver support groups help b) Care giver support groups help
a parental (Mom AND Dad) involvement/engagement
need to travel long distances to specialists

11. Youth with Special Health Care Needs (13-26 years of age)

Response	Count
	98
answered question	**98**
skipped question	**194**

Response
If problems occur, insurance enters into it, and these children don't get preventative care, can't get the proper medications, specialized therapies and care, and families are at a loss as to what to do. It all has to do with prevention and our system is not one of prevention
Access to vocational training
As above and ADA access
vocational preparation
a) complex chronic conditions that require specialist care for effective management, decreased understanding and involvement of the person with the SHCN, obesity b) Comprehensive Medical Home care, affordable and accessible specialists, communication and collaboration among systems of care and education that serves the individual, limited development of physical exercise and leisure interests for life long health, life satisfaction and well-being
Affordable, appropriately care provided locally.
a) A family has to stay within financial restraints to receive help. b) Availability of resources to families who fall out of financial guidelines, yet are unable to afford resources as out of pocket expense. a) Parents not displaying healthy role models. Adolescents making bad choices in regards to sex, alcohol, drugs & tobacco. b) Essential health needs not being met
Same as above
people with more needs as times gets harder and lack of funding in schools and home.
Having services readily available when needed.

Health Concerns. Having insurance coverage to help cover the cost of care. Without it in most cases needed medical care is too expensive. Unmet Needs. Having enough assistance available when needed for both child and family. Having (out of the home) care/housing for those older youth who can no longer reside at home because the family is no longer able to provide the care needed.
The few Camps and programs are all intellectual disability based, few for just physical disabilities.
I believe those needs are being met in our county
Same as above Improve services for independent living needs (medical) Helping youth better understand sexuality
Wraparound services such as state and federal Healthy Start
same as above
a) Keeping up with the demand of quality educated healthcare professionals. From doctors educated in all healthcare specialties as well as in ob gyn and pediatrics. b) same as answer a.
Same as above
N/A
Take a really good look at our middle and high school. Children with disabilities are herded and skills are coloring pages. Everyone can do something. Voc Rehab is literally a joke.
Increase the transition for high school students with special needs. Kids with IEP in high school should have a community specialist meet with them every 6 months to one year after high school to reassess health and mental health needs.
a place where they could learn life skills
Respite for parents of these children, also community based centers
support for parents skill/job training support
Limited specialized services available in the community.
Have no contact.
Motor Vehicle Occupant Protection
unsure
parental support cover medication costs coverage for hospitalizations transportation
uncoordinated and limited resources; quality varies dramatically depending on location
Same as #10
Limited Resources in Northwest Kansas for assistance with special healthcare needs
a. unknown b. unknown
Learn life skills and work skills so they can be a helpful and productive in society
see above.
immunizations for those uninsured; well child checkups dental; lack of mental health providers; lack of school therapists (speech pathologists, occupational therapists, physical therapists, supportive services); obesity and diabetes
Opportunities to interact with others in social setting Access to medical care/mental/psych
Not sure.
care to meet their needs - affordable, safe, reliable
Transition services for children after age 21, social life, meaningful employment, mental health services, medications not covered, independent living facilities, medical, family planning, dental, sexual health, appropriate nutrition, family support, respite care.
UNK

a) the major or emerging health concerns Chronic health management in tandem with parental support b) the essential (or primary) health needs that are not being met Accident prevention. Family education. Access to services. Equipment rental support is minimal due to lack of reimbursement.
Improper child restraints in vehicles
same as above.
a. & b. family coping methods, life skill assessments.
Improved assistance in the school system. IEP's are a joke!
a) There are many new treatments for children with genetic disorders b) No geneticist to treat these children within our state.
a) and b) as above
funding
not sure
same
chronic skin conditions; nutrition; dental; mental/physical needs/development; housing; assistive devices needed skill training; independence; coping with disability daily; self-care;
health insurance navigation immunizations basic health services developmental services employment services
Lack of services to support those with mental and behavioral support.
Proper care and education
A) Safety B) Obesity
a) the major or emerging health concerns: Partly due to the economy, the decline in proper nutritional habits, as well as the increased stress upon adolescents and youth resulting in a reduced focus on effective or incomplete career training for their future. b) the essential (or primary) health needs that are not being met: Recognizing and addressing mental health issues early, that are compounded by prolonged stress related issues in their lives; as well as weak coping skills; declining emotional and financial support from parents & family; and a discouraged sense of control over their personal future. Undetected or undiagnosed mild & moderate emotional or mental disorders are worsened by social stigmas of seeking treatment, counseling and professional assistance. In addition, insurance providers seem to over emphasize medication therapy over more resource-intense therapies, such as talk-therapy, to be used as a combined therapy or as an early-prevention treatment.
The concept of mainstreaming every child, regardless of the severity of their conditions, is not in the best interest (in terms of meeting the learning needs) of other children in the class. See #10.
isolation and lack of support for caregivers.
As above
We have over-emphasized academic performance at the expense of instilling good survival skills. We are also mainstreaming some kids into classrooms even though they don't have the social skills to not disrupt the classroom and distract the other students.
Transition to adult care
Above
Severe lack of affordable services for kids who have private insurance. Many day care providers and therapy options are only for kids who are on a medical card. Those providers are punishing parents who choose to care for their kids outside the "system." Many service care providers (Class LTD in our area) charge outrageous prices to Medicaid, and therefore try to do the same to parents with private insurance or who self-pay. Day/summer care and specified therapies are non-existent for kids who are not on state aid. A great many kids go without adequate care services simply because the state pays better than the parent can.
No parenting skills
access to care and Rx
specialized care for individual needs in rural area

Access to care
health care costs
a) the major or emerging health concerns 1. transition to medical providers who are knowledgeable about "pediatric" conditions (e.g. congenital heart disease, developmental disabilities, etc.). 2. transition to adult mental health providers knowledgeable about mental health problems associated with pediatric conditions. b) the essential (or primary) health needs that are not being met As above
Access to affordable health insurance, and an adequate provider network for low-income populations. Of particular concern is access to dental care for children, especially those that are insured by Medicaid. There are not enough providers in Kansas to meet this need.
access to affordable & appropriate health care
Same as above.
More grant notices on how to apply for special needs equipment for families
Same as above. The upper edge of this age group faces their own special challenges... As most kids who are approaching 18 are preparing to find their independence these kids are often struggling to find a way and the means to function.
a) tobacco use (new products), obesity, mental health, injury, b) access to services, safe and accessible environments, healthy food, family and community supports and education
Support systems
transition services (housing, employment, support, healthy peers
Finding doctors who will take Medicaid patients
a and b) HIV and STD's - TESTING and education
Small communities do not have the funds to provide special services and activities for special needs children.
Need more transitional services to assist youth into some sort of work environment
Continuing assistance, especially if parents are aging
a) b) respite care or care to allow young adults to live on their own
Education and employment concerns.
Improved job training and access to jobs Support for independent living where possible
Cost and availability of services
a. see above #10 b. preparing for adult / independent living
Oral health
same as above
Availability of help for those in need in rural areas.
CYSHCN's benefits and eligibility has really decreased over the past 10 years. This has put several patients and families at risk.
a) Care giver support groups help b) Care giver support groups help
a parental (Mom AND Dad) involvement/engagement
same as #10 answer

Service Delivery Systems for MCH Populations

12. Please select specific programs or service systems that you have experience with: (Please check ALL that apply.)

Response	Percent	Count
Home Visiting	68.5%	115
Children and Youth with Special Health Care Needs	35.7%	60
Newborn Metabolic Screening	22.0%	37
Newborn Hearing Screening	32.7%	55
Infant-Toddler (tiny-k Early Intervention)	38.1%	64
Part C	15.5%	26
Teen Pregnancy	42.3%	71
Women's Reproductive Health	53.6%	90
Child, Adolescent & School Health	47.6%	80
WIC	65.5%	110
Other (please specify) Healthy Start Our health department staff is experienced in and participate in the community in the following areas: Home visiting; Teen Pregnancy; Women's Reproductive Health; Child, Adolescent & School Health. Special Education Voc Rehab Maternal & Infant Program Social Worker, bi-lingual (SP) interpreter assisting in various programs, information & referral to local resources. Title X Family Planning Child Passenger Safety Tech., Safe Sleep. Pregnancy Maintenance Initiative (PMI) Midwifery Care identifying and cultivating career ambitions in middle school students Early detection works vital statistics data "Head Start Latch Key Program" Hospice, Aging, Transportation, KBH, CDRR just use data to calculate cause of death stats Education for teens and their parents to encourage healthy communication and relationships and avoidance of high risk behaviors including use of drugs, alcohol, tobacco, pornography and pre-marital sex and		15
answered question		**168**
skipped question		**124**

13. Based on the specific programs or service system that you selected, what aspects ARE working particularly well? (Please check ALL that apply.)

Response	Percent	Count
Communication	47.2%	68
Access to services	54.9%	79
Hour of operation	47.2%	68
Website information	34.0%	49
Location of services	51.4%	74
Type of services	50.7%	73
Other (please specify) Although we believe the services work well, there are still gaps in services and not enough capacity and funding for all the needs. Service providers are passionate and dedicated and try to coordinate within the		22

health and social services system of care, however needs are great, especially where there are pockets of disparities. Communication about Newborn screenings is working well; not Infant-Toddler (tiny-k Early Intervention) WIC is doing a great job of supporting breastfeeding. I was new in march so I am still learning the ropes. We have a lot of great resources in our community. We truly are only lacking in Mental Health and maybe education. I have knowledge of these programs that I share with families whom I work with; but currently do not have a family member receiving any of these services. School-based adolescent education For the majority of this population this time seems to work well Flyers We communicate with clients and the general public using our website and social media for educational purposes. WIC It varies county by county and organization involved. Generally, there seems to be a lot of redundancy and duplication and definitions of service varies. Some counties have no (or very limited) access to family planning or WIC....a clinic once a month is not access. Agencies still compete for dollars; collaboration if in place is fragile. Some services Communication within the program is good. not sure Communication within the program is good. Meets families' needs registration of vital events for birth and death records All could use improvement We are satisfied that our Maternal and Infant Education is considered a very valuable adjunct to physician care, HSHV, WIC, ITNS, to name a few. Our referral process is great. N/A Good services offered, would love to see expanded access to Part C and Early Intervention	
answered question	**144**
skipped question	**148**

14. Based on the specific programs or service system that you selected, what aspects are NOT working particularly well? (Please check ALL that apply.)

Response	Percent	Count
Communication	37.9%	47
Access to services	48.4%	60
Hour of operation	19.4%	24
Website information	32.3%	40
Location of services	31.5%	39
Type of services	32.3%	40
Other (please specify) I can't really say things are not working well. There is a lack of services for children under the age of three who receive a diagnosis of autism. Infant and Toddler Services alone is not enough to meet best practice recommendation of 20+ hours of evidence-based intervention services (including the use of ABA therapy or components of the Early Start Denver Model Program). ITS providers need additional training in the use of evidence based strategies specific to autism so that they can incorporate these strategies into their coaching family model. I listed communication in both sections because I do not believe we have adequate work-force that have Spanish communication skills. The diverse pockets of Kansas pose interpretation and translation challenges in other languages too. Communication is not working well for the Infant-Toddler (tiny-k Early Intervention) program Others public health providers, such as home visitors and Infant Toddler staff, could improve their support and knowledge of breastfeeding. Additional breastfeeding education should be required for anyone serving mothers and babies. Need to advance social media technology. So far I have not seen any of the service system that isn't working particularly well.		39

Consistency Parents of special needs kids need more services than the school can provide after age 3. The school shouldn't be the only support they get for therapies, especially when one therapist serves 3 or 4 schools. Getting needed equipment on a timely basis. Same as above Parenting education We have outgrown our current building location with the services we provide to the community. Health care services and dental services Unsure, basically just the limits on availability of services in a small community. Brownback and republicans are anti-sex-education. We, as abortion clinic workers, are forbidden from lecturing ourselves at schools, now. Teen pregnancy is going to continue to increase, and their children are going to suffer. Communication, Access to services, Hours of operation, locations, types of services, all irrelevant, IMO. Again, it depends on the agencies involved. To be effective, family planning, immunizations, WIC, etc. must be available on a regular basis at places and times that families can access. It does not appear that funding is based on outcomes or numbers served. Communication to the public is lacking unless clients know to call 211. not sure Communication with the public could be improved Major funding cuts has caused decrease in services available. Increased cost of products and services. QUALITY of services need to improve quality of reporting of congenital anomalies Need more financial assistance with areas like family planning. Many are unable to afford birth control and this county is considering eliminating this program so expect to see a rise in unplanned pregnancies. Would it be more helpful if Kansas goals and objectives were tied to National goals and objectives? Either MCH or Healthy People? Family Planning services are hard for us to advertise, due to the churches in the county, who think we are encouraging teen sex and abortions. Even though we have stressed to the contrary. Our services are basically word of mouth for young teens and unmarried women. Duplication of services, overlapping services- this is a waste of the taxpayers money and wears out the families that these programs are servicing Family Planning services in Miami County. We lost our grant, due to religious decision-making by 3 of 5 county commissioners. Some State support would have been helpful. Lack of low intervention preventative service More medical and social services need to be located in schools and in the early evenings; high-quality day care needs to be available in schools with highly trained teachers and social service providers. quality of data reported for vital events See above "Challenging to find specific providers particularly in non-urban areas of the state. Some programs underfunded (for example Part C)." N/A Funding See above. The scale and reach of home visiting is inadequate. More efforts needs to be made to administratively consolidate the three or four variations of home visiting into a single, more adequate and holistic program. "WIC comes to our community every other month on 1 day. If someone misses or is unable to attend their appointment, they have to drive out of town or do without the service. School nurse funding cut back limits the time the nurse has in the school buildings. Our little community could benefit from special funding for school nurse to be in the school full time to be part to the planning and education of our children and community. The school nurse could help the teachers teach health/wellness topics and get to know the students and their families on a more personal basis increasing the family needs of services related to medical needs and other program needs. (food/sheltering/babysitting/medical)" limited resources in the rural area	
answered question	**124**
skipped question	**168**

15. What particular populations or specific regions in the state need additional supports? Please indicate who or where and what types of supports are needed.

Response	Count
	92
answered question	92
skipped question	200

Response Text
Children with new diagnoses of neurodevelopmental disorders (e.g., autism)
I don't know that that I can speak to this with much factual information. I do know that some of the small counties don't have the services to provide adequate therapy to some children with special needs.
Central, Southeast and Western parts of Kansas. Providers who serve children with autism using evidence-based therapies.
Children with autism
Southeast and Southwest Kansas
Rural
We serve the whole state. Even in Kansas City we experience difficulty accessing specialty care. Across the state, families could benefit from increased access to developmental and behavioral supports.
Wyandotte County would benefit from more outreach to youth and families of childbearing years and programs that would address issues of obesity/nutrition/physical activity; early pregnancy testing and prenatal care; oral health; preventing risky behaviors (smoking, drinking, drugs, driving safety); Mental health supports for youth and parents.
King County in the state of Washington has the lowest fatality rate for heart attack victims because it requires CPR be taught in high schools; thus there are ample people who know how to handle the problem. [http://www.komonews.com/living/health/Bill-would-require-Washington-teens-learn-CPR-191431161.html] Boost Kansans in this same fashion by providing better parenting skills through required education beginning at the 9th grade level.
African American women need additional support for breastfeeding as they historically have low breastfeeding rates. All new mothers need access to breastfeeding information and support upon discharge from the hospital. Many communities in Kansas lack this continuity of care.
We are a rural area & it's hard to get people to participate. We've offered parenting classes, breast feeding classes etc. with little or no participation.
Western KS
parents of multiples in southwest KS. Education and support groups are needed. Also, more teen education on family planning and parenting.
Children with epilepsy need better options of doctors in South-central Kansas. There also needs to be better understanding in schools on what to do to help when a seizure occurs.
Developmentally disabled.
Need better communication between state agencies to address the whole child. Advisory Boards need to include those from each of the relevant and appropriate state and local agencies to address the needs of children and families. Children (and families) with disabilities/mental health or special needs are often an after- thought and not included in plans. May times children in foster care are also not included and they many times have the highest needs for mental health and social emotional health. State wide inclusion for ALL children and families that are in need without the requirement that they meet specific poverty or at-risk population so as to not stigmatize those who may want assistance but don't want to seek assistance due to the negative social impact.
SW Kansas, the support we need is mostly in speech, but all the therapists are trying to serve too many schools.
early prenatal care is needed statewide safe sleep education is needed statewide presumptive eligibility is needed statewide
I would have to say our number 1 weakest resource is Mental Health resource for those needing drug abuse rehab (whether teen, young adult, pregnancy, middle adult, etc.). We have no inpatient rehab resources and our outpatient services are VERY limited and not adequate for the large population of drug use (illicit and prescription usage

especially among teens).
Rural areas they need better access to care
Young men and women; preconception education
Rural areas continue to be underserved for many reasons in regards to healthcare, insurance and available employment.
Urban and rural
Southeast Kansas and Southwest Kansas. Low income population. Pregnancy prevention, more M&I in the home.
rural areas have been stripped of services and we are given an 1-800 number to someone across the state or nation that can't find us on the map. Some agencies in western Kansas serve their city limits, and somehow handle pawning off to some other agency of even a parent.
Tiny K Universal Preschool
here in western Kansas, even though we have small numbers the needs are the same. I would like to be able to create some jobs for women. I would like to start a school where women could come and get skills for cooking, parenting, job skills, breaking the cycle of picking the wrong kind of me. It is a dream of mine. I don't like it that they drop out of school and don't finish. I offer on my own time parenting classes on an individual basis
New teen moms Hispanic population (documented and undocumented)
more support for working, married or unmarried parents who are struggling but trying hard
More low cost prenatal care More choices for birth control
I think the rural areas need more support to ensure that special needs can be handled better at the local level. It is difficult, even with transportation services, to get low-income clients to make and keep follow-up appointments outside of the county because of the length of time involved, especially when they are working at low-income jobs without many benefits. The gap between the wealthy and the poor seems to have increased significantly; the regulations to provide services seem to be increasing and there are funding cuts that further limit the ability of staff to provide basic services to the populations in need.
Hispanic teens are an emerging population that is ignored, IMO. Their parents did not use government services and is likely they will not either. They will just suffer, using old ineffective Mexican remedies to cure their children, being malnourished, eating Mexican foodstuffs high in lead content, causing mild retardation, IMO. They will continue to eat as their parents did, and be much overweight, like their parents, and get diabetes, same as their parents.
Could benefit from more Burmese and Somali interpreters, particularly in Southwest Kansas.
unsure
Obviously, based on data, southeast Kansas has the most identified need. Funding should be leveraged with agencies/organizations with demonstrated success based on measurable outcomes. More coordination of care with the medical homes.
Western Kansas-access to medical care locally, especially specialists.
I feel the rural areas of Kansas could use additional resources in general for the different populations and their needs.
We don't seem to be reaching our adolescents as well as I would like. We need birth control that is more effective that they can afford, but don't have to think about every day.
Again Dental CARE!!!!
Families that are over income for state supported services but cannot afford privately funded insurance. Northeast Kansas needs more providers that are willing to accept state payment through KanCare.
Hispanics-Low German We are designated underserved - sometimes hard for clients to access health care and be understood in their primary language
Rural communities lack access to affordable, quality care of all types. In Western Kansas, focus necessarily needs to be placed on larger population centers just due to the sheer lack of total population in that half of our state.
All the areas that are not major cities. Small areas of populations have great need for increased services and their availability. Accessibility of satellite services for special needs.
Smaller towns. High risk pregnancy populations.
Small rural communities.

We serve vulnerable young children and families in their homes, in the community. Community services are frayed at the edges. The “safety net" of agencies and services for people who live in poverty are stretched extremely thin, or have been eliminated by funding changes. The economy may be turning around, and the poor and marginalized people are still with us. There are large holes in the safety net that used to catch and re-direct people to the services they need. I see infants and young children with disabilities and developmental delays who are in desperate circumstances daily.
Entire state needs more support in Part C/Infant Toddler services. Keep trying to serve more children with less money. NE Kansas needs more Post-Partum support and more Home visiting nurses.
Small, rural counties that have limited resources available to the community. Access to health care, hospitals, child care. Food pantries, Prescription medication assistance.
The entire northwest portion of Kansas has a high number of poverty level residents. They need more financial assistance for birth control measures.
Again, the state needs to be proactive in assessing the access to genetic services and promoting these services within the state.
Areas with low population (frontier etc.) do not have access to all the services of larger communities. These areas still have children with special needs, teen pregnancies, high risk pregnancies etc.
REAL sex education in public schools. Most public schools are teaching abstinence only. Their stance on this is that by teaching birth control and sex ed, we are encouraging pre-marital sex. so they would rather bury their heads in the sand and not see the problems as they really are.
Smaller communities and rural communities
Our Hispanic population needs additional support. We recently lost our interpreter that came to WIC appointments and Kan-B-Healthy appointments.
Teen pregnancy, women's health
Teenage father of baby (employment-development) undocumented immigrates (navigation and help with health related services) working poor (health insurance) infants (through 1st year) (infant mortality prevention
All age groups listed need more access to appropriate dental care.
Rural nature of western Kansas poses challenges in reaching reproductive aged adolescents and women - additional funding to agencies that travel this area is recommended
Low income families who do not have transportation, do not speak English and have no local support system in place. It would be a good idea to have a local agency specifically designed for foreign language , uninsured families to help them receive the services needed.
SEK, this is a very impoverished part of Kansas.
Improvement of emotional-needs support for siblings of children with special healthcare needs.
WIC and all programs offering services to pregnant and postpartum women, and to infants and young children, need to have Board Certified Lactation Consultants available. Salaries or hourly wages for IBCLCs need to be competitive (similar to clinical nurse specialists) in order to attract and keep knowledgeable, skilled LCs. Breastfeeding is critically important to the health of mothers and babies; we are not doing enough to promote and support it.
Women of childbearing age- and services to support them in avoiding pregnancy if desired, and services supporting availability of prenatal care. Support in expanding Medicaid services for women's health and family planning care for two years following births. Expanding access to nurse-midwifery services and Providers in under-served areas. If nurse-midwives were part of the Healthcare Stabilization Fund, more Providers and practices could afford to add services in under-served areas.
More lactation consultants available to those who cannot afford them and insurance does not cover.
PREGNANCY---
Hispanic / Latino pregnant women
Services to rural and frontier areas of the state are under served. As stated previously, it is difficult for rural clients to access care that is not in close proximity to their home community. Time/distance and the cost of travel--in gas and time lost from work--makes it difficult to obtain and follow-up with care. Specialists
automation and outreach training
All areas
Parenting classes for all ages are needed desperately.
low to no income families do not have internet access and do not frequently check their mailbox at post office since

we do not have mail home delivery
In our region we do not have enough opportunities for persons to access services for mental health needs.
I think African-American women need more culturally responsive prenatal and parenting education/support. Also, environmental exposures and causes of fibroids should be explored among this group.
Middle class, assistance with health insurance/immunizations
1. Areas - need more access to mental health providers and to early intervention specialists. 2. Populations - Children with autism spectrum disorders not receiving adequate supports in part because of Kansas' failure to pass autism insurance legislation.
Rural families with traveling parents.
Mental Health Screenings in the health care setting 9-18 years of age More Bullying programming needed in K-12th grade
I feel like rural areas need the most support, of course I am bias, but it feels like rural is where the needs are.
Postpartum depression moms could benefit from: a support group and /or a temporary home heath type care for respite and or support. I had a difficult time last year trying to help a mom who had no family or friends available, to recover from severe depression. She was being treated by the mental health professionals. We could benefit from someone who has been trained to assist these moms short term and facilitate bonding and attachment activities at a time it is most critical for both mom and baby.
Sometimes our access to certain mental health needs or certain therapies is hard in the north central region.
Mexican population - probably state-wide
Females age 12 to 26. Southeast Kansas.
I see the greatest need of children and parents is to support more programs for birth to 5 in McPherson County.
Former premature infants: access has been reduced in recent years. Would like to see any infants that doctors feel are at risk of developmental delay being afforded preventive Early Intervention services to optimize their outcomes. Home equipment: would like to see better funding from Medicaid for supplies so out-of-pocket costs are reduced for families already under great financial stress.
Rural areas need better access to home visiting.
Healthy start programs could use more funding for additional education and visits.
I am only familiar with our local services and we need to continue to provide services for the at risk populations.
Mothers could use more support in Riley County.
Rural
As I mentioned above - School Nurse funding for our small school districts.
All Kansan's deserve equal support regardless of region.
southwest region all types of services

16. What specific recommendations do you have for improving the health of mothers, children and families in the state? (Examples may include but are not limited to: collect certain types of data to better understand an issue; reform or restructure an aspect of the service system; improve availability, development, or quality of programs; strengthen an existing policy that impacts health; share information with stakeholders to provide education about a particular policy).

Response	Count
	98
answered question	**98**
skipped question	**194**

Response Text
-improve insurance coverage for services -Increase the number of providers
Our system needs to change to prevent problems, not try and take care of them after they have occurred. It is a global problem in our country

Increased access to telehealth support
We definitely need a comprehensive data system that helps us better understand Kansas health. I do wonder if a consolidation of multiple tiny-k networks into one state-wide organization would better serve families and providers.
More public awareness and resource sharing related to: obesity/nutrition/physical activity; early pregnancy testing and prenatal care--A Healthy Baby Begins with You campaign; oral health; preventing risky behaviors (smoking, drinking, drugs, driving safety); mental health issues; prevention of domestic violence. Implement a Fetal Infant Mortality Review with community action planning and implementation in the highest infant mortality counties in the State.
Develop a program targeted to 9th graders statewide that teaches them about parenting skills including nutrition and resources they can access. Don't make it a classroom setting. Make it a traveling roadshow. If you can afford a trailer/RV to use as a traveling "lab" that'd be memorable for the kids (EX: see mobile labs at www.trac7.org or KANSASWORKS Mobile Unit). It needs to be unusual and out of the ordinary so students will remember it. Accompanying this campaign should be a website chock full of parenting information. Why? So when they become parents and are struggling with issues they'll recall when that crazy trailer pulled in and gave them info about parenting and how they can seek assistance.
Participation in PRAMS is critical in obtaining breastfeeding data which is currently lacking. Kansas is reliant on the birth certificate data which does not capture exclusive breastfeeding nor duration of breastfeeding. Information on the county level is limited to WIC populations. The CDC Breastfeeding Report Card is not timely. Basic breastfeeding education should be required for all public health workers serving mothers and babies, not just WIC. Improved maternity care practices, workplace support for breastfeeding employees and child care provider education are all area of focus for the Kansas Breastfeeding Coalition (KBC). The KBC is willing to working the MCHB in Kansas to collaborate and improve breastfeeding support in Kansas. The KBC is also working with 34 communities in KS to build strong local breastfeeding coalitions. MCHB agencies and programs are encouraged to connect with their local breastfeeding coalition to increase their impact on breastfeeding support in their community. The KBC is willing to enhance and expand their support of local breastfeeding coalitions in collaboration with the KS MCHB.
24/7 breast feeding support help line Public Health education & services available to adolescents. Health Department will strive to increase our use of social media to communicate with the adolescent & young adult populations.
Better communication on what services are available and how to access them
improve availability of parenting and childbirth classes. There is a need for support group for special needs kids and multiples.
Kancare is a joke. My daughter's medicines are lifesaving it should not take 13 days calls from doctor office, pharmacy, and parents to get them approved. There needs to be better communication on the insurance company's side.
I believe we begin with the state and local agencies collaborating and assisting each other with finding barriers and communication. I have seen many instances where communication and decision makers are not collaborating to find out the barriers and to address these barriers for families. Families have so many hoops to jump through, and there are so many different rules/policies and frustrations they must deal with when seeking assistance. Also, instead of trying to fill in gaps but funding a million other little programs, put funding into current programs that are limping along. There are many great programs, but they need further funding to improve...not another little grant that fills in for a couple of years and disappears or that has not accountability behind it so they provide assistance for a limited amount of time and then reimburse funding into another grant opportunity and then another! Please strengthen the current systems that are serving children and families. Thank you!
More paperwork is definitely not the answer. Listen to the parents and teachers in that area, let them do their jobs and spend more time with the kids.
consistent data collection and report of consistent data cultural competence life course perspective and policy related
strengthen an existing policy that impacts health!
I feel in this area we have many resources that offer the same services to pregnant adults, young mothers, and children less than 5. Our biggest issues is getting these persons that have this great need referred to these programs and then getting them to actually follow up or attend. Much of our population is complacent. I don't know how to help with that.

