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.

KANSAS MATERNAL & CHILD HEALTH

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Kansas Department of Health and Environment

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;

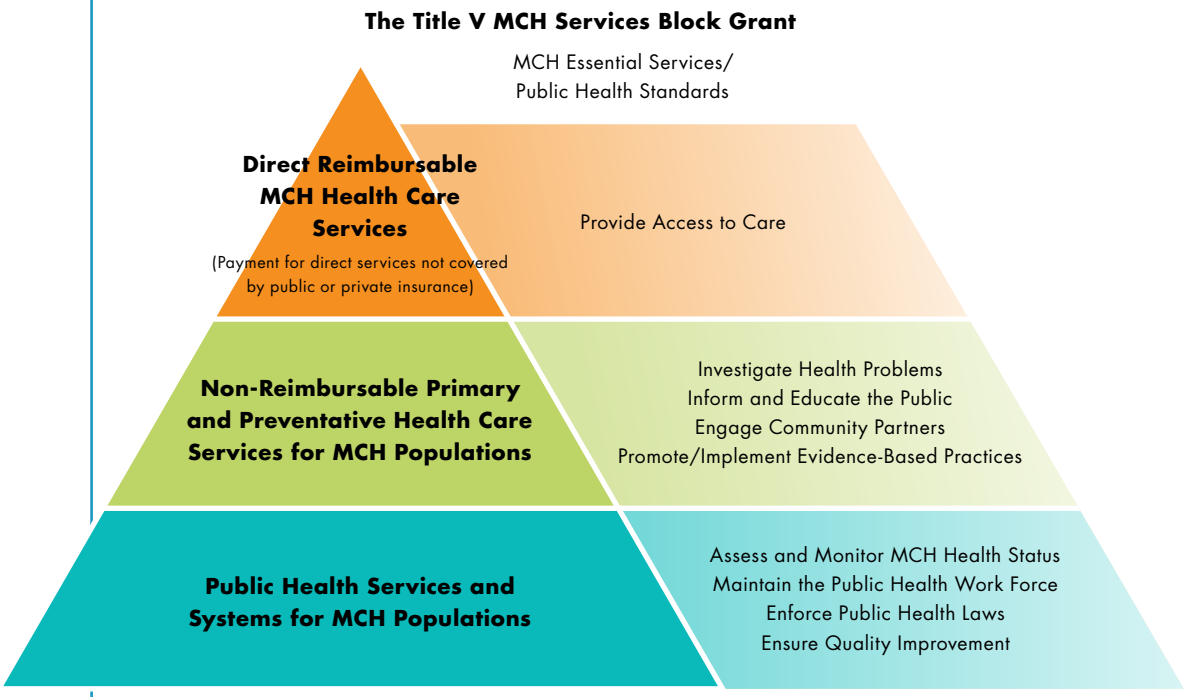
(C) To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

(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.

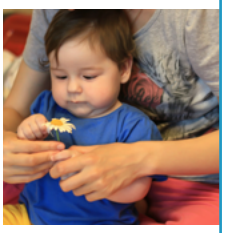
Guiding Principles

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

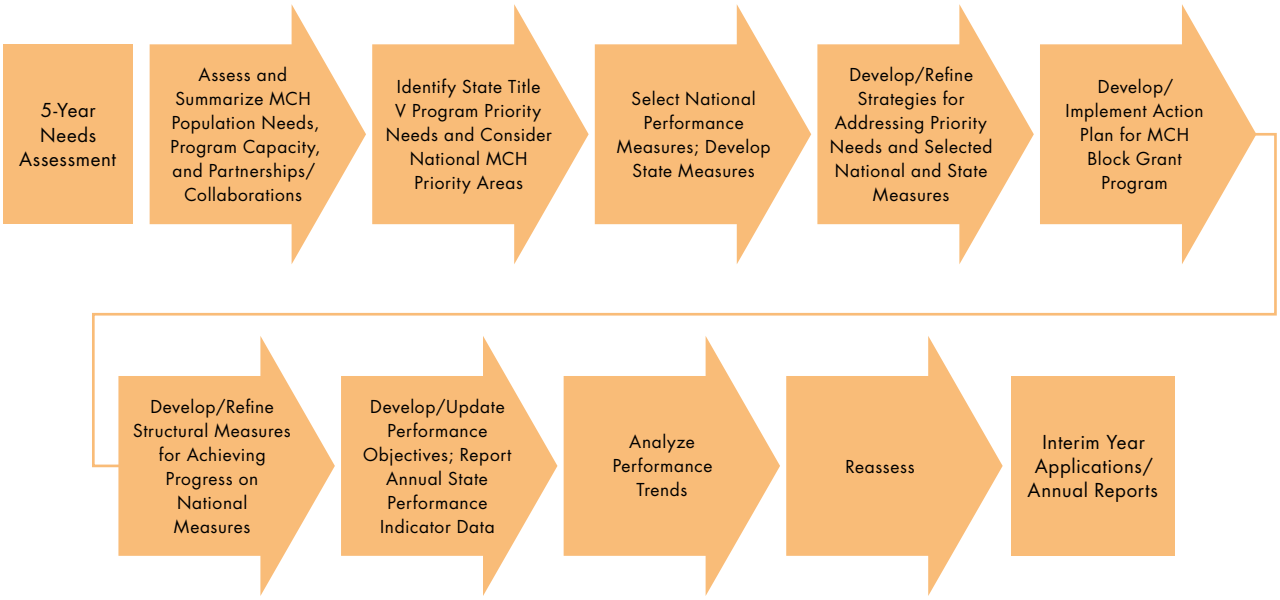
COMMUNITY NORMS Addressing community norms that have created a stigma that is a barrier to people accessing needed services