Improving access to care in rural areas Improved support for families who have a CYSHCN Improve understand by health professionals about how to better communicate with families and partner with them to meet the needs of their children (medical home) Offer more tele med options Improve health literacy for families
None at this time. Would be willing to participate in any of the examples used above if these would indeed improve the health of all.
Provide and promote after hour clinics Promote breast feeding for better growth and development Promote abstinence- "babies having babies" does put a considerable strain on any economy. It lowers the potential for learning and earning to both the young parents. It also impacts families drastically in so many ways
Better communication and support from the schools towards the health departments.
Make people responsible, stop the pandering and enabling for the sake of spending down funding. Put a hold on ALL services benefits and funding until the fraud is stopped.
Pregnant women in Medicaid program should have to have 2 visits with Nurse from the Health Department prior to delivery and then 1 visit afterwards. Becoming a Mom Program should be implemented statewide. Reform Federal Qualified Safety Net Clinic to provide prenatal services till 28 weeks.
Provide more education about the extent of the difficult situations that are here. sometimes it seems like there is no place to turn to for help
Could the program be revamped to be more like the Nurse-Family Partnership? I feel the MCH program needs to be more evidence based. There seems to be a lack of interest for M&I and HSHV appointments. Our staff needs to be able to build a long term relationship with first time moms/new families. But with the amount of funding that we receive for this program it is not possible.
allow flexibility within the local community such as the Health Dept. to develop programs that are needed in their own area, do not make all areas implement grants exactly the same way. Try to minimize paperwork and emphasize service.
I am almost afraid to answer this question, because it seems like every time something is "improved" it adds another layer of dotting i's and crossing t's that further limits the time available to spend with clients and provide basic services. The bottom line is that the majority of clients we serve often have multiple issues when they come into the office and while I understand the business model and efficiency, many of the clients are not going to take education presented in a fifteen minute office visit and go out and make major life changes to show that we have done our job. Change is hard, it takes a lot of time to educate, encourage and support people in the process of making change. I feel our staff do a fantastic job from the entry into the agency until they leave, but it is challenging and exhausting work and people are complicated. This work is so important though, because if we neglect this population or give up on them because they are too big of a challenge, that creates a bigger problem for the community in the long run. I just think we need to do a better job of educating the decision makers in local, state, and federal government on the importance of the services we provide and the reasons the programs were created to begin with and to communicate why the business model does not apply well to health and social services.
preconception/interconception counseling greater availability of mental health counseling more low cost prenatal care
I gave examples in previous panels. Decrease disease transmission in schools and daycare. Improve cleaning. Have a prescribing practitioner and maybe medicines close to school and daycare to more easily get children seen and cured. Improve birth control options for reproductive age females, mostly teens however. Teach teen males to be more responsible, i.e. wear condoms. Try to make inroads into the growing Hispanic population: changing to healthier diets to avoid diabetes (avoid refried beans made with lard, use wheat tortillas instead of corn tortillas because corn is higher in vegetable fats, baked tortillas chips instead of fried, and less use of specialty organ meats, and decrease caffeine intake (coffee, soda, energy drinks) which lowers potassium levels and interferes with insulin levels. Decrease sodium intake. Vegetables help increase potassium levels but that is a tough program to push in today's advertisements of processed sodium-enriched snacks.
More stringent consequences for perpetrators of domestic violence. Change of approach toward perpetrators - specifically, removing the perpetrator from the home rather than the victim(s): followed by Court ordered classes for the perpetrator with severe penalties for noncompliance. Additional counseling could/should be provided to assist the victim(s) and their families in the areas of self-worth/self-concept and personal power.

Keep policies current in reflecting best-practices/best reality. Continue to work with and expand stakeholders for effective collaboration and coordination of services. Expand availability of programs to families and those who work with families (child care, home visitors, school nurses, etc.)
collect data to better understand why there is resistance to having breastfeeding friendly hospitals when we know that a baby that is breastfed is healthier, has decreased medical expenses and mom benefits as well.
Funding should be based on measurable outcomes; agencies should be held accountable. Signing someone up for a parenting class is not pregnancy case management; offering immunizations once a week during working hours is not access to care; charging $10 or $15 per injection for VFC times four or five shots is not affordable for many of the working poor. Accountability, accountability....accountability....its time to base funding on performance.
Develop a statewide surveillance system to collect obesity data on children in pre-K through grade 5.
Gather BMI information with immunization so that there is data available on BMI esp. with children.
Find better ways to communicate with adolescents, find better forms of birth control that is affordable.
Regionalizing the local SRS Offices was a big mistake; The consumers themselves do not even know who to contact or where to call for questions they have about services that they may/are eligible for. Lack of assistance for these individuals with one on one help to complete the application process when many of these individuals are low functioning.
cheap and easy access to birth control, WIC, immunizations, better hours at local health departments, improve the horrible building "temporary" conditions at the Saline County health department
more education in school system
improve availability and quality of programs; education about particular policies
We desperately need more dental care. Currently clients travel 25-50 miles to have a Medicaid dentist treat them, then often the adults have teeth extracted (cheaper) instead of repaired. We need more diabetic education in primary languages. We need education on diet/exercise/dangers of obesity.
Encourage stronger, more cohesive partnerships between existing programs and services, including public/private partnerships.
Adequate funding along with health recommendations. Not targeting the funding to limited areas and disseminate it more evenly across the state. Use population average much the same as the state formula funding. State actively pursuing federal money for the general public health issues.
strengthen and simplify programs and services to families with young children (birth through school age) to help where families need it. I understand and appreciate accountability for funds and services, and the necessary documentation is becoming overwhelming and detrimental to services. Documentation is important, and it is NOT why people seek helping careers.
Help policy makers understand the importance of the investment in early childhood intervention and the gains not only for the child, and the mother, but society as a whole. Economically a huge savings too.
improve prenatal care reporting
Improve availability and economic development in the area, more centers to assist those underserved and not able to qualify for the state assistance available.
Better screening tools throughout
Work with the major providers of health services to recruit and maintain genetic services for the citizens of the state
Improving availability and quality of programs, as well as obtaining buy-in from policy makers and primary care providers.
Implement evidence based interventions with evaluation component.
The media is one of the biggest problems. because of their negative coverage of new clinics opening in the state that serve women's health, as "Abortion Clinics" this has cause people to think of our Title X family planning services as abortion clinics. The mention of "Planned Parenthood" is looked at as "Abortion Clinics"
not sure
Mothers, children, families : Education about health services and when to get the services Health insurance employment opportunities
none
Offer services in more than one location, i.e. either in a neighborhood or a traveling mobile unit.

collect data for specific needs of the underserved. Locate areas of the largest populations of families living with no insurance , no access to health care , and develop programs to help those families with education and tools to help themselves . Have a system in place that allows people access to basic care that have no way of getting assistance through the programs already in place. For example, Spanish speaking family with no insurance using ER for primary care issues.
Strengthen an existing policy that impacts health
Improve health insurance options for pregnancy and delivery outside of a hospital setting Share information with people about the birth statistics for hospitals/birthing centers/home births Strengthen information and advertising for breastfeeding/extended breastfeeding
See #15. Improving availability of, and access to, Board Certified Lactation Consultants to educate, promote and support breastfeeding would have an enormous impact on the health of families in Kansas. Breastfeeding is the single most important thing women can do to protect their children's health.
Strengthen policies that improve access to reproductive healthcare services, instead of giving the impression that the state would like to limit them. Improved support for Family Planning from the state level.
protect the midwifery model of care. provide access to midwifery care in the urban core. provide broad perspective childbirth education within communities, high schools with high child birth rates, etc.
Same answer as #15
Reimbursement to birth centers as FACILITYS...they are NOT being reimbursed for care of mother and baby postpartum---add as facilities! Increased access to midwifery care---save KS money
See my comments in sections 4 through 11. In general, health care records, beginning with the pre-natal records and birth records and infant care visits all the way through high school need to be integrated and designed for improving the developmental trajectories of all children, for preventing damage and optimizing outcomes. This can be done by optimizing the environmental - genetic interactions at the sensitive periods when children and parents are most responsive to the influences around them. This would ultimately save the public great costs, and have the result of reducing later costs associated with everything from heart disease, to teen pregnancy, to dropout and school failure.
All healthcare providers give the same message or confusion patients and clients,
New models of care need to be created that combine existing services. For example, in rural communities having combined clinics with the rural clinic providing well-child visits and local health departments providing immunizations, WIC.
na
Funding
Reform or restructure an aspect of service system. You don't need to collect more info on our kids and families. We are quite able to take care of kids ourselves. If the state would stop allowing service providers to inflate their rates to private pay families, more kids could be served. Special service providers are taking advantage of families, clients, and kids with Medicare/Medicaid benefits. There needs to be reform so that private pay families can afford the same services allowed to those on state aid. My husband and I pay the taxes that allow other kids on Medicaid to receive, but we can't give to our own child. Absurd.
Parenting classes with incentives to attend. Good, stable, local daycare at a reduced rate for low income Moms. Employment training with on site daycare
if the general public and professional health community had more information about the health status related to MCH that would be great. Short easy to read summary stats that we can share with the community to advocate. What is needed is more funding and we need to do more grass roots beyond the limited resources of KHDE and local health dept..
We would like to provide better access to care. We have the ability to expand services in our area but need support for other agencies to develop opportunities for individuals in need.
Explore the relationship of birth control usage and the presence of fibroids.
reform or restructure an aspect of the service system to make healthcare cost affordable to the middle class

1. Expand telemedicine for both medical and mental health and make certain that there is adequate reimbursement for telemedicine through KanCare. 2. Keep adequate funding for early childhood programs funded by the CIF. 3. Support the Kansas State Department of Educations TASN program (providing technical assistance to schools and access to autism diagnostic services in collaboration with autism expertise both in Kansas City and Wichita). 4. Support autism insurance legislation (as exists in 26 other states).
As a state we can better utilize data and information collected by the Kansas Child Death Review Board. We have a significant number of children and mothers that do not have health insurance, and this needs to be remedied. An important step toward improving the health of mother, children and families in this state will be to expand Medicaid in accordance with the affordable care act. Access to dental care for children, expectant moms, and low-income families across the state is a major concern. Kansas simply does not have enough providers to meet the demand, especially for those insured by Medicaid and/or seeking care at a community health center. As a state we need to adopt additional provider models to expand the capacity of current dental offices and community health centers.
These are difficult issues. There is no one cookie cutter remedy. Education and diligent support services are key to success. Primary providers often hold the key to access to services but there are not available services in rural and frontier areas.
I feel like it begins with education, not only of the mothers, but also of providers. It also seems like sometimes as a society we get so caught up in being "politically correct" that we miss out on opportunities to make an impact and change a person's way of living.
More programs through social media for WIC and families
Develop data systems that provide information at the population level for injury, obesity, mental health, oral health, breastfeeding, etc. Support the Safe Kids network of coalitions to improve transportation safety of children, promote breastfeeding, support integration of primary care and public health efforts, promote physical activity in community, ECE and school settings, strengthen and implement ECE policies related to physical activity.
support sex education that is evidence based and promotes prevention of STDs and pregnancy
Keep trying to make more people aware of services available in the communities and educate stakeholders, parents, etc. on areas that need improvement.
We have become a people who expect the government to provide for us, working for our needs is not an option, we want the government to provide. It is handed down from generation to generation. If people are not held more accountable for their actions we will destroy ourselves with a very weak people.
Improve availability of condoms to protect against teenage pregnancies.
Collecting data to find out what specifically is needed. Make programs available at times such as evening or Saturdays.
I feel that we need a more clearly defined and implemented system of care to reduce infant mortality, especially within minority populations.
Strengthen tobacco control Increase programs that include physical activity reduce sugary drink consumption prenatal classes offering in our county
Improve availability and quality of programs.
Information sharing WIC needs to promote breastfeeding by not providing formula at birth
Restructure home visiting into one Kansas home visiting program End formula distribution through WIC
Making sure access to health departments and programs are available to all who have needs
Educate the need to county officials and boards of health, work on obtaining more physician and services (i.e., low income dental services) for the people in rural areas.
CYSHCN - eligibility to services needs to be looked at. We have a lot of families that don't qualify any longer but cannot afford to pay for services themselves. The children then go without services.
Our numbers are low out here. I think if we could start a program in the JR. SR High School to educate the teens on wellness, health and pregnancy, the outcomes would improve.(This would take several years to see the outcomes) Our School has moved to teaching core classes and there is "no time" to teach the basics of life. Most students are too busy to join 4-H and Girl/Boy Scouts and other like organizations to learn HEALTH. Where do we teach/focus on these subjects? Public Health can offer education, but if there is not time for the students/population to attend or if it is not a priority, no one will attend. The

message does not get out there.
improve upon the programs that are already available.
Stick to evidence based interventions
continue to strive to bring services closer to southwest Kansas
the middle class is falling thru the cracks, and we would like to see a better understanding of the policy's that enable this

17. Other general comments

Response	Count
	19
answered question	**19**
skipped question	**273**

Response Text
Today's youth is over-educated about how to become a parent and under-educated at being a parent. Having these skills will reduce child abuse, neglect, obesity, diabetes, blood pressure issues, etc. Teach them what they need to do from the beginning. It's much easier than breaking an established pattern and it will get better with each generation.
none
None at this time
We have a moral obligation to provide the basic care to all of our legitimate citizens in the hope of providing for a healthy and productive future generation.
Policy of Limiting drink size at point of purchase and restaurants. Policy that every restaurant provides calorie information on menu. More low calorie choices at concession stands at athletic events around the state.
I have motor-mouth as it is. :)
Also, stronger Child Support Enforcement efforts and consequences for parents who are not supporting their children!
None
Leadership looking at multiple options, education and knowledge should match what programs are providing.
none
Need more information about upcoming state health insurance opportunities for January 2014
no
None
na
Jamie Kim does an outstanding job and well respected through the state, and beyond!
development of quality programs
I don't think that I commented on the school aged children about our use of medications to control this group. I am beginning to see an obvious overuse of medications in our area. We have actually had two hospitalized d/t overdose in the last four months. It isn't one provider, but a mentality that is causing the problem. Again I think that this is ramification of ignoring the stages of development in our kiddos and shifting all of our focus towards academic achievement (although it seems that even with all the extra focus there we are lowering the bar).
I appreciate the opportunity to explore how we might collaborate with joint resources to improve the health outcomes for women and children.
Access to the new Plan B pill or morning after pill, make this more available to persons who want it.

APPENDIX H

Title V Needs Assessment Survey

Default Question Block

Q1.
Every five years, the Kansas Department of Health & Environment (KDHE), Bureau of Family Health is required to complete a comprehensive needs assessment to assess the health* of women, mothers, infants, children, and adolescents including children and youth with special health care needs. KDHE is collecting information from organizations, professionals, parents, and community members across the state to identify needs and opportunities. Your input is critical to assure the Maternal and Child Health (MCH) Program is guided by the needs of Kansas families and MCH priority populations. Your feedback will be used to inform the MCH State Plan and to identify priorities for programs and services. This work is part of the Title V Maternal and Child Health Services Block Grant.
Thank you for your dedication and commitment to working together for a healthier Kansas.

*Health is a state of physical, social, and mental well-being and not merely the absence of disease. Health is created in the community through social, economic and environmental factors as well as individual behaviors and biology.

Q2.
1. Which best describes your role in filling out this survey? (Select one)

- Parent/Guardian
- Community Service Provider (social worker, home visitor, infant-toddler specialist, others)
- Health Care Professional (physical/medical, behavioral/mental, oral/dental, others)
- Local Public Health Department
- School Nurse
- Educator (administrator, teacher, school-based preschool/after school care, Head Start, or other school-based professional)
- Child Care Provider/Caregiver (home-centered based, school age)
- Policy Maker/Elected Official
- Other (please specify):

Q3. Keeping in mind the definition of health, what do you think are the most important issues facing mothers, infants, children, and children with special health care needs in Kansas? Please be specific.

Q4. 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.

Q5. **In this section, you will be asked your opinion as to what you believe about health in your community.**

Consider women ages 15-44 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.				

Q6. **Consider infants and toddlers ages birth to 3 years 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.				

Q7. **Consider children ages 4-10 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.				

Q8. **Consider both infants and children ages birth to 10 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 childcare available in my community for families that need it.				
In my opinion, most adults in my community believe that there is quality childcare for families that need it.				

Q9. 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 services, playgroups, parenting support, health services, etc...)

Q10. What services in your community have you referred in order to help women, children, and families stay healthy? (For example: WIC, family planning, early intervention services, playgroups, parenting support, health services, etc...)

Q11. What services would you like to see offered in your community to help you and your family stay healthy?

Q12. What services would you like to see offered in your community to help families stay healthy?

Q13. If you have not used a service offered in your community, why not?

Q14. If you have not referred a service offered in your community, why not?

Q15. In some communities, transportation has been identified as a barrier to families having access to services. What suggestions do you have to improve transportation in your community?

Q16. In previous surveys, parent education has been identified as an important way of meeting needs of women and children. Please share what activities you think work best for providing parent education? (check all that apply)

- ☐ Home visiting program (someone comes to my house on a regular basis to share information, answer questions, and support my parenting)
- ☐ Group/Class (I attend a group or class with other parents somewhere in my community every week for several weeks)
- ☐ Workshop (I attend a meeting with other parents somewhere in my community one time, on a specific topic)
- ☐ Clinic/Doctor's appointment (a health professional provides me with information and answers my questions during my child's visits)
- ☐ Child care (my child care provider provides me information and support, either formally or informally, on parenting issues)
- ☐ Written materials (books, brochures, and other printed information that I am given at a doctor's office, school, community-based organization, etc.)
- ☐ Online materials (online training/classes, websites, blogs, other online resources that provide me with information about parenting issues)
- ☐ School (teacher notes, parent-teacher conferences, school newsletters)
- ☐ Health fairs or community events
- ☐ Other (please specify) _____

Q17. The following questions ask you about your primary medical care.

	Strongly Disagree	Disagree	Agree	Strongly Agree
My primary medical care is accessible. Care is provided in my community and all insurance, including Medicaid, is accepted.	○	○	○	○
My primary medical care is family centered. My care provider recognizes that the family is the principal caregiver and the center of strength and support for children.	○	○	○	○
My primary medical care is continuous. The same primary pediatric health care professional is available from infancy to adolescence. My care provider provides assistance with transitions (to school, home, adult services).	○	○	○	○
My primary medical care is comprehensive. If needed, care is available 24 hours a day, 7 days a week. Preventive, primary and treatment issues are addressed.	○	○	○	○
My primary medical care is coordinated. My family is linked to support, education, and community-based services. Information is centralized.	○	○	○	○

Q18. In your opinion, are health services in your community coordinated so people get what they need?

- Very Coordinated
- Somewhat Coordinated
- Somewhat Not Coordinated
- Not Very Coordinated

Q19. What would improve the coordination of health services in your community?

Q20. Do you have an idea for something new or different you would like to see in your community to help mothers, infants, children, and children and youth with special health care needs to be healthy?

Q21. Initial data collected as part of this needs assessment has indicated that mental and behavioral health and screening for health and development are two important issues in the State. The following ask about your experience with these issues:

Q22. Are mental and behavioral health a concern in your community?

- yes
- No

Q23. Have you or someone in your household used mental and behavioral health services? If yes, what services?

- yes
- No

Q24. Have you referred for a mental and behavioral health services? If yes, what services?

- yes
- No

Q25. What populations need mental and behavioral health services the most in your community?

- Women
- Infants
- Children
- Children with Special Health Care Needs
- Adolescents

Q26. What would improve mental and behavioral health services in your community?

Q27. Are health and developmental screenings a concern in your community?

- yes
- no

Q28. Have you or someone in your household utilized a service for health screenings and/or developmental screening? If yes, please describe the service(s)

- yes
- No

Q29. Have you referred a service for health screenings and/or developmental screening? If yes, please describe the service(s)

- yes
- No

Q30. What population in your community, if any, do you believe needs access to health screenings and developmental screenings?

Q31. What is your community doing that is working for the health of women and children? Please describe the bright spots.

Q32. What County do you currently live in?

Q33. How long have you lived there?

- Less than 5 years
- 5-10 years
- 11-19 years
- 20-29 years
- More than 30 years

Q34. What is your gender?

- Male
- Female
- Transgender

Q35. What is your age?

- 21 and under
- 22-34
- 35-44
- 45-54
- 55-64
- 65-Over
- Decline

Q36. Please choose one or more of the following categories to describe your race.

- [ ] White/Caucasian
- [ ] Black/African American
- [ ] American Indian/Native American
- [ ] Alaska Native
- [ ] Asian
- [ ] Native Hawaiian
- [ ] Pacific Islander
- [ ] Other

Q37. Are you of Hispanic, Latino, or Spanish origin?

- Yes
- No

Q38. You indicated that you are completing this survey as a parent.

How many adults live in your household?

Q39. Please indicate the number of children living at home in each of the following age groups. Please enter zero if no children in that age group.

	Number of children
Children 0-1	
Children 2-4	
Children 5-9	
Children 10-14	
Children 15-17	
Children 18-19	
Children over 19	

Q40. What is your current household income?

- Less than $10,000
- $10,000 to 19,999
- $20,000 to 29,999
- 30,000 to 39,999
- $40,000 to 49,999
- 50,000 to 74,999
- $75,000 and above

Q41. What is your primary language (the language you speak in the home?)

- English
- Spanish
- Other

Q42.
Thank you for completing this survey! Your input is valuable to KDHE Bureau of Family Health. For more information or to stay informed about the Title V Maternal and Child Health Block Grant, visit http://www.kdheks.gov/c-f/mch.htm.

Initial Report

Last Modified: 02/03/2015

1. 1. Which best describes your role in filling out this survey? (Select one)

#	Answer	Bar	Response	%
11	Parent/Guardian		40	7%
12	Community Service Provider (social worker, home visitor, infant-toddler specialist, others)		139	24%
13	Health Care Professional (physical/medical, behavioral/mental, oral/dental, others)		102	18%
19	Local Public Health Department		117	20%
20	School Nurse		5	1%
21	Educator (administrator, teacher, school-based preschool/after school care, Head Start, or other school-based professional)		62	11%
22	Child Care Provider/Caregiver (home-centered based, school age)		60	10%
23	Policy Maker/Elected Official		2	0%
24	Other (please specify):		48	8%
	Total		575	

Other (please specify):
Licensing Surveyor
Clergy
FQHC
clinic parent resource specialist
Outreach Coordinator
State Public Health Department
Early Intervention
Health Manager
non profit agency
PTI
patient advocacy organization
Coalition Leader
KanCare Specialist
Community Support/ Probation
community prevention
Early Interventionist
early intervention
Community Development Specialist
Home Visitor
Early Head Start and Head start center based and home based nurse
Mental health community relations specialist
Researcher
State Govt Disability Program
Program Director
parent and educator
State agency
Corrections Director
RN, Lactation consultant
Kids board member
maternal infant health researcher
Non-profit Executive
state agency
contractor
health manager
Public health advocate, non-profit
Health Foundation

State department of health
ECBG grantee
Coalition Director
university professor
Healty Start Home Visitor
WIC
Director of Pregnancy Clinic
Health Care Professional & Community Service
PAT Coordinator

Statistic	Value
Min Value	11
Max Value	24
Mean	16.66
Variance	20.75
Standard Deviation	4.55
Total Responses	575

2. In this section, you will be asked your opinion as to what you believe about health in your community. Consider women ages 15-44 when answering these questions:

#	Question	Strongly Agree	Agree	Disagree	Strongly Disagree	Total Responses	Mean
1	I believe that women have equal access to health care in Kansas.	78	226	198	57	559	2.42
2	In my opinion, most adults in my community believe that women have equal access to health care in Kansas.	76	338	128	15	557	2.15
5	I believe that reproductive health, preconception health, and family planning are important topics.	394	154	7	3	558	1.32
6	In my opinion, most adults in my community believe that reproductive health, preconception health, and family planning are important topics.	72	294	174	18	558	2.25

Statistic	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.
Min Value	1	1	1	1
Max Value	4	4	4	4
Mean	2.42	2.15	1.32	2.25
Variance	0.73	0.45	0.27	0.51
Standard Deviation	0.85	0.67	0.52	0.71
Total Responses	559	557	558	558

3. Consider infants and toddlers ages birth to 3 years when answering these questions:

#	Question	Strongly Agree	Agree	Disagree	Strongly Disagree	Total Responses	Mean
1	I believe that infants and toddlers have equal access to health care in Kansas.	78	230	196	55	559	2.41
2	In my opinion, most adults in my community believe that infants and toddlers have equal access to health care in Kansas.	74	337	134	13	558	2.15
5	I believe that healthy weight and good nutrition for infants and toddlers is a health issue that is being addressed in Kansas	73	303	164	17	557	2.22
6	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	49	325	168	13	555	2.26
9	I believe that breastfeeding is an important part of good child health in Kansas.	390	157	7	1	555	1.31
10	In my opinion, most adults in my community believe that breastfeeding is an important part of good child health in Kansas.	62	294	181	15	552	2.27

Statistic	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.
Min Value	1	1	1	1	1	1
Max Value	4	4	4	4	4	4
Mean	2.41	2.15	2.22	2.26	1.31	2.27
Variance	0.72	0.44	0.50	0.42	0.25	0.48
Standard Deviation	0.85	0.67	0.71	0.65	0.50	0.69
Total Responses	559	558	557	555	555	552

4. Consider children ages 4-10 when answering these questions:

#	Question	Strongly Agree	Agree	Disagree	Strongly Disagree	Total Responses	Mean
1	I believe that children have equal access to health care in Kansas.	66	234	214	44	558	2.42
2	In my opinion, most adults in my community believe that children have equal access to health care in Kansas.	66	341	141	8	556	2.16
5	I believe that healthy weight and good nutrition for children is a health issue that is being addressed in Kansas.	68	301	161	24	554	2.25
6	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.	44	339	165	7	555	2.24
7	In my opinion, my community believes teachers and school environments are prepared to support children's success in school.	68	363	112	12	555	2.12
8	I believe teachers and school environments are prepared to support children's success in school.	63	315	150	28	556	2.26
9	In my opinion, my community supports children entering school ready to learn.	72	364	97	18	551	2.11
10	I believe that children in Kansas enter school ready to learn.	20	263	233	39	555	2.52

Statistic	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.	In my opinion, my community believes teachers and school environments are prepared to support children's success in school.	I believe teachers and school environments are prepared to support children's success in school.	In my opinion, my community supports children entering school ready to learn.	I believe that children in Kansas enter school ready to learn.
Min Value	1	1	1	1	1	1	1	1
Max Value	4	4	4	4	4	4	4	4
Mean	2.42	2.16	2.25	2.24	2.12	2.26	2.11	2.52
Variance	0.64	0.40	0.52	0.37	0.40	0.52	0.43	0.46
Standard Deviation	0.80	0.64	0.72	0.61	0.63	0.72	0.65	0.68
Total Responses	558	556	554	555	555	556	551	555

5. Consider both infants and children ages birth to 10 when answering these questions:

#	Question	Strongly Agree	Agree	Disagree	Strongly Disagree	Total Responses	Mean
1	I believe that children in Kansas have access to healthy physical activities.	41	297	187	15	540	2.33
2	In my opinion, most adults in my community believe that children in Kansas have access to healthy physical activities.	41	366	127	6	540	2.18
3	I believe that children in Kansas have access to healthy social activities.	21	269	229	21	540	2.46
4	In my opinion, most adults in my community believe that children in Kansas have access to healthy social activities.	29	343	158	8	538	2.27
5	I believe that there is quality childcare available in my community for families that need it.	43	206	204	86	539	2.62
6	In my opinion, most adults in my community believe that there is quality childcare for families that need it.	31	276	191	41	539	2.45

Statistic	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 childcare available in my community for families that need it.	In my opinion, most adults in my community believe that there is quality childcare for families that need it.
Min Value	1	1	1	1	1	1
Max Value	4	4	4	4	4	4
Mean	2.33	2.18	2.46	2.27	2.62	2.45
Variance	0.43	0.32	0.40	0.34	0.72	0.52
Standard Deviation	0.65	0.57	0.64	0.58	0.85	0.72
Total Responses	540	540	540	538	539	539

6. In some communities, transportation has been identified as a barrier to families having access to services. What suggestions do you have to improve transportation in your community?

Text Response
mobile busing service - mobile service that comes to the community on a regular basis for some basic primary services
Develop an affordable public transportation system by combining programs to be inclusive of all age groups and needs to maximize dollars rather than parceling out monies to specific groups of individuals i.e. veterans or the elderly.
Everyone wants it for free, but I think that unless you have a means to fund this service, this is a difficult one.
Not really sure
The first thing that needs to happens is a recognition by city and county officials that transportation is truly an issue. Most people would say it is not. Finding funds to help provide transportation at this time would be difficult.
We need to improve public transportation to outlying towns and counties being in a poorer rural area. (southeastern Kansas)
Transportation in my town IS a barrier. We as a community need more transportation avenues, so that people in general can have access and enjoy things in our community. We do not have an inner city bus line. We have taxi cabs which can be costly even if you are on a budget. There is an ATA Bus that many senior citizens use to get to and from doctors appointments but, it is not free and depending on whether a person has the fare may often determine if they can get from point A to point B.
Local transportation company offering free transportation at specific times or days possibly with reimbursement from govt.
Wider range of bus services.
Transpiration and services
buses or lower taxi rates
Most of our clients use friends as access to transportation. We are very flexible in scheduling clients for the most part and are able to meet their needs.
Sometimes it's lack of education. Medicaid will reimburse families for health care visits. For me personally, I think there is a lack of pediatricians in my area. I have to go out of state for children's physicians and dentists.
Improve the internet services so Tele-Medicine was utilized more often--have computer stations for Tele-Medicine set up in every library Offer weekly transport from small rural communities to facilities---maybe dovetail the meals on wheels transportation Expand the role of health departments (with increased funding) in rural areas.
I don't know what would help.
I realize we cannot give transportation to all because it is just not cost effective but I believe transportation to preschool or to some therapy is essential.
more affordable and accessible community transportation, increase school buses
bus service or light rail but that costs money and families may not be able to pay fares
Transportation services that could be free or reduce to use
bus tokens for routine health care visits, especially for children; improved bus routes and/or use of smaller vehicles specific to medical appointment routes
We have an agency transportation service, I usually only see older citizens using it. I am not aware that younger citizens, childbearing age use the agency transportation.
transportation seems fine in my community, old town, olathe
That is a hard one. Many of the services available are not located within our community, but rather across the county.
I am unsure how to increase public transportation while keeping it well funded?
I have no idea. My families all have transportation. I know there is a JoCo bus, and that some medicaid programs offer help, but I do not know how helpful they are.
EMPLOYERS COULD PROVIDE VANS FOR THEIR OWN EMPLOYEES SUCH AS NURSING HOMES AND HOSPITALS. iT WOULD HELP REDUCE ABSENTEEISM
Public Bus
Bus services are increasing which is a step in the right direction
None
Provide information to families about job opportunities, coops, and other resources that help them become self-sufficient!
Have drivers available.
Have designated bike paths throughout our area. Not just in town but in the rural areas as well.
We have transportation services available at a nominal fee. It would be nice to have services that are free or based on a sliding scale.
I think a twice a day bus ride to county health dept would be good, also a income based taxi type service to local dr office would be helpful.
More bus services with longer hours, more funding for he services
having a service that if parent or adult meet certain requirements that this service of transportation be available to them on a sliding scale payment option
Prepaid bus cards.
Bus Routes could run more often and pick up closer to the homes of families with young children, people with disabilities.
More accessibility to bus stops or more bus stops
Increase scope of Quivera Transit
We are very fortunate as our RSVP Provides Transportation Services. 620-672-7811.
Our community now has a public bus system yet it only runs from 6:00am to 6:00pm.
Our community has a public transportation that is low cost.
Our community does have a plan in place to address the tranportation issues. There is a bus route scheduled to begin with several busses running.
Increased methods of AFFORDABLE, REDUCED-COST public transportation (i.e. bus system, taxi services, insurance covered taxi services)
Some people use the free transportation the insurances might provide, but some parents are just not putting the effort in to make that call and scheduling something
The Leisure Center bus needs to be accessible to all citizens all day long. Public transportation should be available for everyone.

Better access, stipends for those who qualify, volunteer drivers to assist in transporting

MORE REASONABLE TRANSPORTATION , LOWER FEES FOR OUR TRANSPORTATION BUS, IT TAKES TOO LONG TO ARRANGE TRANSPORATION WITH DCF. MAKE THAT MORE STREAMLINE.

More public transportation

The state needs to provide more grant money for local transportation. Improving biking in communities.

Bus available for longer hours each day.

Re-examine how all the general public transportation funds are utilized; complete a statewide transportation assessment and identify opportunities for improvement. In our region, if you don't have a car, your access to resources is very limited.

Transportation isn't much of a problem in our community we have public transportation.

Public transportation be expanded to several communities and counties

Better bus services. Develop a peer transportation system.

Keep advertising and enlarging the bus routes available in our town.

more transportation within the county would be great

Affordable, available, child friendly.

Offer more transportation to the place of services clients use in the community.

Put money back in Head Start to allow all children are picked up for the program, public transportation to cover the town for people to get to work, appointments, clinics, etc.

improve the city bus services to be accessible and schedules more user friendly. Improve the safety of walking routes.

Reno County currently has a bus system called RCAT (Reno County Area Transit). One improvement suggestion for area transit the bus running later in the evening.

To save the money they spend on Tattoos, alcohol, drugs, cigarettes, hair, nails and or anything else to use for transportation.

We have public transportation bus that cost 1.00 People need to walk more for appts etc for excercise

Our community could definitely use an expanded bus route. It will be interesting to see if Uber can improve transportation in our community.

Free or reduced priced public transportation.

The city's bus system is lacking funding. More funding to increase routes and buses would improve transportation in our community.

THE HEALTH PROVIDER NEEDS TO MAKE IT KNOWN TO FAMILIES HOW TO USE IT.

It would help if there was funding available to enable the local hospital, or community health centers to provide transportation in a 50 mile radius of their hospitals or clinics so that patients could come to appointments or scheduled testing.

Have a bus/van for county health dept for transportation and charge a small fee. City bus routes expanded

This is a big problem for rural communities that have high poverty rates. I'm really not sure what the solution is. They can't afford public transportation either.

We are currently in a very good position because of the way that our public transportation is delivered. It is run out of our LHD and we use it for all community members across the board. We have VERY affordable ride prices and are able to transport folks to meet their needs. We do have issues with meeting needs for folks who need to travel outside of our service area...

Subsidized public transportation; community volunteer network

Make public aware of public transportation routes and times

Transportation is a great barrier in my community. i believe that increased public transportation in addition to late hours would be of great impact in my community.

I believe we need to focus more on providing mobile services to the locations in our community that have the highest need.

I feel like our community is working well to improve transportation by adding buses for the community.

No ideas.

Waivers that provide funding specifically for transportation directly to parents so they can get the transportation they need

I'm not sure what would help here.

Public transportation systems

Maybe have a grandmother/grandfather type be able to pick up families that transportation is a need.

Improved bus system/public transportation - as of now it is not convenient and can take an hour on the bus to get to a doctor's appointment. Offer vouchers for public transportation, if not already done, that is covered through their insurance plan.

Vouchers for buses or taxis, volunteer drivers to transport patients.

Many rural areas do not have transportation options for families.

Affordable busing services

a bus system more in tune with the needs of its riders, ride share program

Public transportation

Middle-class get no help with transportation costs to Kansas City where many children are served. The current system of funding or obtaining transportation calling the number on the back of the Kan Care card is not easy to manipulate or plan for.

I notice that as the seniors age and are no longer able to drive, they are trying to walk to the store. Johnson County needs small buses to transport seniors for rides to their doctors' appointments and to the store to by their food, etc. Our community doesn't take care of each other.

Improve public transportation

Bus, family or friends

School based healthcare-utilize telemedicine

We have the Access Bus which provides transportation at a minimal cost to the passenger. This is a service that helps many of our low income families. Especially those who can not afford the costs of running a vehicle, (gas/maintenance).

Transportation is the major issue as there is no public transportation. There are multiple services just 10-15 miles away but the bus does not come here.

bus passes, transportation vouchers

There is a community transportation bus, this is a small community
There are some public transportation options, but most in Southeast just find someone to give them a ride.
Transportation is a major barrier. We have an Access Van, however it is very well used, & has regular users for work transportation & is very limited for other transports. Our community would benefit from another transportation service, or addition to the current service.

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	453

7. In previous surveys, parent education has been identified as an important way of meeting needs of women and children. Please share what activities you think work best for providing parent education? (check all that apply)

#	Answer	Bar	Response	%
1	Home visiting program (someone comes to my house on a regular basis to share information, answer questions, and support my parenting)		452	84%
2	Group/Class (I attend a group or class with other parents somewhere in my community every week for several weeks)		311	58%
3	Workshop (I attend a meeting with other parents somewhere in my community one time, on a specific topic)		231	43%
4	Clinic/Doctor's appointment (a health professional provides me with information and answers my questions during my child's visits)		407	76%
5	Child care (my child care provider provides me information and support, either formally or informally, on parenting issues)		323	60%
6	Written materials (books, brochures, and other printed information that I am given at a doctor's office, school, community-based organization, etc.)		250	46%
7	Online materials (online training/classes, websites, blogs, other online resources that provide me with information about parenting issues)		284	53%
8	School (teacher notes, parent-teacher conferences, school newsletters)		348	65%
9	Other (please specify)		51	9%
10	Health fairs or community events		275	51%

Other (please specify)
public media instructional ads
all above
peer support
current health/education programs during hours parents are required to work
PAT
Support groups
All the above is great!
Hope in Oklahoma has a person mentoring a new parent and meeting with them weekly
interpurters
Case management with one-on-one support on an ongoing basis reinforced by organizations/institutions that the parents trusts.
Mandatory classes
Behavioral Health Programs
church support
Early Intervention
Prenatal visits
Social worker consult...similar to home visiting program but fewer visits.
I find it interesting you do not include fathers in parenting? Homevisiting is an excellent way to share information and answer questions but parents truly listen to their doctor. Now I don't believe doctors know everything about parenting but parents listen to them. Group - it is great because people can learn from each other. Naturally online now has become very popular way of learning.
classes for life skills
prenatal education
all of the above.
All of these can work, tailored to specific groups of parents
community baby showers, dental clinics, brieges out of poverty/circles of hope
Mentoring
Parent education needs to do more than help mothers with parenting. It needs to help them gain knowledge and skills and experience that can help them move out of poverty. It also needs to include fathers. Children need families.
Church involvement and volunteers who educate parents
Help with identifying people that they can relate to, 800 hotline number for anonymous advice
information on special care services seemed to bring in more attention and better awareness than other surface information
Texts, social media posts
asking other families who access services to share with their friends and neighbors
scouts, BBBS, Boys and Girls Club, 4H
A clear and consistent message deliverd at ALL of these activities. Messaging across agencies in multiple ways- hearing the message over and over again...
Information from friends and family
Social media - twitter, texting

I think brief social media messages work well
one on one parent education/mentoring, tangible incentives for involvement in parent education
YouTube videos
School PTO organizations
none of the above will work even if the offering is top notch if there is not buy-in from those needing the education. May be a better way to look at it how to get consumer buy in. However, both are important!
offering service right in the neighborhood where the people live. Come to where they are at a time that is convenient to them.
Free community activities
Conferences given by different organizations that work with children with special needs
To receive services mandated to attend topic specific classes identified as the need for the parent(s)
direct services and help setting up appts is necessary
Facebook&Twitter
Consolodated Appts--"one stop shopping"
texting
parents engaging other parents is very effective.
Church
Social Media seems to be a way clients relate. If clients have a reliable source they reference vs. reading anything on the internet it would be preferred. So if they had one source to consistantly go & reference it would be a good idea.
Family activities such as school carnivals that also have information- like the state fair

Statistic	Value
Min Value	1
Max Value	10
Total Responses	539

8. The following questions ask you about your primary medical care.

#	Question	Strongly Disagree	Disagree	Agree	Strongly Agree	Total Responses	Mean
1	My primary medical care is accessible. Care is provided in my community and all insurance, including Medicaid, is accepted.	52	121	253	95	521	2.75
2	My primary medical care is family centered. My care provider recognizes that the family is the principal caregiver and the center of strength and support for children.	42	108	297	72	519	2.77
3	My primary medical care is continuous. The same primary pediatric health care professional is available from infancy to adolescence. My care provider provides assistance with transitions (to school, home, adult services).	51	152	246	65	514	2.63
4	My primary medical care is comprehensive. If needed, care is available 24 hours a day, 7 days a week. Preventive, primary and treatment issues are addressed.	70	203	189	56	518	2.45
5	My primary medical care is coordinated. My family is linked to support, education, and community-based services. Information is centralized.	70	221	193	32	516	2.36

Statistic	My primary medical care is accessible. Care is provided in my community and all insurance, including Medicaid, is accepted.	My primary medical care is family centered. My care provider recognizes that the family is the principal caregiver and the center of strength and support for children.	My primary medical care is continuous. The same primary pediatric health care professional is available from infancy to adolescence. My care provider provides assistance with transitions (to school, home, adult services).	My primary medical care is comprehensive. If needed, care is available 24 hours a day, 7 days a week. Preventive, primary and treatment issues are addressed.	My primary medical care is coordinated. My family is linked to support, education, and community-based services. Information is centralized.
Min Value	1	1	1	1	1
Max Value	4	4	4	4	4
Mean	2.75	2.77	2.63	2.45	2.36
Variance	0.75	0.62	0.69	0.73	0.63
Standard Deviation	0.87	0.79	0.83	0.86	0.79
Total Responses	521	519	514	518	516

9. In your opinion, are health services in your community coordinated so people get what they need?

#	Answer	Bar	Response	%
1	Very Coordinated		31	6%
2	Somewhat Coordinated		264	51%
3	Somewhat Not Coordinated		139	27%
4	Not Very Coordinated		80	16%
	Total		514	

Statistic	Value
Min Value	1
Max Value	4
Mean	2.52
Variance	0.68
Standard Deviation	0.83
Total Responses	514

10. What would improve the coordination of health services in your community?

Text Response
Opportunities for leadership development for community leaders - effective leadership; conducting a needs assessment; facilitating collective impact work with either existing groups or new groups based on community readiness to engage in the work of coordination and results oriented work.
one clearinghouse for all services offered in the community
I believe our community tries to reach people, but it takes their effort to access the information as well as being provided the information. Not sure if people always have the interest or fully understand the importance and I'm not sure how to encourage this other than what is currently being done. I guess just keep at it and by word of mouth.
More Doctors
less competition between hospitals and more cooperation
if persons given options would accutally go to appointments
Gathering outlying communities into the main county granted funding for services instead of treating them as secondary to the population of the main county.
We need more Specialty Clinics in my community so that we don't have to drive 60 plus miles one-way.
Customer service
Shared knowledge/awareness of what is available in the community.
If physicians would actually read what other physicians have charted
Make it affordable to the lower income families. Provide transportation for illness in families.
Better communication.
There is a lack health providers in rural areas. I have to go out of state for all our appointments and coordination of services is difficult when you are crossing state lines.
One stop shopping of some sort An understanding of the billing codes for insurance
Not sure.
Wait times are absurd. 4 months for mental assistance, not ok.
Instead of having to contact separate agencies maybe a central agency could be provided to set up services for the families/children for their specific needs.
Increase sharing of electronic health records among providers, encourage coordination of care between providers
Family medical homes, preventative approaches, home visitation
somehow to reach all children and their parents. I have no idea how to do that if they don not participate in a childcare or educational setting.
open lines of communications between all doctors and patients--if you have more than one issue you have to go to more than one doctor and it always seems like one doesn't know what the other is doing
Use of less expensive professionals than physicians to coordinate health services for individuals
I don't know
?
I feel they are coordinated.
unsure
Aside from healthcare providers coordinating all aspects of care, a central information depot would be helpful to parents. A database that licensed health providers enter their specialty and what insurance they take, who has extended hours, etc would be an incredible resource. As i mentioned earlier- I have no idea where a parent with an ODD child can go to in order to help their child, as well as to learn effective parenting techniques. My own child is another example- I have not been able to find ANY therapist that is experienced with Tourrette's and that accepts medicaid. I have spent months searching- how many people would just give up? I still have not found anyone specializing in it! A centralized health information depot would help connect people to the resources they are looking for.
COMMUNICATION AND TEAM EFFORT APPROACH.
I would prefer to not have to go to Kansas City for health care.
Dr. and dentist offices open after 5 without having to pay for an afterhours clinic. If you can't get off work during the day, you can't go to appointments. As a day care provider, I have children who need to see a Dr, but the parents can't afford to go to an after hours clinic and they cannot get off work to take them during Dr. hours.
Not just cater to Hispanics, but to all races. Why do all the forms ask if you are Hispanic or not. It shouldn't matter. Why are Hispanics getting the benefits of our tax dollars that are taken from me, then I or my child can't benefit from services when they are needed for us? Just Wrong!
It would take a cultural change. Most organizations are silos. They are too afraid to venture out because then they just might lose control. So they simply won't work with others.
communication
Doctors that go to a different hospital. Currently the doctors in town go to only one hospital, so if a patient wants or needs another hospital due to insurance reasons they must go put of town for a routine check up let alone an illness
I would guess that they are more coordinated than I realize but I don't know where to find information or who to ask.
Cooperative effort to get services to children and families. Working together, communicating with other organizations. We should think of ourselves as a community of neighbors, friends and families.
More interaction between clinics, hospital and health department
We have a good referral system in place. I'm not sure the entire community is aware of what services are available.
Prevention of illnesses is not promoted with our Medical Care Providers, they only focus on Acute illness. Also there is very little if any communication between providers and other services in our community. For example there are Breastfeeding Support Services available in our community yet the OBGYN offices or the Pediatricians do not refer to these. Also our County Health Department and our local providers never communicate with one another, unless it is H1N1 or some type of outbreak, and even then it is not in a manner of confidence.
n/a
More consistency and coverage via insurance. Flexible scheduling.
maybe the schools and the health dept and the physicians office meeting quarterly ?? but who needs more meetings?

I don't know.

Agencies not aware of or understanding what the other one involved with the family does. A family might have 5 different agencies working with them and duplication of services as well as gaps in service.

Need time and cooperation from other agencies.

Easy transfer of EMR information between systems, bilingual services

linked EHR

Hospital more willing to collaborate with other agenciesno

As an organization, coordinating care is what we do....that said, the private medical community in most of the communities we have clinics operates extremely independently and does little to coordinate services. Care is still very much delivered in silos; there is very little cooperation let alone collaboration. This has undermined the overall health and well being of the region as evidenced by the county health outcomes.

Having more specialized doctors

Opportunity to collaborate

Health care providers need to be educated on what kind of services are available to help clients. It would also be a good idea for there to be more social workers available to coordinate care.

Better communication between physicians offices would improve coordination of health services.

better communication among providers

Going the full mile-transportation, education, explanation, reminders, and transportation home.

Have health services available in one building.

Transportation

a consistently maintained centralized source of information related to health and related services.

Community collaboration between the private and public sector would allow for resources and services to meet the needs of our population.

Education

Health fairs and informational exchanges could improve the coordination of health services in our community.

Additional funding would help improve the coordination of health services in my community.

EACH FAMILY RECEIVE CARE COORDINATION IN ORDER TO LEARN ABOUT AND OBTAIN NEEDED SERVICES. I KNOW FROM PERSONAL EXPERIENCE AS A PROFESSIONAL THAT THIS COORDINATION IS NOT EFFECTIVE WHEN THE INSURANCE PROVIDER IS RESPONSIBLE FOR THIS COORDINATION. THEY LACK THE INTIMATE KNOWLEDGE OF THE PATIENT/PERSON WHO NEEDS THE HELP WHICH IS IMPORTANT IN ORDER TO EFFECTIVELY ENSURE THEIR NEEDS ARE BEING MET.

Continue to find unique ways of reaching people in our communities. 1. Not everyone can afford to subscribe to the local newspaper, if one is even available. 2. Not everyone has a local cable channel that provides this type of advertising, and if they do, people probably don't think to check it for this kind of information. 3. Using radio advertising 4. Social media, not everyone has a computer, but a lot of people do have cell phones with access to Internet 5. Utilize county health departments as a referral site 6. Offering child healthcare screenings through rural health at school has been a wonderful benefit in our three county area.

Partner with local hospital to provide certain services for our clients (x-rays)

I don't know

Over regulation has caused our community to lose some of our valuable services. The community regrettably had to come to the decision to stop offering both hospice and home health as well as several other outpatient services. Attempts are made at coordinating other health services, but often times there are to many roadblocks to overcome to do the job efficiently.

Client/ family liaisons

Com Care is big in Salina and i feel that they run people in and out as fast as they can.

Better communication between all provides.

holding individuals accountable for participating in care coordination, Medicaid/Medicare billing for care coordination services

Need more good quality doctors. Especially pediatricians. Too many children and not enough doctors leads to long waits and short visit when actually with doctor. Need a 24 hour, fully staffed, affordable, urgent care clinic.

Don't know.

Getting information on what services are available to parents. Increasing services.

Agencies talking to each other so services are not duplicated. Having one place where parents can go to get resource information.

It is my understanding a committee has been formed and needs are beginning to be addressed. A local clinic will open soon.

improved access to care, more case workers to help with the growing need for health services - the case workers could then help coordinate care to doctor's offices, WIC apppointments, and other appointments, and make sure referrals were not missed

More primary care physicians available with better trained reception staffs

Better referral to tiny-k. Increased interaction from primary providers with community programs.

Billing across disciplines so that behavioral health and physical health care services can be integrated in the same settings.

several services would benefit from being in the same location

Specialty services and direct referrals

Better access to specialists closer to home.

If Health Insurance Companies worked with more doctors and hospitals so that the health services could coordinate together for the well being of the patent.

Everyone has access to a primary care provider

health information exchange so all EHRs are shared and accessible

If we could retain doctors more than just 2 or 3 years.

transportation

Instead of everybody protecting their own turf and meager resources there should be a conscious attempt to reach to one another and figure out what would be the most

efficient way NOT to duplicate services and to offer what is truly needed to women and children.
Small community, not all insurances are accepted
Most communities do not have a pediatrician and often utilize medical services over 30 miles from their home. Those who have insurance are unable to access care due to high deductibles and other costs.
More access to free services or assistance.
We have clinics and doctors who will not see children with a medical card because their parent has a owed bill at the clinic. So the family is forced to use the ER. This cost more!
Decreased time pressures at work to allow health care providers to talk w/ others.
They do a very good job. The only thing is when a specialist is used for something there is often a lag in the report being given back to the primary care provider.
A more focused approach as a group instead of hit and miss with separate organizations
Crossing county lines for coordination
Develop personal Health Improvement Plans for chronically ill and those at risk. Case management.
Many staff have too large of caseloads which leaves little time for coordination of care.

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	379

11. What is your community doing that is working for the health of women and children? Please describe the bright spots.

Text Response
WIC, Parents as Teachers, early headstart, Healthy Start Home Visitor, Becoming a mom
wic
We have different departments that are actively involved in trying to meet the needs of infants and children. They also meet regularly and with other agencies to resolve some of these situations.
Offering services at Four County
Women's Community Y practices, teaches and shares with families the components of good nutrition. Parents As Teachers also offers education in this area. Both are in cooperation with County Extension Service.
WIC, classes for parents, providing resources to childcare providers to share with parents, mother baby visits
Montgomery County's 4 county services are doing well but hurdles are still in place
Public Relations within the community as an Outreach effect.
Early Headstart, Headstart, WIC, planned parenthood
District 501 speech therapy Parents as Teachers
Learn and Play program, our family planning services. Moms group and WIC. We are a great support for moms and encourage them to come in or call with questions or concerns.
WIC, PAT, Faith-based and Facebook support groups
Free weekly clinic for individuals who are under or not insured Health department is good at getting information out--WIC, Developmental Screenings, Immunizations, Free clinic,
I am not sure. I do not work with women. For children and adolescents, KanCare is a very positive program that provides health insurance.
Developmental screenings, parents as teachers services, immunization services, child care licensing inspections, women infant and children programs
ASQ screens are now being done in some pediatrician offices to help with earlier detection of developmental concerns.
the mental health facility has opened a new facility and appears to be working very hard trying to educate the community
Kansas Children's Service League's Parent HelpLIne
They are invisible. Our local health dept is the only place and it is limited in availability.
screening in schools
Unsure
I participate with Parents as Teachers in my program. Great resource. I love Infant Toddler services, although, I think we end up with many children slipping through the cracks with the 3 year cutt-off. Many more children would benefit if that was expanded to age 4. Thanks to the Health Partnership in Olathe, I can at least get basic medical care, despite my lack of insurance. I felt like my needs were met and the doctors were concerned and thorough.
WIC HEALTH START HOME VISITOR
Strong support group for breastfeeding
Agencies that work with children and their families are trying to collaborate to assist families!
Not much. Health Dept. wouldn't give flu shots to children with respiratory issues (such as asthma), when doctor's office was out and not getting any more in, because child had health insurance.
We have a home for unwed expectant mothers. Breastfeeding is promoted quite a bit. Our Early Steps to School Success is a bright spot as well as our healthy start home visitor.
My community has two community health fairs - one geared for all ages and one for families with children 3-8. Community partners come together and do fun activities encouraging physical activities and provide information on their organization.
The Recreation commission has a lot of free and cheap programs for kids, sports and other activities. The city library has a couple of programs for kids and the schools have some extra-cuticular programs
WIC
Horizon's Health Center staff come into Head Start Program and work with Head Start students who have been identified as being at risk do to social/emotional delays or illnesses.
no idea
Health Department services
The health department sees women and children and refer to other health providers as necessary.
We do have Family Planning available at our County Health Department, that is on a "sliding fee scale". We have a number of practicing Nurse Practitioners in our community who see women and children. for services and are preventative focused.
There are two walk in clinics, the health department has programs for women and children. A mental health professional is available to see one day a week.
There are Count you kid in screening clinics regularly as well as Women's Day out days periodically.
Non-profit therapeutic mental health services
We have WIC to help with meeting family food needs, parenting classes through the Health Dept, Family Planning, Healthy start home visit that is not really utilized
I don't know.
Procviding services such as WIC in more than one location as well as women's health-related services-family planning, colposcopy, STI, prenatal. Working with reps from the private sector so they have a greater nderstanding of these needs.
Headstart, Infant Toddler services, open access at some clinics and mental health centers
WIC is very successful in our community, Becoming A Mom prenatal classes, Some mental health services are available.

WIC

It's a mistake to ask what the community is doing because, historically, most of our communities have focused on economic development or sewer systems or highways. The one exception is in Allen County with THRIVE who have -- as a county -- set about to improving health. This has included walking trails, recruitment of health providers, funding a new hospital, rebuilding/building parks, starting a farmer's market and community gardens and so on....they get it....

WIC

Providing family planning for women and Prenatal care

Family planning services at the Health Department. Rainbows United for developmental issues.

The programs available through Ashby House and DVACK are bright spots for the health of women and children.

WIC and Kan Be Healthy services are two of the most important services as well as all of them I mentioned above.

WIC, programs for first time moms and at risk moms, mobile health clinic that goes to schools.

Success by six and preschool screenings to identify at risk kids

see early question on services provided

WIC, our county health department, organizations like Health Partnership Clinic and many others!

WIC, Life Care has the Baby Bucks program.

parents as teachers, infant toddler, healthy famlies; coordination between programs

The bright spot I see in health of families in Kansas is the Affordable Care Act.

FAMILY ENGAGEMENT ACTIVITIES; COORDINATION BETWEEN AGENCIES THAT PROVIDE SERVICES TO WOMEN AND CHILDREN

The Early Detection Works program is actively seeking eligible women for our program and enrolling them to be screened at no cost for breast and cervical cancers.

Family Planning WIC Community Health Assessment Teen Pregnancy Maintenance Program-help reduce a second pregnancy

Nothing

We are working with other community groups to bring better nutrition and physical activity to these groups. We are also trying to help fill the gaps in care (especially for those without insurance). We don't really see any kids without insurance, most have medicaid if they don't have private but we do see parents or the grandparent who are their caregivers. They either don't qualify for medicaid or insurance or choose not to have it, we are trying to help those folks get basic screening's and education. We do this as a donation only service so cost is not a deterrent for them. This is something that is very successful for us so far and we hope to expand it.

Active WIC and Family Planning services; active child care services; promoting Quit LIne; promoting healthy nutrition and physical activity

We are providing, access to care.

Don't know.

.

Walking trail with playground that is new in our community. Encouraging community garden, parenting classes. Breast feeding education and support.

It is my understanding a committee has been formed and needs are beginning to be addressed. A local clinic will open soon.

Some projects are starting to be develop in our community, walking path, community garden,

Providing prenatal care, well child care to patients whether or not they have health insurance

Advertising health dept. services available to the community

The Educational Service Center and Early Childhood Programs. Head Start, Early Head Start, tiny-k and Smart Start

Participation in Black Grant Activities; Family Place Libraries; WIC programs with ASQ screening; Infant Mental Health programs; Parenting Classes and Parent Child Learn and Plays; Day Care Consultation Programs.

school district offers free all day kindergarten

We have Familt Servuce and Guidance avaible

Prenatal care, head start, early head start RCDC

We cover 5 counties and there are WIC, Early Head Start, Parents as Teachers, and Infant Toddler services in all areas. These agencies work well together. We have been lacking in cooperation with mental health and medical professionals, but this is increasing somewhat. Our County Health Departments are very active and work well to screen and meet the health needs of the families in our counties.

I don't think they are doing anything to help on this issue. We would have to vote people out of office to get anything down. Again, why aren't we helping all mentally ill people and not just women?

There are a number of agencies that are trying to work together. Development of school clinics (i.e. at Wyandotte High)

Early Childhood Connections-Giving children a good start on learning when parents fall short. Hays Area Children's Center-Not only screen children but offer parenting classes for families. Healthy Start-To get into the home and help new parents deal with all their questions. Sadly not used very much but should be. WIC

very little, touting the few services that exists but not adding anything new or improving the existing ones

We have the Agape Clinic, a free clinic for low income people

Working to increase smoking cessation education and improve WIC.

Breastfeeding classes, WIC, First Care Clinic,

Offering WIC and providing Health Education in schools.

WIC, Head Start, Early Head Start, Kids in Crisis

Improved communication to people using free clinics, stressing the importance of keeping appointment.s

Our health department works very hard to meet the needs of the area . They are a young energetic group and track people down.

the Healthy Families home visiting program providing support to families that are overburdened

not sure

Our WIC clinic is providing motivational interviewing intervention with our clients. This is designed to help clients set attainable goals that are important to them.

Public transportation is available which is a big help to families.

Early intervention services
The health department offers family planning, prenatal care through the University of Kansas Hospital, pregnancy programs which offer case management, WIC, and we have an Early Learning Programs pamphlet that lists all the programs and services for children in our community.
In early intervention having providers and resources that work as a team with families to try to brainstorm ways to pool resources and help families find the service they need.
Healthy Families Program , Tiny K services, PAT, Headstart
I feel the Health Department is doing great work being a resource for our communities. Many times the concern is that families do not know what the health department can help them with or they are prideful and do not want to access care at the health department. There are many local organizations and churches that are trying to offer support like Mom's Day Out programs, Mom support groups, and day trips for our retired populations.
As described above, the "Becoming A Mom" program has brought together resources from several community partners.
Recently have opened a clinic that is open after hours, there are more preschool slots open in the school district and serve both "at risk" and developmentally delayed children.
Educating the parents of age appropriate kan be healthy- what each age should a doctor check for. educate them of the important of health- to be able to learn. we show them screening tools doctors should be using.