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

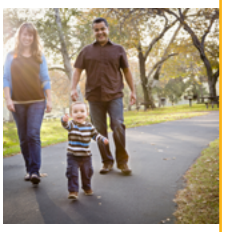
**KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas, KAAP is willing to assemble individuals 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

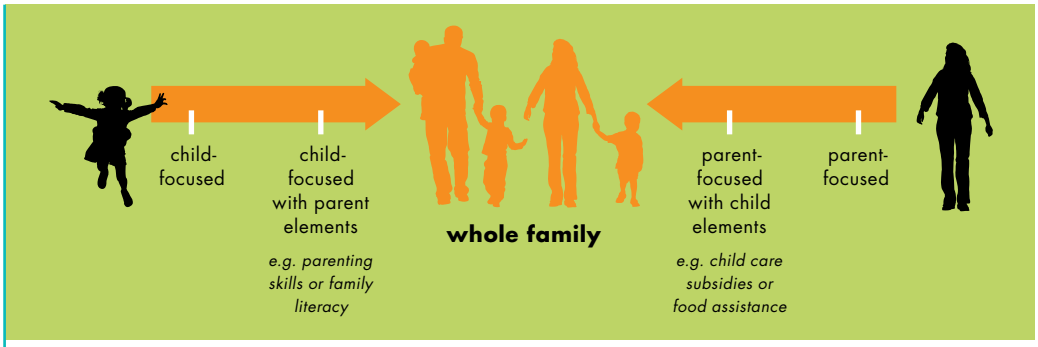
Methodology

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.

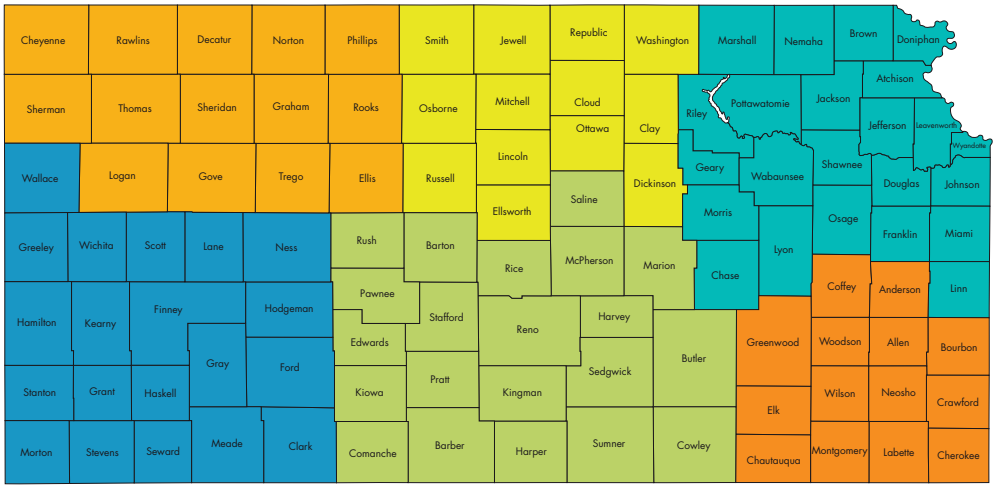
Quantitative indicators were compiled and presented at regional meetings to stakeholders and partners and much of the discussion toward specific needs for each MCH domain came from sharing this data. Limitations were noted as data were disseminated. Data sources included, but not limited to:

- 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

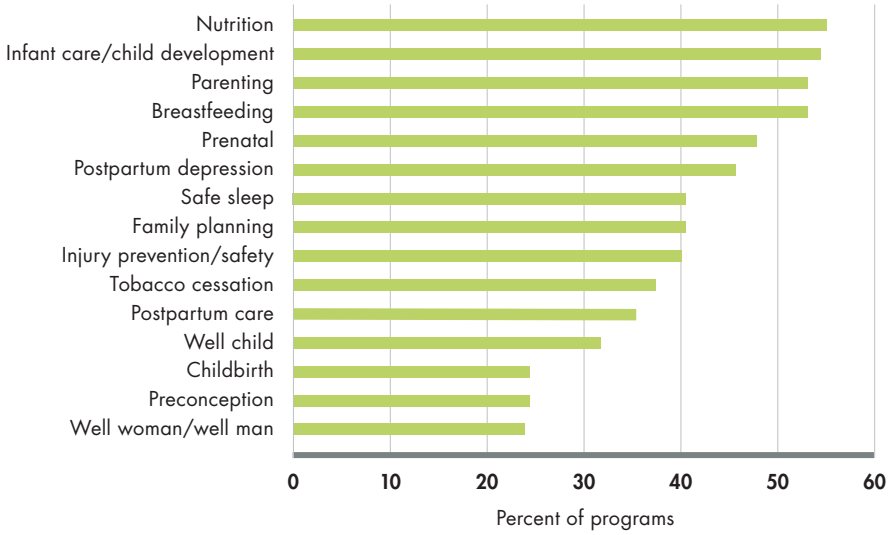
- Review the AMCHP Birth Outcomes Compendium, including the Health Impact Pyramid within, and come prepared to discuss recommendations/actions to be considered for your community.
- Review the Stanford Social Innovation Review on Collective Impact.
- Review the Kansas MCH Block Grant Website.
- Optional: 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)

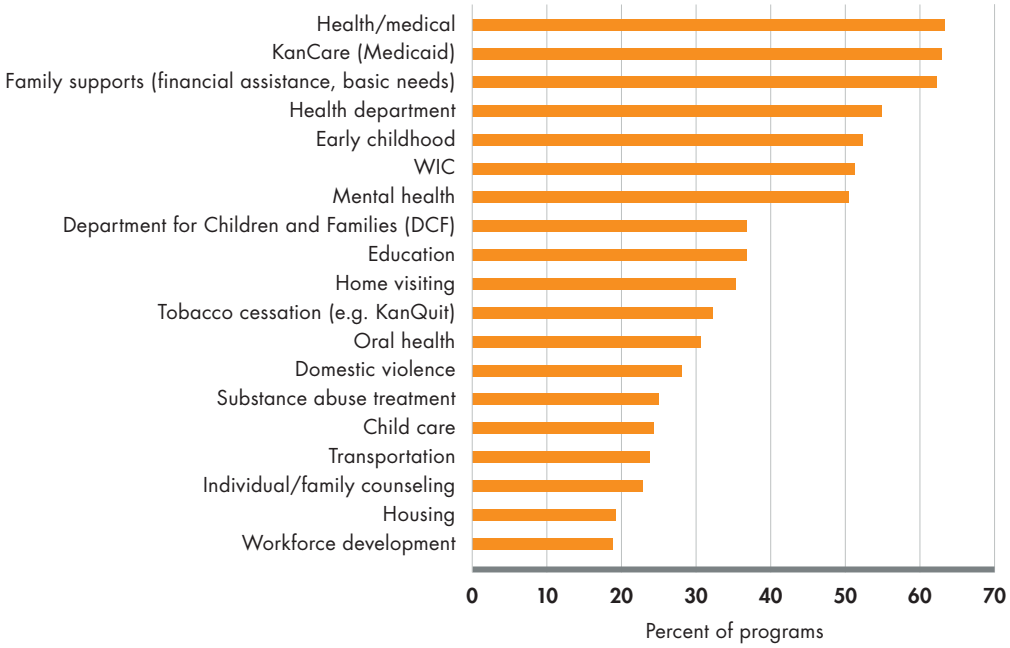


As expected in a survey of public health partners, there is a distribution of programs across the Health Impact Pyramid, with a balance along the continuum of direct services through systems change efforts. In discussions at the regional meetings, participants expressed some confusion about the utility 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.