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	334

12. What County do you currently live in?

#	Answer	Bar	Response	%
1	Allen		1	0%
2	Anderson		0	0%
3	Atchison		8	2%
4	Barber		3	1%
5	Barton		1	0%
6	Bourbon		0	0%
7	Brown		6	1%
8	Butler		7	1%
9	Chase		0	0%
10	Chautauqua		1	0%
11	Cherokee		10	2%
12	Cheyenne		0	0%
13	Clark		2	0%
14	Clay		9	2%
15	Cloud		0	0%
16	Coffey		0	0%
17	Comanche		0	0%
18	Cowley		1	0%
19	Crawford		11	2%
20	Decatur		1	0%
21	Dickinson		4	1%
22	Doniphan		3	1%
23	Douglas		31	6%
24	Edwards		1	0%
25	Elk		0	0%
26	Ellis		4	1%
27	Ellsworth		1	0%
28	Finney		15	3%
29	Ford		3	1%
30	Franklin		5	1%
31	Geary		14	3%
32	Gove		0	0%
33	Graham		0	0%
34	Grant		6	1%
35	Gray		1	0%
36	Greeley		1	0%
37	Greenwood		0	0%
38	Hamilton		0	0%
39	Harper		1	0%
40	Harvey		7	1%
41	Haskell		2	0%
42	Hodgeman		1	0%
43	Jackson		7	1%
44	Jefferson		9	2%
45	Jewell		0	0%
46	Johnson		73	15%
47	Kearny		1	0%
48	Kingman		0	0%
49	Kiowa		0	0%
50	Labette		3	1%
51	Lane		1	0%
52	Leavenworth		10	2%

53	Lincoln		1	0%
54	Linn		2	0%
55	Logan		4	1%
56	Lyon		4	1%
57	Marion		2	0%
58	Marshall		5	1%
59	McPherson		8	2%
60	Meade		5	1%
61	Miami		4	1%
62	Mitchell		1	0%
63	Montgomery		9	2%
64	Morris		0	0%
65	Morton		1	0%
66	Nemaha		3	1%
67	Neosho		1	0%
68	Ness		1	0%
69	Norton		1	0%
70	Osage		3	1%
71	Osborne		2	0%
72	Ottawa		1	0%
73	Pawnee		2	0%
74	Phillips		0	0%
75	Pottawatomie		17	3%
76	Pratt		3	1%
77	Rawlins		1	0%
78	Reno		6	1%
79	Republic		2	0%
80	Rice		1	0%
81	Riley		14	3%
82	Rooks		4	1%
83	Rush		0	0%
84	Russell		1	0%
85	Saline		10	2%
86	Scott		0	0%
87	Sedgwick		48	10%
88	Seward		11	2%
89	Shawnee		20	4%
90	Sheridan		0	0%
91	Sherman		1	0%
92	Smith		0	0%
93	Stafford		1	0%
94	Stanton		0	0%
95	Stevens		1	0%
96	Sumner		2	0%
97	Thomas		7	1%
98	Trego		0	0%
99	Wabaunsee		4	1%
100	Wallace		0	0%
101	Washington		3	1%
102	Wichita		0	0%
103	Wilson		4	1%
104	Woodson		0	0%
105	Wyandotte		10	2%
	Total		496	

Statistic	Value
Min Value	1
Max Value	105
Mean	54.27
Variance	800.57
Standard Deviation	28.29
Total Responses	496

13. How long have you lived there?

#	Answer	Bar	Response	%
1	Less than 5 years		56	11%
2	5-10 years		64	13%
3	11-19 years		92	18%
4	20-29 years		106	21%
5	More than 30 years		189	37%
	Total		507	

Statistic	Value
Min Value	1
Max Value	5
Mean	3.61
Variance	1.90
Standard Deviation	1.38
Total Responses	507

14. What is your gender?

#	Answer	Bar	Response	%
1	Male		35	7%
2	Female		470	93%
3	Transgender		1	0%
	Total		506	

Statistic	Value
Min Value	1
Max Value	3
Mean	1.93
Variance	0.07
Standard Deviation	0.26
Total Responses	506

15. What is your age?

#	Answer	Bar	Response	%
1	21 and under		0	0%
2	22-34		13	38%
3	35-44		15	44%
4	45-54		4	12%
5	55-64		2	6%
6	65-Over		0	0%
7	Decline		0	0%
	Total		34	

Statistic	Value
Min Value	2
Max Value	5
Mean	2.85
Variance	0.74
Standard Deviation	0.86
Total Responses	34

16. Please choose one or more of the following categories to describe your race.

#	Answer	Bar	Response	%
1	White/Caucasian		491	96%
2	Black/African American		9	2%
3	American Indian/Native American		9	2%
4	Alaska Native		0	0%
5	Asian		2	0%
6	Native Hawaiian		2	0%
7	Pacific Islander		0	0%
8	Other		14	3%

Other
Hispanic
Bi racial Hispanic
White European
Indian
Mexican
Mexican
Hispanic

Statistic	Value
Min Value	1
Max Value	8
Total Responses	513

17. Are you of Hispanic, Latino, or Spanish origin?

#	Answer	Bar	Response	%
1	Yes		24	5%
2	No		477	95%
	Total		501	

Statistic	Value
Min Value	1
Max Value	2
Mean	1.95
Variance	0.05
Standard Deviation	0.21
Total Responses	501

18. You indicated that you are completing this survey as a parent. How many adults live in your household?

Text Response
2
1
2
2
2
2
2
2
2
1
2
2
2
2
2
3
2
3
1
2
2
2
2
2
2
3
1
2
2
2
2
Three
2
2

Statistic	Value
Total Responses	34

19. Please indicate the number of children living at home in each of the following age groups. Please enter zero if no children in that age group.

Default - Children 0-1
Number of children
0
0
1
0
1
0
1
1
0
1
1
1
1
1
1
0
1
1
1
0
0
0

Default - Children 2-4
Number of children
0
0
1
0
0
1
1
1
1
1
1
1
0
1
1
0
0
0
1

Default - Children 5-9
Number of children
1
1
0
0

0
1
1
1
1
2
1
1
1
2
0
0
1
1
0
1
1
1
0
0

Default - Children 10-14
Number of children
1
1
1
0
0
2
2
0
0
2
0
1
2
0
0
0
0
0

Default - Children 15-17
Number of children
0
1
0
0
0
0
1
0
1
0
0
0
0

0
1
Default - Children 18-19
Number of children
0
0
1
0
0
1
0
0
1
0
0
0
0
0
Default - Children over 19
Number of children
0
0
0
0
0
0
0
0
0
0
1
1

Statistic	Children 0-1	Children 2-4	Children 5-9	Children 10-14	Children 15-17	Children 18-19	Children over 19
Min Value	-	-	-	-	-	-	-
Max Value	-	-	-	-	-	-	-
Total Responses	-	-	-	-	-	-	-

20. What is your current household income?

#	Answer	Bar	Response	%
1	Less than $10,000		0	0%
2	$10,000 to 19,999		0	0%
3	$20,000 to 29,999		1	3%
4	30,000 to 39,999		7	24%
5	$40,000 to 49,999		4	14%
6	50,000 to 74,999		6	21%
7	$75,000 and above		11	38%
	Total		29	

Statistic	Value
Min Value	3
Max Value	7
Mean	5.66
Variance	1.73
Standard Deviation	1.32
Total Responses	29

21. What is your primary language (the language you speak in the home?)

#	Answer	Bar	Response	%
1	English		497	98%
2	Spanish		8	2%
3	Other		4	1%
	Total		509	

Other
both English/Spanish
american sign language

Statistic	Value
Min Value	1
Max Value	3
Mean	1.03
Variance	0.05
Standard Deviation	0.22
Total Responses	509

22. Keeping in mind the definition of health, what do you think are the most important issues facing mothers, infants, children, and children with special health care needs in Kansas? Please be specific.

Text Response
Homeless/transient population Lack of access to COMMUNITY level health services (mental, oral, primary care - public health and school nurses/health) both in terms of actual services AND in terms of services offered where families already are - for example: mobile services to schools or child care centers and at times friendly for working families. Lack of coordination at the local level to ensure family friendly referrals to existing services.
Quality affordable health and dental care
Respite care for parents of children with special needs, Access to health care due to lack of transportation, Access to quality affordable preschool classes
Having enough money for healthy food choices and appropriate housing issues (affordable housing that is clean and maintained reasonably safe and warm/cool in seasons changes).
Having good health insurance.
1. access to insurance to help with the affordability of medical and special services 2. access to quality early learning, i. e. child care, preschool, pre-k, school age care 3. help with the financial burden of quality programs 4. safe affordable housing
Quality early learning in safe, healthy environment Healthy affordable food and beverages Safe and healthy living environment
child care
Too little money to create, maintain, and support this population. Paying the top at the governmental level does not address the needs such organizations should be addressing.
Awareness of where to seek medical services for children that may/may not have health insurance. Also,, some mothers miss or leave work to take the kiddos to the doctor. There needs to be a place that moms, dads and single parents can go after hours so that missing work does not jeopardize the financial stability of their household.
Working moms, having sick children to care for.
Low income families lacking money to buy healthy food
available services, educators (those at all levels from infant care and up) prepared to care for children with a wide range of needs.
Cost of services and insurance.
education of parents at all levels especially related to behavior (parenting is the hardest job on the planet) and quality child care so that parents and work (living wage) and afford child care and jobs for parents
Early detection and Access to appropriate care.
As a parent with private insurance and child with special health care needs, costs are definitely a concern. It is a no win situation when you are desperately seeking new innovative treatments to cure your child, but the cost of research drives pharmaceutical companies to charge ridiculous fees for developing drugs. Hoping to see the government support new development for active research.
Money- The health care model is difficult to access for individuals who need it the most. Often times, prevention programs are not well funded. Nutrition - often times the cheap foods are processed. Some families have no access to fresh fruits, vegetables and food
One of the most important issues I come across is the lack of education regarding sexual abuse, sexual assault, incest, rape, molestation. The children in Jefferson County are not receiving the proper training, beginning in preschool, on what appropriate touch is, how to prevent inappropriate contact, what to do if it happens, and treatment for those who have been victims. Parents are not receiving training on how to talk to their kids about it, how to prevent their children from becoming victims, how to respond when it happens in their family. Another important issue is mental health. I am not sure if kids who are on KanCare, or any other insurance, can receive counseling, therapy, screenings by a psychologist, etc.
Car seat safety. Way to many parents have no clue how to use or install.
Cost effective services
developmental screenings and services, proper nutrition, safe sleep
All children to be kept up on their immunizations.
Affordable and available high quality (healthy) child care.
education on nutrition, developmental issues, and parenting skills
Education, getting the word out to parents of the help available. I have a nine year old with minor health needs (that he has had them since birth) and up until I started working at my local health department I was completely unaware of all the resources that were available that I could have used when he was little.
Low cost preventive health care Adequate and appropriate mental health care Transportation to and from appointments
Stability of home environment. Healthy relationships with family and friends and a belonging in the community. This in my opinion prevents: destabilization of the home environment do to relationships between both parents. Your question only cites mothers. A stable home is more apt with both parents. They have each other in a common family goal, to rely on, their financial circumstances are better, children get an opportunity to accept role modeling from both parents.
Knowing about the services that are available.
I feel adequate health insurance is an issue.
More awareness of health services for low income. If possible, please have some of these monies go toward resuming evening WIC voucher pick-up/health checks. My daughter had to drop out of WIC because, one she started school full time, she had no way to get her vouchers and make it to health appointments for her children without greatly jeopardizing her Nursing classes as attendance is imperative. I was listed as her back- up person. However, as a child care provider, I cannot take off time without pay and inconvenience my families to pick up the vouchers. I am sure this dilemma applies to one income families where one parent works during the day, taking the vehicle, or if one parent does not have a license. making it impossible to participate in WIC. Also, she complained about feeling Less-Than by staff in attitude and conversation. It's hard enough to be in a position of dependence without feeling like a total loser or that the staff is doing a huge favor by serving her. She has participated in WIC in Jackson County, Mo and said the staff at the two locations she has visited are very nice, treat her like a person of worth and conduct themselves as though they are performing a worthy service by helping WIC participants.
Difficulty for mothers is to get coverage to keep themselves healthy. Me, for example: I could not qualify for a plan via Obamacare because my husband's work offered an "affordable" plan. We could not really afford the premiums, but even when we tried to pay for those, I could not actually use the insurance because we had no money for the deductibles and co-insurance. I have medical conditins that left untreated have a high mortality rate, but I cannot go to the doctor. Children needing specialists are severely limited with medicaid. My son has Tourette's and we have had a very difficult time finding mental health providers that accept it. One of my daycare children also has Tourette's, and his mother has been searching for months for an in-network provider with experience with this condition. She cannot afford out of network fees. So even having private insurance is no guarantee that a child with special medical needs will be covered. For under privileged children, Medicaid can be a godsend, but there are so many issues with the system. They make mistakes and drop children from coverage by accident- it can take months to get it fixed- meanwhile the child is unable to go to the doctor because the parents cannot afford $200-300 per visit. Medicaid "loses" information- it can take numerous calls and faxes to get a child added. For example, my children have Medicaid. They missed one of my children. I have been trying for THREE years to get him added on with the other kids. Each time I call, they say they will "expedite" the case and fix it.

Never happens. I have heard dozens of similar stories from other people. I am also a nurse, and research things thoroughly. Many studies indicate that food additives and preservatives serve as triggers to genes, which explains some of the increases in ADHD, Autism and other brain based problems (like my son's Tourrette's), Cancers, childhood diabetes, etc. Everyone is so focused on sugar content, they are ignoring that chemicals known to be dangerous for human consumption are in the foods they serve. My family receives WIC. The approved cereals all have BHT in them. BHT is as bad as, or worse than sugar when you look at long term health effects. That is just one of the preservatives and carcinogens carried in the products. But if you need help via WIC, you much choose a chemically laden food. Chemicals also are leading to other conditions like eczema. Children in my daycare rarely get rashes, because I make their baby wipes myself. There is no formaldehyde or other toxic chemicals being wiped on their skin. Children's systems are flooded with chemical exposure from the womb and beyond. So I think that the sugar scare is keeping many from having a more holistic view on how all of these elements come together and affect a child's health, growth and development.

Local support groups and resources and lack of transportation to needed medical services.

Access and qualification for services

Long waiting periods for services and assesment. Single parents unable to get time off work. Conflict between infant special needs provider and university health facility.

Mothers- mental health including education on stress, time management, physical well being, mental health resources, support groups, education on childhood behavior and disorders. ADHD, learning disabilities, sensory processing disorders, autism are all areas that an increase in education and awareness can benefit both children and adults

Lack of affordable health care during the hours that they can take children to the Dr.

Programs to help them become independent of government monies!

For mothers- A break to have some time off to regroup and rejuvenate. When you have a special needs child and are a single parent, it's literally 24-7. You never know when that child will wake up, or what he/she will do. A friend who is a single mom with an autistic child, never has a break from that child unless she is at work. Being in a stressful work situation is not any better than being in a stressful home situation. There need to be centers for special needs children only, at affordable costs for these single moms. For infants and children- parents who take them to the doctor when they are sick. Parents want to bring their children to day care or school, when they are sick. Need to be more stringent rules, not just guidelines.

Our housing for under privledged is substandard. The young mothers simply do not know how to cook a homecooked meal. Therefore their children do not develope as they should. Our drug and alcohol usage is rampant and our unemployment is quite high. In my opinion these are the issues we face and have a direct impact on the health of our citizens.

accessibility to health care and affordable insurance

The option parents have of not immunizing their children is causing huge issues within the daycare system. We are seeing a regrowth of the major illnesses that we as a nation have worked so hard to curb. This should not be an option. If the parent chooses to not immunize their child, they should not be allowed into the daycare setting.

I think more funding to provide education and medical care to children with special needs is vital. When a family has to send their children to seperate school districts so that the child with special needs can get the education he/she deserves, then expect the parents to keep up with 2 different school schedules more funding is necessary to keep the family in the same school district . Medically special needs children already have a lot of issues and more training for child care providers and schools would be a great help.

Health care, nutrition, physical exercise

Making sure child is updated with all vaccinations

Finding time to prepare healthy meals.

Getting in to see the doctor quickly when they are ill. It is sometimes difficult to get an appointment with a doctor if you have not been able to find a doctor to be your G.P. or Pediatrician or OB. County Health Clinics such as Prairie Star and Reno County Health department do the best job they can to get people in to see a doctor. However, sometimes there isn't a doctor available and the sick person must see a nurse who can not prescribe medicines that may be needed. Perhaps Physicians Assistants in the community health care system who would be able to write prescriptions for people with infections, or other issues that are making them ill.

Fear of deportation. Proper discipline methods regarding different ethnic groups Teen pregnancy

Access to care Family stability

1. Health Insurance 2. Family Physician 3. Being able to provide healthy food.

1. The ability to afford healthy ways to feed their families on a budget and in a timely manner. 2. Having well educated, progressive thinking healthcare providers within a few hours drive from their homes. 3. Of course having good quality health care that covers preventative services along with illness and emergency services.

Being able to afford the medical services that they need (eg, office visits, medication).

Access to medical care for those without insurance as well as lack of proper nutrition for women and children living in poverty. Transportation is also an issue in this community. The stress of either being a single mother or a married couple living in poverty with children is not good for the famiy's mental health.

Adequate emotional support, social service support, prenatal care, and item/financial assistance for helping pregnant women carry their pregnancies full-term with the plan of parenting or adoption planning.

Education during pregnancy and in parenting during early childhood. So many new parents don't have any good role models around and do not have a clue what is normal for their baby or young child. Dental health is a very big deal. We do not have a dentist in our county, so the distance and time traveling to neighboring counties for dental care is not feasible for may people.

The anti-vaccination movement, and people not getting the vaccinations that they need.

Access to health care, having a professional act as a case manager//coordinator to be the family's link to care.

AFFORDABLE CARE

Access to health care, health insurance, those falling in the ACA gap due to no Medicaid.

Adequate health care and nutrition.

Lack of financial support from deadbeat fathers

Poverty, poverty and more poverty. In turn, disparities in access to basic healthcare services -- medical, dental and mental health. Major gaps in services/providers -- especially in mental health. Many children eligible for autism waiver but all slots filled; consequently services are inadequate or piecemeal. In many counties, providers do not accept or limit their acceptance of Medicaid so much of the care is in ERs that are poorly suited for this purpose. Health literacy is minimal among the population and chronic disease common. Tobacco and drug use far exceeds state average in our region and smoking during pregnancy common. Access to social/nutritional support also varies drastically by county and region.

Keeping well nutritional foods available for the family. And making available classes/help for not only to WIC/food stamp mother's and children but to all families.

access to health care family economics for stability mental health care availability, including substance abuse treatment domestic violence family stability, including health promoting relationships (limited screen time, sharing meals, shared recreation)

Availability of services

Childcare so that mothers can work outside of the home. Being able to obtain low cost prenatal care.

Knowledge and information about the need for immunizations.

Mothers-learning to be mothers very often comes from mothers who were not mothered or fathered as children. THey haven't got a clue as to how to take care of children. Infants and Children- Able to go to and receive services that are needed. Transportation is a big issue with our clients. Special care needs children need to have services in

their community and not have to travel long distances for services.
The most important issues facing mothers, infant, children, and children with special health care needs in Kansas is obesity in children.
Access to transportation to get to appointments, quality child care, parenting classes, reaching children so that they can be successful in school coming from an environment not conducive to the importance of early education, discipline, nutrition, and overall well being of the child.
Safe housing, access to healthy food, access to a medical home, understanding of health and what day-to-day self-care helps maintain good health.
Social and emotional needs of both children and parents are such a big issue and play a huge role in other aspects of Health. Post partum depression and antepartum depression place both the mother and child at risk from the very beginning. Inter-conception care and education regarding birth spacing, family planning and general health are topics that are often overlooked.
Education and Time. Parents are so busy they tend to overlook their children's health care needs by not taking the time they need for their family. Education on the other hand is very important as well. Symptoms tend to get missed diagnosed by the parents a few times before the parents realize their child's health care needs is to see a Dr. We all need to be current on our education for our children's health care needs as parents..
Access and affordability
Lack of in home qualified nursing care
Poverty and language barriers are important issues facing access to health care for these populations. Specifically, they are barriers to acquiring health insurance and navigating the health system of specialists, doctors, hospitals, and emergency departments.
Access to dental care, lack of transportation to medical care, daycare costs and availability.
access to care
A crucial health issue facing families is the lack of affordable quality childcare. Quality childcare improves the mental, emotional and physical health of children. The financial burden that childcare puts on working families is additional stress to family life. Families with children with special health care needs are even more limited in finding affordable quality care.
Need for affordable in-home behavioral intervention that is covered by KanCare and/or affordable to most families who have children with an autism spectrum disorder. Licensed childcare for children with special needs especially with behavioral issues. Ability to obtain a diagnosis within 3 months of request.
I think that good nutrition before, during and after pregnancy is key both for mother and child. I understand that there have been some very positive changes in the foods provided through the WIC program which offers more alternatives and even addresses the special needs of children who need to be on gluten-free diets. This is definitely a program that needs to be continued and well funded. I do feel that every mother should try to breastfeed for as long as possible, if possible, for the benefits both to herself and her infant. I would like to see more emphasis applied to breastfeeding benefits, especially for young mothers who are accessing the WIC program, but also for the general working public who may not qualify for government programs.
Cost Transportation Lack of knowledge Lack of resources
Accessibility to quality care and cost
Rising cost of healthcare Having parental rights being chipped away at
The marginalization of the role of the father figure in society. This contributes to income inequality, and lack of healthy male and female role models for physical, mental, and social well-being. Limited access or desire to make healthy food choices---default choices tend to be less healthy. Over abundant screen time--under utilized physical activity time.
Being able to purchase healthy choices on a fixed budget.
Health Care
Toxic stress from unstable living environments, unhealthy relationships, poverty.
Access to medical care.
Getting adequate healthcare to have healthy mothers and their children.
Mental health issues are often over looked. More needs to be done to get services to parents of children with mental health needs and those children that have special needs. Parents of autistic children in particular. Older autistic children/teenagers are the most overlooked group of children where services are involved.
Stress and the effects of it on a person's health. Addiction is also something that many families struggle with.
Quality Child Care that is affordable.
Available services in rural Kansas.
High infant mortality rate, lack of access to services, low health literacy (specifically regarding importance of prenatal care, child care), lack of knowledge about services that are available
Transportation to clinics, child care
Poverty, lack of income which prevents health care and healthy food purchases
Underfunded programs such as Early Head Start, tiny-k, Parents as Teachers etc. Supports are limited and it carries over to areas such as health.
Lack of support programs, access to care, access to resources in rural communities, child care
access to excellent prenatal care, screening for learning disabilities and delays, safe neighborhoods and schools
This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	512

23. 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.

Text Response
Drug use, tobacco use, malnutrition.
Affordable housing, affordable food, affordable health and dental care
I feel the community thinks that major problem facing children in the community is the lack of care for children who are impacted by severe, chronic, or major life threating illnesses such as cancer.
Having enough dentists, doctors, or available service providers to meet the needs of my child that is affordable.
Having Doctors in our area seems to be an issue.
1. vaccinations 2. food supplement programs: free breakfasts and lunches, backpack buddies
physical activity healthy nutrition health care access
Need for education of proper parenting methods, supports for meeting these appropriate processes be it counseling, instruction,monetary supports, and/or sufficient quantity and quality of staff to carry these needs to the population.
For mothers and fathers: Birth control, sexually transmitted diseases. For children/special needs: What medical facility of specialist can I take my child to that is not two hours away from my home, and how do I get there if I don't have a car, how do I pay for it and where do I stay if I have family that can help me or, the money to pay for a hotel?
Education
Services
Health and cost of health care.
They seem to be focused on health issues strictly. What about jobs for those parents and a living wage to go with it so they can afford child care?
Access to healthy nutrition in rural areas at affordable prices, education and training at-risk mothers, access to free birth control at local health departments, equal employment for women with affordable health insurance, breastfeeding initiatives for working mothers and lack of dental providers are all concerns that Kansans face.
Right now---the flu
I am not sure what the community thinks. I think mothers, infants, and children probably receive the basic health care they need. It would be specialized care that is lacking. Orthodontic, dermatologist, mental health, substance abuse prevention programs and nutrition programs.
Don't know
Nutrition and health care insurance
Obesity
Food, housing, postpartum depression
Afforable health care
--
In my opinion, I believe my community thinks substance abuse and dependence contributes to the dis-ease of mothers and children. I am convinced substance abuse/dependency is the by product of not being in healthy relationship with self, family and community.
The flu and ebola.
I feel financial stability has created families working more and having less and less family time. Support for appropriate parenting skills - many of our parents do not possess the skills and knowledge needed.
Again, getting the word out of services available. Please network more successfully. I have found services by having to search on the Internet or consulting with places like TFC.
I think most people think obesity is a big issue, as well as ADHD. Autism and ADHD have reached epidemic proportions, and everywhere we look we are bombarded with the numbers for childhood obesity.
Lack of insurance and jobs
Cost of services like doctors visits and out of pocket costs for equipment and services.
Community is unaware and or unsympathitc of these parents needs, why do you specify only mothers? i am very pro-life, these questions seem to be of the "Leading" nature. please rephrase, or reveal if there is an agenda here.
Immunizations, emotional disorders.
Lack of affordable health care (high deductibles), high cost of many prescriptions that Dr want you to use instead of a generic.
I believe it is the nutritional needs of the children.
Having enough money/assistance to get the healthcare they need.
In my community the lack of opportunities for higher learning just is not there. I have several young adults that would love a college education but absolutely do not have the resources to attain it. Our 2 biggesst problems are lack of public transportation and affordable, (yet good quality) day care is non exsistant.
employers that are understanding when children are ill and mothers must miss work.
I believe the general population is most concerned with the cost of daycare/preschool. They are not willing to pay for good care and quality providers therefore we have unqualified, non licensed "friends" providing care.
Quality health care at affordable and convenient places. Quality food at schools and daycare that is affordable.
same as above
Ensuring infants have formula.
Exposure to serious illness such as measles, whooping cough when they are not immunized due to age, health, or religious belief. A co worker recently was in the hospital with a sick child and unfortunately became acquainted with a mother whose 6 week old baby died of whooping cough. The sadness of this kind of loss is unimaginable.
prenatal and post.
Access to care Family stability

1. Having a good support system. 2. Having the appropriate resources available to assist with care. 3. Health insurance or the money to pay for care. 4. Access to medical care.

That we only need a hospital or a doctor that treats illnesses and does not promote wellness or prevention of illness.

Getting vaccines.

Access to medical care and proper nutrition.

pre-term birth, minimal financial and emotional support to expecting mothers and their families, inexpensive prenatal care

People needing food stamps, and children not having enough food to eat during the weekends when they are not in school.

Access to carre. Respit care for the families and someone to coordinate with the various agencies the families need to deal with.

SPECIALITY CLINIC NEAR OUR COUNTY, DISTANCE FOR OBTAINING HEALTH CARE,TIME TO CARE FOR THE HEALTH NEEDS OF INFANTS, CHILDREN, ETC.

If you can't afford health care it's your own fault

Same as above.

Dependent on the community -- and we serve several -- access to quality prenatal and obstetrical care. The aging medical and dental community is starting to retire with few replacements. (only 3% of new grads indicate they want to locate in a rural area). Access to specialty services is also a problem so it's not unusual to drive two hours for care. No public transportation also limits access. Also, the typical problems of obesity and lack of exercise which have led to the high rate of chronic disease prevalent in our region. Ultimately, the high level of generational poverty has resulted in many single mothers who may have yet to finish high school and have minimal parenting skills and are struggling daily just to survive.

Obesity, malnutrition, neglect

access to special care and services for disability mental health/substance abuse treatment economic stability

Availability of services

Smoking and drug abuse among pregnant women. Receiving low cost prenatal care.

"Vitamin D milk"-juice-immunizations and food for the children. For moms to have children that are smart, healthy, and beautiful. Children who mind well and are capable of doing what they haven't a clue how to do themselves. Special health care needs children have parents who are supposed to be the care givers and who need special education to take care of their special shildren. They are ill prepared to handle the job-look how long it takes people to be nurses, etc. We expect parents to do this with little training and they are concerned they will hurt the child by doint something wrong.

Community believes the most important health issues facing mothers, infants, and children with special health care needs in Kansas is childhood obesity and transportation issues for mothers who have to travel long distance for special health care needs.

A way to educate parents so that they can understand how to raise and healthy, happy child.

Income stability ans well as those noted above.

Generational poverty is not necessarily a health issue but plays a role in the care and education received by women and children, which in turn effects birth outcomes of infants. Obesity is another important health issue. Not only obesity of our children but obesity of our expecting mothers and women in the inter-conception period.

I can not speak for the community.

Lack of initiative of parents to pursue services available in our community

In my opinion, my community believes the most important health issue is insurance and access to health care. I think my community also thinks reproductive and sexual health are big issues today for mothers.

Lack of good daycare, jobs that don't support mothers with children, food needs.

access to care

My community has been involved in improving education about SIDS and safe sleeping practises.

Behavioral supports in-home and center-based that are affordable to children with Medicaid/KanCare. Licensed childcare for children with special needs

Making sure that children are nutritiously fed, receive routine immunizations, and that everyone has access to medical care for both routine, preventative and acute care visits.

No one offers those services in our area (only have PACT) Lack of knowledge of parents Lack of resources to healthcare providers

Accessibility and cost

Rising cost of healthcare Having parental rights being chipped away at

Low income; access to grocery stores; obesity

Obesity in children

Health insurance, food, a place to live (shelter), money, and transportation

Mental health

Financial needs

Help those in need and can't afford healthcare.

Affordable quality childcare and getting services to those parents that have children with special health care needs.

I think the big buzz right now is physical activity and encouraging our community to be activity friendly.

Social Emotional needs are growing in younger children. It is visibly noticeable in the classrooms. Finding Dentists that will take young children and medicaid in all communities.

The want to get involved with organizations that can benefit their children.

lack of access to care, cost of health care

Lack of funds to pay medical bills

poverty, lack of income which prevents health care and healthy food purchases.

Quality and Affordable Child Care.

Lack of support programs, access to care, access to resources in rural communities, child care

community safety in regard to crime and violence. poverty and blight in many areas of wichita

Healthy behaviors

transportation to specialists/clinics poverty

Unemployment is too high, and women are having to work for less income and no health insurance for themselves and children. They are turning to the food banks which are also low on donations because the demand is high.
Access to health care and lack of insurance coverage
It seems like everyone is talking about medical insurance and you have to have it.
Health care costs, insurance costs, medication costs
One size fits all for infants shots - too much in the first year!
Same as above.
1. nutritional issues regarding adequate caloric intake 2. support with occupational and physical therapy 3. housing
I don't know

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	463

24. 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 services, playgroups, parenting support, health services, etc...)

Text Response
Parents As Teachers
WIC and health services.
Prior to having children and also between children I used Family Planning services within my community. When our children were young we took part in a single Healthy Start Home Visit, play groups, preschool, MOPPS program, Sunday School services within our local church, Kids Inc. program, Boy Scouts, City Parks and Rec. organized sports, Summer Reading Programs at our local Library and Swim lessons.
WIC (over 5 yrs ago), play groups , church activities, playing outside, library, sports, ect
None. There aren't any. If there were we would use them!
Members of the YMCA, parks and rec. sport teams
FS and G, our primary doctor, and friends and family.
I haven't utilized any services in my community that help keep me and my children stay healthy.
wic parenting support
Parent as Teachers, church organizations, city sport activites
WIC, church support
I am not sure this is applicable but I have used YMCA resources for my children's sports. I have not used any government services for myself or my immediate family.
breastfeeding support through hospital, organic food options, YMCA participation, Screen for Success
Parents as teachers group
None.
Home visiting services after birth, breastfeeding support groups, library story times and activities, local trails and parks, WIC cooking classes
Martial Arts, Sports Camps, YMCA, PE at School.
My daughter attends daycare and the daycare provider utilizes playgroup. We also have PAT come to out home.
Church activities, YMCA, the library, groups at church
Parents as Teachers, Riley County Child Care Center, Hylton Heights Kindercare
play groups an sports
WIC, Infant/Toddler Services, health services, 2 children on T/A Waiver, 1 child on IDD Waiver, Play Therapy with therapist that is able to do EMDR, Susan B Komen fund for female screening and mammograms, KanCare for our bio-daughter, KanCare for our 3 adopted special needs sons, KanCare for our foster daughter, FMS provider, Casemanager services for both waivers.
WIC, health services for single mothers
Home visiting, quality childcare, health services
children's dance and swimming classes through parks and rec, story times at the library
Playgroup, Parents As Teachers, Church-led mothers support group
Family planning and health services.
Parenting training support (i.e. PTI) and mental health services.
WIC, Parents as Teachers
Health services.
wic, playgroups, parent support, health services, library, parks
Parent as teacher

Statistic	Value
Total Responses	32

25. What services in your community have you referred in order to help women, children, and families stay healthy? (For example: WIC, family planning, early intervention services, playgroups, parenting support, health services, etc...)

Text Response
I provide resources such as, WIC, parenting support, child care information, nutritional guidelines, local doctors information, and information on immunizations.
Parenting education through Parents as Teachers, Healthy Families or other evidence based programs. Infant Toddler/tiny k Public health department School nurse school for preschool services
parents as teachers. Child Care aware
WIC, Health Department prenatal care, well child, immunizations, and pregnancy programs, Tiny K, Parents as Teachers, STAR program at the Guidance Center, Child Care Aware, Family Conservancy, public library, Head Start, NEK--CAP
Family Services and Guidance for children with questionable behavior issues or might need evaluated for what is needed for the child.
Wic
1 WIC 2 Tiny K 3 Parents as Teachers 4 Women's Community Y early learning programs 5 County Extension programs 6 Library programs
mental health, infant toddler services, safety net clinics, food program for daycare facilites
all of the above
Such are available but parents don't understand how much time and effort is needed to insure physical, cognitive, and emotional health. With regard to educators, we have gone for years with too little support and resources that our services are not as effective as should be.
My community is small and does not have a lot of activities for children unless they are school related. I continually refer individuals to WIC as a measure to help balance the family life.
Wic, srs services, parenting support, health services
WIC, Family Planning, early intervention services, child care resource and referral
WIC, parent support, Early Headstart, Headstart, local health dept and mental health center
Caring Center
Family Service & Guidance, taxi service
WIC, Family planning, EDW, Learn and Play, Moms group, arrowhead west, medicaid, assistance.
WIC, Medicaid, early intervention services
parenting support, mental health counseling, drug and alcohol treatment--although it is not available in our community
Srs, wic
Health services, WIC, early intervenion services
All above
Community mental health, part B and C services, DCF, PAT, Healthy Families, SB6
Parents As Teachers programs, Johnson County Infant Toddler Services, Blue Valley Recreation Center, Shawnee Mission Parks and Recs, area Public Libraries
WIC, Early Detection Works (EDW), Family Planning, Parents as Teachers, Free summer lunch program, Rainbows United, Count your Kid In, Maternal and Infant program, Healthy Start
--
Making the referral is easy. We have the services available in my county. Accessing the services can be a challenge for many because of transportation and distance.
WIC special-needs preschool and occupational/speach/physical therapy
Parents as Teachers, playgroups, health department, Guidance Center
WIC The Family Conservancy, Day Care Connection, food pantries.
WIC, Food assistance, Child care assistance, Infant Toddler Services, physicians, YMCA, play groups. I offer parent support to my daycare families.
WIC, HEALTHY START HOME VISITOR, HEAD START, BIRTH TO THREE
Parents as Teachers, WIC, Family Conservancey
Early intervention services
Family Conservancy
early intervention, speech, parents as teachers
I have referred families to WIC, Head Start, TOP Early Learning Centers, Health Services, Extension Office, & YMCA,
WIC, Health Dept.
WIC & Kan-Quit as well as our CHC for family planning and dental services.
WIC, Maternal & Infant Program, Rainbows Bright Beginnings, Parent's As Teachers, Family and Pregnancy Care Center,
WIC, health services, counseling.
WIC, local school district for early screening,
Child care, parenting services, WIC, foster care, community resources
Wicked children and families
WIC, Health Department, Horizons Mental Health, Early Education Center, Parents as Teacher, Early Head Start, Head Start, Four Year old at risk preschool programs, Food Bank, Clothing Bank, Christian Soup Ministry, Adult learning center, Harvest of Hope, Guardians of the Children, Hutch Rents, Hutchinson Public Library, Interfaith housing Services, Income Tax help programs, Mexican Consulate, New Beginnings Inc, Salvation Army, Good Will, St. Francis Community Services, Substance Abuse Center of Kansas, Summer Meals Program, Training and Evaluation Center of Hutchinson, Bargain Stores in our community, Domestic Violence Center, and DCF many more.
Resource and Referral Agency Child Care Aware Maternal and Infant Program Teen Pregnancy Targeted Case Management Program Local Library

WIC Family Planning Food Stamps/Medicaid Head Start Parents as Teachers

WIC, Family Planning, Immunizations, HOPE Center, Agape,Pass It Forward and Eagle Wings Ministry.

WIC, Family Planning, Home visits, Mental Health services, Local food bank.

WIC, Bright Beginnings, Mental health centers, Arrowhead West, Inc., Russel Child Development

Local health departments, WIC, Family Connections, Head Start/Early Head Start, La Leche Leage, Becoming A Mom Programs, Life Choice Ministries, local physican/pediatric offices, local prenatal care offices, local hospital birthing and parenting classes, DCF, Parents As Teachers, Infant Toddler Programs, Adult Learning Centers, Job Corps, Veteran Affairs Offices, etc.

WIC, FP, early intervention services, sliding scale dental out of county, parenting classes,

WIC, family planning, Early Detection works, food stamps, Stop smoking, Preschool, Arrowhead West preschool services, immunizations

Wic, prenatal, family planning, infant toddler services, early head start, parents as teachers, new parent support groups

WIC, FP, HEAD START,EARLY ENTERVENTION SERVICES, ASSIST THEM WITH APPLICATION OF MEDICAID IF THEY MEET THE GUIDELINES, REFER TO SPECIALITY CLINICS,DENTIST, EYE CARE, M.O.P.S,CHILD CARE, ETC.

All of the above plus Healthy Hawks at KUMC,

Wic, Family Planning, Becoming A Mom prenatal program FQHC, immunizations , headstart, parents as teachers, birth to 3.

WIC, Family planning, mental health, health services.

We refer daily to everyone for everything....all of the above plus YMCA, Big Brothers/Big Sisters, local churches, etc. That said, quality varies...

local private medical providers, ECKAN, WIC, local economic assistance, mental health

WIC, family planning clinics, primary care through FQHC, Childbirth and parenting classess.

WIC, family planning, SCAMU clinics, COMCARE, DCF, Healthy Babies

I've referred families to the Health Department immunization clinic and to Heartland Programs for early intervention.

All of those listed plus mental health

WIC, Healthy Start, Health and Family Services, Health Department services, Early Head Start, Head Start, after school programs, Parents as Teachers, Home health programs that Birth to Three program, Dept for CHildren and families, Mental HEalth, Addiction Tx Center, Vie Medical Clinic, Dental Clinic, Wesley House, Red Cross, Salvation Army

I have referred women, children and families to WIC, family planning, mental health services, early intervention services and health services.

Childcare Aware, WIC, Early Head Start and Head Start, Birth-3, Parents As Teachers.

WIC, primary care, domestic violence intervention, food resources,

WIC, Healthy Families, Parents as Teachers, Early Head Start, Family Planning, MCH support services, Kan Care.

Playgroups, Early Head Start, WIC

WIC, KCSL, TARC, Family Service and Guidance

Wic, family planning, early childhood intervention, parents as teachers, parenting classes, kan be healthy, immunizations, hope center, mentoring programs, childbirth classes, Kan Quit

WIC, family planning, parenting support (Parents as Teachers/Family Conservancy), local medical and dental clinics, general assistance for food/clothing/shelther.

WIC, family planning, early intervention services, playgroups, parenting support, health services, etc

parenting support; WIC, family planning, food pantries, early intervention, mental health resources

I have referred families to WIC, early intervention services and health services.

ITS, PAT, ECSE, CENTER FOR CHILD HEALTH AND DEVELOPMENT AT KU MEDICAL CENTER, HEALTH DEPT

WIC Family Planning Early intervention services, meaning, screening pap smears and mammograms for women 40-?, but for un-insured women ages 40-64 who meet income guidelines, we refer to the Early Detection Works program through KDHE.

WIC PACT HeadStart Health Department for family planning M&I program Guidance Center Rape Crisis and Domestic Violence

all of those above as well as: medical home, local work groups, chiropractor, local food assistance program, local church's

WIC; Family Planning; early intervention services;

WIC, family planning, healthy start, teen pregnancy case management, housing, pediatrics, primary care provideers, dentists, child aware, military advocacy etc

WIC, tinyk, Healthy Families Douglas County, Parents As Teachers, Early Head Start, Heartland Community Health Care, Health Care Access, Bert Nash Mental Health, private mental health therapist that provide services in the home.

WIC, parenting classes, health services, community programs addressing weight/ exercise/ nutrition

No involved in that area of patient care.

Special education services for early childhood children from the public schools, Parents as teachers, WIC

WIC, Family Planning, Early Intervention services, parenting classes, social services, health services, mental health services, addiction and treatment agencies.

Parenting classes-Family Life Center Health Department for immunizations Local churches Mental Health Services such as Prairie View

Immunization Program, Wic , family planning, breastfeeding meetings, health services of all types

WIC, infant toddler services, Head start, nutritional programs

WIC and family planning services

We need more child care (quality is there--just not enough providers). We need more Head Start in rural areas.

WIC, family planning, pre-natal care organizations, churches, Housing Authority,Families together, child development centers, head start, parents as teachers, county health clinics

wic, dcf, community open kitchens

Parents as Teachers,

WIC, Health Department, diabetes education, prenatal classes

WIC, Early Head Start, Parents as Teachers, Part C Infant Toddler services, playgroups, doctors,
Parents as teachers
Infant and Toddler Program, Free eye exam by OD for 3 years olds, Jo Co Health Client, Jo Co Mental Health, Shawn Mission School Dist. for free hearing test.
WIC, family planning, child development, parenting support, home halth
This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	467

26. What services would you like to see offered in your community to help you and your family stay healthy?

Text Response
Parents As Teachers
Educational courses relating to healthy planning, preparation and storage for parents.
I would like to see a Multi-generational Recreation Center, like a YMCA in our community. This has been taken to the public for a vote, yet the majority of people to get out to vote voted "No".
More things for the whole family to do together. Instructional classes to help families to stay healthy. May a boys and girls club.
playgroups, closer emergency health care
Affordable child care at the YMCA for families that have infants and want to work out.
Can't think of any.
Early childhood education available to every child ages three and four in the state of Kansas.
MOre parenting support most of the programs have lost funding.
More community activities for children
.....???
After school care that includes healthy exercise.
more providers - dental and medical - especially in rural areas more organic and non-GMO food offerings, subsidies/discounts on these types of food items more YMCA programming throughout the state better public transportation less pollution - less gas-guzzling vehicles, less fracking for natural gas (waste of clean water, causes earthquakes) more holistic medical options covered by insurance
Nutrition
Mommy and me physical activity groups that meet at times that are conducive to a variety of work schedules. Almost all of the local mommy and me activities, including workouts, are during working hours for a lot of moms. They tend to be convenient for stay at home mom's but there is not a lot of support for working moms.
More cost effective activities
I think there are options out there - just not ones that are available for lower income families that can't afford to pay for some of these services. However, I feel the YMCA does their best to offer services to families that have difficulty with paying.
Quality child care closer to home
Would love to see a pediatrician in our community, even if he/she only came 1-4 times a month to our rural health clinic. Respite care for our medically fragile children. The MCO's offer it but no one in 60 mile radius can provide it.
Safe playgrounds within walking distance
I feel that my family has appropriate access to services that meet our needs. My concern is that not all family have equal access to these services.
affordable preschool, fitness classes that can be done with babies and young children
Breastfeeding support, V-BAC services and trained professionals within the hospital/medical team
More affordable child care and early education programming. More parenting support. Wide access to family planning resources.
Additional support services for assisting all adolescents to be prepared for and find suitable employment.
Access to indoor play areas in the winter.
walking or bike trail
not sure

Statistic	Value
Total Responses	28

27. What services would you like to see offered in your community to help families stay healthy?

Text Response
Tobacco, alcohol and drug cessation programs; work well programs designed to target both physical and mental health
Information about some of the free activities available such as walking paths.
I would like to see a Multi-generational Recreation Center, like a YMCA in our community.
We need more things for the families that don't qualify for help. We need help too.
playgroups, closer emergency health care, improved early intervention services, better access to mental health care and medical care
same as above
Better MH options, day care, and dentist for low income parents.
New leadership in our state government would significantly improve our community.
Home visitation programs
Nutritional help
Low cost health clinic/Urgent care or transportation available to a neighboring town for these clinics (if needed.)
I would like to see more funding in schools so children at risk (little to no resources) have more access to nutrition. In addition, I would like to see schools bring back more gym time. I feel that proper food and exercise are so important and those things are being cut as school's lose more and more of the budget.
more providers - dental and medical - especially in rural areas more organic and non-GMO food offerings, subsidies/discounts on these types of food items more YMCA programming throughout the state better public transportation less pollution - less gas-guzzling vehicles, less fracking for natural gas (waste of clean water, causes earthquakes) more holistic medical options covered by insurance
Free excersize
Same as above. And work on access to healthy foods.
Healthy snack options at the schools
See Q11
Quality child care close to home
More physical activiites low at cost
Ambulance service 12 months of the year!!!!!!
Safe playgrounds within walking distance
Access to affordable, quality mental healthcare
more prenatal and postpartum exercise, pregnancy and birth education, new parenting education and support
Breastfeeding support, V-BAC services and trained professionals within the hospital/medical team, soup kitchen or other hot meal services on the weekends,
More affordable child care and early education programming. More parenting support. Wide access to family planning resources.
Preventive education and information to minimize healthy habits such as avoiding substance abuse. Also, education of evidence-based data on the risks involved with firearms in the home, and the paramount importance of securing firearms by the adult owner.
Access to indoor play areas in winter.
walking or bike trail
not sure

Statistic	Value
Total Responses	29

28. If you have not used a service offered in your community, why not?

Text Response
I do not qualify for most services provided.
Not sure where to look for services.
I was unaware of the WIC program in my community when my children were younger.
I have
Need to do a better job getting the word out to families that need it.
no time
May not know about it.
I am not in need of the services offered. It is possible that there are services out there that I simply do not know about.
Most options are limited by cost, time and convenience
Have means to pay.
N/A
n/a
I was asked to take our medically fragile children to other places due to the complex care needed for them.
N/A
Likely because it wasn't needed.
Our family income is too high for most of the services offered in my community
Most often, services have not been used due to a lack of awareness of the services available, or due to a resistance to using services that carry a stigma (such as financial need).
n/a
semi rural and prefer traveling to better populated/established practices
don't know what's available

Statistic	Value
Total Responses	20

29. If you have not referred a service offered in your community, why not?

Text Response
No mental health providers, no oral health providers - rural community Transportation issues
Not sure about all services avaliable
I have.... Many times.
Do not work directly with those in need of services.
Nothing offered in our town
none.
It is not available
--
n/a
I refer what I am aware of.
I have not referred for mental health services, because I cannot find the community resources available. For example, one of my daycare children exhibits all of the signs of Oppositional Defiance disorder. I have not been able to find resources to refer the parent to.
not aware of them or parents have not used because of hours of availability
NA
I didn't know some of those services were available
I do not know of very many so I tell them to call county health department or child care aware in K.C.
N/A
N/A
I do it all the time
N/A
We hesitate to refer when our clients/patients are not treated with dignity and respect or the quality of their services are below standard. Cost of the service can also be a deterrent.
I refer services from providers that I am familiar with by word of mouth from clients or other professionals.
don't have knowledge of a service provider and the services they offer
N/A
none
We refer services daily and try to stay on top of new resources that are becoming available or old resources that are become unavailable.
not applicable
n/a
I do refer to services offered in my community.
No in my area of care of patients.
n/a
N/A
N/A
N/A
Families are fully aware of what is available and not requiring my information. Hey, not all parents are not involved with their children and their needs.
I do refer but transportation is an issue
n/a
I am a clerk, not really asked
There are some agencies such as mental health, that are not adequate.
I have referred.
I have referred
We have
n/a
n/a
NA
If the service lacks the education, acceptance, or understanding of assisting a family with children with special needs. Also if the service is at a cost and the family can not afford it.
I don't feel there is a place to make the referral to as the services are not there.
Communities that Care have been vague about their services.
N/A- we always refer if needed
n/a
N/A

There are not many Parent Support groups or open play groups available.
na
NA
n/a
We would like to have more people walking outside but there isn't a safe place to do so. Our community is in desperate need of walking trails.
Fiscal and geographic barriers
N/A
unsure what services are available and to whom they are available
N/A
I am not a primary care provider and I have others provide the necessary referrals.
N/A
More parenting peer support is needed.
N/A
n/a
No comment.
n/a
I refer to services as I am aware of them.
N/A
CMHC does not have early childhood professionals and are not able to bill for services approriately to families needs, long waiting periods
My population of patients
we usually do.
n/a
I do not serve individual families, only the organizations that serve them. Families do call me directly for guidance on finding dental care, which I respond to based on their needs.
NA
n/a
Do not provide direct care to families.
n/a
NA
NA
I have not been asked.
Unsure how to approach families with the information.
As a reasearcher, this is not my role
If I have not - it would be because I didn't know if a service existed.
I haven't received any inquiries.
NA
NA
don't know
I have referred
Only if I don't know about it would it not be a referral.
n/a
They don't exist!!!!!!!!!!!!!
I refer generally every week
N/A
N/A
n/a
I do not do primary care
I do not provide direct services, however I collaborate with clinicians and have shared information about local programs such as Healthy Babies, the KIDS Network, etc.
na
At times I don't know what is an option and I don't have a social worker to help me w/it
The local mental health center serves children over the age of three; we are a birth to three program.

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	170

30. Do you have an idea for something new or different you would like to see in your community to help mothers, infants, children, and children and youth with special health care needs to be healthy?

Text Response
mobile care to the community on a regular basis for oral health, basic primary care, MULTIPLE opportunities for FAMILY participation in learning activities that are health oriented and fun - health fair; group meetings that include simple cooking activities to include adults with their children; family exercise - adults & children together rather than separate that is friendly for working families - Parenting education through evidence based home visiting
one central place to call then be redirected
A "one stop" care center that attends to all needs.
For person's receiving food stamps or other assistance, make some mandatory trainings or meetings after receiving assistance on a monthly basis to ensure the children are getting their needs met and for asking questions or address other things that hamper providing this for the children. Parents also need encouragement and incentives, for their well-being and to see positives happen in their lives, as well.
Not sure
Universal care, education, counseling, and supervised play centers for each county taking into account not just how many people need to be served per square mile but more to the point those limitations of rural areas with fewer people, less ability to travel further than 30 miles from home, and higher need due to drug addiction, alcoholism, lack of job availability, and generational parent abuse and neglect visited upon their children.
For a small town, I think that we are doing everything that we can based on "budget."
i think that if free continuing education was mandatory for those who receive assistance, we would be able to educate many who need it and offer it at a cost for those not on assistance to help cover costs would reach even more people
Support of child care is needed. Care providers are one of the lowest paid employees in the town. There needs to be a sick room or place where working parents can bring sick children so they can keep working.
Get specialized providers to local areas!!
Offer families free first aid CPR certification classes coordinated through the health departments Offer families free mental health certification
Community centers that allow for non-competitive, low cost sports and play groups. Soccer, gymnastics, tumbling, dance, other sports, exercise classes, substance abuse classes, healthy activities such as gardening for youth, or other hobbies, healthy social activities for adolescents, support groups for parents, educational classes for parents.
Instead of teaching all cleaning all the time, teach importance of building immune systems and practice needed for those systems. We're too preoccupied with cleaning everything all the time, it's not healthy. Also, the elimination of good fats in diets...children need fats, not processed food.
More access after hours for some of the services...not everyone is home during the day to take advantage of such services.
Classes and support group meetings that provide transportation and child care so the mothers actually have access to the information.
education and parenting required and provided during prenatal care or before released from the hospital with new infant no matter if have other children at home.
community working together. It seems the hospitals do their thing, the doctors offices do their things, the health department does their thing and the schools do their own things---no one really ever works together as a community---or they start to work together and then it gets too hard and they continue to go back to the old ways of not working together
--
I'd like to see community centered wellness activities available at no or nominal charge. People need to see and be seen by each other.
Maybe some more fairs?
Child care fairs. I would like to see occasional community events where numerous child care providers set up, and parents can "shop" , ask questions, learn about the variety of programs. This would also help them understand how daycare "works". At these fairs, guest speakers could offer short seminars about things parents are interested in: behavior modification, breast feeding and the working parents, toilet training, cloth diapers, developmental milestones, healthy meal tips...etc.
no
NA
More walking paths in decent areas of town that are accesible by walking. Not so far out of town that you have to drive.
no
A branch of the county health dept would be very helpful
Better training for child care providers, workshops for parents.
Home Health Care Visitors who go into homes and provide services to prenatal, newborn babies, and those with chronic illnesses including those who have mental illnesses.
small groups for mothers in different ethnic groups
Community Baby Shower
A support group would be wonderful!
A number of local families must travel 4 hours to higher level Pediatric care. It would be nice if there was some type of assistance with matters such as this. Weather it is helping with gas money or hotel expenses or maybe food vouchers. Or an outreach clinic that was closer to our community with a Pediatrician or a Specialist for children.
More support groups where people can get together and discuss what works and does not work for their child.
inexpensive, quality pregnancy, birthing, parenting, adoption services with strong emphasis on prenatal care to achieve full-term births. An increased amount of collaboration via events, fairs, phone calls, meetings, groups, online support (linked in).
We have a family close to the OK line. She talks about this Hope clinic where they go to meetings and discuss normal pregnancy and breastfeeding and caring for newborn. She cares enough to drive an hour to get to this meeting, but I wonder how many of our families would be able to do that?
No.
More support groups, easier eligibility and services for the children so mothers don't have to quit their jobs to fight for every right the child has for these. Somehow shorten waiting lists for paras and other professionals to get into the homes to work with these families.
We use to have a community wrap around group and all agencies would meet and work to see all needs were met.
multigenerational bilingual group activities for social, physical and emotional support
Nutrition classes, exercise classes for kids and adults at no cost or very little cost. Parenting classes perhaps even in the workplace where people are able to go to them.
no

In Pittsburg, the Family Resource Center was created to be a one-stop resource for families. This has included providing child care for special needs children which is very difficult to find in many communities. In addition to being one of the largest non-profit child care centers in the state, they have brought together several helping organizations that focus on ensuring children are "ready to learn." The concept was to bring services to mothers/children/families rather than expect them from make multiple stops. It was modeled after a center in Leadville, Colorado. There are many variations on the theme, but it has worked well in Pittsburg and could be replicated if there was funding -- which has been dwindling over the last decade. Sustainability is and always will be the challenge.

More health and community events/fair to outreach with different organizations and let the community know what is available

We need more low cost prenatal care. More childcare.

Special health needs children and parents need support groups, easy access to care and home check ups for more confidence in caring for their child. Any help with these would be appreciated by them I think.

More education in the hospital after having a baby and making sure they watch or go over the material one on one with a nurse.

no

Not known at this time.

Higher Quality Child Care

Possibly one evening a week to be open at health dept so people who work are more apt to come in for services

I would like to see more of an effort in our community to educate and support women with unplanned pregnancies in such a way that they do not abortion is the only answer. I would like more existing organizations to be honest about how birth control and abortion are not the healthiest answers for unplanned pregnancies.

ONE PERSON WHO IS COORDINATING THEIR CARE SUCH AS OUT OF A MEDICAL HOME. COORDINATION THAT OCCURS WITHIN SPECIFIC SERVICES IS SHORT LIVED AND THEREFORE NOT EFFECTIVE.

No

We are wanting to take advantage of our farming community and are hoping to put to use some of the Farm to the Fork principles. We are also toying with the idea of a community orchard as well as "morning marathon" at the schools.

Special needs family liaisons

Not at this time.

Earlier identification- families that have 4 or more ACE (Adverse Childhood Experiences) have a higher likelihood of having children with special needs.

No.

More services for children with special needs to include mental health. Specifically autistic children. There is a lot of focus on younger autistic children which is great but some children go undiagnosed until late childhood/teenage years. There NEEDS to be an increase in services in mental health for children.

Group meetings.

Dental support is not being met in most communities

The early childhood block grants were very effective, but too many partners backed out when demands for outcome measures became ridiculous in amount, invasive in administration, and overly taxing to programs with limited manpower.

No

Better, consistent referral to the early intervention programs that already exist. Medical professionals and child care providers should refer more to Infant toddler, Early Head Start and Parents as Teachers. WIC could also help more with this.

It would be nice if the mother's doctor and her children's were in the same location/building so that it would be convent for the families. Also so that the mom's are able to take care of herself. Even better, if the same doctor would be their family doctor.

health care clinics in all schools with parent input and support

Support groups. Specialized services. Closer than Kansas City or Wichita.

Youth programs that include activity and socialization for youth for free

A true medical home, continuity of care in transition from adolescent into adulthood, improved mental care services for children Developmental issues - only one place offer these services -KU in KC

Closer locations and for telemed to be covered as a co-pay and not to the deductible.

Transportation, preventative education

Maybe new programs and better awareness.

This area needs a minor emergency care facility for those after hour needs that are not really a emergency room issue.

Education to prevent childhood obesity

No

no

I would like their needs to be recognized by local policy makers.

General clearing house site

Yes doctors to have more info and understanding of resources and to have more funding and resources for families.

monthly meetings to connect families with each other and community resources

Unfortunately I do not

Continue free & nearby dental clinic services.

Right now there is great enthusiasm for "Becoming a Mom" throughout the healthcare community. I think that utilizing that energy to focus on perinatal care would help children from the womb to school. I like the idea of a services fair offered during a BAM session or highlighting one community service during each BAM session would help expand awareness of services available. We are kicking around the idea of a "So..Now I'm a Mom" class that would reinforce topics discussed during BAM (safe sleep, infant cares, folic acid, family planning), potentially utilizing the Early Head Start community partnership.

I would like to see more ot that coordination piece, esecially as it relates to how economic factors influence health, especially in regards to proper nutrition, medical access and mental health issues.

more information-workshop for mother to be. for Doctors to pay more attention on nutrition- lots of little children over weight.

Public event showcasing/educating on 0-3 early brain development and screenings. Include screenings that could be well done in a health fair type setting and referrals and

information for parents on how to talk with their pediatrician about obtaining routine screenings over the growing years of their child - Kan Be Healthy, etc
Specialty clinics where single problems are addressed in detail - eg: asthma clinic at KU Peds clinic
no
Our community will be utilizing Life of An Athlete that incorporates the importance if health in all areas of life and growing up. If communities schools and coalitions would adopt this program we could work with children from young ages to be strong and healthy understanding why that is important.
No, but I think the one doing this survey is educated enough to create some new or different things, because what we've been doing isn't helping.
Easy access is the key --- if it isn't easy for the parents, or the youth to get to, use and afford, it just won't happen.
Free long term mental Health services for children and parents is a huge need.
I would want to have more dentists take KanCare with prenatal mothers. Most of our mothers will not get a prenatal dental visit, because the KanCare only covers an exam and cleaning. If further work is required, nothing is covered so they will not do even the initial screening during pregnancy.
More funding for high quality child care. Funding for para professionals to work in Child Care settings, to assist with Special needs children. (ages birth to 5) Health insurance for working mothers...
AWARENESS to parents. I think we all see the ads on tv but some parents do not comprehend that information and things go on way to long for their children. It should be discussed like RSV; with mothers of children uder the age of 2. ask more questions of their nutrition choice. What are the eating and how often. Not how often are they eating and wetting diapers.
in home mental health services for children and families, such as Moving Beyond Depression, a program offered to select home visiting programs in wyandotte County tfunded by MIECHV, which targets moms of infants and toddlers with depression thru a specialized form of Cognitive Behavioral Therapy provided in the home
No real ideas
I think better access to healthy Mom/Baby visits in the home for at risk families would be wonderful.
Environmental health education
An additional nurse in the health department to help carry out some of the opportunities available. A health department building that would function better. Lack of space is a huge issue.