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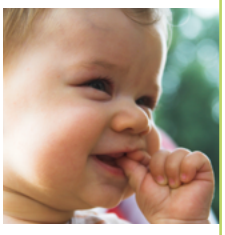


Building on Current Infrastructure and Successes

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.

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

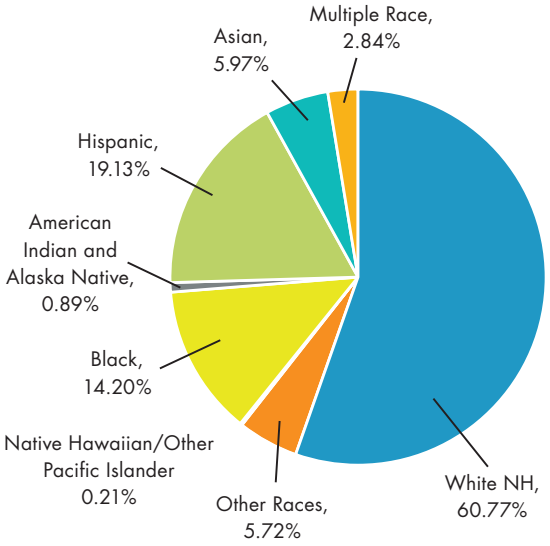
Objective 1.1 All women age 15-44 who access Title V services will receive prenatal risk assessments and well-woman visits at least once annually in order to reduce birth complications and risks, while improving women's health

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

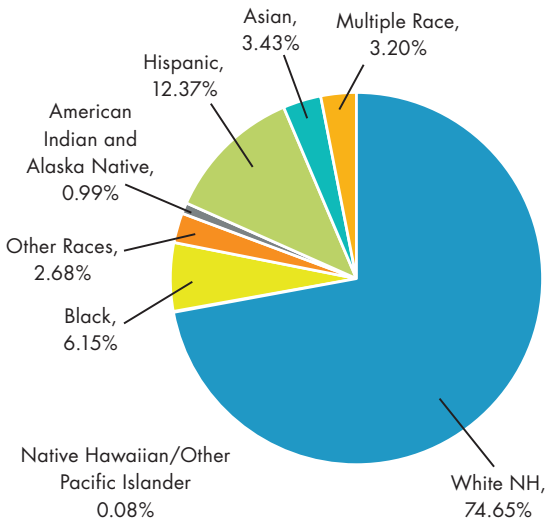
Objective 1.3 There will be an increase in access to services through supplemental resources provided throughout the community to promote education, screening, referral, and treatment for women and families

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

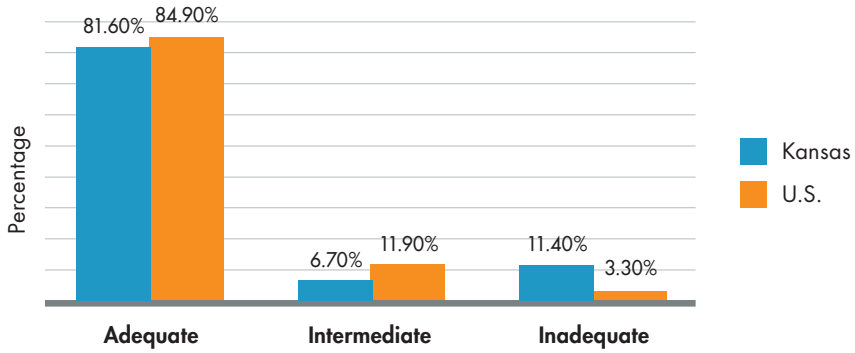


Women (ages 15-44) by race and ethnicity Kansas, 2013

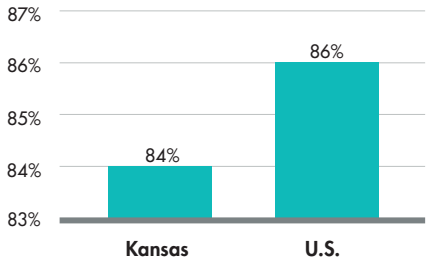


Prenatal care utilization 2013

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

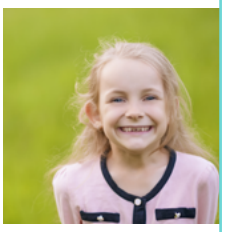
Services and supports promote healthy family functioning. **(Cross-Cutting)**