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	291

31. Are mental and behavioral health a concern in your community?

#	Answer	Bar	Response	%
1	yes		468	92%
2	No		43	8%
	Total		511	

Statistic	Value
Min Value	1
Max Value	2
Mean	1.08
Variance	0.08
Standard Deviation	0.28
Total Responses	511

32. Have you or someone in your household used mental and behavioral health services? If yes, what services?

#	Answer	Bar	Response	%
1	yes		15	44%
2	No		19	56%
	Total		34	

yes
counseling
neurological
Counseling
Counselor
counseling
therapy and med management
emergency counseling
individual counseling, medication management
medication, counseling
Private counseling
Play therapy since 2007
County mental health caseworker and professional counseling.
behavioral therapist

Statistic	Value
Min Value	1
Max Value	2
Mean	1.56
Variance	0.25
Standard Deviation	0.50
Total Responses	34

33. Have you referred for a mental and behavioral health services? If yes, what services?

#	Answer	Bar	Response	%
1	yes		340	72%
2	No		135	28%
	Total		475	

yes
behavior
children emotional and physical needs
screening for young children in all aspects of development
severe behavioral issues in daycare setting
parent training about infant child mental health, crisis counseling, suicide prevention, child and adult mental and cognitive evaluation
Pawnee Mental Health
Usd coop
Mental and behavioral
Family Service & Guidance
therapy
counseling, therapy, psychologist, for issues such as self injury, victims of abuse, substance abuse
basic assessment at a community mental health center
SED Waiver
mental and behavioral
all
Mental
JoCo Mental Health
mental and behavioral
autism
COMMUNITY MENTAL HEALTH
counseling
Jo Co mental health
Rainbows United
counseling center
Southwest guidance center
Mental and drug abuse.
Mental
therapy
local mental health centers, my own agency (catholic charities), private clinician's, primary care physicians
Horizons
crisis intervention, substance abuse, suicide prevention
there is no mental services in our community, they have to travel to services. It is CHA concern.
Mental Heatlh Center in our office
Mental Health Evaluation
mental health
We have started offering many of the services ourselves but continue to refer for everything from emegency interventions to hospitalizations to medication management.
depression, paranoia, others
Bahvioral
COMCARE
behavior, substance abuse
Mental Health
mental health center
Horizons Mental Health Center
Family Service and Guidance
counseling
Johnson County Mental Health

evaluation
INTENSIVE BEHAVIORAL THERAPY IN-HOME AND CENTERED BASED
grief counseling
mental health issues-depression, anxiety, suicide
counseling, evaluation
counseling; alcohol dependency
mental
postpartum depression, anxiety, dual diagnosis, boderline personality, multiple personality. These are individuals that have had a diagnosis but for whatever reason did not continue mental health services and are not eligible for state health insurance. But most of them would qualify if Medicaid was expanded.
counselor/ guidance center
Assessment from a behavioral specialist.
counseling, hospitalization
psychology, psychiatry, social work
Mental health facilities
evaluation and counsel
Family, Group, and Individual Therapy; Case Management; SED Waiver Services, Infant and Maternal Mental Health programs
counseling
Pawnee Mental Health
mental and behavioral
counseling
Valeo
outpatient & inpatient mental health
Child Behavior
Play therapy
psychologist, counselor, Comcare
Comcare, KCSL, Rainbows,
counseling, therapy
screening
play based therapy
conseling
mental health
parenting, adhd
Counseling/therapy
behavioral health services, Parenting with Love & Logic classes
Horizons Mental Health, SEEK
local mental health center
compass behavioral
Eliz Layton Behavioral Health Services
comcare
crisis intervention
Both
all range of services
Drug and alcohol- behavioral
Refer to our local mental health provider and other providers regularly for both mental and behavioral health.
COMCARE, Rainbows Mental Health Services
Bi-polar
Central Kansas MH and also Pawnee MH Centers
we have to refer to our catchment Pawnee for kids more servere. Other wise we give a variety of options.
Project Before
mental health /counseling, assessment
Pawnee Mental Health
evaluation and treatment
suicide, drug abuse
depending on the age of the child - there can be a variety of services but local mental health centers do not have much for children under the age of 3 and their families.
Compass Behavioral health

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Min Value	1
Max Value	2
Mean	1.28
Variance	0.20
Standard Deviation	0.45
Total Responses	475

34. What populations need mental and behavioral health services the most in your community?

#	Answer	Bar	Response	%
2	Women		128	26%
3	Infants		14	3%
4	Children		131	26%
5	Children with Special Health Care Needs		64	13%
6	Adolescents		162	32%
	Total		499	

Statistic	Value
Min Value	2
Max Value	6
Mean	4.24
Variance	2.43
Standard Deviation	1.56
Total Responses	499

35. What would improve mental and behavioral health services in your community?

Text Response
adequate funding
broader range of services
Available dollars
I just know that since they closed Menninger's there has been a gap in meeting the needs of adults and children with mental issues or behavioral issues.
Maybe more classes so many offered are during daytime and can't always attend
more providers trainined to work with young children
if people would go to appointments and take med as ordered
Better trained diagnostic professionals. Rubber stamping diagnosis is too common.
More services for the low income with or without insurance.
Extra funding to hire more professionals to help those needing mental health services. There client/professional ratios are too high!
It needs to be affordable. FSG is expensive. Lower income families cannot afford help there.
Better services! People are not confident in our local facilities.
If the medical model would fund mental and behavioral services like they do other diseases, perhaps everyone would have better services. There is such a stigma attached to mental and behavioral health. If the medical diagnostic model and the educational model for mental and behavioral health were aligned, it would help families through transitions
Probably a centralized place where people could get the services they need without having to drive 30-50 miles. Free screenings, information on what their insurance provides, access to treatment and prevention services, proactive, preventative programs in the schools. Mandatory programs in the schools on mental health and wellness, prevention of abuse, nutrition.
Increasing funding for mental and behavioral health services in at community mental health centers
Services that children under the age of 4 can access. Otherwise they are considered too young to have mental health, let alone need services.
once again--education, educating the community of the services and resources available
Help the parents to help themselves, so that they can also help their children
Better quality providers. 50% of all mental health providers graduate in the bottom half of their class.
Knowledge of what is available. We battled with my daughter throughout elementary and middle school, but no one ever recommended JoCo Mental Health and I didn't know about their services.
accessablility
More awareness.
To make it legal for teachers, child care providers, etc to initiate basic screenings. Example: I had a child that exhibited the majority of the signs for autism. Screening for his delays would have been free via infant toddler services, and could have been done in the child care setting. Mom never made the call, despite being told the same thing at previous daycare environments. Had a screening been done, I think that would have pushed her to have the child properly evaluated. Outcomes are much, much higher with early intervention. As mentioned earlier, a centralized database where we could find all licensed providers specializing in what we are looking for (as well as their hours and insurance accepted).
More doctors trained in mental and behavioral health in the community
more programs open during the evening/weekend hours
Not make it so difficult to get help for people if they have insurance, but no one is accepting the insurance they have.
To have access to better professionals. Ours are simply not very good.
affordable services
A branch office would be helpful
Finding a way to make it more affordable. Counseling requires multiple visits and can be pricy for those of us on a budget.
Funding and support.
More services for men
More providers
They need to be affordable. Not everyone has health insurance.
I am not as familiar with these services yet having services closer to our community would make these services more available.
Having a mental health professional in the community more than one day a week.
Affordable, insurance covered services. Sliding Scale Fee
more acceptance?
I don't know.
Removing the stigma associated with mental illnesses, more public awareness campaigns, encouraging people to open up and discuss mental health-related issues and not ignoring them
To have local present at least weekly. The person has to drive to get services at least 30 miles. School seems to meet most student needs but other family members it is a problem.
Easy access to meds with loss of health insurance
Mental Health would be improved if the drug and alcohol use in partents would be lower. Also having access to mental health care workers on the job sites would help alot of adults as they can not get off work to go to an appointment. Also having those specialists in the schools would help. Increased education to the entire population.
More clinicians available Not be spread over such a big area eg. (8 counties)

More school-based mental health services. There is a major shortage of providers throughout the region. Also, breaking out of the model that has been in place for decades and no longer is meeting the needs.

Specialist

more funding to be able to serve more people and in patient care availability

Increase services through more locations

More staff for agencies that provide low cost mental health services.

in the community more often

Programs that start from infancy through adults.

More mental health specialists, stop the cuts.

great access to low cost services, inpatient services in the community

A strong referral system.

Education on where to find care.

Decrease the amount of drug use. Parents being home more and being more involved with what is going on in their childs life.

I don't know.

More awareness of the issues of mental and behavioral problems would improve care in our community. With all health services most improvement is linked with additional funding.

BEHAVIORAL SUPPORTS FOR CHILDREN WITH INTELLECTUAL DEVELOPMENTAL DISABILITIES THAT ARE COVERED BY KANCARE AND HAVE SUPPORTS ACCESSIBLE TO FAMILIES IN THEIR OWN COMMUNITIES.

A public push to really enlighten the general public that most of these issues are completely normal at some point in our lifetime and that there is help available. There shouldn't be a stigma attached to those seeking help, and those with medical conditions that require regular mental health shouldn't feel that they are stigmatized either.

Reduced cost More awareness More help at guidance center Male help to assist those that are males in gender

Accessibility and affordability

Access to care as well as quality of care... we have limited providers in our area (per patient reports they are not very well suited to do the job that we need done... I have personally worked with patients to coordinate care through this facility and those experiences confirmed client reports). Because of this we have primary care providers who are trying to treat complicated mental health issues.

increased awareness of assistance available; follow through

Better follow up with foster families.

More providers accepting KanCare or a sliding fee scale.

Services provided in the home, local community mental health center increasing their collaboration with early childhood community, local mental health center recognizing and providing Infant-Toddler Mental services and practice.

More money.

Increase services. Make parents aware of services that are currently available. Have insurance and Medicaid cover more of these services.

Decrease the stigma associated with mental illness so services would be accessed earlier. Also have mental health providers and addiction providers work together as so much overlaps.

More professionals in the school systems to support students in teachers with behaviorally challenged students.

More health care professional dealing in psychiatry

Quality Providers

Funding Skilled Clincially licensed Practitioners Better access to specialized care programs (SUD Programs, Co-occuring programs, IOP, Medically Assisted Detox programs) Better responses from DCF in cases of child welfare investigations and CINC interventions Billing across disciplines so that behavioral health and physical health care services can be integrated in the same settings.

make them low cost or sliding scale

More awareness, signs for parents to look for.

Increased access

Better access for 0 to 5 years of age and their parents. It appears parents do know how to discipline appropriately and the mental health facility can not serve a child without a diagnoses and that is not appropriate for ages 0 to 3. Medicine is not the answer in most cases, but parents do need to know how to say No and appropriately deal with bad behaviors, especially in public.

Why isn't there a place to answer for men above? I feel that a lot more men need mental & behavioral health services more than anyone else. This is why are jails are over crowded. If we spent more money on mental health, we wouldn't have to spend as much on jails. 1. Invest in more employees who can help the people who need mental health. 2. Count down the waiting time for their appointments. 3. Less people would hurt themselves or others 4. There would be less mentally ill people in jail, and getting the help that they need.

More providers of behavioral health and payment for this by the primary care providers

awareness, support groups

more psychologists and specialists trained in childhood development, better trained midlevel providers,

More qualified counselors, psychologist, psychiatrists, school counselors, DCF workers and ministerial staff. Sometimes from lack of training and education, cases are either not recognized, dropped or pursued to heavily.

easier access to inpatient mental health facility

The importance of early detection and understanding of Mental Health services.

Full time therapist. Right now therapists are only in town a couple times a week. Makes for a long time between sessions.

availability of residential counseling for adolescents

Easy access and affordability

more providers able to serve families with limited ability to cover co-pays

not sure

More mental health centers
Drug and alcohol treatment available in the community and appropriate refferals made.
Wider acceptance of Medicaid by mental health professionals, expansion of Medicaid services to cover more adults.
More and better services
Community awareness of how to access services and what services are available. Also, people who make threats about harming others should be locked up. Many people in the community feel mental health screenings are not done often enough nor thorough or strigent enough.
Funding and accessibility
qualified in serving young children and issues that families face in raising young children
inpatient facility to do screenings for mental health
Better access to it.
More affordable options. Community center access has several weeks wait for appointment which is not ideal for some one that is currently experiencing acute mental health issues.

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	372

36. Are health and developmental screenings a concern in your community?

#	Answer	Bar	Response	%
1	yes		281	56%
2	no		221	44%
	Total		502	

Statistic	Value
Min Value	1
Max Value	2
Mean	1.44
Variance	0.25
Standard Deviation	0.50
Total Responses	502

37. Have you or someone in your household utilized a service for health screenings and/or developmental screening? If yes, please describe the service(s)

#	Answer	Bar	Response	%
1	yes		15	45%
2	No		18	55%
	Total		33	

yes
out of state
school district
throughh the school district
early ed
PAT
Preschool Screening
Pre-K screening
Screen for Success
USD 259
pat
asq
Infant/Toddler Services
PAT Early child screening

Statistic	Value
Min Value	1
Max Value	2
Mean	1.55
Variance	0.26
Standard Deviation	0.51
Total Responses	33

38. Have you referred a service for health screenings and/or developmental screening? If yes, please describe the service(s)

#	Answer	Bar	Response	%
1	yes		323	69%
2	No		143	31%
	Total		466	

yes
preschool screenings
Tiny K, "paents as Teachers, Count your kid in
developmental mostly
physical delays of children
for babies, children all ages...see above commentary
Usd 320
Developmental
speech
learn and play, arrowhead west.
Count Your Kid In
autism diagnosis
basic developmental health screening
Part C after ASQ screen
Johnson County Infant Toddler Services and the 3 adjacent school districts
behavioral preschool
Connecting Point
eye test at school
Couont Your Kid In
Count Me In
PT/OT via infant toddler services
speech, social
Screen for Success
Autism
developmental - Part C
Preschool development
mental health screenings
Russell Development
Count your kid in
our county has this Spring and late summer
preschool screenings
Parents as teachers, Infant Toddler Services, Early head Start
mental health, and developmenta
Again, we provide a lot of these services but do refer for audiology, speech delays, etc.
pedicatric health screens
Heartland Programs
infant children
Kan Be Healthy
Kan Be Healthy
Early Education Center for developmental screening.
TARC, Family Service and Guidance, local school districts
developmental and health
evaluation, KBH
parents as teachers; infant toddler
Screen for Success
DEVELOPMENTAL SCREENINGS BY PEDIATRICIANS
PACT-developmental

PCP, Heartland, EHS, etc
developmental screening
KanBeHealthy
0-3 & 3-5 developmental screening,
developmental screening - school district
Developmental screenings from our public schools
educational, speech, hearing, vision, development, medical.
KBH
developmental and health
Autism spectrum disorders
screen for success
RCDC
medical professionals
all preventive screening and child development
Basic screenings for inf
KUMC, wait period several months
for not passing health screening and for cognitive delays.
ASQ's
speech screening
Screen for Success
Special Education cooperative
all types of referrals
an infant who was developmentally delayed
tinyk
Screen for Success
tiny k services
developmental screening
Early Education Center developmental screens and community wide screenings
tiny-k, Autism screening
compass Behavioral
Dev Peds KU Pediatrics
early childhood screenings
Preschool screening
Screen for Success
Infant/Toddler disability
Monthly Child Finds (called Child Checks) are offered in our county.
B-3, Tri-county
school districts
Child Check
Kid Link
our agency does developmental screenings and some basic health screenings.
vision and hearing screenings
B&D consult
General developmental screening, autism-specific screening
early childhood
dev check
Birth to Three
OT/PT/speech/developmental pediatric eval
Infant-Toddler developmental screening
Well Child Checks
infant toddler services Pawneee relared to PPD
Developmental screening for developmental delays.
wheelchair assessments
with a developmental pediatrician or Infant toddler services

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Min Value	1
Max Value	2
Mean	1.31
Variance	0.21
Standard Deviation	0.46
Total Responses	466

39. What population in your community, if any, do you believe needs access to health screenings and developmental screenings?

Text Response
Age 26-65 adult population without inurance.
young children new parents for maternal depression Families for substance abuse/domestic violence However, there has to be an increase in services to access when screening identify needed services. Won't do any good to increase the level of screening if families cannot access needed services
Individuals with mental health needs
I usually deal with children and adolescence so I only know there is some access issues with this age.
Not sure
low income families
low income, and undocumented residents
The majority who don't understand the need or feel it will be too expensive or inconvenient
I think all ages infancy to adulthood should have the opportunity to health and developmental screenings.
infant thru kindergarten entry
ALL children
lower income families with no health insurance
0-5 age group.
I think everyone should have equal access to healthcare. At this time, I have to go out of state for providers.
Everyone--especially the un and under insured
Infants and toddlers, of course, but also school age children that have not had it done when they were younger.
Low income and middle income families
Homeless Shelter and other homeless families. Families receiving mental health services at the community health clinic,
the youth
all ages - even senior adults undergo developmental changes as their lives progress
100%
Elderly
All ages
ALL. Children from ALL socio-economic backgrounds can struggle with brain-based issues such as ADHD, ODD, Autism, depression, etc. Wealth, in my experience, is not much of a factor in whether evaluations are done early. No one wants to recognize that something is "wrong" with their child, and those feelings often interfere with getting early care. That is another good reason for providers and teachers to have the ability to set up basic screenings. Once that information is in hand from someone who specializes in developmental issues, it is more likely that parents will face the issue and intervene earlier, thereby improving their child's long term outcome.
SCREENING FOR AUTISM
the poor
young children
3-6 year olds.
The 30 to 50 year olds.
children from birth to age 5 most important
Young children and elderly
Infants and children. There is free screening available but not very many people know about it
Low income
I believe there are people in every population that need access to health, especially mental health, screenings. I think that there should be more development screenings for infant and toddlers to address possible problems as early as possible.
Infants, Toddlers, young children, elementary age children, adolescents, teens, adults with special needs, adults with mental illnesses.
Once forced by the legal system
Infants and young children
Infants and children.
Children should always have access to Health screenings and not just children who need Kan Be Healthy Physicals, all children. The College age population also need health screenings that are low in cost.
All. I feel the screening should be free for everyone. The provider could start charging for anything done after the screening process.
Latino
All populations. Low-income, middle class, high-income, chronically mentally ill, individuals, couples, adolescents, children, older adults, all races, all ethnicity.
children
adolescents
Vulnerable populations: the poor, isolated, those with transportation issues
0-5
All, we need to destigmatize and offer screenings on an ongoing basis, through schools, day cares and preschools.
Adults and Children

Infants, children
School-aged children.
All people
all
Children, adolescents, women, men
Infants, children and adolescents. I think adults need health screenings.
The homeless and illegal aliens need access to health screenings and developmental screenings.
0-5y
Infants through adolescence.
All population needs access to health screening and developmental screenings.
Preschool and early grade school years children.
Low income
women and children
All preschool age children
poverty guideline children
Recent immigrants, impoverished families.
children
infants toddlers preschoolers
My guess would be that 50% of the population needs access to health/developmental screenings.
ALL INFANTS AND CHILDREN,
For my own position, primarily women without health insurance benefits that fall into that Medicaid gap.
toddlers and adolescents
Children
infants, children for developmental older uninsured population for health
infants, children, youth
Latino/Hispanic children.
Low income adults who are not low income enough for Medicaid (unless expanded) and are not able to afford the sliding scale.
Adolescents
All ages.
All.
I think the services are there but the information needs to be more publicized to the community.
Young families.
Birth thur 2nd grade.
the undocumented population, refugee population, non-English speaking community
children and adolescents
Everyone
All populations haave access to basic screen services, but once a problem is identified, there are no services available to address the concerns.
poor, minorities, elderly
Children
Children-low income
The screenings/evaluations for 0 to 3 for developmental skills are available, but unfortunately there are not enough referrals to the early intervention programs. The doctors need to provide better screenings for developmental delays using an evidence-based tool. The WIC and Kan Be Healthy screenings are not consistent and do not catch the delays early and they do not refer consistently.
N/A
Poor, immigrants, minorities
Once children enter school, there is very little done in the way of health screenings except eye and hearing. Developmental screenings should be done. Social behavior screenings should be done. Mental health screenings should be done. Children fall in the cracks and many of them that come from low income families could use some evaluations. Many of them don't know the stability of a family life. We see this all the time with our WIC parents. Lack of discipline and simple common courtesies to the rest of society.
infants, children and adolescents
toddlers, children
The Hispanic community has been largely ignored in Southeast. We have a large amount of citizens who do not believe in immunizations and will not access them for their children. Also children in poverty are not accessing services as much as other children.
all ages, feel this is important for overall good health
Hispanics and Burmese.
Uninsured Women.
infants who were premature or other NICU stay, at risk for developmental disabilities.

Infants and children

This table has more than 100 rows. Click here to view all responses

Statistic	Value
Total Responses	379

APPENDIX I

Key Stakeholder Meetings

Kansas Department of Health and Environment
Bureau of Family Health
Title V Maternal Child Health Needs Assessment

Priority Setting for 2016-2020
March 24, 2015

Agenda

9:00-9:10am	Welcome & Introductions
9:10-9:30am	Overview of Title V Maternal Child Health & the 5 Year Needs Assessment
9:30-9:45am	Goals & Process for Priority Setting
9:45-9:50am	Break/Move to Small Groups
9:50-11:30am	Small Group Work Setting Priorities & Objectives • 20 minutes per priority population
11:30-11:35am	Break/Return to CSOB Room 530
11:35am-12:00pm	Debrief, Wrap Up & Next Steps

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020
Initial Priorities March 24, 2015

Small Group Assignments

Room 1	Room 2	Room 3	Room 4
Facilitator: Tracy VanVlack	Facilitator:	Facilitator:	Facilitator:
Rachel Sisson Carrie Atkin Mary Murphy Christina Flyntz	Heather Smith Debbie Richardson Liz Abbey Lori Steelman David Thomason	Kayzey Bigler Lori Haskett Jamey Kendall Barbara Kramer Stephanie Wolf	Traci Reed Martha Hagen Kelly Blake Jamie Kim Sarah Walters

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020
Initial Priorities March 24, 2015

Small Group Instructions

- Each person in your group should have a packet of materials containing the Title V Initial Priorities Overview and Initial Priorities and Objectives for each of the 5 target population domains.

- Each group will spend 20 minutes talking about each of the 5 target population domains. Your group should talk about the target populations in the order identified by your facilitator.

- During your 20 minutes on each target population domain, your group should:
    - Confirm priorities
        - Are the priorities correct?
        - What is missing?
        - How would you prioritize the priorities? Where would you focus if resources are limited?
    - Confirm or draft objectives
        - Are the objectives correct?
        - What would you add or change?
    - Identify strategies to reach objective
        - Be specific about initiatives or programs that support each objective. Include specific activities if appropriate.
    - Identify key linkages between target population priorities and objectives (see linkages outlined by on the Title V Initial Priorities Overview).

- Be prepared to report out on your small group work during the debrief and wrap up.

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020
Initial Priorities, March 2014

The purpose of this document is to provide an overview of the initial priorities for Title V work in Kansas over the next five years. The priorities were identified through extensive public input gathered via a comprehensive needs assessment conducted across Kansas. Data for the needs assessment were collected from July 2014 through February 2015.

The initial priorities include priorities and objectives for five target population domains:

Women/Maternal
Infant/Perinatal
Children
Children with Special Health Care Needs
Adolescents

The needs assessment highlighted the importance of recognizing and understanding the connections between priorities across these population domains. The initial priorities reflect the critical connections that emerged from the needs assessment. In addition, three overarching themes were identified as cross-cutting or life course priorities:

1) The need for increased collaboration/partnership/integration
2) The importance of relationships within families and with service providers
3) Addressing community norms that have created a stigma that is a barrier to people accessing needed services

Through the Title V Needs Assessment and 5 Year Plan (2016-2020), the Bureau of Family Health is focused on creating systems changes and delivering services that address the generation to generation transfer of negative experiences and their outcomes.

Maternal/Women	Perinatal/Infants	Children	Children with Special Health Care Needs	Adolescents
Self-care/care coordination • Physical health • Emotional well-being • Reproductive life planning • Substance abuse/smoking • Health literacy ○ Understanding insurance	Preventive care • Availability of care • Screening • Immunization • Oral health	Preventive care • Availability of care • Screening • Immunization • Oral health • Injury prevention	Preventative Care • Availability of care • Screening • Immunization • Oral health • Injury prevention • Transitioning • Chronic health care needs	Self-care/care coordination • Well care • Reproductive life planning/sexual health education • Teen pregnancy • Stress/coping skills • Substance abuse
Mental health • Early experiences/trauma		Social-emotional development • Bullying • Child care • ACEs	Mental Health • Bullying • Child care • ACEs	Mental health • Suicide • ACEs
Family functioning • Healthy relationships/Men • Domestic violence			Family Functioning • Stress • Sibling care • Health literacy	Home environment
Parenting • Life skills • Dealing with challenging behaviors • Respite care • Education/training	Infant care/parenting practices • Safe sleep • Lack of routine • Child care		Parenting • Life skills • Dealing with challenging behaviors • Respite care • Education/training	Life skills
Social isolation • Transportation			Social isolation • Transportation	Social isolation • Transportation
	Nutrition • Breastfeeding • Inadequate nutrition	Nutrition • Healthy affordable food • School lunch • Physical activity	Nutrition	Nutrition
		Qualified/trained adults • Lack of school supports • Social emotional development • Behavior management	Qualified/trained adults • Lack of school supports • Chronic health care needs • Behavior management	Qualified/trained adults • Lack of school supports • Lack of mentorship

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020

Maternal/Women

Priority: Self-care/care coordination
Objective: Physical health Strategies: • • •
Objective: Emotional well-being Strategies: • • •
Objective: Reproductive life planning Strategies: • • •
Objective: Substance abuse/smoking Strategies: • • •
Objective: Health literacy Strategies: • • •

Priority: Mental Health
Objective: Early experiences/trauma Strategies • • •

Priority: Family Functioning
Objective: Healthy relationships/Men Strategies • • •
Objective: Domestic Violence Strategies • • •

Priority: Parenting
Objective: Life skills Strategies: • • •
Objective: Dealing with challenging behaviors Strategies: • • •
Objective: Respite Care Strategies: • • •
Objective: Education/training Strategies: • • •

Priority: Social Isolation
Objective: Transportation Strategies: • • •

Priority:
Objective: Strategies: • • •

Priority:
Objective: Strategies: • • •

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020

Perinatal/Infants

Priority: Preventative care
Objective: Availability of care Strategies: • • •
Objective: Screening Strategies: • • •
Objective: Immunization Strategies: • • •
Objective: Oral Health Strategies: • • •

Priority: Infant Care/parenting practices
Objective: Safe sleep Strategies • • •
Objective: Lack of routine Strategies • • •
Objective: Child care Strategies • • •
Priority: Nutrition
Objective: Breastfeeding Strategies: • • •

Objective: Inadequate nutrition Strategies: • • •

Priority:
Objective: Strategies: • • •

Priority:
Objective: Strategies: • • •

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020

Children

Priority: Preventive Care
Objective: Availability of care Strategies: • • •
Objective: Screening Strategies: • • •
Objective: Immunization Strategies: • • •
Objective: Oral Health Strategies: • • •
Objective: Injury prevention Strategies: • • •

Priority: Social-emotional development
Objective: Bullying Strategies: • • •
Objective: Child care Strategies: • • •

Objective: Adverse Childhood Experiences Strategies: • • •

Priority: Nutrition
Objective: Healthy affordable food Strategies: • • •
Objective: School lunch Strategies: • • •
Objective: Physical Activity Strategies: • • •

Priority: Qualified/trained adults
Objective: Lack of school supports Strategies: • • •
Objective: Social-emotional development Strategies: • • •
Objective: Behavior Management Strategies: • • •

Priority:
Objective: Strategies: • • •

Priority:
Objective: Strategies: • • •

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020

Children with Special Health Care Needs

Priority: Preventive Care
Objective: Availability of care Strategies: • • •
Objective: Screening Strategies: • • •
Objective: Immunization Strategies: • • •
Objective: Oral Health Strategies: • • •
Objective: Injury prevention Strategies: • • •
Objective: Transitioning Strategies: • • •
Objective: Chronic health care needs Strategies: • • •

Priority: Mental Health
Objective: Bullying Strategies: • • •
Objective: Childcare Strategies: • • •
Objective: Adverse Childhood Experiences (ACEs) Strategies: • • •

Priority: Family Functioning
Objective: Stress Strategies: • • •
Objective: Sibling care Strategies: • • •
Objective: Health Literacy Strategies: • • •

Priority: Parenting
Objective: Life skills Strategies: • • •
Objective: Dealing with Challenging behaviors Strategies: • • •
Objective: Respite care Strategies: • • •
Objective: Education/training

Strategies: • • •

Priority: Social Isolation
Objective: Transportation Strategies • • •

Priority: Nutrition
Objective: Strategies • • •

Priority: Qualified/trained adults
Objective: Lack of school supports Strategies • • •
Objective: Chronic health care needs Strategies • • •
Objective: Behavior management Strategies • • •

Priority:
Objective: Strategies: • • •

Priority:
Objective: Strategies • • •

Kansas Department of Health and Environment
Maternal Child Health Title V
Needs Assessment 2016-2020

Adolescents

Priority: Self-care/care coordinating
Objective: Well care Strategies: • • •
Objective: Reproductive life planning/sexual health education Strategies: • • •
Objective: Teen pregnancy Strategies: • • •
Objective: Stress/coping skills Strategies: • • •
Objective: Substance abuse Strategies: • • •

Priority: **Mental health**
Objective: Suicide Strategies: • • •
Objective: ACEs Strategies: • • •

Priority: Home Environment
Objective: Strategies • • •

Priority: Life Skills
Objective: Strategies • • •

Priority: Social isolation
Objective: Transportation Strategies • • •

Priority: Nutrition
Objective: Strategies • • •

Priority: Qualified/trained adults
Objective: Lack of school supports Strategies • • •
Objective: Lack of mentorship Strategies • • •

Priority:
Objective: Strategies • • •
Priority:

Objective:

Strategies

-
-
-

Kansas Department of Health and Environment
Bureau of Family Health
Title V Needs Assessment Partners Meeting
April 20, 2014

Agenda

I. Welcome & overview of Title V (1:00-1:30pm)
Instructions for small group work

II. Small group work (1:30-3:15pm)

Facilitated small group discussion to Identify strategies, outcomes & partners to achieve priorities across the Maternal & Child Health population domains:

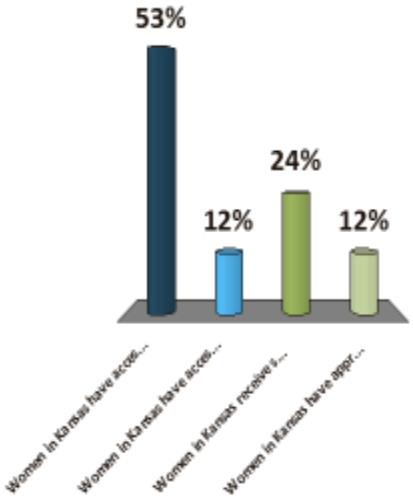
- Maternal/Women
- Children
- Adolescents
- *Infant/Perinatal*
- *Children with Special Health Care Needs*

III. Reflection (3:15-3:45pm)

IV. Next steps (3:45-4:00pm)

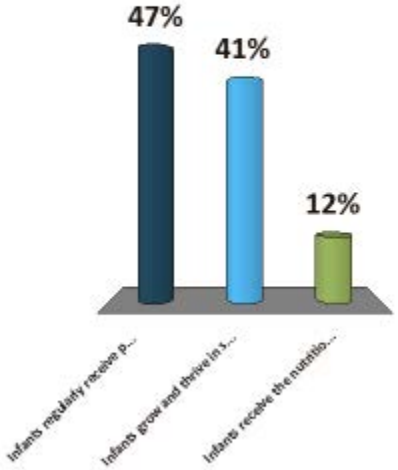
Maternal/Women

A. Women in Kansas have access to comprehensive, coordinated care.
B. Women in Kansas have access to mental health services and education.
C. Women in Kansas receive support toward positive family functioning and healthy relationships.
D. Women in Kansas have appropriate support to develop positive parenting practices.



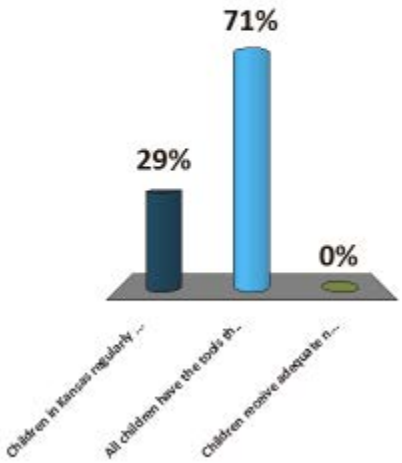
Infant/Perinatal

A. Infants regularly receive preventive care that is coordinated among providers
B. Infants grow and thrive in safe environments through supported parenting practices
C. Infants receive the nutrition that they need for healthy development



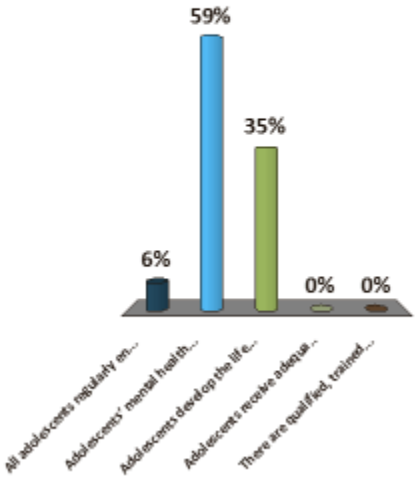
Children

A. Children in Kansas regularly receive preventive care that is coordinated among providers
B. All children have the tools they need to be socially and emotionally healthy
C. Children receive adequate nutrition to support healthy growth and development.



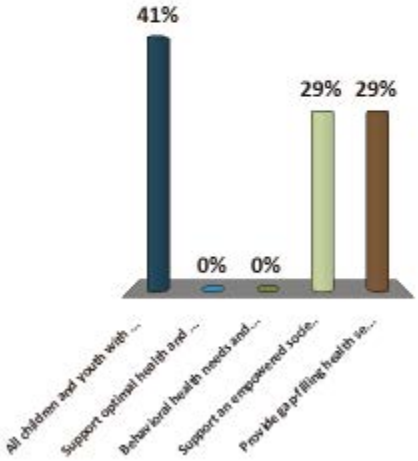
Adolescents

A. All adolescents regularly engage in self-care/preventive care that is coordinated among providers.
B. Adolescents' mental health and emotional well-being is addressed proactively.
C. Adolescents develop the life skills they need to thrive.
D. Adolescents receive adequate nutrition to support healthy growth and development.
E. There are qualified, trained adults available to work with adolescents.



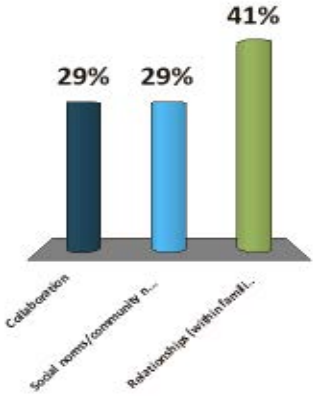
Children & Youth with Special Health Care Needs

A. All children and youth with special health care needs (CYSHCN) receive family-centered, coordinated care.
B. Support optimal health and well-being for family caregivers of CYSHCN.
C. Behavioral health needs and supports will be integrated into the Kansas Special Health Care Needs system of care.
D. Support an empowered society that is culturally sensitive, well-informed, and respectful of all people with disabilities through training and education.
E. Provide gap-filling health services for CYSHCN and their families through partnerships, collaboration, and direct care supports.



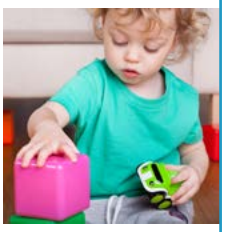
Life Course/Cross-Cutting

A. Collaboration
B. Social norms/community norms change
C. Relationships (within families and with service providers)



APPENDIX J

Key Documents



MCH Population Health Domains	Maternal & Women's Health	Prenatal & Infants	CYSHCN	Child	Adolescents	Life Course/Crosscutting
AMCHP recommendations	• Quality of Care • Maternal Screening • Access to Care	• Service Integration for Infants and Children				• Implementing Health Promotion • Data Systems • Promote Social Equity
Governor's Road Map				• 4th Grade Reading		• Protecting Health Insurance
Kansas Blue Ribbon Panel	• Access to Care • Implementation of Programs					• Data and Surveillance • Public Awareness and Education • Social Equity
Infant Mortality COIIN	• Enhance access to & quality of care in women's health before, during, and after pregnancy	• Implement multi-sector (individual, health care/social service provider, community, organization) approach to reduce SUID				• Build community capacity to promote education, screening, referral and treatment for women • Utilize data to understand/ synthesize/drive linkages (policy decisions & outreach programs)
Life Course Indicators (AMCHP)	• Experiences of race-based discrimination among pregnant women (PRAMS) • Stressors during pregnancy (PRAMS)	• Preterm births (NVSS)		• Experiences of discrimination among children (NSCH) • Children living in households where smoking occurs inside the home (NSCH) • 4th graders scoring proficient or above on math & reading (NAEP)	• Depression among youth (YRBSS)	• Adverse childhood experiences among children (NSCH) • Households with a high level of concentrated disadvantage (ACS) • Children or adults who are currently overweight or obese (NSCH, YRBSS, BRFSS, PRAMS) • Household food insecurity (USDA ERS) • Incarceration rate (BOJ, NPSP)
		• Children who receive services in a medical home (NSCH)				

Title V MCH National Performance Measures (NPMs) ***(from Block Grant Transformation Document)***	• Preconception Care • Maternal morbidity, defined as severe maternal morbidity per 10,000 hospitalizations • Early elective delivery at less than 39 weeks • Perinatal regionalization (percent of VLBW infants born in a hospital with a Level III NICU)	• Safe sleep (related infant deaths)	• Transition for children and youth with special health care needs		• Adolescent well visit (percent of adolescents/young adults with a preventive services visit last year).	• Insurance coverage (percent of the population that is uninsured and underinsured) • Nutrition and physical activities/obesity, which includes gestational weight gain, breastfeeding, physical activities, consumption of fruits and vegetables among pregnant women, children, adolescents • Oral health, focusing on two possible measures (percent of women who had their teeth cleaned during their last pregnancy; percent of children under six who had a cavity in the last six months) • Open
		• Developmental screening (% of children receiving dev. screening using a parent-completed screening tool) • School readiness, aligned with the President's Early Learning Initiative (expansion of home visiting, quality child care & Early Head Start, & universal pre-K)/supporting the early childhood system.				
		• Medical home (percent of children with a medical home) • Immunization (tied to legislation: percent of children and adolescents who have completed recommended vaccinations)				

MCH 2020: Perinatal/Infant Health

Reduce infant mortality and the incidence of preventable diseases (pregnancy through 1 year)

Related Title V National Performance Measures & Outcome Measures (NOMs)

- Perinatal Regionalization [Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)]
- Breastfeeding: (A) Percent of infants who are ever breastfed; (B) Percent of Infants breastfed exclusively through 6 months
- Safe Sleep (Percent of infants placed to sleep on their backs)
- NOM: Percent of low birth weight, very low birth weight, and moderately low birth weight deliveries
- NOM: Percent of preterm, early preterm, late preterm and early term births
- NOM: Percent of non-medically indicated early term deliveries
- NOMs: Mortality rates including infant, neonatal, post-neonatal, preterm-related, sleep related SUID; fetal alcohol syndrome; neonatal abstinence syndrome; newborns screened

Priorities

- All infants regularly receive preventive care that is coordinated among providers
- All infants grow and thrive in safe environments through supported parenting practices
- All infants receive adequate nutrition

Public Input/Guiding Plans

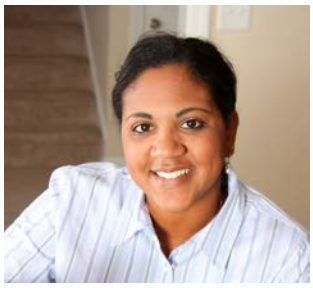
- Infant Mortality CoIIN* *Blueprint for Change*
- Blue Ribbon Panel on Infant Mortality
- Kansas MCH Council
- MCH Services Input Survey
- Home Visiting and tiny K (Part C) Programs
- Public Health Regional Meetings
- Communities for Kids Tour
- Child Care Town Hall Meetings

**Collaborative Improvement & Innovation Network*

Kansas Department of Health and Environment

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

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



MCH 2020: Women's and Maternal Health

Provide and assure mothers and children access to quality MCH services (women 15-44 years)

Related Title V National Performance Measures & Outcome Measures (NOMs)

- Well Woman Care (Percent of women with a past year preventative visit)
- Low Risk Cesarean Deliveries (Percent of deliveries among low risk first births)
- NOM: Prenatal Care (beginning in the first trimester)
- NOM: Rate of Severe Maternal Morbidity per 10,000 Delivery Hospitalizations
- NOM: Maternal Mortality

Priorities

- All women have access to self care and coordinated care
- All women have access to Mental health services and education
- All women receive support toward positive family functioning and healthy relationships

Public Input

- Blue Ribbon Panel on Infant Mortality
- MCH Services Input Survey
- *Becoming a Mom* Community Programs
- Domestic Violence Outreach
- Pregnancy Crisis Centers
- Public Health Regional Meetings

Kansas Department of Health and Environment

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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 2020: Child Health

Preventive and primary care services for children ages 1-11 (consider varying needs for children 1-4 and 5-11 years)

Related Title V National Performance Measures & Outcome Measures (NOMs)

- Developmental screening (Percent of children, 10-71 months, receiving a developmental screening using a parent-completed screening tool)
- Child injury (Rate of hospitalization for non-fatal children 0-9, adolescents 10-19)
- Physical activity (Percent of children 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day)
- Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
- Percent of children ages 1-17 who have decayed teeth or cavities in the past 12 months
- Child mortality rate ages 1-9
- Percent of children in excellent/very good health
- Percent of children 2-4 who are overweight or obese (BMI at or above the 85th percentile)
- Percent of children without health insurance
- Percent of children ages 19-35 months who received the 4:3:1:3(4):3:1:4 series of vaccinations

Priorities

- All children have access to healthy social-emotional development
- All children receive adequate nutrition
- There are qualified, trained adults available to work with children in Kansas
- All children have safeguards to injury prevention
- All children regularly receive preventive care that is coordinated among providers

Public Input

- Kansas MCH Council
- MCH Services Input Survey
- KVC Behavioral Healthcare
- Foster Parents Association
- Regional Public Health Meetings
- Communities for Kids Tour
- Child Care Town Hall Meetings

Kansas Department of Health and Environment

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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 2020: Adolescent Health

Preventive and primary care services (consider varying needs for children/adolescents 12-17 and 18-22 years)

Related Title V National Performance Measures & Outcome Measures (NOMs)

- Child injury (Rate of hospitalization for non-fatal children 0-9, adolescents 10-19)
- Physical activity (Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day)
- Bullying (Percent of adolescents, 12-17, who are bullied or who bully others)
- Adolescent well visit (Percent of adolescents 12-17 with a preventive medical visit in the last year)
- Adolescent mortality rate 10-19
- Adolescent motor vehicle mortality rate 15-19
- Adolescent suicide rate ages 15-19
- Percent of adolescents 10-17 who are overweight or obese (BMI at or above the 85th percentile)
- Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza
- Percent of adolescents, ages 13 through 17, who have received at least one dose of HPV vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of Tdap vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of meningococcal conjugate vaccine

Priorities

- All adolescents regularly engage in self-care/ preventive care that is coordinated among providers.
- All adolescents' mental health and emotional well-being is addressed proactively.
- All adolescents develop the life skills they need to thrive.
- All adolescents receive adequate nutrition
- There are qualified, trained adults available to work with adolescents

Public Input

- Adolescent Health Online Survey (Kansas State University)
- Community Focus Groups (Kansas State University)
- MCH Services Input Survey
- Public Health Regional Meetings
- Communities for Kids Tour
- Child Care Town Hall Meetings

Kansas Department of Health and Environment

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MCH 2020: Children & Youth with Special Health Care Needs

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

Related Title V National Performance Measures & Outcome Measures (NOMs)

- Medical Home (Percent of children with and without special health care needs having a medical home)
- Transition (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care)
- Percent of children with special health care needs
- Percent of children with special health care needs receiving care in a well-functioning system
- Percent of children diagnosed with autism spectrum disorder
- Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)
- Percent of children with a mental/behavioral conditions who receive treatment or counseling

Priorities

Public Input

- MCH Services Input Survey (2013 and 2014)
- 3-Phased SHCN Stakeholder Input Sessions (July 2013 through September 2014)
- Communities for Kids Tour (December 2014 through February 2015)
- SHS Family Advisory Planning Sessions (August 2013 through May 2015)
- Public Health Regional Meetings (May 2014 through February 2015)

Kansas Department of Health and Environment

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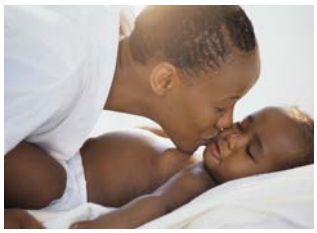

MCH 2020: Life Course/Cross-Cutting Health

Provide and promote family-centered, community-based, coordinated care, and facilitate the development of community-based systems of services.

Related Title V National Performance Measures & Outcome Measures (NOMs)

- Oral Health [(A) Percent of women who had a dental visit during pregnancy; (B) Percent of children, ages 1 through 17 , who had a preventative dental visit in the last year]
- Smoking during pregnancy and household smoking [(A) Percent of women who smoke during pregnancy; (B) Percent of children who live in households where someone smokes]
- Adequate insurance coverage (Percent of children 0 through 17 years who are adequately insured)

Priorities

Public Input

- Kansas MCH Council
- MCH Services Input Survey
- Community Forums
- Public Health Regional Meetings

Kansas Department of Health and Environment

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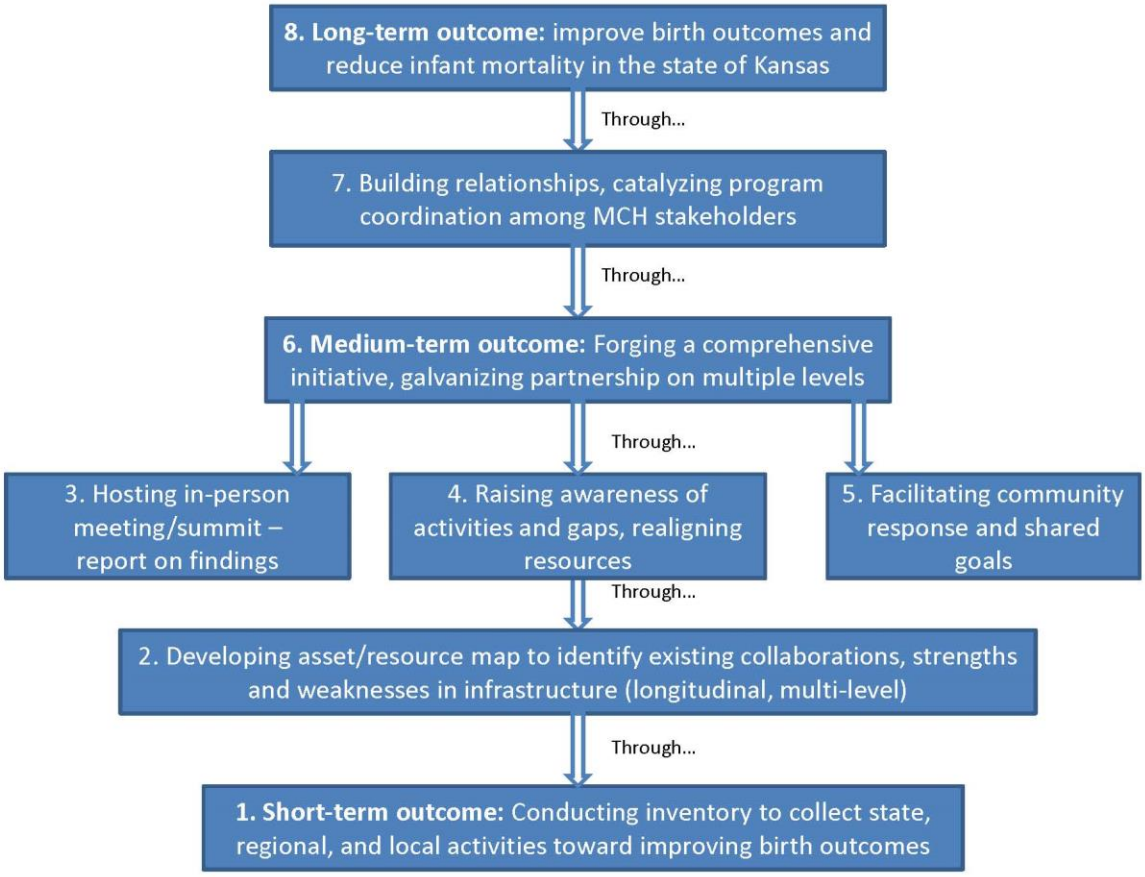
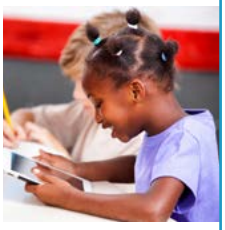

8. Long-term outcome: improve birth outcomes and reduce infant mortality in the state of Kansas
Through...
7. Building relationships, catalyzing program coordination among MCH stakeholders
Through...
6. Medium-term outcome: Forging a comprehensive initiative, galvanizing partnership on multiple levels
Through...
3. Hosting in-person meeting/summit – report on findings
4. Raising awareness of activities and gaps, realigning resources
5. Facilitating community response and shared goals
Through...
2. Developing asset/resource map to identify existing collaborations, strengths and weaknesses in infrastructure (longitudinal, multi-level)
Through...
1. Short-term outcome: Conducting inventory to collect state, regional, and local activities toward improving birth outcomes

APPENDIX K

Data

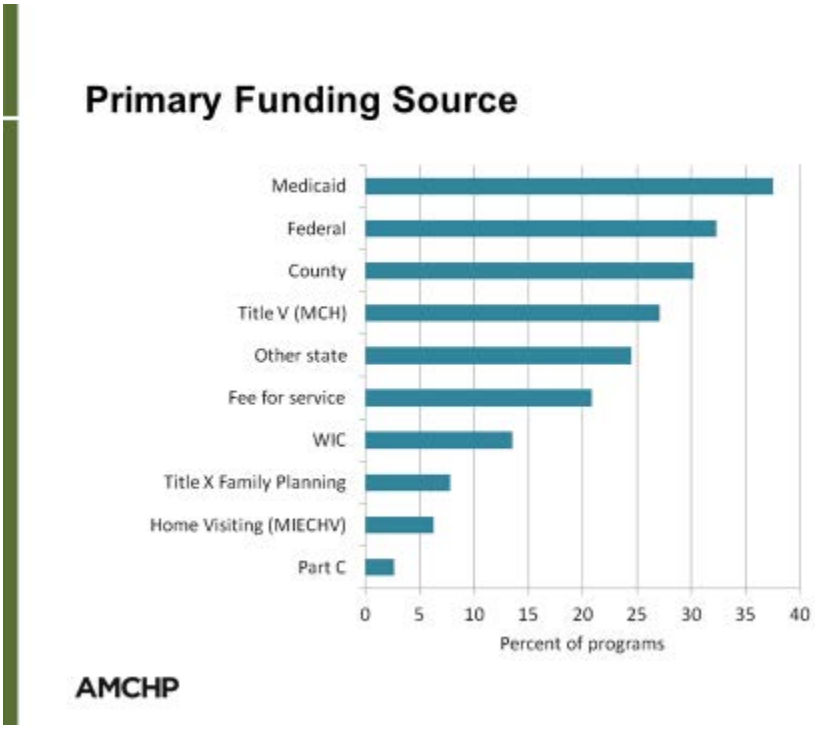


Aggragate data from regional meeting state inventory

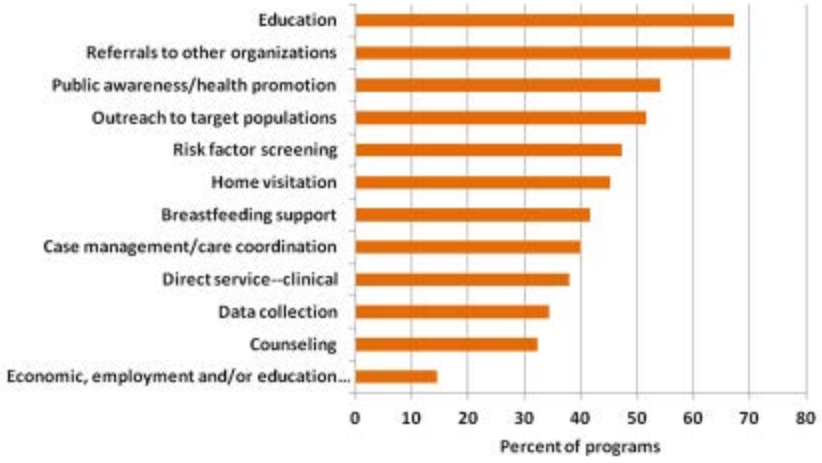
State-wide summary of respondents

192 Programs

5 Regions: North Central, Northwest, Southeast, Southwest, South Central



Main Services Provided



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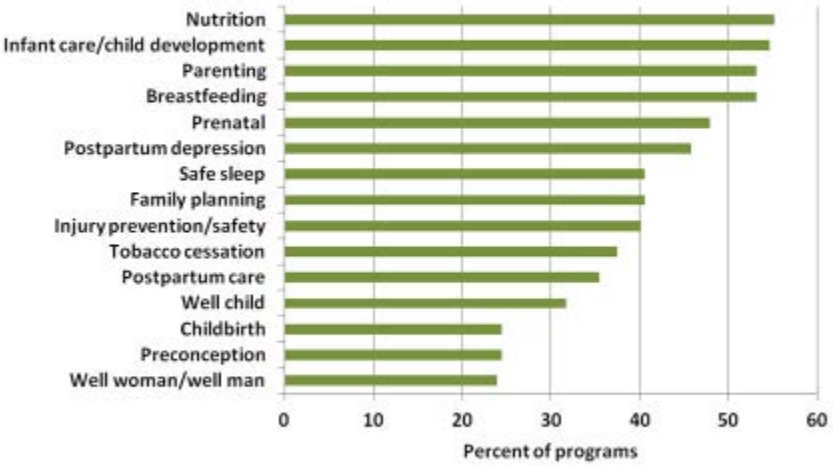
Type of Education Provided



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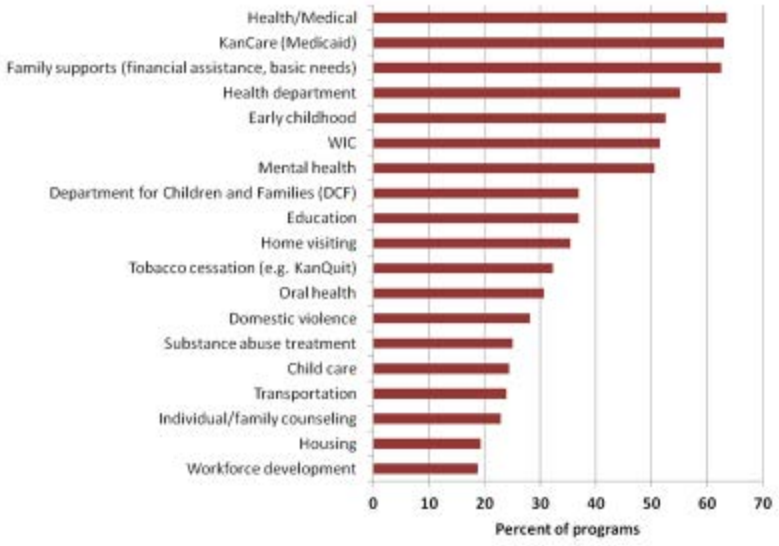
Referral Organizations



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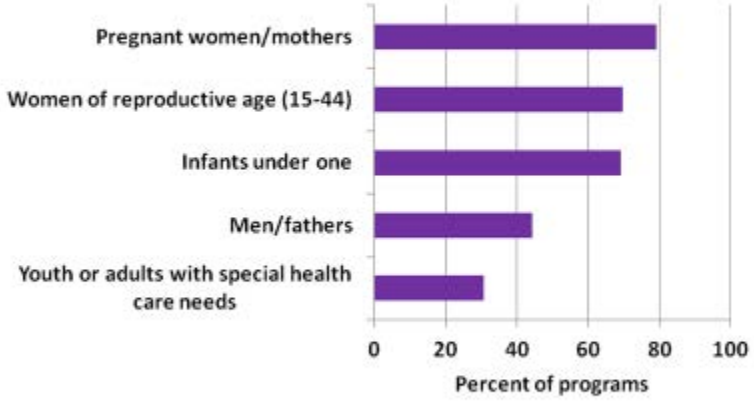
Populations Served



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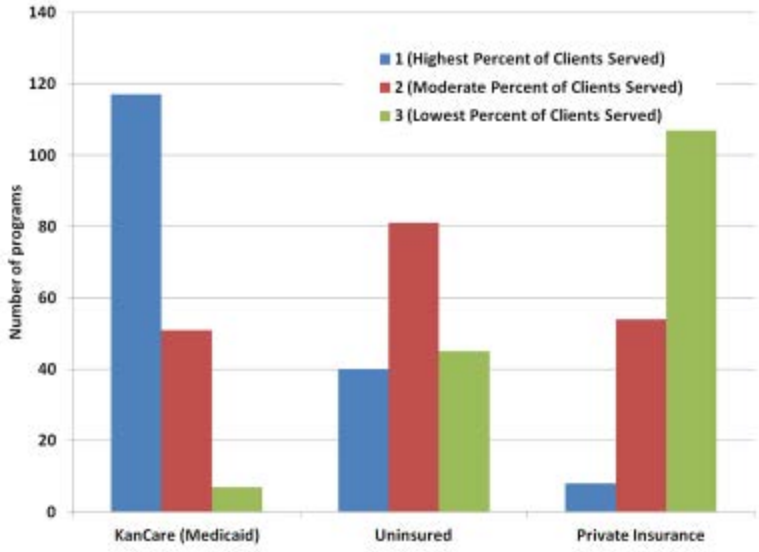
Insurance Status



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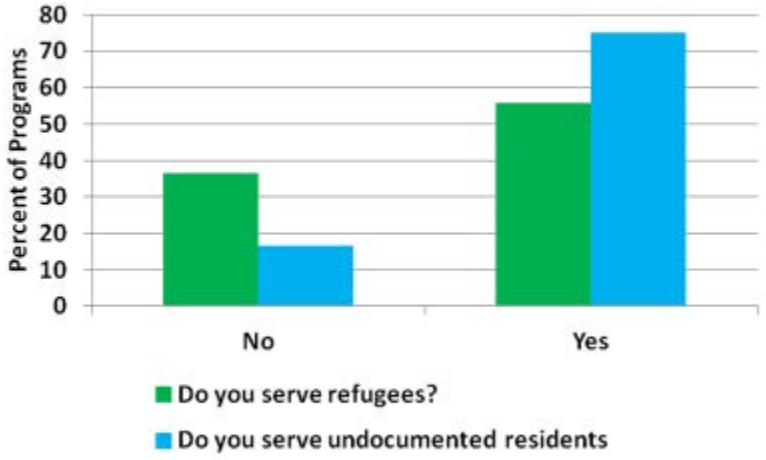
Refugees and Undocumented Residents