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

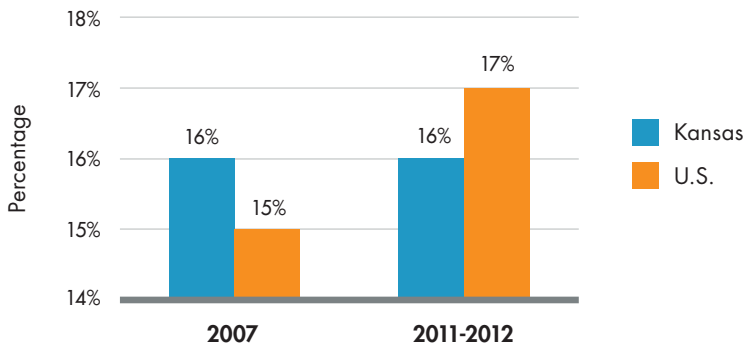
Objective 2.3 Increase client access to services through coordination of home visiting programs and expanding services through informing and referring families to services in order to ensure proper linkage



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

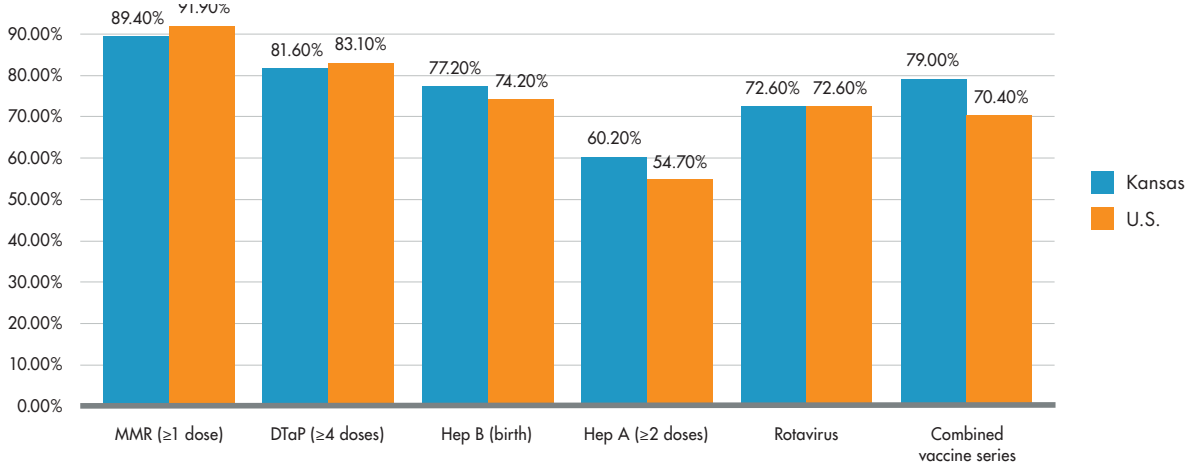
Objective 3.3 Multi-sector (individual, health care and social service providers, community-based organization) approaches are in place to reduce annual SIDS and SUID rates

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

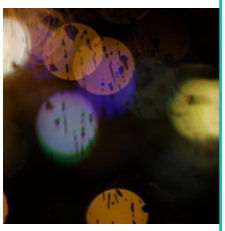
Objective 3.5 All children receive an age appropriate developmental screening annually with a valid and reliable tool

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

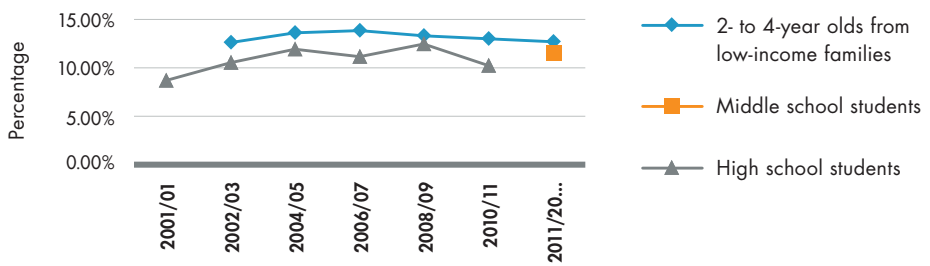
Objective 4.1 Children and adolescents ages 0-17 years old and older have access to healthy foods and increased knowledge of opportunities for physical activity in order to adhere to and achieve optimum lifelong health

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.

Children and adolescents obesity rate in Kansas



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)**

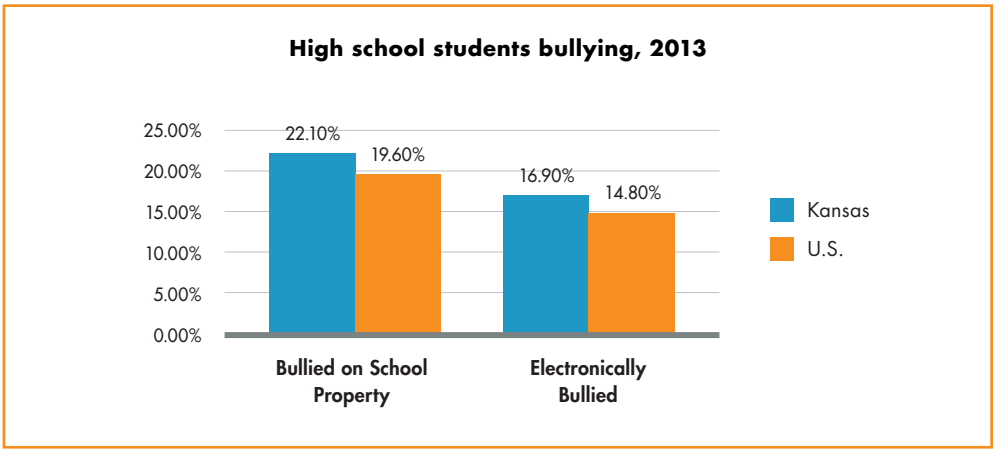
Goal. Enhance the health of all adolescents in Kansas across the lifespan

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

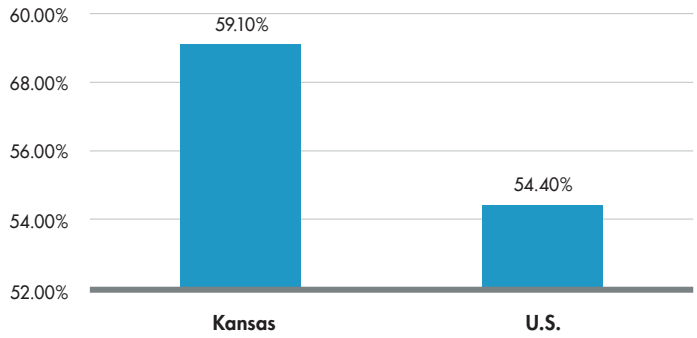
Objective 7.1 By supporting collaborative efforts of partners (MCO's, primary care providers) toward the timely implementation of a family-centered medical home to help with coordination of care, communication and outreach improves among service providers, individuals, and families

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

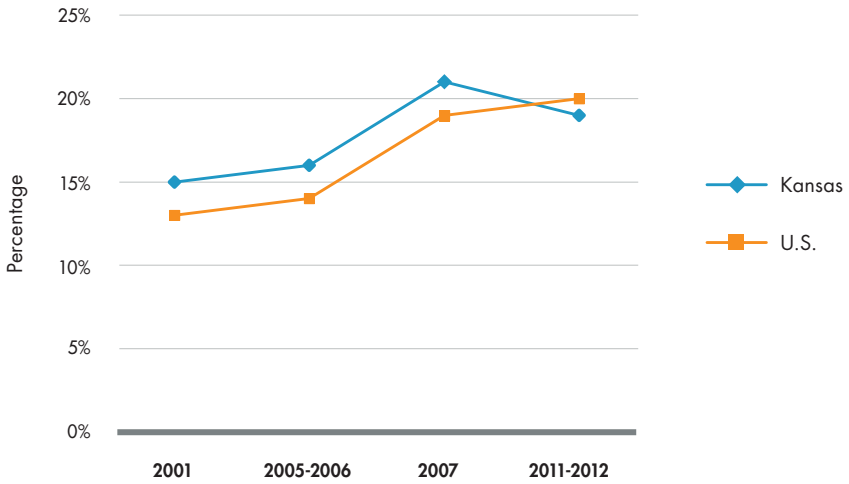
Objective 7.3 A patient-centered action plan that assists and empowers individuals and families is developed, monitored, and evaluated to help navigate systems for optimal health out¬comes throughout the life course

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.

Children (0-17) with medical home, 2011



Children with special health care needs



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.