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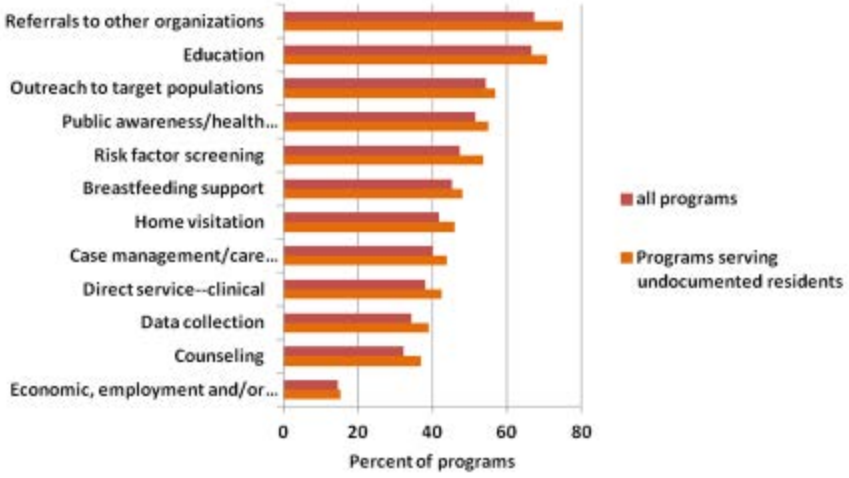
Main Services Provided: All programs vs programs serving undocumented residents



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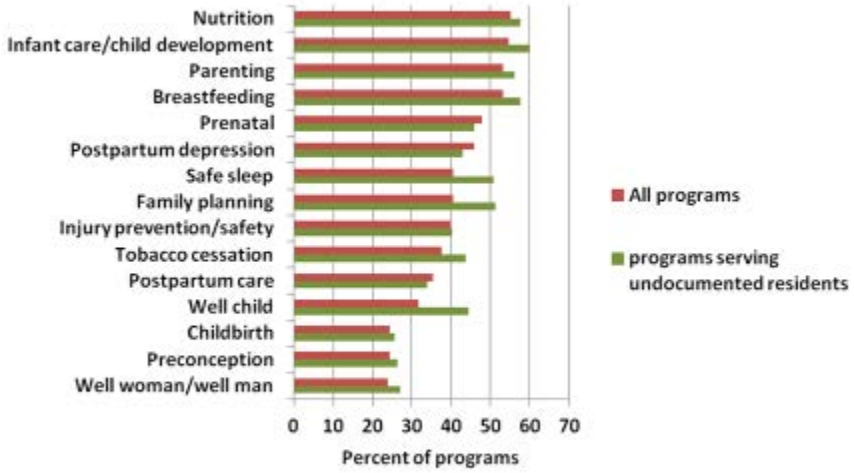
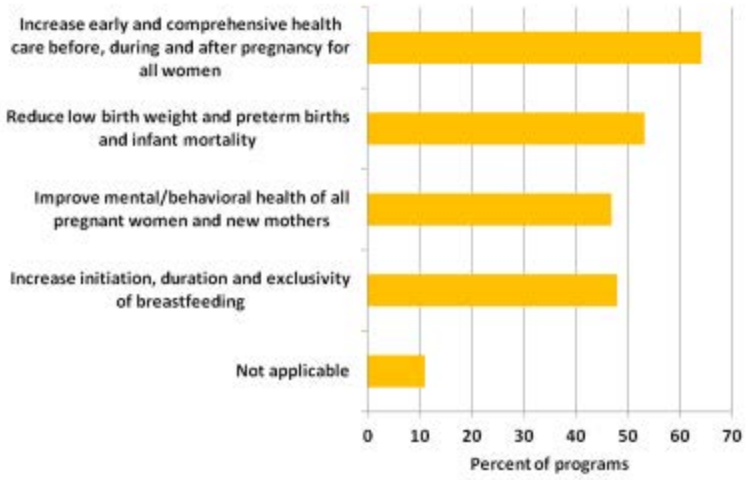
Type of Education Provided: All programs vs programs serving undocumented residents



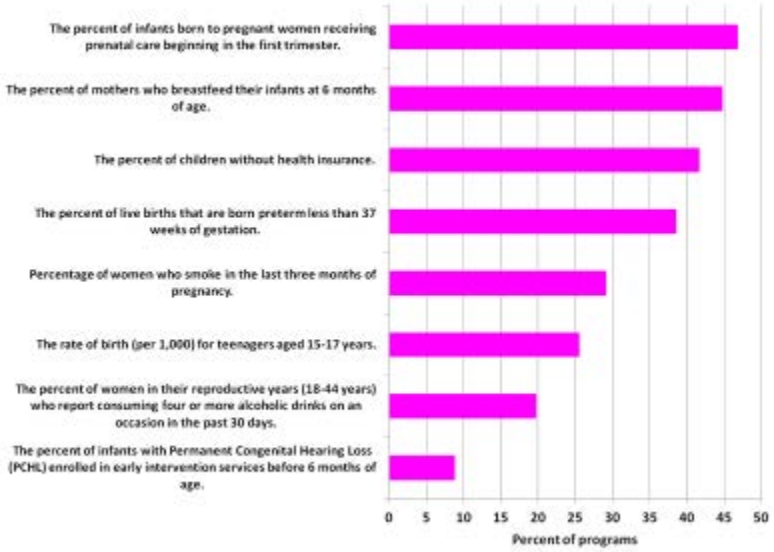
AMCHP

MCH State Priority Needs



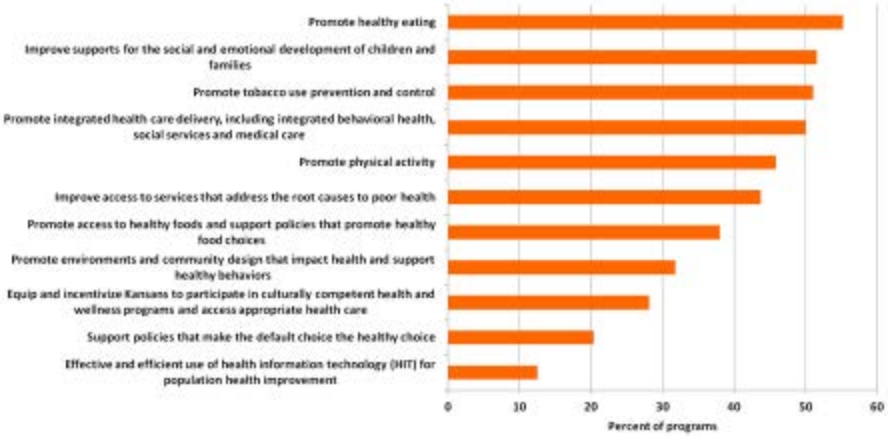
AMCHP

Title V Performance Measures



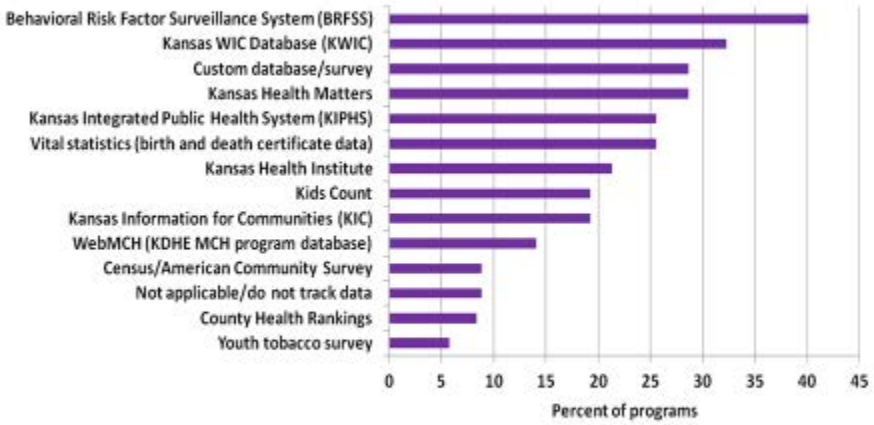
AMCHP

Healthy Kansans 2020



AMCHP

Primary Data Sources



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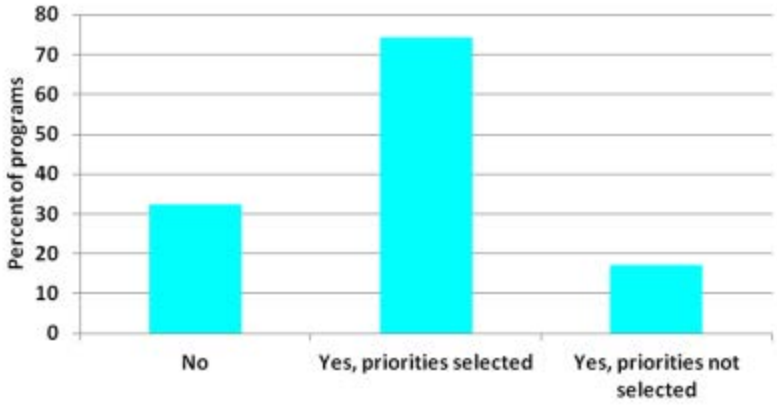
Participation in a Community Health Assessment



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Compendium Strategies

Implement health promotion efforts - Top priority for 22 programs

Ensure quality of care for all women and infants – 46 programs

Improve maternal risk screening for all women of reproductive age - 10 programs

Enhance service integration for women and infants - 14 programs

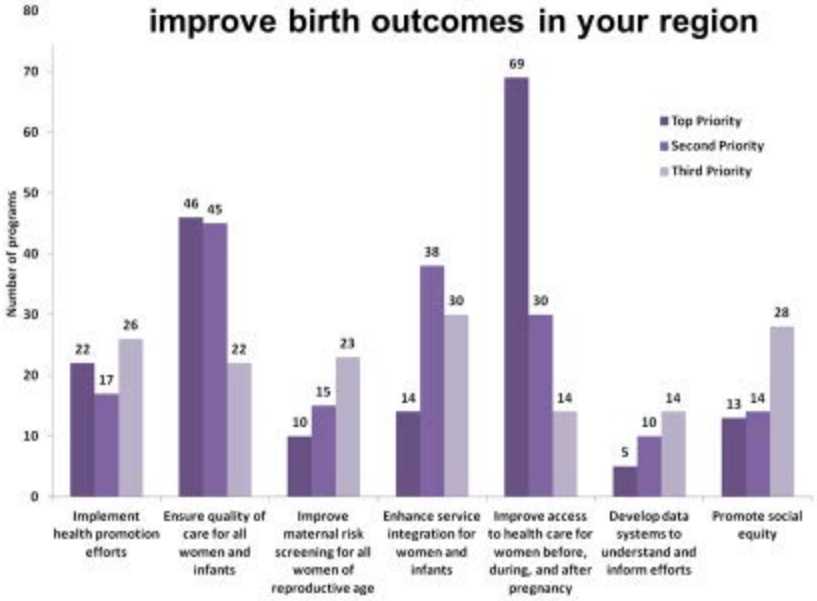
Improve access to health care for women before, during, and after pregnancy - 69 programs

Develop data systems to understand and inform efforts – 5 programs

Promote social equity – 13 programs

AMCHP

Identify the Top 3 most important areas of focus to improve birth outcomes in your region



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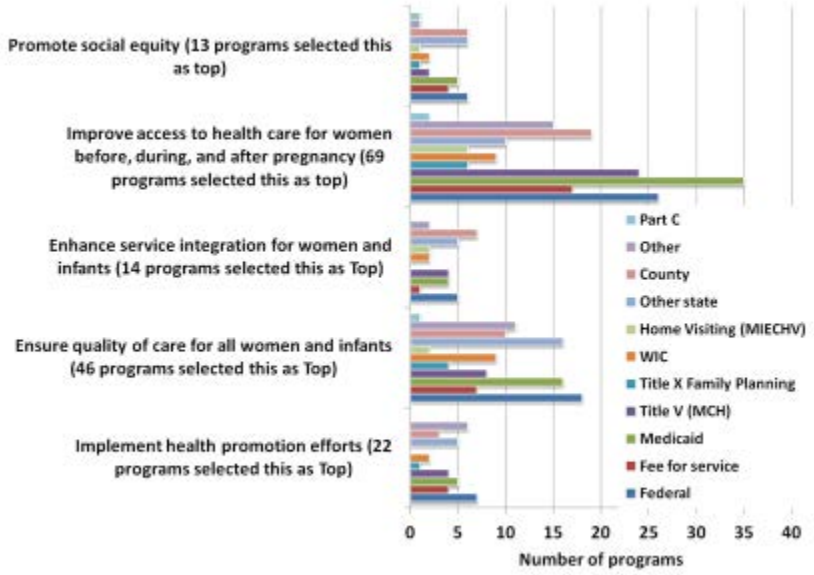
By Primary Funding



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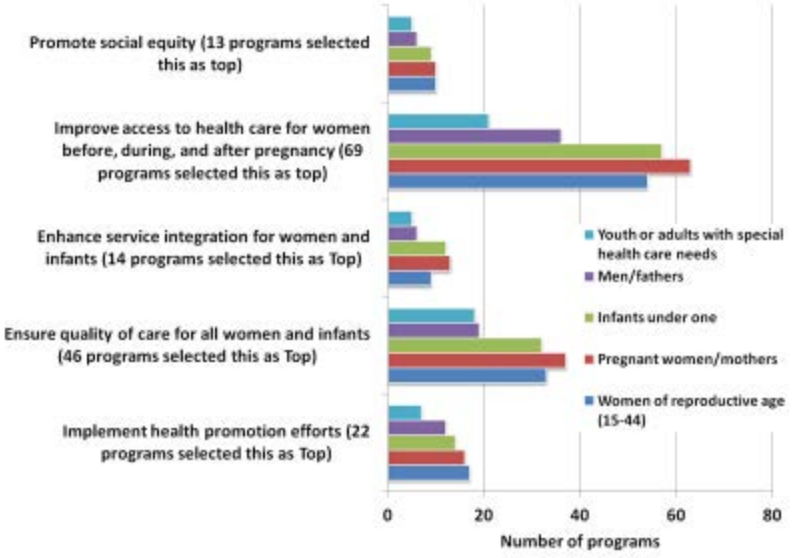
By Populations Served



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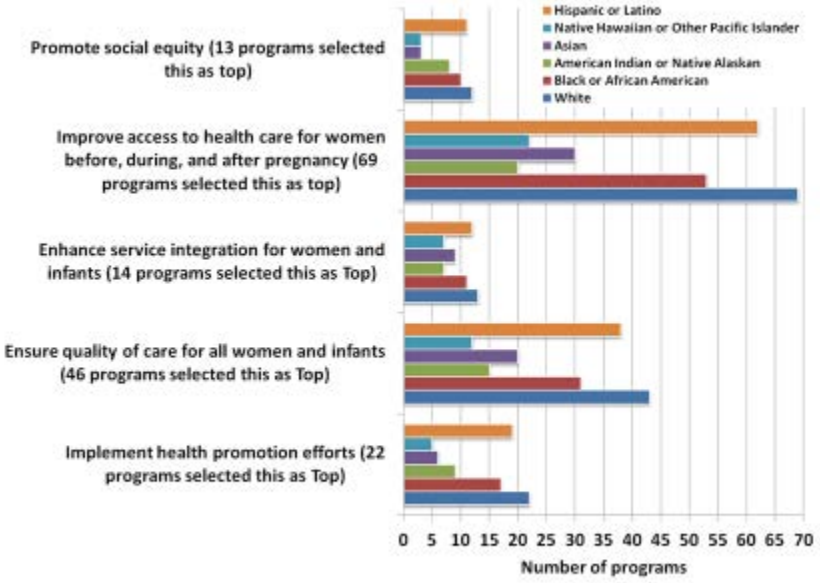
By Race / Ethnicity of Clients Served



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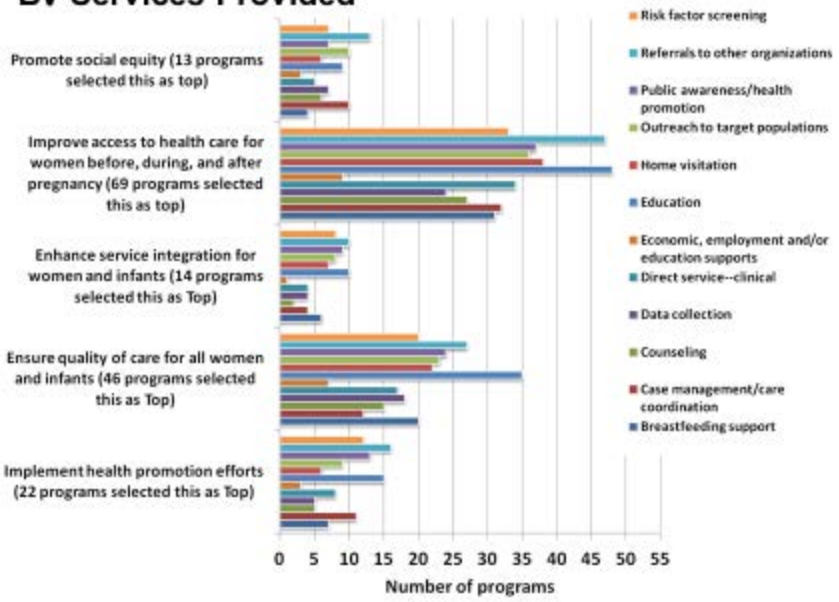
Bv Services Provided



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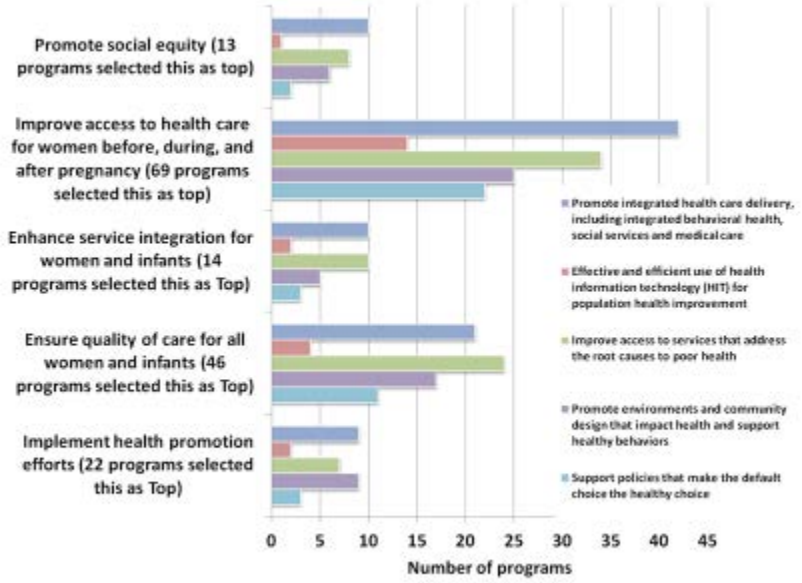
By Healthy Kansans 2020 Priorities (2 of 2)



AMCHP

APPENDIX L

Statewide Strategic Action Plan

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	Women receive prenatal risk assessments and education to improve birth outcomes.	Obtain consensus among providers on standards of care and practice guidelines related to prenatal risk assessment	*NPM 01: Well-woman visit (Percent of women with a past year preventive medical visit)*	*ESMs will be developed in FY16 and include State-initiated Evidence-based or -informed Strategy Measures*
		Expand the HBWW/BAM program model, targeting areas with disparities and poor birth outcomes	*NPM 14-A: Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy)*	
	Women are connected to the services and supports that they need to promote their emotional well-being.	Integrate behavioral health education into community, clinic, and home settings	*State performance measure will be developed*	
		Implement a standard screening protocol and utilization of standard tool for maternal risk and depression		
	Communities have the capacity and resources to promote education, screening, referral, and treatment for women and families	Promote and collaborate with family planning and Title X to improve women's health		
		Increase community capacity through asset mapping and forging partnerships to address MCH population health needs		
Services and supports promote healthy family functioning.	Women and families establish healthy relationships and learn life skills that support daily family functioning.	Address family functioning in all MCH contacts	*NPM 14-B: Smoking during Pregnancy and Household Smoking (B. Percent of children who live in households where someone smokes)*	
		Utilize the Kansas Special Health Care Needs (KS-SHCN) "Family Caregiver Assessment" to identify needs and resources for family members of clients	*State performance measure will be developed*	
	Provide opportunities that promote and support informed, engaged, and empowered families.	Utilize peer and social networks for women including to promote and support access to preventive health care		

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
		Develop a progressive family leadership program to empower families and build strong MCH advocates		
		Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (Foster Care, Special health care needs, other)		
	Align home visiting programs and expand services as necessary to ensure families are matched to services that meet their needs	Using an evidence-based model, provide parenting resources and mentors for adolescent caregivers		
		Redesign the universal MCH Home Visiting program to serve more families		
		Replicate MIECHV central intake model across the state to support appropriate referral and level of service/intervention		
Developmentally appropriate care and services are provided across the lifespan. (Children)	**3.1:** As a result of infants, children and adolescents being in environments where there are safeguards against preventable injury and harm, the infant mortality rate is reduced to a 3-year low.	Assure appropriate motor vehicle safety education is provided for all individuals transporting infants and children	*NPM 06: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)* *NPM 07: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19*	
		Establish prevention activities focused on reducing motor vehicle crash injuries and deaths to adolescents due to distracted or impaired driving (SAFE)		
		Engage home visiting in evaluating safety concerns in the home and provide education regarding prevention and risk		

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
		Increase the number of MCH grantees that serve as the home agency for local Safe Kids Coalitions		
		Provide education and support to assist parents with selecting a child care setting that meets health and safety requirements		
	3.2: 90% of children receive immunizations according to the recommended schedule.	Improve access to childhood immunizations for families by reducing barriers and improving delivery processes		
		Support medical and early intervention providers through appropriate tools and resources to encourage parents resistant of immunizing their child(ren)		
	3.3: Multi-sector (individual, health care and social service providers, community-based organization) approaches are in place to reduce annual SIDS and SUID rates.	Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need		
		Launch a campaign on safe sleep practices targeted to relative caregivers and those providing family-friend- and neighbor care		
		Inventory existing safe sleep initiatives and activities to determine what services are needed and areas to target education, training, and materials		
	3.4: To achieve overall good health and desirable outcomes over the life course, preventative oral health services are integrated into existing programs and services for the MCH population starting in the prenatal and infancy periods	Integrate oral health education into prenatal and infant health education		

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
		Promote oral health in all programs targeted towards CYSHCN through care coordination activities		
		Implement collaborative oral health initiatives to expand oral health screening and education to targeted to infants and children		
	3.5: All children receive an age appropriate developmental screening annually with a valid and reliable tool	Conduct statewide campaign to coordination among providers who screen for developmental delays, including recommended protocols for information sharing		
		Build MCH capacity for screening follow-up through complete referrals to providers and community-based services		
		Develop a standard and consistent message to communicate importance of developmental screening among home visiting and child care programs		
Families are empowered to make educated choices about nutrition & physical activity. (Perinatal/Infant)	**4.1:** Children and adolescents ages 0-17 years old and older have access to healthy foods and increased knowledge of opportunities for physical activity in order to adhere to and achieve optimum lifelong health.	Increase the availability of healthy food and beverages in sufficient supply in schools	*State performance measure will be developed*	
		Increase opportunities for students to participate in regular physical activity both in and out of school (e.g., non-competitive sports leagues, intramural)		
		Promote and implement "brain breaks" in schools including recess and designated time between classes and activities		
	4.2: Parents have access to information and resources on infant nutrition and feeding education in a multifaceted way using existing programs starting in the prenatal period, initiated during the first trimester	Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including home visiting and WIC	*NPM 4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)*	

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
		Support breastfeeding mothers and babies by creating communities that provide a multifaceted approach		
		Develop prenatal education content to support an accurate, consistent message for women related to optimal infant feeding		
	4.3: Increased opportunities for regular physical activity for families are provided through structured environments and improved accessibility to facilities that support physical activity	Explore opportunities to engage local businesses in health and wellness activities		
		Provide resources and educational materials to child care and home visiting programs on healthy eating and physical activity in early childhood to decrease obesity risk in childhood and adolescence		
		Support local health departments and or community centers in local initiatives to promote physical activity and utilization of walking and biking trails		
Communities and (providers/systems of care) support physical, social and emotional health. (Adolescents)	**5.1:** All children and adolescents receive comprehensive preventive health care that addresses social and emotional aspects of health at annual child and adolescent well visits, promoted through a developed cross system partnership (schools, community partners, Health Department)	Promote annual well-child visits through adolescence into adulthood.	*NPM 09: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)* *NPM 10: Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)*	
		Engage school nurses to identify and refer children with an Individualized Healthcare Plan who have not had a well-child visit in the past year	*State performance measure will be developed*	
		Promote incorporation of behavioral health/behavioral health screening into annual child and adolescent well visits		

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
	5.2: All youth are provided with the support, relationships, and resources they need in order to build and improve coping skills and manage stress through measurable, positive youth development interventions and the implementation of evidence-based practices to prevent suicide	Partner with community partners to connect children and adolescents with supports that promote protective factors		
		Implement evidence-based/ evidence-informed practices to support healthy behaviors and choices and the development of positive coping mechanisms among adolescents.		
		Provide services that support reducing the impact of Adverse Childhood Experiences (ACEs) on children and adolescents.		
	5.3: Adults, children, and adolescents are aware of and have access to prevention and intervention programs that educate and empower them to practice protective factors to reduce the impact of bullying through MCH community and school trainings provided annually	Increase awareness of options for educating and reporting unsafe digital content		
		Bullying and Cyberbullying intervention and prevention		
		Make connections among schools, families, communities and health providers through programs such as Communities in Schools (CIS) and school-based clinics		
Professionals have the knowledge and skills to address the needs of maternal and child health populations. (Cross-cutting)	**6.1:** MCH provides on-going support toward the development of a trained and qualified workforce that serves Kansas children and families by providing professionals with up-to-date best practices and evidence-based services using a multi-faceted approach (referral network, mid-level training for home visitors, partnership support)	Increase knowledge of Maternal Child Health	*State performance measure will be developed*	
		Professionals are up to date on best practices and evidence-based interventions and services		
		Improve coordination with the Center for Population Health specific to workforce development for primary care, etc.		

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
	6.2: Annual training and education is delivered to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the SHCN population into adulthood	Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN.		
		Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course.		
		Partner with NAMI to offer youth and adult education programs to KS-SHCN clients.		
	6.3: MCH provides and ensures availability to on-going, up to date education and training opportunities that promote consistent messages and curriculums for childcare providers in Kansas aimed at the social-emotional development of children	Make available and provide training to child care providers		
		Consistent messages across all entities working with early childhood (coordination)		
		Tie early learning standards		
Services are comprehensive and coordinated across systems and providers. (CYSHCN)	**7.1:** By supporting collaborative efforts of partners (MCO's, primary care providers) toward the timely implementation of a family-centered medical home to help with coordination of care, communication and outreach improves among service providers, individuals, and families	Support implementation of family-centered medical homes through increased awareness, professional development, and collaboration	*Medical home (Percent of children with and without special health care needs having a medical home)*	
		Implement communication and referral protocols for SHCN Care Coordinators and providers.	State performance measure will be developed	
		Expand KS-SHCN to have care coordinators located in all regions.		
	7.2: Systems that support age & are developmentally appropriate, universal behavioral health that increase collaboration efforts through partnerships with existing programs (KDADS, KAIMH) and between primary care and behavioral health providers are continually integrated and reviewed	Explore partnerships with and support existing structures that promote behavior health services		

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
		Promote collaboration between primary care and behavioral health providers		
		Integrate behavioral health assessment results in the KS-SHCN action plan resources/referrals.		
	7.3: A patient-centered action plan that assists and empowers individuals and families is developed, monitored, and evaluated to help navigate systems for optimal health outcomes throughout the life course	Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients.		
		Complete the online navigational tool kit to provide resources and services		
		Increase access to primary and specialty care in underserved areas.		
Information is available to support informed health decisions and choices. (Cross-cutting) [health literacy]	**8.1:** MCH works with existing programs (pediatricians, youth programs, local schools) to increase the number of partnerships that will help parents and youth ages 17 and under understand the importance of and make informed decisions about healthy choices and regular self-care	Determine appropriate avenues for reaching children in middle childhood (ages 6-11) to empower them to make informed choices about health and wellness	*State performance measure will be developed*	
		Provide resources to increase education/knowledge of healthy decision-making		
		Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence [avoiding risky behaviors], more easily available to youth and their families.		
	8.2: Through collaboration with local school districts to implement and provide youth-focused initiatives & curriculums that include progress measures, children and youth ages 17 and under, and families are better equipped to advocate for all needed services, supports, and family/professional partnerships to achieve 100% of successful and healthy transitions	Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution to children as part of orientation – incorporate into assemblies, school counselor classes, etc.	*State performance measure will be developed*	

Priority	Objective	Key Strategies	National Performance Measures	Evidence-Based Strategy Measures
		Provide youth-focused and youth-driven initiatives to support successful transition, self-determination and advocacy		
		Provide opportunities for parents to improve their skills in seeking out quality health-related information and services		
	8.3: In partnership with local health departments, MCH increases the number of individuals/families with medical insurance by 100% by assisting with locating and enrolling in the appropriate health care coverage, and through outreach by hosting current regional training around service planning, delivery, and navigation of resources to ensure utilization of acquired health care coverage	Provide support to local health departments in providing services in alignment with health transformation, including insurance enrollment and outreach	*State performance measure will be developed*	
		Identify opportunities to optimize health transformation in maximizing service delivery to families		
		Educate MCH staff		